THE
Great-West Life
ASSURANCE COMPANY

My Group Benefits Plan

HEALTH ASSOCIATION NOVA SCOTIA

Active Employees

Policy No. 58528

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Benefit Details

This booklet describes the principal features of the group benefit Plan sponsored by **Health Association of Nova Scotia (HANS)**, but **Plan Document No. 58528** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the Plan Document, the Plan Document will prevail.

The information contained in this booklet summarizes the important features of your group program; is prepared as information only; and does not, in itself, constitute an agreement. The information contained in this booklet is important, and we suggest it be kept in a safe place. This booklet replaces any previously issued booklet.

Great-West Life administers the following benefits on behalf of Health Association of Nova Scotia:

- Dental Benefit
- Drug Benefit
- Extended Health Benefit
- Hospital Benefit
- Vision Benefit

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

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.

What to use for Plan and ID numbers:

- Above the name on your pay direct drug card is a number; here is an example:

  11 0**58528** 0000**012345** 01

  The two digits at the beginning and the two at the end are only required for drug claims at the pharmacy. For purposes of identifying your Plan Number and ID they can be ignored.

  For the Plan Number, use the 58528 number.

  For the ID number, refer to the ten digit number following the Plan Number (in the example above, the ID number is 0000012345). For this field on the system, enter all of the numbers except any zeros at the beginning.

  The final two digits (01 in the example), identify the current issue number of the card. The issue number changes if your card is replaced due to its being lost or stolen. Please notify your pharmacist of any new issue number.

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

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Extended Health Benefit, Vision Benefit and Dental Benefit sections of this booklet
- extensive health and wellness content

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

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

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

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

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

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

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

Great-West Life's Toll-Free Number

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

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

Health Association of Nova Scotia has an agreement with Great-West Life to process claims. Great-West Life may exchange personal information with your health care providers, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the Plan.

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

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

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

ASO (Administrative Services Only) Provider

Health Association of Nova Scotia has contracted The Great-West Life Assurance Company to adjudicate claims and issue payment for eligible claims to the appropriate party. The Plan is self insured and Great-West Life has no liability for any benefits outlined in this booklet.

Legal Actions

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

Appeals

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

Benefit Limitation for Overpayment

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

Eligibility for Coverage

To be eligible for Health or Dental benefits, you must be a permanent employee or long assignment casual employee who is a resident of Canada, covered under your provincial government plan, actively at work and working 40% or more of a regular work week, minimum of 14 hours per week on a regular basis and have completed the Plan waiting period. The waiting period for your group Plan is following 30 days from the date of hire or meeting the above criteria.

You may elect coverage, within 31 days of becoming eligible following the waiting period, by completing an application. Coverage is effective on the date of eligibility, except when:

(a) you are not actively at work on the day that coverage would otherwise become effective, or
(b) the application is made after the 31 day period. If coverage is not applied for within this 31 day period, late limitations will apply.

If not actively at work when you would normally have become eligible, your coverage will commence when you return to work.

Eligible Dependents

Dependents are defined as your legal spouse (as described below), and unmarried dependent children including natural, legally adopted or step-children. Children of a common-law spouse may be covered if they are living with the employee. All dependents must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

The term “spouse” is defined as a person of the opposite or same sex who is legally married to the employee, or has continuously resided with the employee for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation (common law spouse), you may elect to continue coverage of the former spouse or to provide notice to Health Association of Nova Scotia to terminate coverage for the spouse. Coverage may continue with or without a court order. The Plan will at no time provide coverage for more than one spouse under the same Plan.

Dependent children are eligible for benefits if they are less than 21 years of age or, if 21 years of age but less than 26 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

Unmarried children 21 years of age or older qualify if they are dependent upon the employee by reason of a mental or physical disability and have been continuously so disabled since the age of 21. Unmarried children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to the age of 26 and have been continuously disabled since that time also qualify as a dependent.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, late limitations will apply.

Late Applicant

When an employee and/or dependent become eligible for benefits, the group enrolment form must be received by the Employer within 31 days of their eligibility date. If this form is received after 31 days, the employee and/or dependent will be considered a late applicant and coverage will be limited to the following benefits for the first six months following the effective date of coverage:

- Eye Refraction only,
- Prescription Drug Benefit, and
- Recall examinations, bite-wing x-rays, fluoride application, one time unit each of scaling (cleaning) and polishing.

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.

  Reimbursement under this Plan for Dental Claims will not exceed the Dental Fee Guide or Specialist Fee Guide in effect on the date treatment is rendered for the province in which treatment is rendered.

Termination of Benefits

All benefits cease at the earlier of retirement or termination of employment or upon death of the employee, or when you no longer qualify for coverage.

Prescription drug coverage for the employee and/or dependents, ceases upon attainment of age 65 years.

Except to the extent otherwise required by law, your dependents' coverage terminates on the earliest of the following dates:

- the date your coverage terminates;
- the date you cease to be a qualified employee;
- for prescription drug coverage for your spouse, the date your spouse reaches age 65;
- the date you cease to be in a class eligible for dependent coverage;
- the date your dependent ceases to be a qualified dependent; or
- for your spouse, the day before the effective date of a change to a new covered spouse.

Survivor Benefits

If you die while your coverage is in force, the health and/or dental benefits for your dependents will be continued for a period of 30 days or until they no longer qualify, whichever occurs first.

Conversion Privilege

If you should terminate employment, you may convert to an individual Health and/or Dental Plan. Please contact your Benefits Department for further information within 31 days following your termination.

Prior Authorization of a Claim

In order to determine whether coverage is provided for certain services or supplies, Great-West Life maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to www.greatwestlife.com.

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Great-West Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Great-West Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Great-West Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Great-West Life has recommended or approved health case management, Great-West Life can require that a service or supply be purchased from or administered by a provider designated by Great-West Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Great-West Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Great-West Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Great-West Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Great-West Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Great-West Life requires participation, Great-West Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Claims for expenses for paramedical services, vision and dental benefits**, 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 claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain a form from your employer. Complete this form making sure it shows all required information. For dental claims, have your dental service provider complete the form.

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 12 months after you incur the expense.

  Great-West Life Assurance Company
  London Health and Dental Benefit Payment Office
  P.O. Box 5160, Stn B
  London, ON N6A 4K1
  Toll Free: 1-800-957-9777

- **For drug claims**, Great-West Life will issue a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

Direct Billing to Provider – Assignment of Benefits

Benefits will be issued to the employee unless you choose to assign benefits to the service provider. This method of payment is valid only if assignments to the service provider are acceptable according to the Plan Administrator's practices at the time of claim.

Hospital Benefit

This benefit is designed to supplement your government hospital insurance plan which provides coverage at the standard ward level only. The following services are covered under your Health Association of Nova Scotia Health Benefit.

If you (or your dependents, if applicable) incur charges in Canada for any of the following while covered, the Plan will pay reasonable and customary charges for these eligible expenses, based on any deductible, reimbursement level or maximum amount shown below. Benefit maximums are applied on a per person basis.

Reimbursement Level: 100%.

Hospital Room: The difference between standard ward accommodation and semi-private room accommodation.

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

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

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

When and How to Make a Claim

Hospital benefit is paid directly to the hospital by providing your identification card. The hospital will arrange to bill Great-West Life directly.

Claims must be submitted within 12 months of receiving services or supplies. No claims will be paid by the Plan after the termination date of this Plan.

Drug Benefit

Co-payment: An amount equal to the dispensing fee portion of the drug charge, to a family maximum of $492 per calendar year*

If you purchase drugs from a provider designated by the plan administrator as a part of Prior Authorization or Health Case Management, you will not be required to pay the dispensing fee portion of the drug charge.

Reimbursement Level: 100% of the remaining eligible expense (subject to enhanced generic substitution).
Unless medical evidence is provided to the plan administrator that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable drug.

Method of payment: paid directly to the pharmacy.

Includes prescription drug items approved by Great-West Life and certain over-the-counter items that are considered life-sustaining in nature and that are approved by Great-West Life.

Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada.

- 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 antihistamines and contraceptive drugs and products containing a contraceptive drug.

- Drugs that must be injected including vitamins, insulin, antigens and allergy extracts. Syringes for self-administered injections are also covered.

- Diabetic supplies: Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, sensors for flash glucose monitoring machines, and insulin infusion pump supplies. For employees age 65 and over, these diabetic supplies are covered under the Extended Health provision.

- Drugs used to treat erectile dysfunction:$250 each calendar year.

- Specially made preparations or compounds if one of the ingredients is a covered drug.

- Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your Plan Administrator before incurring the expense.

Unless medical evidence is provided to the plan administrator that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable drug.

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

Allergy Serums, Antigens, Antihistamines

* Deductible and Maximum**:**	A $50 deductible per person per calendar year will be applied to each benefit with a maximum family deductible of $150 per calendar year. Allergy serum is limited to a $1,000 maximum per person per calendar year.

Charges for allergy serums, antigens and antihistamines obtained on the written prescription of a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada.

Drug Benefit General Exclusions & Limitations

- The quantity of each separate prescription order or refill shall not exceed a maximum of one hundred (100) days' supply, unless prior written authorization is obtained from Great-West Life.

- A Participant is not entitled to an additional supply of a prescription drug either as an original prescription or refill during any period covered by a previously dispensed prescription for the same drug unless necessitated by a change in dosage.

- Authorized prescription refills are covered provided they are dispensed within one year from the date of the original prescription. Thereafter, a new prescription from a person entitled by law to prescribe them is required.

- When, in the opinion of Great-West Life, quantities of prescription drugs excessive to normal requirements are requested or obtained, or refills are requested or obtained at intervals more frequent than deemed acceptable, Great-West Life may limit coverage to the approved quantities or frequencies of prescription refills or limit access to a provider selected by Great-West Life.

- The Plan will not pay charges for prescription drugs exceeding the charges which would be paid directly to a Direct Payment Provider for the same prescription drugs.

- At Great-West Life's sole discretion, coverage may be limited to prescription drugs dispensed by a Great-West Life Approved Provider.

- Prescription drug benefits cease when the participant reaches the age where they become eligible for the government provided drug benefit program.

No benefits are paid for:

- Drugs or drug supplies that appear on an exclusion list maintained by the plan administrator. The plan administrator may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseased or injuries or the stages or progressions of specific diseases or injuries. The plan administrator may add or remove a drug or drug supply from an exclusion list at any time.

  For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

  - the plan administrator determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or

  - the plan administrator determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

- Any drug that is not dispensed in compliance with federal or provincial legislation governing the prescribing and dispensing of drugs.

- Vaccines, biological or immunological products including allergy serums compounded in a lab and not bearing a Drug Identification Number (DIN).

- Fertility drugs, anti-obesity drugs and smoking cessation products.

- Homeopathic and naturopathic medications, nutritional supplements or herbal remedies.

- Experimental drugs, research drugs, or drugs available through the Emergency Drug Release Program.

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment (may be eligible under the Extended Health benefit).

- Non-disposable insulin delivery devices or spring loaded devices used to hold lancets (may be eligible under the Extended Health benefit).

- Delivery or extension devices for inhaled medications (may be eligible under the Extended Health benefit).

- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or nutrition solutions related to intravenous feeding.

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.

- Preventative immunization vaccines and substances used in immunization.

- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.

- Diaphragms, condoms, contraceptive jellies, foams, sponges, or suppositories, contraceptive implants, or appliances normally used for contraception, whether or not prescribed for a medical reason.

- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada. This limitation does not apply to any product with a natural health product number.

Extended Health Benefit

A deductible may be applied before you are reimbursed. Benefits may be subject to Plan maximums and frequency limits.

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

If you are a late applicant, the Extended Health Benefit coverage for you and your dependents will be limited during the first 6 months of coverage. See the Eligibility for Coverage (page 6) and Late Applicant (page 7). See the Termination of Benefits section for information on when your coverage, or that of your dependents, ceases.

Accidental Dental

Dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered or reported and approved for payment by the Plan Life within 12 months following the date of the accident, unless delayed by a medical condition, provided your coverage remains in force. Please contact Great-West Life for additional information.

No benefits are paid for:

- accidental damage to dentures, or
- orthodontic diagnostic services or treatment.

Ambulance Services

Charges for professional ground ambulance services required to transport a stretcher patient to or from the nearest hospital able to provide essential care when, due to the medical condition of the person, no other form of transportation can be utilized.

Limitation: Where a government program or plan for ambulance services exists, coverage will be limited to ambulance user fees applicable under such government program or plan. For ambulance services that are a result of a workplace incident, the maximum for each Participant is limited to $750 per incident.

Exclusion: Charges for transportation to and from scheduled appointments and transportation home from the hospital.

Emergency Transportation: Charges for emergency transportation by air, rail or water from an area not serviced by regular licensed professional ground ambulance to the nearest hospital or medical facility able to provide the required care when the urgency of the situation requires that only such form of transportation will be adequate.

Benefit includes the cost of return transportation for a Registered Nurse when it is medically necessary for a Registered Nurse to accompany the participant. Charges up to $500 per participant for any one emergency illness or accident shall be considered covered expenses.

Braces, Cervical Collars, Splints (including shoes attached to a splint), Traction Devices and Trusses

- Dependent children under age 18 — $400 each calendar year
  Cervical collars are further limited to 1 every 12 consecutive months
- All others — $300 each calendar year
  Cervical collars are further limited to 1 every 12 consecutive months
  (Trusses are further limited to 1 every 60 consecutive months)

Repairs to Braces, Cervical Collars, Splints and Trusses

- Dependent children under age 18 — $400 each calendar year
- All others — $300 each calendar year

Replacement prior to the eligible time period must be due to pathological or physiological change.

Burn Pressure Garments

Special, made-to-measure dressings when prescribed by a physician for burn patients.

Communication Aids

- Hearing aids, including tubing, and ear molds provided at the time the hearing aid is purchased. The maximum amount payable every 3 calendar years is $1,000.

- Phonic ear auditory (FM) systems are covered for dependent children only, to a lifetime maximum of $1,000.

- Speech aids, such as Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible. The maximum amount payable is $500 in a person’s lifetime.

Diabetic Supplies

Deductible: None.

Diabetic supplies prescribed by a physician or any other licensed or legislated practitioner. Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms, and insulin infusion sets (not including infusion pumps).

For Plan members under age 65 years, diabetic supplies are purchased via your drug card at your pharmacy. If you choose to pay for your drugs and/or supplies at the pharmacy and then submit a paper claim to Great-West Life, you will only be reimbursed for the amount that you would have received if you had used your card.

For Plan members age 65 years and older, diabetic supplies would be purchased and the claim submitted to Great-West Life via a paper claim submission.

Food Substitutes

Deductible: A $50 deductible per person per calendar year will be applied to each benefit with a maximum family deductible of $150 per calendar year.

Charges for food substitutes required to sustain life, obtained on the written prescription of a physician or any other licensed or legislated practitioner.

Intrauterine Contraceptive Device (IUD)

Maximum: Purchase of one in a calendar year.

Laboratory Testing/X-Rays

Diagnostic services including laboratory tests and/or x-rays in a private laboratory or diagnostic clinic as ordered by a Physician or duly licensed/certified practitioner. Such charges would be in excess of allowances provided under government medical insurance. Any test performed privately when coverage is available under the provincial government plan is excluded.

Excludes: Magnetic resonance imaging and bone density tests are excluded.

Medical Equipment

Maximum: Medical Equipment maximum is $10,000 in a lifetime.

All charges must be pre-approved by Great-West Life with such approval being subject to periodic reassessment. Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every 60 consecutive months to the lifetime maximum, where applicable.

***Medical Equipment and/or Medical Supplies, items listed below may not be an exhaustive list. Contact Great-West Life to determine eligibility OR have a Prior Authorization completed and submitted to Great-West Life to ensure you are knowledgeable of the amount that will be reimbursed.**

***Medical equipment, prescribed by a physician or any other licensed or legislated practitioner:**

- Blood glucose monitoring machines and control solutions.
- Blood pressure monitors.
- Breast feeding pumps..
- Breathing equipment.
- Cervical supports.
- Crutches, canes, walkers and parapodiums.
- Elevated toilet seats and shower chairs.
- Enuresis detection devices.
- Extremity pumps for lymphedema or severe postphlebitic syndrome.
- Flash glucose monitoring machines.
- Hospital beds, bed rails, trapeze bars and traction apparatus. Air-fluidized hospital beds are not covered.
- Insulin infusion pumps.
- Mechanical or hydraulic patient lifters.
- Non-union bone stimulators.
- Prone standers.
- Transcutaneous nerve stimulators for the control of chronic pain (TENS machine).
- Tube feeding pumps and pump sets.
- Wheelchairs, including repairs. Electric wheelchairs necessary to permit independent participation in daily living are included.
- Wheelchair approval is subject to items that are medically necessary (Powered Scooter is not an eligible benefit).
- Wheelchair features required primarily for participation in sports are not covered.
- Rechargeable batteries for eligible wheelchairs.

***Other Medical Supplies**

- Catheters and catheterization supplies.
- Colostomy and ileostomy supplies.
- Custom-made pressure supports for lymphedema.
- Custom-made graduated compression hose with a minimum compression factor of 15 mmgh (Maximum: 2 pairs each calendar year).
- Elastic support hose (Maximum: 2 pairs per calendar year to a maximum of $250 per calendar year).
- Head halters.
- Wigs for cancer patients undergoing chemotherapy (Maximum: $200 each calendar year).

Orthopedic Shoes and Foot Orthotics:

- Orthopedic Shoes – Custom Fitted: $150 maximum every 12 consecutive months for dependents under 18
  $150 maximum every 24 consecutive months for any other person

Charges for custom-fitted orthopedic footwear when the footwear has been customized with special features to accommodate, relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending Physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for footwear modifications, adjustments and supplies when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

Shoes purchased to accommodate orthotics or comfortable walking shoes, such as Nike, Birkenstock, Brooks, Rockport, Allegra, Naot, etc. are not covered.

- Foot Orthotics – Custom made: $150 maximum every 12 consecutive months for dependents under 18
  $150 maximum every 24 consecutive months for any other person

Charges for custom-made foot orthotics to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), on the written authorization of an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending physician.

Claim requirements include:

- copy of the prescription written by an eligible prescribing practitioner indicating:
  - the patient's diagnosis necessitating the use of orthotics
  - a copy of a detailed biomechanical examination
  - a copy of the patient's s stance and gait analysis
  - details of the casting technique used for the patient
- an official receipt issued by the dispensing practitioner which shows:
  - the name and address of provider
  - a detailed description of type of orthotics provided
  - a breakdown of charges for the orthotics
  - the date of full payment for the orthotics
  - the date the product is received

See the information for claim requirements at:

https://groupnet.greatwestlife.com/secureGnPM/bulletins/Orthopedic%20Eng.pdf

Replacements are only covered within 24 consecutive months if they are required as the result of a pathological change.

You should discuss the eligibility with your provider and receive a Pre-Determination from Great-West Life.

Ostomy Supplies

Essential ostomy supplies.

Oxygen

Oxygen and the equipment needed for its administration are covered.

Paramedical Practitioners

Maximum: Up to $1,500 per calendar year for all practitioners combined.

Treatment, including diagnostic x-rays if applicable, by a speech therapist, occupational therapist, massage therapist, clinical psychologist, chiropractor, osteopath, homeopath, physiotherapist, acupuncturist, chiropodist/podiatrist or naturopath.

Practitioners must meet the licensing, registration, or certification in their particular area of practice.

Paramedical expenses are further limited to the following customary amounts (subject to change):

Acupuncturists	$110	per visit
Chiropractors	$ 80	for the first visit
	$ 55	per visit for each subsequent visit
Homeopaths	$125	per visit
Naturopaths	$150	per visit
Occupational Therapists	$ 75	per visit
Osteopaths	$120	per visit
Podiatrists	$ 75	per visit

Excluded: Services performed in hospital.

Private Duty Nursing/ Personal Care

Maximum: $10,000 each calendar year.

Home **nursing services** of a registered nurse or a licensed practical nurse, 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 licensed practical nurse.

Home **personal care services** of a personal care worker, who is not a member of your family, when services are provided in Canada, but only if the patient:

- requires the specific skills of a trained personal care worker, and

- is under the care of a nurse, or requires convalescent care at home following a hospital confinement.

A Personal Care Worker offers essential services such as bathing, dressing, toileting, feeding and mobilization. Home personal care is further limited to 4 hours per day.

Coverage is not provided for custodial care, housekeeping, meal preparation, shopping, transportation or respite care for a family member.

Foot care provided in your home or at a location such as a pharmacy or nursing home, by a nurse or home personal care worker, is further limited to 1 visit every 4 weeks, to a maximum of $40 per visit (subject to change).

All nursing and personal care services should be pre-approved by Great-West Life in order to be considered for reimbursement.

Excluded: Services performed in hospital.

Prostheses

Charges for the purchase, repair, adjustment or maintenance of prosthetic limbs (excluding myoelectric prostheses) and prosthetic eyes required as a result of bodily injury or disease.

• Artificial Eyes	Once every 60 consecutive months
• Standard Artificial Limbs	Once every 60 consecutive months
• Repairs to Artificial Eyes and Limbs	$400 each calendar year for dependents under age 18 $300 each calendar year for all others

Artificial eyes: includes the repair, rebuilding and polishing of artificial eyes, prescribed by a physician or any other licensed or legislated practitioner.

Standard **artificial limbs**, including repairs, stump socks, and shoulder harnesses, prescribed by a physician or any other licensed or legislated practitioner.

• External Breast Prosthesis	1 left and 1 right every 2 calendar years
• Surgical Brassieres	2 each calendar year

Hair prosthetics (wig); when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $200 every calendar year. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (e.g., male pattern baldness).

Extended Health Benefit General Exclusions & Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the Plan Administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

Treatment must be reasonable, and is considered reasonable if it is: accepted by the Canadian medical profession; proven to be effective, and of a form, intensity, frequency, and duration essential to diagnosis or management of the disease or injury.

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

- Any item or service not listed as a benefit in this Plan.
- Medical examinations or routine general checkups required for use by a third party.
- Expenses private benefit plans are not permitted to cover by law.
- Charges for services or supplies for which a charge is made only because you have coverage.
- Charges which normally would not be made if the covered person was not covered under a plan.
- 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.
- Medications restricted under federal or provincial legislation (this refers to any medications not approved by Health Canada or regulated provincially or federally).
- Services performed by an unqualified practitioner.
- Charges for missed appointments or the completion of forms.
- Charges for health-care planning assessments.
- Convalescent, custodial or rehabilitation services, unless otherwise specified.
- Conditions not detrimental to health.
- Benefits the covered person receives or is entitled to receive from Workers’ Compensation.
- Mileage or delivery charges.
- Services or supplies not listed as covered expenses unless determined by the Plan Administrator to be covered expenses.

- Extra medical supplies that are spares or alternates.
- Services or supplies received outside Canada.
- 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.
- Expenses arising from war, insurrection, or voluntary participation in a riot.
- Participation in the commission of a criminal offense.
- A service or supply that is experimental or investigative in nature.
- A service or supply that is not medically necessary or proven effective.
- Services for which the government prohibits the payment of benefit.
- Services provided without charge or normally paid for directly or indirectly by the employer.
- Services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement.
- Exercise, weight loss or physical fitness.
- Environmental or atmospheric control in the home or workplace.
- Visioncare services and supplies required by an employer as a condition of employment.
- Services or supplies that the plan administrator has determined are not proportionate to the disease or injury or, where applicable, the stage or progressions of the disease or injury. In determining whether a service or supply is proportionate, the plan administrator may take any factor into consideration including, but not limited to, the following:

    - clinical practice guidelines;
    - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies; information provided by a manufacturer or provider of the service or supply; and
    - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

- Services or supplies associated with:

    - treatment performed only for cosmetic purposes,
    - the diagnosis or treatment of infertility, or
    - contraception, other than contraceptive drugs, intrauterine devices (IUDs) and products containing a contraceptive drug.

Vision Benefit

The following services and supplies are covered under your Health Association of Nova Scotia Vision Benefit.

If you (or your dependents, if applicable) incur charges for any of the following expenses while covered, the Plan will pay the reasonable and customary charges for these eligible expenses, based on any deductible, reimbursement level or maximum amount shown below. Benefit maximums are applied on a per covered person basis.

Reimbursement Level: 100%

- Eye Examinations: 1 every 12 consecutive months for dependents under age 18
  1 every 24 consecutive months for all others

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, Contact Lenses And Laser Eye Surgery: $150 every 12 consecutive months for dependents under age 18
  $150 every 24 consecutive months for all others

Charges for corrective eyeglasses, including lenses, frames and contact lenses, and **glasses and contact lenses** required to correct vision when provided by a licensed ophthalmologist, optometrist or optician. Excludes intra-ocular lenses, safety glasses or glasses for cosmetic purposes.

Laser-eye surgery required to correct vision when performed by a licensed ophthalmologist.

- Visual Training / Remedial Therapy: $20 per visit

Visual training and remedial therapy to correct faulty visual skills when performed by a licensed ophthalmologist or optometrist.

Dental Benefit

Your dental program covers you and your dependents for a wide range of dental services. Dental benefits are based on the reasonable and customary charges up to the current Dental Fee Guide in effect on the date and where services are rendered.

If you are a late applicant, the Dental coverage for you and your dependents will be limited during the first 6 months. Benefit coverage is limited to oral examinations, limited periodontal examinations, bitewing x-rays, topical application of fluoride and one time unit each of polishing and preventive scaling (cleaning). See the Eligibility for Coverage and Late Applicant sections of this booklet for further details.

Deductible: None.

Plan Maximums

Basic and Major Treatment	$1,500 each calendar year
Orthodontic Treatment*	$1,500 lifetime

Reimbursement Levels

• Basic Coverage (other than periodontal services, endodontics, and appliance maintenance)	100%
• Periodontal services, endodontics, and appliance maintenance	80%
• Major Coverage	80%
• Orthodontic Coverage*	50%

See below for coverage details.

*Orthodontic treatment is available to covered dependents age 6 to 18 when treatment starts.

The Plan covers customary charges to the extent they do not exceed the Dental Fee Guide level noted above. 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. Specialist Fee Guides are applicable when a specialist provides services within his or her specialty.

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.

See the **Eligibility for Coverage and Termination of Benefits** sections of this booklet for information on when the Dental Benefit terminates.

Treatment Plan

Before incurring any large dental expenses expected to cost more than $300, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

Diagnostic services including:

- one complete oral examination every 24 consecutive months,
- limited oral examinations twice every 12 consecutive months for dependent children under age 18 and once every 12 consecutive months for all others, 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 consecutive months for dependent children under age 18 and once every 12 consecutive months for all others,
- orthodontic examinations,
- specific, temporomandibular, and emergency examinations,
- complete series of x-rays every 24 consecutive months,
- periapical and cephalometiric x-rays to a maximum of 5 films each every 24 consecutive months and a panoramic x-ray every 24 consecutive months. Services provided in the same year as a complete series are not covered,
- bitewing, occlusal, and extra-oral and temporomandibular joint x-rays, other than panoramic and sialography, limited to 4 films of each type every 12 consecutive months for a dependent child under age 18, and 2 films of each type every 12 consecutive months for all others,
- hand and wrist x-rays,
- diagnostic photographs,
- orthodontic diagnostic casts.

Preventive services including:

- polishing and/or topical application of fluoride each twice every 12 consecutive months for dependent children under age 18 and once every 12 consecutive months for all others,
- scaling (cleaning), limited to a maximum combined with periodontal root planing of 8 time units every 12 consecutive months.

  More frequent services may be allowed on an independent consideration basis for cases of severe periodontal conditions. You must submit a Prior Authorization prior to the service being rendered.

  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 for dependent children under age 18,
- space maintainers including appliances for the control of harmful habits,
- finishing restorations,
- interproximal disking,
- recontouring of teeth.

Minor restorative services including:

- caries, trauma, and pain control,
- amalgam and tooth-coloured fillings,
- retentive pins and prefabricated posts for fillings,
- prefabricated crowns for primary teeth.

Endodontics:

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

Periodontal services including:

- root planing, limited to a maximum combined with preventive scaling (cleaning) of 8 time units every 12 consecutive months.

  More frequent services may be allowed on an independent consideration basis for cases of severe periodontal conditions. You must submit a Prior Authorization prior to the service being rendered.

  A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.
- occlusal adjustment and equilibration,
- desensitization,
- topical application of antimicrobial agents,
- periodontal re-evaluations, limited to one time unit per visit.

Prosthodontic Services – Appliance maintenance, including:

- denture relines for dentures at least 6 months old, once every 36 consecutive months,
- denture rebases for dentures at least 2 years old, once every 36 consecutive months,
- resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 consecutive months,
- denture repairs and additions and resetting of denture teeth following the 3-month post-insertion period,
- denture adjustments following the 3-month post-insertion period, once every 12 consecutive months,
- repairs to covered bridgework,
- removal and recementation of bridgework.

Oral surgery

- extraction of teeth, pre-and post-surgical care.

Adjunctive services

- emergency treatment of pain, general anaesthesia, local anaesthesia (not in conjunction with operative or surgical procedures) as well as conscious sedation.

Major Coverage

The following expenses will be covered:

Crowns

Onlays and inlays

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

Prosthodontic

The following appliances when required to replace one or more extracted teeth:

- standard complete dentures,
- standard cast or acrylic partial dentures,
- complete overdentures or bridgework,
- implant-retained appliances.

Replacement appliances are covered only when:

- the existing appliance is a covered temporary appliance,
- the existing appliance cannot be made serviceable.

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

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

- denture remakes, once every 36 consecutive months,
- tissue conditioning.

Orthodontic Coverage

Orthodontic appliances

- orthodontics are covered for children age 6 to 18 years when treatment starts,
- charges for orthodontic services will not be covered until the services relating to such charges are actually rendered,
- an orthodontic Prior Determination must be submitted to Great-West Life and confirmation of the payment schedule will be provided at that time.

Dental Benefit General Exclusions & 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 - subgingival periodontal irrigation, charges for post surgical treatment.
- 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 implantology, remodelling and recontouring oral tissues will be covered under Major Coverage.
- Hypnosis or acupuncture.
- Recontouring existing crowns, and staining porcelain.
- Veneers.
- Expenses covered under another group plan's extension of benefits provision
- Services or supplies covered under Extended Health. If the amount payable would be greater under this Dental Benefit, then benefits will be paid under Dental and not Extended Health.
- 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.
- Temporomandibular joint disorders, except examinations and x-rays listed under Diagnostic Services.
- Vertical dimension correction or myofacial pain.
- Expenses arising from war, insurrection, or voluntary participation in a riot.
- Splinting for periodontal reasons if a cast, crown or inlay is used for this purpose, whether or not an onlay was provided.
- Accidental dental services do not form part of the Dental Benefits being offered.
- Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.

- Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

- Charges for services provided for cosmetic reasons only, except for orthodontic services when such services are included under Orthodontic Benefits.

- Charges for missed or cancelled appointments, completion of forms, communications, or any other non-treatment services.

- Charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice.

- Charges which are covered under any other benefit in this Booklet.

- Fees for anesthetic or an anesthetist for a general procedure.

- Replacement of any lost, stolen or broken prostheses or appliances.

- Protective appliances for athletic purposes.