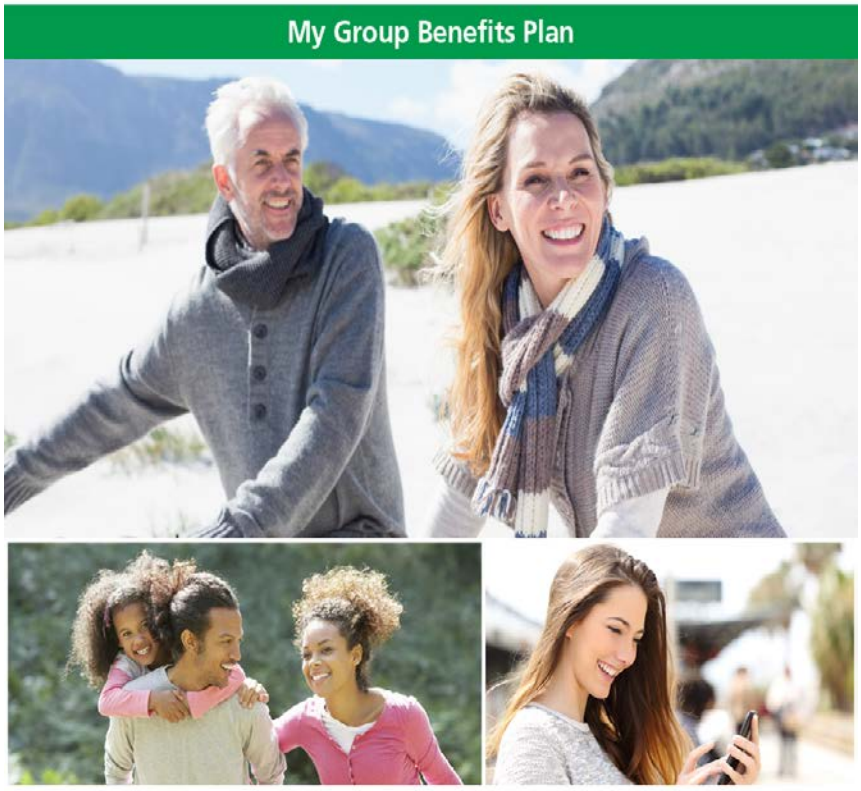
THE Great-West Life ASSURANCE COMPANY



Kruger Products

New Westminster - Active Union Employees

BENEFIT DETAILS

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

Great-West Life Online

Visit our website at www.greatwestlife.com for:

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

Great-West Life Online Services for Plan Members

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

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

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

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

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

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

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

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

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

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

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-866-408-0212.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 154850** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail.

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

The Plan is underwritten by

THE Great-West Life ASSURANCE COMPANY

This booklet was prepared on: April 25, 2018

Access to Documents

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

Legal Actions

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

Appeals

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

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

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

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

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

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

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

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

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

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Benefit Summary

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

Employee Life Insurance

Effective May 1, 2018	$110,370
Effective May 1, 2019	$112,580
Effective May 1, 2020	$114,840

Short Term Disability Income Benefits

Waiting Period *

Injury	No waiting period
Disease/Sickness	3 days 1 day if the disease/sickness requires kidney analysis, chemotherapy, radiation or other similar recurring treatments If you are hospitalized or have day surgery before the last day of the waiting period for disease/sickness, benefits will begin on the day you are hospitalized or the surgery is performed

* You should consult your physician within the first five days of disability

Maximum Benefit Period	52 weeks
Amount	62% of your weekly earnings to a maximum benefit of:
- effective May 1, 2018	$1,020;
- effective May 1, 2019	$1,050; and
- effective May 1, 2020	$1,080.

Long Term Disability Income Benefits

Waiting Period	52 weeks from original date of disability
Amount	50% of your monthly earnings to a maximum benefit of $7,500
	Any amount of LTD insurance over $5,000 is subject to approval of evidence of insurability

Healthcare

Covered expenses will not exceed customary charges

Deductibles

Individual	$40 each calendar year
Family	$60 each calendar year

The individual and family deductibles do not apply to In-province Private Hospital, Chronic Care, Out-of-province Care and Global Medical Assistance expenses

Reimbursement Levels

In-province Semi-Private Hospital, Chronic Care, Out-of-province Care and Global Medical Assistance Expenses	100%
All Other Expenses	80% until $4,000 of benefits have been paid to you and your dependents in a calendar year and 100% for the remainder of the calendar year

Basic Expense Maximums

In-province Hospital	Private room
Convalescent Hospital	Semi-private room
Home Nursing Care	720 hours each calendar year
Chronic Care	Semi-private room $25 per day
In-province Prescription Drugs	Included
Hearing Aids	$600 every 2 years
In-province Ambulance	$500 each calendar year
Custom-fitted Orthopedic Shoes	1 pair every 12 months for a maximum of $400 per pair
Custom-made Foot Orthotics	$300 each calendar year
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 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	Included
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	$100 each calendar year

Wigs or Hairpieces for Patients suffering from Cancer or Alopecia	$500 lifetime
Intra-uterine Devices	Included
Out-of-province Non-emergency Care	$50,000 lifetime
Out-of-province Care (Emergency and Non-emergency combined)	$1,000,000 lifetime

Paramedical Expense Maximums

Acupuncturists	$150 per person each calendar year
Chiropractors, Naturopaths and Occupational Therapists	$350 combined each calendar year
X-rays for treatment by a Chiropractor	$10 per person each calendar year
Massage Therapists	$325 per person each calendar year
Osteopaths	$150 per person or $500 per family each calendar year (including $10 per person for x-rays each calendar year)
Podiatrists	$150 per person or $500 per family each calendar year (including $10 per person for x-rays each calendar year)

Physiotherapists	$325 per person each calendar year
Psychologists	$350 per person each calendar year
Speech Therapists	$100 per person each calendar year
Visioncare Expense Maximum	
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery	$450 every 24 months
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	90%
Major Coverage	50%
Orthodontic Coverage	50%
Plan Maximums	
Orthodontic Treatment	$4,000 lifetime
All Other Treatment	Unlimited

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 40 days of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

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

  You may waive health and dental coverage if you are already covered for these benefits under your spouse's plan. If your coverage under your spouse's plan terminates, you must apply for coverage under this plan no later than 60 days after termination. After 60 days, you must provide evidence of insurability for you and your dependents before you can participate. Your dental benefits will be subject to certain restrictions.

- 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. No change will take effect during a disability period, except for changes to the inflation protection of the long term disability income benefit or the following changes which may occur during the long term disability waiting period:

  - changes in earnings
  - changes to the maximum of the short term disability income benefits
  - changes to the life insurance amount

- Temporary, part-time and seasonal employees may not join the plan.

Your coverage for healthcare and dentalcare insurance terminates on the last day of the month in which your employment ends, or when you are no longer eligible, or the policy terminates, whichever is earliest.

Your coverage for any other insurance terminates when your employment ends, or when you are no longer eligible, or the policy terminates, whichever is earliest.

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

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

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

Survivor Benefits

If you die while your coverage is still in force:

- the health benefits for your dependents will be continued for a period of 24 months;and
- the dental benefits for your dependents will be continued for a period of 12 months,

or until they no longer qualify, whichever happens first, provided they have no other coverage

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.

BENEFICIARY DESIGNATION

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

EMPLOYEE LIFE INSURANCE

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

- If you become disabled while insured, Great-West Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

- If any or all of your insurance terminates, 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.

SHORT TERM DISABILITY (STD) INCOME BENEFITS

The plan provides you with benefits to replace income lost because of a disability due to disease/sickness or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled, until the end of the benefit period, until the date you reach age 65 or until you retire, whichever comes first. However, if disability began prior to age 65, STD benefits will continue until you have received at least 15 weeks of benefits, or until you are no longer disabled or retire, whichever comes first.

Check the **Benefit Summary** for the benefit amount, waiting period and benefit period.

- STD benefits are payable after the waiting period if disease/sickness or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

- Benefits will not be payable until after your first visit to the physician. However, if you consult your physician within the first five days of disability, benefits will be payable at the end of the waiting period.

- Separate periods of disability arising from the same disease/sickness or injury are considered to be one period of disability unless they are separated by at least 2 weeks of continuous full-time work.

- Because your employer contributes to the cost of STD coverage, benefits are taxable.

Other Income

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

- disability benefits you or another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts

- benefits under any Workers' Compensation Act or similar law

- to the extent permitted by law, loss of income benefits payable under a provincial or territorial automobile insurance plan that does not take income benefits payable under the Employment Insurance Act (Canada) into account when determining its benefits

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

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

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

Limitations

No benefits are paid for:

- Any period:

  - preceding the date you are first treated by a legally licensed doctor of medicine; or
  - in which you do not participate or cooperate in a reasonable and customary treatment program.

  A reasonable and customary treatment program is systematic treatment:

  - that is performed or prescribed by a legally licensed doctor of medicine or other health care provider or health care facility;
  - that is of the nature and frequency usually required for the condition involved; and
  - where attendance, participation and progress can be verified through medical records.

  Notwithstanding the above, based on the nature or severity of the condition, for a treatment program to be considered reasonable and customary, Great-West Life may:

  - require you to be under the care of a legally licensed doctor of medicine instead of or in addition to another health care provider or health care facility; and
  - require the treatment program to be prescribed, performed or supervised by a legally licensed doctor of medicine certified as a specialist for the condition involved.

  If the use of drugs or alcohol contributes to your disability, the treatment program must be overseen by a legally licensed doctor of medicine and the treatment program’s primary goal must be abstinence, unless otherwise approved by Great-West Life.

- The scheduled duration of a lay-off or leave of absence. However, if disability began prior to notice of lay-off, STD benefits will continue until you have received at least 15 weeks of benefits or until you are no longer disabled or retire, whichever comes first.

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

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

- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- The normal recovery period for treatment performed for cosmetic purposes only. This limitation does not apply where such treatment was undertaken as a result of a disease or injury.

- Any period of confinement in a prison or similar institution.

- Disability arising from war, insurrection or voluntary participation in a riot.

- Any claim submitted more than 90 days after the onset of your disability.

- Any period during which you are receiving long term disability benefits under the recurrence provision of your employer's long term disability plan.

- Any statutory holiday paid to you by your employer.

How to Make a Claim

Notify your employer of your disability as soon as possible.

- To submit claims online, go to www.greatwestlife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M5454) and follow the guide's instructions.

  You can get this form from your employer, or online from the Great-West Life corporate website. To access the form online, go to www.greatwestlife.com.

Please ensure that your claim is submitted to Great-West Life within 10 days after the onset of your disability.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease/sickness or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 60 (if you have less than 11 years of service) or age 65 (if you have 11 years or more of service), whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease/sickness or injury. If your STD benefits are still being paid when the waiting period ends, the waiting period will be extended until the end of the STD benefit period, but not later than one year after your disability started.

- LTD benefits are payable for the first 18 months following the waiting period if disease/sickness or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

- After 18 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

- After the waiting period, separate periods of disability arising from the same disease/sickness or injury are considered to be one period of disability unless they are separated by at least 6 months.

- Because your employer contributes to the cost of LTD coverage, benefits are taxable.

- If you have less than 11 years of service, your LTD insurance terminates when you reach age 60. If you have 11 years or more of service, your LTD insurance terminates when you reach age 65.

Other Income

Your LTD benefit is reduced if the total of it and the other income you are entitled to receive while you are disabled exceeds 80% of your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount. However, your LTD benefit will never be lower than $25 per month. Other income includes:

- disability benefits you or another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you

- retirement benefits under the Canada or Quebec Pension Plan

- benefits under any Workers' Compensation Act or similar law

- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

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

- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

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

Inflation Protection

If you become disabled on or after October 3, 2008 and still disabled at the recalculation date and are under 60 years of age, the income benefit will be multiplied by the cost-of-living percentage described as follows:

Effective May 1, 2017	2.0%
Effective May 1, 2018	2.0%
Effective May 1, 2019	2.0%
Effective May 1, 2020	2.0%

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

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

Limitations

No benefits are paid for:

- Disability arising from a disease/sickness or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease/sickness or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

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

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

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a leave of absence.

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

- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- Any 12-month period in which you do not live in Canada for at least 6 months.

- Any period of confinement in a prison or similar institution.

- Disability arising from war, insurrection, or voluntary participation in a riot.

How to Make a Claim

Before the end of the short term disability benefit period, Great-West Life will ask your employer to provide information to begin processing your LTD claim. All information must be submitted within 6 months of the request.

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

Covered Expenses

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

- Private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided the province of residence and the treatment received is acute, convalescent or palliative care.

    - Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

    - Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.

    - Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

    The plan also covers the hospital facility fee related to dental surgery.

The plan also covers confinement in a convalescent care hospital provided that it occurs within 48 hours following discharge from an active unit in a public hospital and is required for at least 5 consecutive days.

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

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

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

- 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. Confinement in a chronic care hospital provided that it occurs within 48 hours following discharge from an active unit in a public hospital and is required for at least 5 consecutive days.

- Drugs described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in your home province. Benefits for drug expenses outside your home province are payable only as provided under the out-of-province care provision.

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives

  - Injectable drugs and syringes for self-administered injections

  - Certain life-sustaining drugs. If you have any questions, contact your plan administrator before incurring the expense.

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

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician

- Diabetic supplies, including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets, when 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

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

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

  No benefits are paid for:

  - accidental damage to dentures

  - dental treatment completed more than 12 months after the accident

  - orthodontic diagnostic services or treatment

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a qualified occupational therapist
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment by a registered psychologist
- Out-of-hospital treatment of speech impairments by a qualified speech therapist

Visioncare

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

Global Medical Assistance Program

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

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

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

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

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

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

Out-Of-Province Care

- **Emergency care** outside your home province is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside your home province for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

  A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease/sickness that could not have been reasonably anticipated based on the patient's prior medical condition.

  Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

  If your condition permits a return to your home province, benefits are limited to the lesser of:

  - the amount payable under this plan for continued treatment outside your home province, and

  - the amount payable under this plan for comparable treatment in your home province plus the cost of return transportation.

  No benefits are paid for:

  - any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency

  - any subsequent and related episodes during the same absence from your home province

- expenses related to pregnancy and delivery, including infant care:

    - after the 34th week of pregnancy, or
    - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

- **Non-emergency care** outside your home province is covered for you and your dependents if:

    - it is required as a result of a referral from your usual physician in your home province

    - it is not available in your home province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties

    - you are covered by the government health plan in your home province for a portion of the cost, and

    - a pre-authorization of benefits is approved by Great-West Life before you leave your home province for treatment.

    No benefits will be paid for:

    - investigational or experimental treatment

    - transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-province care:

- 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 your home province
- drugs
- out-of-hospital services of a professional nurse
- for emergency care only:
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in your home province.

Limitations

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

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

  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable 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 and intrauterine devices (IUDs)
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates

- Services or supplies received outside Canada except as listed under Out-of-Province Care and Global Medical Assistance

- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance

- Expenses arising from war, insurrection, or voluntary participation in a riot

- Visioncare services and supplies required by an employer as a condition of employment

- Any drug or item which 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

- Homeopathic preparations, unless federal or provincial legislation requires a prescription for their sale

- Food products, weight-loss products and drugs prescribed for the treatment of obesity

- Vaccines used to prevent disease/sickness

- Smoking cessation products

- Fertility drugs, whether or not prescribed for a medical reason

- Drugs used to treat erectile dysfunction

How to Make a Claim

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

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

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

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

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

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

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

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

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

DENTALCARE

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

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

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

Treatment Plan

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

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination every 36 months
  - limited oral examinations twice every 12 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations twice every 12 months
  - complete series of x-rays every 36 months
  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 24 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing and topical application of fluoride each twice every 12 months
  - scaling, limited to a maximum combined with periodontal root planing of 16 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - pit and fissure sealants on bicuspids and permanent molars once per tooth every 24 months
  - space maintainers including appliances for the control of harmful habits
  - finishing restorations

- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth
  - gold foil restorations when used to repair existing gold restorations
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 16 time units every 12 months
  - gingivectomy, limited to once every 5 years per site
  - 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
  - periodontal appliances once every 5 years

- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 24 months
    - denture rebases for dentures at least 2 years old, once every 24 months
    - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
- Oral surgery
- Adjunctive services

Major Coverage

- 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

  Replacement crowns, onlays and inlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable
- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
    - the existing appliance is a covered temporary appliance

- the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

- Denture-related surgical services for remodelling and recontouring oral tissues

- Denture and bridgework maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 months

  - denture adjustments, once every 12 months

  - denture repairs and additions, tissue conditioning and resetting of denture teeth

  - repairs to covered bridgework

  - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Limitations

No benefits are paid for:

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

- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants

- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations

- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

- Crowns, onlays, inlays or gold foil restorations if the tooth could have been restored using other procedures. If crowns, onlays, inlays or gold foil restorations are provided, benefits will be based on coverage for fillings.

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

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

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

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

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

- Expenses covered under another group plan's extension of benefits provision
- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare
- Expenses private plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage
- Services or supplies that do not represent reasonable 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

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

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

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.