THE
Great-West Life
ASSURANCE COMPANY

PEBA

PS/GE SGEU AND CUPE 600-3 OR 600-5

Group Policy #168850
Effective Date: January 1, 2017

BENEFIT DETAILS

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile
- 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 and cards
- online claim submission for many of your claims, as outlined in the Healthcare section 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.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 168850** 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

Great-West Life's Toll-Free Number

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

05-17

Access to Documents

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. 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.

Healthcare

Please Note:
A policy year means January 1st to December 31st.
All maximums are per person.

Deductible	Nil

Basic Expenses	**Maximum**	**Reimbursement Level**
Ambulance		
Air Ambulance	$4,000 each policy year	100%
Road Ambulance	Included	100%
Breathing Equipment		
AeroChamber	$1,000 lifetime	50%
Aerosol Equipment	$1,000 lifetime	50%
Apnea Monitors	$1,000 lifetime	50%
Nebulizers	$1,000 lifetime	50%
Oxygen Equipment	Included	100%
Communication Aids		
Hearing Aids	$500 every 5 policy years	100%
Diabetic Supplies		
Blood-glucose Monitoring Machines	$1,000 lifetime	50%
External Insulin Infusion Pump	$1,000 lifetime	50%
Diabetic Supplies and Equipment	$1,000 each policy year	100%
Drugs		
In-Canada Prescription Drugs	Included	100%
Smoking Cessation Products	$100 lifetime	100%
Hospital		
Convalescent Hospital	$20 per day to a maximum of 90 days per injury	100%
Hospital	Semi-private room	100%
Mobility Aids		
Canes	Included	100%
Crutches	Included	100%
Wheelchairs	Included	100%
Nursing Care		
Home Nursing Care	$7,500 each calendar year	100%
Orthopedic Equipment		
Braces made of rigid material such as metal or hard plastic	Included	100%
Casts	Included	100%
Cervical Collars	$1,000 lifetime	50%
Custom-made Orthopedic Shoes and Custom-made Foot Orthotics	$300 combined each policy year	100%
Splints	Included	100%

Prosthetic Equipment		
Artificial Eyes and Limbs	Included	100%
External Breast Prosthesis	1 every 3 policy years	100%
Surgical Brassieres	2 every policy year	100%
Other Medical Supplies		
Colostomy and ileostomy supplies	Included	100%
Hospital Beds	Included	100%
Mozes Detectors	$1,000 lifetime	50%
Traction Apparatus	$1,000 lifetime	50%
Transcutaneous Nerve Stimulators	$1,000 lifetime	50%
Wigs/ Hair Pieces	$200 lifetime	100%

Paramedical Expenses	**Maximum**	**Reimbursement Level**
Acupuncturists	$400 each calendar year	100%
Chiropractors	$400 each calendar year	100%
- for Saskatchewan residents, for services rendered in Saskatchewan	$23 for initial visit, $17 for subsequent visits and $25 for emergency visit to an overall maximum of $400 each calendar year	100%
Massage Therapists	$200 each calendar year	100%
Naturopaths	$400 each calendar year	100%
Osteopaths	$400 each calendar year	100%
Physiotherapists	$400 each calendar year	100%
Podiatrists/ Chiropodists	$400 each calendar year	100%
Psychologists	$400 each calendar year	100%
Speech Therapists	$400 each calendar year	100%

Accidental Dental Treatment	**Maximum**	**Reimbursement Level**
Accidental Injury	Included	100%

Visioncare Expenses	**Maximum**	**Reimbursement Level**
Eye Examinations		
- dependent children under age 21	1 every calendar year	100%
- all others	1 every 2 calendar years	100%
Glasses and Contact Lenses	$300 every 2 calendar years	100%

Overall Lifetime Healthcare Maximum	Unlimited

Out-of-Country Expenses	**Maximum**	**Reimbursement Level**
Emergency Care	$3,000,000 lifetime	100%
Non-Emergency Care (Referral)	$50,000 lifetime	100%

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the first day of the month coinciding with or next following the date on which you complete 6 months 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 must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  To satisfy this requirement, you must be fully capable of performing your regular duties; and be either:

  - actually working your employer's place of business or a place where your employer's business requires you to work; or
  - absent due to vacation, weekends, statutory holidays, or shift variances

- If you are not at work because of disease or injury, maternity or parental leave, temporary lay-off, leave of absence, or you go on strike or are locked-out, the date will be extended to the earliest of:

  - the date premiums stop being paid or otherwise determines that insurance has terminated,
  - for a disabling disease or injury, the end of the disability period. No extension will be considered for a non-disabling disease or injury,
  - the date you starts to work in another job more than 20 hours per week,
  - for temporary lay-off or leave of absence including maternity or parental leave, 12 months after your lay-off or leave starts, plus any further period your employer is required by law to extend insurance,
  - an earlier date as determined by your employer,

- Employees working on a non-permanent basis must work no less than 37.5% of the hours of a full-time position.

Your coverage terminates when your employment ends, 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.

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 26 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 26, and the disorder has been continuous since that time. Satisfactory proof must be provided.

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.

- For you and your spouse, the plan with no coordination of benefits (COB) provision in the policy or plan document determines benefits first (primary carrier). If the other plan(s) has a coordination of benefits provision, priority goes to the plan in the following order:

    1. the group plan where the insured person is covered;
    2. if a person is a member of two plans, priority goes to:
        a. the group plan where the member is an active full-time employee
        b. the group plan where the member is an active part-time employee
        c. the group plan where the member is a retiree
    3. the group plan where the person is covered as a dependent spouse;
    4. the private plan (Individual Health Plan) where the insured person is covered.

- 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.

HEALTHCARE

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.

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. Great-West Life may use service providers located within or outside Canada.

Covered Expenses Incurred Within Canada

The following medical supplies are covered when prescribed by a physician. For supplies available on a rental basis, Great-West Life covers either the rental cost or, at its discretion, the cost of purchase.

Ambulance

- Ambulance transportation, including air ambulance (including the fare of one medical attendant when medically necessary), to the nearest centre where adequate treatment is available

Breathing Equipment

- AeroChambers, Aerosol equipment and Nebulizers
- Apnea monitors
- Continuous positive airway pressure supplies
- Oxygen and the equipment needed for its administration, when prescribed by a physician, excluding CPAP machines

Communication Aids

- Hearing aids, including the cost, installation and/or repairs, tubing and ear molds provided at the time of purchase when fitted by an audiologist or when an audiogram is conducted by an audiologist. This excludes routine hearing tests, maintenance, batteries and replacement or additional ear molds.

Diabetic Supplies

- Blood-glucose monitoring machines, including control solution, when prescribed by a physician
- External insulin infusion pumps prescribed by a physician
- The following supplies are also covered:
    - Novalin-Pens, or similar injection devices using a needle
    - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips
    - Blood letting devices, including penlets, platforms and visual blood testing supplies
    - Subcutaneous catheters, and
    - Insulin infusion sets, not including infusion pumps

Drugs and Drug Supplies

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

  - The following drugs are covered if they are listed in the Saskatchewan Health Prescription Drug Services Formulary in effect on the date of purchase:

    (a) drugs which require a written prescription
    (b) injectable drugs including vitamins and insulins
    (c) extemporaneous preparations or compounds if one of the ingredients is a covered drug
    (d) certain other drugs may be covered when they are prescribed.

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

You are eligible to have a portion of your prescription drug expenses paid for by the provincial government under the Saskatchewan Special Support Program, or SSP. The program works together with your employer sponsored plan to ensure you have affordable access to the vast majority of prescription drugs. This plan covers your prescription drug expenses up to the level of your family deductible under the SSP program. Once this deductible is reached, the SSP assumes responsibility for most of your prescription drug expenses. The only way to ensure you can utilize this coverage is by submitting an application to the SSP.

When your drug claims reach a designated dollar amount in a policy year, you will receive a letter from Great-West Life Drug Services requesting you apply to the SSP. After you apply, the SSP will send you a letter confirming coverage and the deductible amount required for eligibility. When you receive this notification please send Great-West Life a copy to ensure your claims can be paid accurately and without interruption. For more information contact Great-West Life at 1-800-957-9777. You may also contact the SSP directly at 306 787-3317, or toll free at 1 800 667-7581.

Drug and Drug Supplies Limitations

No benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment

- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices

- Delivery or extension devices for inhaled medications

- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions

- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances normally used for contraception

- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy

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

- Preventative immunization vaccines and toxoids

- Allergy extracts

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

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

- Drugs used to treat erectile dysfunction

Hospital

- Semi-private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care. If there is no semi-private room available, charges up to the semi-private rates for the local health district will be covered. If rates vary within health district facilities, 80% of the rates charged for a private room will be covered.

  - 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 occurs within 48 hours immediately following 5 or more days of confinement for acute care.

    Coverage is limited to $20 per day to a maximum of 90 days per injury, unless more than 30 days has lapsed since discharge for the same condition.

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

  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.

  A hospital is an institution that is legally termed a hospital, is open at all times, offers in-patient accommodation, has a staff of one or more physicians available at all times; and continuously provices 24-hour nursing by graduate registered nurses.

Mobility Aids

- Canes and crutches

- Wheelchairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.

  If special wheelchairs are provided in circumstances where the condition does not warrant a special one, Great-West Life will provide alternative benefits based on coverage for the type of wheelchair required to permit independent participation in daily living.

Home Nursing Care

- Home nursing services of a registered nurse, a registered nursing assistant or a licensed practical nurse, when services are provided in Canada and begin immediately following release from hospital.

  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.

  A nursing home is an institution or part of an institution that offers in-patient accomodation, has a staff of one or more physicians available at all times; and continuously provides 24-hour medical care by or under the supervision of professional nurses.

  Facilities established primarily as residences for senior citizens or which provide personal rather than medical care are not included.

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

Orthopedic Equipment

- Braces. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not covered.

- Casts and Cervical Collars

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

- Splints, including shoes attached to a splint. Intra-oral splints are not covered.

Prosthetic Equipment

- Artificial eyes, including rebuilding and polishing of artificial eyes

- Standard artificial limbs. Replacement is allowed when needed due to pathological changes

- External breast prosthesis

- Surgical brassieres

Other Medical Supplies

- Hospital beds. Air-fluidized hospital beds are not covered
- Mozes detectors
- Colostomy and ileostomy supplies
- Traction apparatus
- Transcutaneous nerve stimulators for the control of chronic pain
- Wigs / hair pieces for cancer patients undergoing chemotherapy or surgery where the head was shaved

Accidental Dental Treatment

- Treatment of injury to sound natural teeth is covered if:
    - the accident occurs while you are insured and is reported to Great-West Life within 6 months of the accident
    - the treatment is performed by a licensed dentist, oral surgeon or denturist.

    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

    Reimbursement for dental treatments will not exceed the prices shown for a general practitioner in the Saskatchewan dental fee guide in effect on the date treatment is rendered

    To determine the extent of benefits provided under this policy, it is recommended that you submit a treatment plan to Great-West Life before having dental treatment that will cost $300 or more

    On receipt of the treatment plan, Great-West Life will advise you of the estimated amount payable under this policy. This pre-determination of benefits is only valid for 90 days.

- A treatment plan must contain the dental service provider's confirmation of:
    - the recommended treatment for complete correction of the person's condtion
    - the approximate date of completion; and
    - the estimated cost

- No benefits are paid for:
    - accidental damage to dentures
    - dental implants

Paramedical Practitioners
(A physician's prescription is not required for paramedical services)

- 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 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 of foot disorders by a licensed chiropodist
- 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. Eye color tests are also covered.
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

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

  The maximum amount payable for air ambulance is $5,000 each calendar year. 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 a minimum of 5 days while travelling alone. Benefits will be paid to a maximum of $1,000 for airfare, and for moderate quality lodgings to a maximum of $150 for each day, to a maximum of 5 days in a calendar year. A person is considered to be on his own when no family member is with him

- 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 past the scheduled return date due to you or your dependent's medical condition. 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 and no other trip cancellation or interruption insurance has been purchased. A rental vehicle is not considered prearranged, prepaid return transportation. Both the accommodation and return transportation are limited to a combined maximum of $1,000 each calendar year

- In case of death, preparation and transportation of the deceased home, limited to $2,000

- 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, limited to $1,500 each calendar year. Return or round trip transportation for an escort for the children is also covered when considered necessary

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

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

Out-Of-Country Care

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

  A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease 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 the patient's condition permits a return to Canada, benefits are limited to the lesser of:

  - the amount payable under this plan for continued treatment outside Canada, and

  - the amount payable under this plan for comparable treatment in Canada 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 Canada

  - 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.

  - expenses related to any medical condition and/or related condition and/or symptom, which was not stable at any time in the 90 days preceding departure from Canada

  - expenses related to any heart or lung condition which was not stable at any time in the 90 days preceding departure from Canada

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

  - it is required as a result of a referral from your usual Canadian physician

  - it is not available in any Canadian 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 Canada for treatment.

No benefits will be paid for:

- investigational or experimental treatment
- transportation or accommodation charges
- any condition that existed in the 12 months prior to effective date of coverage

The plan covers the following services and supplies when related to out-of-country 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 of a physiotherapist, chiropractor, osteopath, podiatrist/ chiropodist provided during a covered hospital confinement, to a maximum of $300 combined each calendar year, per person
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada
- drugs, to a maximum of $300 each calendar year
- 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 Canada, to a maximum of $1,000 each calendar year

No benefits will be paid for expenses incurred while traveling to a country that has been issued a travel advisory by the Canadian government.

Benefits will be limited to 70% of eligible charges, to a maximum of $50,000 per occurance if treatment or admission in a hospital is not reported within 24 hours.

Healthcare 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 contraceptive drugs and products containing a contraceptive drug
- 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 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
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

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 the Public Employees Benefits Agency. 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 PEBA Extended Health Care 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 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 the Extended Health Care Claim form (M635D) from the Public Employees Benefits Agency website:

  http://peba.gov.sk.ca/benefits/extended-health-care-plan/employees/forms.html

  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.

Great-West Life
Regina Benefit Payments Office

1901 Scarth Street
Regina, Saskatchewan
S4P 4L4

Mail to be sent to:
PO Box 4408
Regina, Saskatchewan
S4P 3W7

If your coverage terminates, claims must be submitted no later than 30 days after the date of termination.

- **For drug claims**, you will be provided with 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.