Group Benefit Plan

Lambton Kent
District School Board
Student Achievement Community Success

Secondary Teachers
Division 2

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

Great-West Life Online

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website **www.greatwestlife.com**.

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.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy Nos. 153336** (Employee Basic Life Insurance and Global Medical Assistance) and **133740** (Optional Life Insurance) and **Plan Document No. 51804** (Healthcare (excluding Global Medical Assistance) and Dentalcare) issued by Great-West Life and **Policy No. GSR 16238** (Basic Accident Insurance) issued to your employer by RBC Life Insurance Company are the governing documents. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail.

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

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

and arranged by

PBL Benefits Limited
150 Ouellette Place Ste. 100
Windsor, Ontario N8X 1L9

Phone: 519 974-0019
Fax: 519 254-2150

08-09

Protecting Your Personal Information

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

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

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

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

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

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

Liability for Benefits

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

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Benefit Summary

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

Employee Basic Life Insurance	$275,000, reducing by 50% at age 65
Optional Life Insurance	
Employee	Available in $10,000 units to a maximum of $250,000, subject to approval of evidence of insurability
Spouse	$15,000
Child	$7,500
Basic Accident Insurance (Underwritten by RBC Life Insurance Company)	See description
Healthcare	
Covered expenses will not exceed customary charges	
Deductibles	
In-Canada Prescription Drug Expenses	
- Individual	$25 each calendar year
- Family	$25 each calendar year
All Other Expenses	Nil
Reimbursement Level	100%

Basic Expense Maximums

Hospital	Private or semi-private room
Home Nursing Care	90 eight-hour shifts each calendar year
Chronic Care	$3 per day to a maximum of 120 days each calendar year
In-Canada Prescription Drugs	Included
Hepatitis B Vaccines	3 injections
Rabies Vaccines	6 doses
Fertility Drugs	$18,000 lifetime
Hearing Aids	$500 every 3 years
Custom-fitted Orthopedic Shoes	Included
Custom-made Foot Orthotics	2 pairs each calendar year to a maximum of $400 per pair
Braces	1 per body part every 2 years
Myoelectric Appliances	An amount equal to the amount that would be paid for standard artificial limbs
External Breast Prosthesis	Included
Surgical Brassieres Following Mastectomy	6 every 12 months
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	$2,000 lifetime
Blood-glucose Monitoring Machines, External Insulin Infusion Pumps and Needleless Insulin Jet Injectors	$1,000 each calendar year
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	6 pairs each calendar year
Wigs for Cancer Patients	1 lifetime

Paramedical Expense Maximums

Chiropractors	$7 per visit 20 visits each calendar year $25 for x-rays each calendar year
Chiropodists	$7 per visit 20 visits each calendar year
Dieticians	$200 each calendar year
Physiotherapists	$750 each calendar year
Podiatrists	$7 per visit 20 visits each calendar year
Naturopaths	$7 per visit 20 visits each calendar year
Osteopaths	$7 per visit 20 visits each calendar year
Psychologists/Social Workers	$420 each calendar year
Speech Therapists	$260 each calendar year
Massage Therapists	$225 each calendar year

Visioncare Expense Maximums

Eye Examinations	$75 every 24 months
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery	$500 every 24 months

Note: Eye Examinations are included in the visioncare expense maximum of $500 every 24 months

Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect in your province of residence one year prior to the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	50%
Orthodontic Coverage	50%
Accidental Dental Injury Coverage	100%
Plan Maximums	
Basic Treatment	Unlimited
Major Treatment	
- tooth-coloured retainers and pontics on molars	$50 per occurrence
- all other major treatment	$3,500 each calendar year
Orthodontic Treatment	$2,500 lifetime
Accidental Dental Injury Treatment	Unlimited

COMMENCEMENT AND TERMINATION OF COVERAGE

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

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide evidence of good health for you and your dependents before you can participate.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

Your coverage terminates when your employment ends, you are no longer eligible, you stop making the required contributions, or the plan terminates, whichever is earliest.

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

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

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 12 months or until they no longer qualify, whichever happens first, provided the applicable premium payments are continued.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

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

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

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

EMPLOYEE BASIC LIFE INSURANCE

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

- If you become disabled while insured, you may be entitled to have your life insurance continued without premium payment throughout the benefit period. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

- If any or all of your insurance terminates before age 71, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself, your spouse and your dependent child. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance for yourself or your spouse, you must provide proof of you or your spouse's insurability, and your application must be approved by Great-West Life. To cover your dependent child, you must apply for coverage within 31 days of becoming eligible for coverage. If you apply after 31 days, your dependent child will be required to submit medical evidence satisfactory to Great-West Life before coverage takes effect. If you or your spouse die within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

You may name a beneficiary for your optional life insurance and change that beneficiary at any time by completing a form available from your employer. On your death, Great-West Life will pay your life insurance to your beneficiary. If your spouse or dependent child dies you will be paid the amount for which he or she was insured. Your employer will explain the claim requirements.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for you, your spouse and your dependent children will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

BASIC ACCIDENT INSURANCE PLAN

(Underwritten by: RBC Life Insurance Company)
Policy No. GSR 16238

The Plan

You are insured against the perils described in the Loss Schedule. Your protection is world-wide, 24 hours a day, on or off the job. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than the Company, or any other organization.

Definition

"The Company" means RBC Life Insurance Company.

Who Is Eligible

You are eligible if you are an active full-time or permanent part-time secondary teacher, or you are a retiree, of the Policyholder and you are under age 65.

Principal Sum

Your current Principal Sum amount is a flat $250,000 increasing to a maximum Principal Sum amount of $275,000 effective September 1, 2009.

Retirees under age 65 are insured for the amount of coverage in effect on the date of retirement.

Reduction/Termination

The Principal Sum amount reduces by 50% upon attainment of age 65 and further reduces to a maximum of $25,000 at age 80. All benefits terminate at retirement.

When Is This Plan Effective

Your insurance is effective on the first of the month following your date of hire.

Loss Schedule

If an accident causes a loss payable under this schedule within one year from the date of the accident, the Company pays the sum set opposite such loss, and not more than the aggregate of the Principal Sum is paid for injuries resulting from the same accident.

	Percentage of Principal Sum
For Loss of:	
Life	100%
For Loss of or Loss of Use of:	
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Leg or One Arm	75%
Either Hand or Foot	66 2/3%
Speech or Hearing in Both Ears	66 2/3%
Sight of One Eye	66 2/3%
Thumb and Index Finger of the Same Hand	33 1/3%
Four Fingers of the Same Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Quadriplegia (for Total and Irreversible Paralysis of All four limbs)	200%
Paraplegia (for Total and Irreversible Paralysis of Both lower limbs)	200%
Hemiplegia (for Total and Irreversible Paralysis of One arm and one leg on the same side of the body)	200%

"Loss" means, with regard to:

Hands and Feet:	Actual severance through or above the wrist or ankle joint;
Eyes:	Entire and irrecoverable loss of sight;
Leg or Arm:	Actual severance through or above the knee or elbow joint;
Thumb and Fingers:	Actual severance through or above the metacarpophalangeal joints;
Speech and Hearing:	Entire and irrecoverable loss;
Toes:	Actual severance through or above the metatarsophalangeal joints;
Quadriplegia, Paraplegia, Hemiplegia:	Complete and irreversible paralysis of such limbs;
Loss of Use of:	Must be total, irrecoverable and be continuous for 12 months after which the benefit is payable, provided the nerve damage is determined to be permanent.

Indemnity provided under this section for all losses you sustain as a result of any one accident does not exceed the following:

a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum.

b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum.

Exposure And Disappearance

If loss results from unavoidable exposure to the elements and indemnity is otherwise payable hereunder, such loss is payable under the terms of the policy.

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

Waiver Of Premium

If you become totally disabled from an accident or sickness and waiver of premium is approved under your applicable Group Life Insurance Plan, premiums under this plan are waived while total disability continues, until the earlier of your attainment of age 65, your eligibility terminates or the policy is terminated.

Repatriation

If you lose your life as a result of a covered accident occurring at least 50 kilometres from your principal city of residence, the Company pays up to **$10,000** for the preparation and transportation of your body back to your principal city of residence.

Rehabilitation

If you receive benefits for a loss described in the Loss Schedule and you require special training to allow you to work in an occupation that you would not have engaged in except for the injuries you sustained, the Company pays for that training, considering the expenses are reasonable and necessary (other than travelling, clothing and ordinary living expenses), up to **$10,000**, occurring within two years from the date of the accident.

Conversion Privilege

You may convert to an individual plan of insurance similar to this one, subject to the terms and conditions of the Company's individual program. The maximum principal sum available under the converted policy and between all policies issued with the Company is **$100,000**, and the rates are those in effect at the time of conversion. This conversion must take place within 31 days of termination of coverage under the policy.

Education

The Company pays for tuition fees in the event of your accidental death. To qualify, eligible dependent children must be enrolled as full-time students in a post-secondary "institution of education" at the time of your death or must enroll within one year following your death.

The amount paid for tuition fees and textbook expenses is equal to the lesser of **5%** of your Principal Sum or **$5,000**, per year per child, for a maximum of four consecutive years. The Company must receive proof of enrollment and attendance for each year that a payment is to be made for each child. If there are dependent children not eligible for this benefit, your Principal Sum is increased by **$1,500**.

For the purpose of this benefit, "dependent child" means your legally adopted child, step-child or any child dependent upon you in a “parent-child” relationship as defined under the Income Tax Act, for support and maintenance, who is unmarried under **21** years of age inclusive or unemployed and under age **25** years of age and is a full-time student. In addition, a child incapable of self-support by reason of mental or physical infirmity is covered beyond the maximum age.

"Institution of education" includes any University, CEGEP, Trade School or College, as defined where you live.

Spousal Retraining

If you receive benefits for a loss described in the Loss Schedule, the Company pays for the expenses actually incurred by your spouse within three years from the date of the accident, for an approved and mutually agreed upon formal occupational training program, specifically qualifying him to gain active employment in an occupation for which he would otherwise not have had sufficient qualifications. The maximum payable hereunder is **$10,000.**

"Spouse" means a person who is living with you and who is legally married to you; or if you are not married, is a person whom you have publicly represented as your spouse and with whom you have resided continuously for at least 12 months in a conjugal-like relationship, civil union, adult interdependent relationship, or any other formal union defined and recognized by law and who is:

- At least 18 years of age;
- Competent to contract; and
- Not related by blood closer than would legally bar marriage.

If more than one person meets this definition, the Insurance Company will only pay one benefit, which will be paid in equal shares to the persons meeting the definition.

Continuation Of Coverage

Your coverage continues by the payment of premiums, for a maximum period of 12 months, while you are on an approved leave of absence, temporary layoff, strike, maternity leave or compassionate care leave. Coverage ends on the earlier of the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

Family Transportation

If while on a trip, you sustain an injury and as a result, are confined as an in-patient in a Hospital, are under the Regular Care and Attendance of a physician or surgeon and require the personal attendance of a Member of the Immediate Family as recommended by the attending physician or surgeon, the Company pays for the expense incurred by the family member for transportation to your bedside by the most direct route by a licensed common carrier, but not to exceed an amount of **$10,000** as the result of any one accident.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with twenty-four (24) hour nursing service. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

"Member of the Immediate Family" means your spouse or common-law spouse, parents, grandparents, children over age 18, brother or sister.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

In-Hospital Indemnity

If an accident requires that you be hospitalized for more than seven consecutive days, the Company pays a monthly benefit of **1%** of your applicable Principal Sum or for periods of less than one month the Company pays **1/30th** of the above monthly benefit per day. Benefits are retroactive to the first day of Hospital confinement.

The benefit does not exceed a monthly amount of **$2,500** and a total of 12 months for any covered accident. Successive periods of hospital confinement for loss from the same covered accident, separated by a period of less than three months, are considered as one period of hospital confinement.

"Hospital" means an institution licensed as a hospital (if licensing is required in the province), open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with 24 hour nursing services. Hospital does not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

Seat Belt

Your benefits under the Loss Schedule are increased by **10%** if your injury results while you were a passenger or driver of a private passenger type automobile and your "seat belt" was properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

The driver of the "vehicle" must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician, at the time of the accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the accident occurs.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a seat belt.

"Vehicle" means a passenger car, station wagon, van, jeep-type automobile or truck.

Comatose
(Applicable To Employees Only)

If you suffer a covered accidental bodily injury which, independently of all other causes, results in your being in a coma, the Company pays a comatose benefit. The benefit amount is equal to the difference between the Principal Sum amount and any other benefits received as a result of such accident.

The benefit is paid to you at the end of the waiting period, at the rate of 1% each month: (a) for 100 months, (b) until you die, or (c) until you are no longer deemed to be in a coma or comatose state, whichever occurs first. Any other benefits remaining at the time of your death will be paid to your designated beneficiary.

"Coma or comatose" means during the waiting period, being in a profound stupor or state of complete and total unconsciousness.

"Waiting period" means the 31 day period from the date the covered person becomes comatose and for which no benefits are payable.

Day Care
(Applicable To Employees Only)

A dependent child is eligible for this benefit until he reaches age 12 and is enrolled in a licensed day care facility within 90 continuous days from the date of the accident.

If you sustain accidental loss of life, the Company pays a Day Care benefit equal to the lesser of **5%** of your Principal Sum or **$5,000**, per year per child. The Day Care benefit is paid for a maximum of four consecutive years. If, at the time of your death, there are dependent children not eligible for this benefit, your Principal Sum is increased by **$1,500**.

For the purpose of this benefit, "dependent child" means legally adopted child, step-child or any child who is dependent upon you in a parent-child relationship (as defined under the Income Tax Act) for support and maintenance, and where such child is between the ages of **1** day and **12** years inclusive.

Home Alteration And Vehicle Modification

If you receive benefits for a loss described in the Loss Schedule and are subsequently required (due to the cause for which payment under the Loss Schedule is made) to use a wheelchair to be ambulatory, the Company pays, upon presentation of proof of payment, the one-time cost of (a) alterations to your residence to make it wheelchair accessible and habitable and (b) modifications necessary to your motor vehicle to make the vehicle accessible or driveable for you.

Benefits herein are not paid unless: (a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users and (b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

The maximum payable under this benefit is **$10,000**.

To Whom Are Benefits Paid?

Your accidental death benefit is paid to the beneficiary designated at the time of payment, or to your estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

Exclusions

The insurance does not cover losses caused in any way from suicide or any suicide attempt; self-inflicted injuries; nuclear war or war between a country of North America and/or the states of the former Soviet Union, China, France or the United Kingdom; full-time active service in the armed forces of any country; travelling as a pilot or crew member of any aircraft or travel in the Policyholder's owned or leased, operated aircraft; being under the influence of a controlled substance as defined by federal or provincial law, unless administered on the advice of a Physician; operating a motor vehicle either under the influence of any intoxicant or if your blood alcohol concentration is in excess of 80 milligrams of alcohol per 100 millilitres of blood.

Claim Procedures

To make a claim under this plan, written notice of the accident must be given to the Company within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. The Company provides the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

If the Company does not receive the required notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is good reason for the delay. In no event is a claim considered after one year from the date of the accident if the Company was not notified and the necessary forms not completed and submitted to the Company.

Disclaimer

This booklet should be kept with your Employee Handbook. It is a summary of the principal features of the plan and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policy **GSR 16238** underwritten by RBC Life Insurance Company.

Collection And Use Of Personal Information

Collecting Your Personal Information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

- Information establishing your identity (for example, name, address, phone number, date of birth, etc.) And your personal background;

- Information related to or arising from your relationship with and through us;

- Information you provide through the application and claim process for any of our insurance products and services; and

- Information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using Your Personal Information

This information may be used from time to time for the following purposes:

- To verify your identity and investigate your personal background;

- To issue and maintain insurance products and services you may request;

- To evaluate insurance risk and manage claims;

- To better understand your insurance situation;

- To determine your eligibility for insurance products and services we offer;

- To help us better understand the current and future needs of our clients;

- To communicate to you any benefit, feature and other information about products and services you have with us;

- To help us better manage our business and your relationship with us; and

- As required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

We may also use this information and share it with RBC® companies (i) to manage our risks and operations and those of RBC companies and (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Your Right To Access Your Personal Information

You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information or to ask questions about our privacy policies, you may do so now or at any time in the future by contacting us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: 1-800-663-0417
Facsimile: (905) 813-4816

Our Privacy Policies

You may obtain more information about our privacy policies by asking for a copy of our “Straight Talk®” brochure about privacy, by calling us at the toll free number shown above or by visiting our web site at www.rbc.com/privacy

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

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

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

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

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

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

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

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

Services intended primarily as custodial care are not covered.

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

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

- Chronic care, provided in a hospital, nursing home or for home nursing care in Canada, for a condition where improvement or deterioration is unlikely within the next 12 months

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

  - Drugs which require a written prescription, including oral contraceptives

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

- Disposable needles for use with non-disposable insulin injection devices, lancets and test strips

- Extemporaneous preparations or compounds if one of the ingredients is a covered drug

- Certain other drugs that do not require a prescription by law may be covered when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense.

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

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

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

- Custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician. A letter from the physician must be submitted stating the diagnosis, price and material used.

- Custom-made foot orthotics, including arch supports, when prescribed by a physician. The physician's prescription must be renewed every 9 months.

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

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs. Scales, cookbooks and carrying cases for insulin are not covered.

- External insulin infusion pumps prescribed by a physician
- Needleless insulin jet injectors prescribed by a physician
- Blood-glucose monitoring machines prescribed by a physician
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan. PSA Tests (Prostate Cancer Screening Tests) are not covered.
- Physician services provided outside your province of residence, limited to 3 times the amount stated in the Ontario Medical Association Suggested Fee Guide in effect on the date the service is rendered
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor. Assessments are not covered.
- Out-of-hospital treatment of nutritional disorders by a registered dietician
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist, including treatment at the Canadian Back Institute
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist. Assessments are not covered.
- Out-of-hospital services of a qualified chiropodist. Assessments are not covered.
- Out-of-hospital treatment by a registered psychologist or qualified social worker. Tests for Attention Deficit Hyperactivity Disorders (ADHD) are covered only when performed by a registered clinical psychologist. Tests of Variables of Attention (TOVA) are not covered.

- Out-of-hospital treatment of speech impairments by a qualified speech therapist

- Out-of-hospital services of a qualified massage therapist including:

  - reflexology

  - trager massage when referred by a physician

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

- Out-of-hospital services of a qualified naturopath. Assessments are not covered.

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

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

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

Global Medical Assistance Program

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

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

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

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

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

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

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

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

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

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

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

Out-Of-Country Emergency Care

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

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

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

No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada unless you are a full-time student. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

Limitations

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

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
    - treatment performed only for cosmetic purposes
    - recreation or sports rather than with other daily living activities
    - the diagnosis or treatment of infertility
    - contraception, other than oral contraceptives
    - magnetic field treatment
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance

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

  This limitation does not apply to Global Medical Assistance

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

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

- Obus Formes or pillows

- Eneuretic devices for bed wetting

- Blood pressure monitoring kits

- Transcutaneous nerve stimulators for the control of chronic pain

- Treatment by a homeopath

- Treatment by an acupuncturist

- Hydrotherapy

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

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Proprietary or patent medicines registered under the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs dispensed during treatment as an in-patient or an out-patient in a hospital

- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens
- Synvisc
- Drugs used to treat erectile dysfunction

How to Make a Claim

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

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

  If you are a resident of the Territories, you must submit your out-of-country claims to your territorial government for processing before submitting the claim to Great-West Life. When you receive your Explanation of Benefits back from the 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 territory
  - a completed Statement of Claim Out-of-Country Expenses form (form M5432)
  - all required information
  - copies of all original receipts

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

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

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

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

- **For drug claims**, your employer will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

  When your coverage ends, return your direct pay drug identification card to your employer.

PREFERRED VISION SERVICES (PVS)

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

Preferred Vision Services (PVS) entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist.

PVS also entitles you to a discount on laser eye surgery obtained through an organization that is part of the PVS network.

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 for yourself and your dependents.

Using 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 the eyewear is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage for the product or service, 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**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

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

Treatment Plan

- Before incurring any large dental expenses over $500, 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 36 months

- limited oral examinations once every 6 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed

- limited periodontal examinations once every 6 months

- complete series of x-rays every 36 months

- intra-oral x-rays, except bitewing x-rays, to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- intra-oral bitewing x-rays once every 6 months

- Consultations required by the attending dentist, limited to a maximum of 2 time units every 12 months

- Preventive services including:

  - polishing and topical application of fluoride each once every 6 months

  - scaling, limited to a maximum combined with periodontal root planing of 8 time units every 12 months

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

  - oral hygiene instruction once every 6 months

  - pit and fissure sealants on bicuspids and permanent molars for dependent children under age 19 only

  - space maintainers, including appliances for the control of harmful habits, for dependent children under age 19 only

- finishing restorations
- interproximal disking
- recontouring of teeth

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

- Endodontic services, including isolation of teeth

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

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

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

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

Major Coverage

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

  Replacement crowns, onlays and inlays are covered when the existing restoration is at least 4 years old and cannot be made serviceable
- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
    - the existing appliance is a covered temporary appliance

- the existing appliance is at least 4 years old and cannot be made serviceable. If the existing appliance is less than 4 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

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

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

  - denture remakes, once every 48 months

  - denture adjustments, once every 12 months

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

  - repairs to covered bridgework

  - removal and recementation of bridgework

Orthodontic Coverage

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

Accidental Dental Injury Coverage

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

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

Limitations

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

- Basic Coverage expenses are limited to $100 during the first 12 months of your coverage

- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage

- No benefits will be paid for Orthodontic Coverage expenses during the first 24 months of your coverage

No benefits are paid for:

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

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

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

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

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

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

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

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

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

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

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

- Expenses covered under another group plan's extension of benefits provision

- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

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

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

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