

## Group Benefit Plan



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



**York University Faculty Association (YUFA)  
Pensioners & YUFA Exempt Pensioners**

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

### **Great-West Life Online**

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

### **Great-West Life's Toll-Free Number**

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-800-263-5742.

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This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Plan Document No. 55055** 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.

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

**The Plan is administered by**



03-08

## Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. When you apply for coverage or benefits, we establish a confidential file of personal information. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

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

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

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

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

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

## **Liability for Benefits**

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

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# Benefit Summary

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

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## Healthcare

Deductible \$130 per individual each calendar year

The deductible does not apply to In-Canada Hospital and Hearing Aid expenses

### Reimbursement Levels

In-Canada Hospital Expenses	100%
All Other Expenses	80%

### Basic Expense Maximums

Hospital	Private room for a maximum of 120 days per stay
Home Nursing Care	The maximum in a person's lifetime is the lesser of 120 days and \$10,000
Convalescent Care	120 days per illness
In-Canada Prescription Drugs	Included
Smoking Cessation Products	3-month supply lifetime
Hearing Aids	Included
Speech Aids	Included
Insulin Infusion Pumps	1 pump every 5 years
Insulin Jet Injectors	\$350 each calendar year
Custom-made Foot Orthotics	Included
Myoelectric Arms	\$10,000 per prosthesis
External Breast Prosthesis	Included
Mechanical or Hydraulic Patient Lifters	Included

Blood-glucose Monitoring Machines	\$200 each calendar year
Transcutaneous Nerve Stimulators	Included
Extremity Pumps for Lymphedema or Severe Postphlebotic Syndrome	Included
Stump Socks	6 pairs each calendar year
Custom-made Compression Hose	3 pairs each calendar year
Surgical Stockings	3 pairs each calendar year
Elastic Support Stockings	3 pairs each calendar year
Glasses or Contacts following Non-refractive Eye Surgery	One pair to a maximum of \$100 per eye lifetime
Intrauterine Devices (IUDs)	\$50 each calendar year
Eneuretic Devices	
- mozes detectors	3-month supply
- other eneuretic devices	\$100 each calendar year
Diagnostic Testing	\$200 per family every 12 months

#### Paramedical Expense Maximums

Chiropractors	\$120 each calendar year \$6 per visit
Christian Science Practitioners	Included
Naturopaths	Included
Osteopaths	Included
Physiotherapists	Included
Podiatrists	Included
Psychologists	Included

#### Healthcare Maximums

- Out-of-Country Care Expenses including Ambulance Expenses	\$10,000 lifetime
- Nursing Care Expenses	The lesser of 120 days and \$10,000 lifetime
- All Other Expenses	\$75,000 lifetime
Annual Reinstatement	\$1,000

## Dentalcare

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	
- minor restorative and repairs, relines and rebases to dentures and resilient liners	50%
- all other Basic Coverage	100%
Major Coverage	50%
Plan Maximum	\$1,250 each calendar year

## **COMMENCEMENT AND TERMINATION OF COVERAGE**

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

- 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 31 days after termination. After 31 days, you must provide evidence of good health for you and your dependents before you can participate. Your dental benefits will be subject to certain restrictions.

- Increases in benefits while you are in hospital will not become effective until you are released from hospital.

Your coverage terminates when you are no longer eligible or the plan terminates, whichever is earlier.

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

### **Survivor Benefits for Your Spouse**

If you die while your spouse is covered, your spouse may elect at any time after your death, to continue health and dental benefits provided your spouse makes the required contributions for coverage back to the date of your death. Coverage will continue until the earliest of the date of your spouse's death or the due date of the first premium to which a required contribution has not been made.

## **DEPENDENT COVERAGE**

Dependent means:

- Your spouse, legal or common-law.
- 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 and the disorder has been continuous since that time.

## 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 or injury.

### Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Private room and board in a hospital in Canada

For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is covered. Charges made by the Homewood Health Centre must be approved by your employer.

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.

- Convalescent care for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care
- Accommodation in a licensed private hospital

Facilities established primarily as a place for alcoholics or drug addicts or as residences for senior citizens or which provide personal rather than medical care are not covered.

Facilities established primarily as clinics, sanatoriums or convalescent or chronic care hospitals are not considered licensed private hospitals.

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

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

- Drugs and medicines which require the written prescription of a physician or other person entitled by law to prescribe them, and are dispensed by a licensed pharmacist, as well as certain life-sustaining drugs, smoking cessation products, injectable drugs and syringes for self-administered injections, when provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care provision.

Certain drugs that would not otherwise qualify for coverage may be covered at your employer's discretion.

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

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician
- Custom-made foot orthotics prescribed by a physician

- Hearing aids, excluding batteries, tubing and ear molds, when prescribed by a physician

No benefits will be paid for hearing aids due to accidental bodily injury to physical organs if:

- the accident occurs while the person is not covered under the plan, and
  - notification of the accident is not submitted to the plan administrator within 12 months after the accident
- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible
  - 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
  - External insulin infusion pumps recommended by an endocrinologist, or prescribed by a physician for a pregnant diabetic
  - Needleless insulin jet injectors prescribed by a physician
  - Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan
  - Treatment of injury to sound natural teeth or repair of accidental damage to dentures if:
    - the injury results from an external blow to the mouth
    - notification of the accident is submitted to the plan administrator within 12 months after the accident, and
    - treatment starts within 12 months 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

Oral surgical procedures are covered for the excision of cysts or tumors

No benefits are paid for:

- dental treatment resulting from biting accidents
- orthodontic diagnostic services or treatment
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified Christian Science Practitioner
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital treatment by a registered psychologist

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

If you reside permanently outside Canada, out-of-country non-emergency care is covered if it is required while you are residing outside Canada, it is for non-elective treatment, and you are covered by the government health plan in your home province or the government coverage replacement plan sponsored by your employer.

For all other employees, out-of-country emergency care is covered if it is required as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes, and you are covered by the government health plan in your home province or the government coverage replacement plan sponsored by your employer.

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

## Limitations

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

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - 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-Country Emergency Care
- 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

- Chronic care
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
- 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
- Vaccines used to prevent disease

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

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

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

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

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

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

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

- For all other Healthcare claims, obtain form M635D from your employer. Complete this form making sure it shows all required information.

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

## PREFERRED VISION SERVICES (PVS)

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

Preferred Vision Services (PVS) entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish to purchase eyewear for yourself and your dependents at a reduced cost.

Shopping for eyewear through PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program
- Arrange for a fitting or eye examination, if needed
- Present your group benefit plan identification card to identify your preferred status as a PVS member through Great-West Life at the time of purchase
- Select your eyewear and pay the reduced PVS price. If you have vision care coverage, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

## DENTALCARE

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

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

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, or performed by a denturist.

### Treatment Plan

- Before incurring any large dental expenses, ask your dentist to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

### Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - complete oral examinations
  - oral pathology, periodontal, surgical, prosthodontic and endodontic examinations
  - limited oral examinations once every 6 months
  - limited periodontal examinations once every 6 months

- complete series of x-rays
- intra-oral x-rays and a panoramic x-ray
- radiopaque dyes used to demonstrate lesions
- interpretation of x-rays or models from another source
- microbiological, histological, cytological and pulp vitality tests
- laboratory reports
- consultations required by the attending dentist
- Preventive services including:
  - polishing, limited to 2 time units every 6 months
  - topical application of fluoride
  - scaling
  - oral hygiene instruction once each calendar year
  - pit and fissure sealants on bicuspid and permanent molars
  - appliances for the control of harmful habits, excluding related observations, adjustments, repairs, alterations and removal
  - finishing restorations
  - interproximal disking
  - recontouring of teeth
  - custom fluoride appliances

- 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
  - gold foils
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary and permanent teeth
- Endodontics including:
  - 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
  - bleaching
- Periodontal services including:
  - root planing
  - occlusal adjustment and equilibration if not performed in conjunction with a fixed or removable prosthesis by the same dentist within 6 months
  - periodontal appliances, including adjustments, relines and repairs
  - gingival curettage limited to 4 sites every 6 months
  - desensitization
- Denture-related surgical services for remodelling and recontouring oral tissues

- Denture maintenance:
  - denture relines for dentures at least 3 months old
  - denture rebases after the 3-month post-insertion care period has elapsed
  - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed
- Oral surgery
- Adjunctive services

### **Major Coverage**

- Crowns. Coverage for complicated crowns is limited to the cost of standard crowns
  - Onlays, inlays and veneers. Coverage for tooth-coloured onlays or inlays on molars is limited to the cost of metal
- Replacement crowns, onlays, inlays and veneers are covered when the existing restoration cannot be made serviceable
- Dentures and bridgework, including overdentures and implant-retained appliances when required to replace one or more teeth extracted while the person was covered for major coverage. Replacement appliances are also covered when:
    - the existing appliance is a covered temporary appliance
    - the existing appliance is at least 5 years old and cannot be made serviceable

- Appliance maintenance:
  - denture remakes
  - denture adjustments after the 3-month post-insertion care period has elapsed
  - denture repairs and additions and tissue conditioning
  - resetting of denture teeth after the 3-month post-insertion care period has elapsed
  - repairs to bridgework
  - removal and recementation of bridgework
  - removal of implant-retained prostheses for repair
  - reinsertion of implant-retained prostheses

### **Limitations**

No benefits are paid for:

- Duplicate x-rays, audio-visual oral hygiene instruction, nutritional counselling and space maintainers
- 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 - topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment, periodontal re-evaluations and periodontal surgery

- The following denture-related surgery – reduction or augmentation of the alveolar bone, reconstruction of the alveolar ridge, extensions of mucous folds, mylohyoid ridge remodelling, genial tubercles remodelling, sequestrectomy, mandibulectomy, maxillectomy and glossectomy
- The following oral surgery services – implantology, surgical removal of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty), palatal obturators, cleft palate obturators and surgical exploration. Services for implantology will be covered under Major Coverage
- The following adjunctive services – minor remedies for relief of dental pain, anesthesia required in relation to covered services (general anesthetic facilities, equipment and supplies are covered only when a separate anesthetist is required), hypnosis, acupuncture, emergency services and services of a second surgeon
- Recontouring existing crowns and staining porcelain
- Crowns, onlays, inlays or veneers if the tooth could have been restored using other procedures. If crowns, onlays, inlays or veneers are provided, benefits will be based on coverage for fillings
- 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
- Orthodontic treatment
- 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 other than xrays, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

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

Obtain form M445D from your employer. Have your dentist complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

## COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.
- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:
  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

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