Retiree Benefits Program

The Ottawa Professional Fire Fighters' Association



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Welcome to Your Retiree Benefits Program

About Your Program

Taking care of your health can be challenging at any age. It is even more so at retirement, when health concerns often increase. You have worked hard throughout the years to make Ottawa the great city it is today. To help you stay healthy and financially secure, the City of Ottawa (the City) offers you group health coverage.

Government health plans can provide coverage for medical expenses such as hospital charges and doctor's fees. But government plans provide only basic coverage. Medical expenses can create financial hardship for you and your family.

Private health care plans – such as the benefits offered by the City and described in this booklet – supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

About This Booklet

At the front of this booklet, you will find a Benefits Summary, which provides a high level summary of your coverage. The remainder of this booklet provides important details about your coverage, such as important limitations to your coverage that you should be aware of (under What's Not Covered).

The Glossary provides a brief explanation of the important terms (shown in **bold**) used throughout this booklet.

We suggest you read this benefit booklet carefully, and then file it in a safe place with your other important documents.

Important Notes

This booklet describes the principal features of the group benefits program sponsored by the City; however, the group policies/contracts issued by

Great-West Life are the governing documents, and if there are variations between the information in this booklet and the provisions of the group policies/contracts, the group policies/contracts will prevail.

You should note that your benefits are provided directly by the City. Great-West Life (the carrier) has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices.

The purpose of this booklet is to outline the benefits for which you are eligible as a retiree of the City. The information in this booklet is a summary of the provisions of the group policies/contracts. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of the City and the carrier are governed by the paper versions of the group policies/contracts. The final interpretation of your coverage is governed solely by the terms of the official group policies/contracts. No alteration of the electronic copy of this booklet is permitted by any person, except by an authorized representative of the City or the carrier, as applicable.

Possession of this booklet alone does not mean that you or your **dependents** are covered. The group policies/contracts must be in effect and you must satisfy all the requirements of the policies/contracts.

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

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 or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, *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

Great-West Life recognizes and respects the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. They 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.

Great-West Life uses 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

Great-West Life 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 a plan member, you are responsible for the claims submitted. Great-West Life 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 Great-West Life's head office.

For a copy of Great-West Life's Privacy Guidelines, or if you have questions about Great-West Life's 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.

Benefits Summary

Who Is Eligible...

As a retiree of the City represented by the Ottawa Professional Firefighters' Association (OPFFA), you are eligible for the benefits described in this booklet, provided that at retirement you were covered under the Employee Benefits Program and:

- you began receiving an OMERS pension with at least 20 years of credited **service** with the City,
- you retired as a result of a medical reason and had 25 years of credited **service** with the City and when your age plus credited **service** met the criteria for a pension from OMERS as if you had continued to work, or
- you were age 60 or older.

You and your **dependents** must also maintain coverage under the provincial health plan to be eligible for retiree benefits.

Your **spouse** and **children** are eligible for coverage as long as they meet the definition of **dependents**. Coverage for your **dependents** begins on the date you become eligible or the date you first acquire a **dependent**, whichever is later. You must have coverage for yourself in order for your **dependents** to be eligible.

If one of your **dependents** (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will begin on the day following discharge from the hospital.

Limitations for Making Changes to Your Benefits

You may choose to opt out of coverage at any time (for example, at retirement or during retirement). If you opt out of coverage, you are not eligible to enrol at a later date, under any circumstance.

You may choose to decrease your coverage from family to single at any time, for any reason. However, you may only increase your coverage from single to family if you request the change within 31 days of a qualifying life event. For information about life events, consult Change in Family Status under the What Happens When section.

What's Provided...

For a more detailed description of your benefits, including important limitations, please consult the applicable sections of this booklet.

All expenses are reimbursed based on Great-West Life's assessment of **reasonable and customary** fees.

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- annual **deductible** of $25 for single coverage and $50 for family coverage (does not apply to health care facilities and vision care)

100% reimbursement

- vision care, including:
  - purchase and repairs of prescription glasses, elective contact lenses and elective laser vision correction procedures:
    - until June 3, 2017:
      - to a maximum of $200 per person every 24 consecutive months
    - starting June 4, 2017:
      - to a maximum of $300 per person every 24 consecutive months
- semi-private hospital room accommodation, above the amount covered by the provincial health plan
- out-of-Canada emergency medical services, as long as your provincial health care coverage is in effect, maximum first 60 days of the trip, to an overall lifetime maximum of $1,000,000 per person (includes travel assistance with toll-free telephone service)

- drugs legally requiring a prescription, plus certain life-sustaining drugs that do not legally require a prescription
  - generic substitution (unless doctor specifies no substitution)
  - purchase with benefits card
- professional services of the following paramedical practitioners (as long as they are qualified and registered in the province in which the services are rendered), above the amount covered by any provincial plan, where applicable:
  - chiropractor (including x-rays), speech therapist, osteopath, podiatrist, chiropodist, naturopath, to a maximum of $300 per

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person per type of practitioner per calendar year
  - physiotherapist:
    - until June 3, 2017:
      - to a maximum of $300 per person per calendar year
    - starting June 4, 2017:
      - to a maximum of $400 per person per calendar year
  - psychologist, to a maximum of $500 per person per calendar year
- services provided in your home or in a hospital by a registered nurse, to a maximum of 90 eight-hour shifts per person per calendar year (prior approval from the carrier is recommended)
- hearing aids, to a maximum of $300 per person every five consecutive calendar years (starting June 4, 2017)
- orthotics, to a maximum of $400 per pair and two pairs per person per calendar year
- certain other prescribed medical supplies and services to specified maximums

When Coverage Ends...

For You and Your Dependents

Coverage will terminate on the earliest of:

- your death
- the date you enter the armed forces of any country on a full-time basis
- the date the group contract/policy terminates

Your **dependent's** coverage terminates on the date your coverage terminates or the date the **dependent** ceases to be an eligible **dependent**, whichever is earlier.

Drug coverage for you ends at the end of the month in which you reach age 65. Drug coverage for your **spouse** continues until your **spouse** dies or the last day of the month in which your **spouse** reaches age 65, whichever is earlier, and drug coverage continues for your **children** until they are no longer eligible.

For Your Survivors

When you die, coverage for your **dependents** may continue, at no cost to your **dependents**, until your **dependents** become eligible for similar coverage elsewhere.

Who Pays the Cost...

- City pays 100%

Health

If you or one of your **dependents** incurs charges for any of the eligible expenses specified, your Health Plan benefit can provide financial assistance.

Managed care initiatives are intended to be part of the plan. These currently include positive enrolment/coordination of benefits and drug ingredient cost adjudication. Over time, these initiatives could be expanded to include, for example:

- mandatory generic substitution
- managed formularies

Refer to the Benefits Summary, located at the front of this booklet, for the reimbursement levels, applicable maximums and other important information, including the annual **deductible** and the lifetime maximum for expenses incurred outside Canada.

All expenses are reimbursed based on Great-West Life's assessment of **reasonable and customary** fees.

What's Covered

The expenses specified are covered to the extent that they are **reasonable and customary**, as determined by Great-West Life, provided they are:

- **medically necessary** for the treatment of sickness or injury and recommended by a physician, except for the expenses listed under the About Travel Assistance section and as noted under the paramedical practitioners listed under Professional Services
- incurred for the care of a person while insured under this group benefits program
- not covered under the provincial health plan or any other government-sponsored program

Payment of In-Canada Prescription Drugs

The covered expense is subject to any **deductible**, drug dispensing fee maximum and reimbursement percentage for drugs, as specified in the Benefits Summary.

The maximum amount for any eligible expense is the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as

listed in the Provincial Drug Benefit Formulary. If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

Where a prescription contains a written direction from the physician or dentist that the prescribed drug or medication is not to be substituted with another product, the full cost of the prescribed product is covered if it is an eligible expense under this benefit.

Drugs and Medicines

- **drugs** or medicines dispensed by a licensed pharmacist, and which by law or convention, require the written prescription of a physician. Smoking cessation products are eligible, to a combined lifetime maximum of a three-month supply
- injectable drugs
- potassium supplements, as determined by Great-West Life to be life-sustaining in nature and which are licensed for sale in Canada as a natural health product
- life-sustaining **drugs**

The following expenses are not covered:

- the administration of injectable drugs
- fertility drugs
- smoking cessation drugs
- drugs, biologicals and related preparations, which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- erectile dysfunction drugs

Preventive

- preventive vaccines and toxoids
- oral contraceptives

Charges for the following are not covered:

- intrauterine devices and diaphragms

Health Care Facilities

- hospital charges in excess of the charges for standard ward accommodation, up to the level of accommodation specified in the Benefits Summary,

provided:

  - the person was confined to hospital on an in-patient basis, and
  - the accommodation was specifically elected in writing by the patient
- confinement in a licensed private hospital up to $10 per day, to a lifetime maximum of 120 days
- confinement in a chronic care facility up to $3 per day, to a maximum of 120 days per person every 12 consecutive months, including, where permitted by law, the portion of the cost of ward accommodation which the hospital must bill the patient directly, as required by provincial government regulations

Charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered, except as specified under confinement in a chronic care facility.

Medical Transportation Services

- licensed ambulance service provided in the covered person's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

See the Claims section for information about receiving reimbursement for ambulance services.

Medical Supplies and Services

Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician and covered under this provision, eligible expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Medical Equipment

- rental or, when approved by Great-West Life, purchase of:
  - mobility equipment – crutches, canes, walkers, and wheelchairs
  - durable medical equipment – hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses and Supports

- artificial eyes and limbs (myoelectric or sport prostheses will be covered up to the amount that would typically be paid for standard type artificial limbs)
- breast prostheses

- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, to a maximum of one per person per lifetime
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- corrective prosthetic lenses and frames once only following cataract surgery or when the person lacks an organic lens
- modifications or adjustments to stock-item orthopaedic shoes or regular footwear
- custom-made shoes (must be constructed by a Certified Orthopaedic Footwear Specialist) that are required because of a medical abnormality that, based on evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to two pairs per person per calendar year, to a maximum of $1,200 per pair
- casted, custom-made orthotics, to the maximum specified in the Benefits Summary
- surgical stockings, to a maximum of six pairs per person per calendar year
- surgical brassieres, to a maximum of six per person per calendar year

Other Supplies and Services

- the cost of standard syringes, needles and diagnostic aids, if required for treating diabetes (unless specifically included here, charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered). You may use your pay-direct benefits card for diabetic expenses until the end of the month in which you reach age 65 (after age 65, you must submit a paper claim)
- ileostomy, colostomy and incontinence supplies
- oxygen
- medicated dressings and burn garments
- microscopic and other similar diagnostic tests, including x-rays, and services rendered in a licensed laboratory, to a maximum of $1,000 per person per calendar year

Dental Services

- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months and begins within 90 days of the accident, unless the patient is under age 18, in which case treatment must be completed by the patient's 19th birthday
- injuries due to biting or chewing are not covered

Professional Services

- private-duty nursing services that are deemed to be within the practice of nursing and that are provided in the patient's home or in a hospital by a registered nurse

  Eligible expenses are subject to the maximum specified in the Benefits Summary. Great-West Life suggests that a detailed treatment plan be submitted with cost estimates before private-duty nursing services begin. Great-West Life will then advise you of any benefit that will be covered.

  Charges for the following services are not eligible:

  - service provided primarily for custodial care, homemaking duties or supervision
  - service performed by a nursing practitioner who is an **immediate family member** or lives with the patient
  - services that can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household
- services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields), to the maximum specified in the Benefits Summary:
  - physiotherapist, chiropractor, psychologist, speech therapist, chiropodist, podiatrist, osteopath and naturopath

Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses before reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this group benefits program are payable only after the provincial plan's maximum for the benefit year has been paid.

Recommendation by a physician for professional services is not required.

Hearing Aids

- charges for cost, installation, repair and maintenance of a hearing aid or aids (including charges for batteries), to the maximum specified in the Benefits Summary

Vision Care

- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to the maximum specified in the Benefits Summary

Out-of-Province or Out-of-Canada Expenses

- emergency medical treatment of a sickness or injury that occurs while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the provincial plan during the absence from the province of residence. Refer to the Benefits Summary for the maximum number of days allowed per trip and the lifetime maximum for expenses incurred outside Canada

A medical emergency occurs when a covered person, travelling outside his or her province of residence, requires immediate medical attention due or related to:

- a sudden, unexpected injury that occurs, or a new medical condition which begins while a covered person is travelling outside his or her province of residence
- a previously identified medical condition that was **stable**, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his or her province of residence

Such medical emergency no longer exists when, supporting medical evidence shows and in the opinion of the attending physician, the covered person is able to return to his or her province of residence.

For all non-emergency medical treatment outside Canada, Great-West Life requires that it be recommended by a physician practicing in Canada and suggests that a detailed treatment plan be submitted with cost estimates before treatment begins. Great-West Life will then advise you of any benefit that will be provided.

Charges for the following are payable under this expense:

- physicians' services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable as specified under hospital coverage in the Benefits Summary
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available

The amount payable for these expenses will be the **reasonable and customary** charges less the amount payable by the provincial plan.

All other charges incurred while outside the province of residence are payable under the appropriate eligible expense on the same basis as if they were incurred in the province of residence.

Great-West Life, and the company contracted by Great-West Life to provide the services described in the About Travel Assistance section, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Travel Assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances that interfere with or prevent the provision of any services.

What's Not Covered

No payment will be made for expenses resulting from:

- a medical emergency related to pregnancy for a covered person who is pregnant and travelling outside her province of residence within four weeks of the due date
- self-inflicted injuries or illness while sane or insane
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot
- any injury or illness for which the person is entitled to benefits under any provincial worker's compensation act
- examinations required for the use of a third party
- travel for health reasons
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication
- cosmetic surgery or treatment (when so classified by Great-West Life) unless such surgery or treatment is for accidental injuries and began within 90 days of an accident
- any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of coverage
  - which are performed or provided by an **immediate family member** or a person who lives with the patient
  - which are provided while confined in a hospital on an in-patient basis
  - which are not specified as an eligible expense under this plan
- expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (as listed

in the Out-of-Province or Out-of-Canada Expenses section). Such expenses incurred outside Canada on an elective basis or on the referral of a physician located in Canada are not payable

- drugs, sera, injectables and supplies that are not approved by Health Canada or are experimental or limited in use whether or not so approved
- experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate medical specialty society
- services, treatments or supplies eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan. Great-West Life will only consider that amount of an eligible expense that is over and above the amount that would be payable by the government plan
- any **deductible** or co-payment the person is required to satisfy under a provincial drug benefit program

About Travel Assistance

The Travel Assistance Program provides medical assistance through a worldwide communications network that operates 24 hours a day. The network locates medical services when required as a result of a medical emergency arising while you or your **dependents** are travelling. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from your home. You must be covered by the government health plan in your home province to be eligible for travel assistance benefits.

A medical emergency occurs when a covered person, travelling outside his or her province of residence, requires immediate medical attention due or related to:

- a sudden, unexpected injury that occurs, or a new medical condition which begins while a covered person is travelling outside his or her province of residence
- a previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his or her province of residence

Such medical emergency no longer exists when, supporting medical evidence shows and in the opinion of the attending physician, the covered person is able to return to his or her province of residence.

The following assistance services are provided, subject to Great-West Life's prior approval, when required as a result of a medical emergency that occurs during the first 60 days while travelling outside your normal province of residence.

- **On-site hospital payment –** When required for admission, to a maximum of $1,000
- **Medical evacuation –** 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
- **Visitation of a family member –**Transportation and lodging for one family member joining a patient hospitalized for more than seven days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket
- **Lodgings for your travel companion** – 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
- **Return transportation** – 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
- **Return of deceased to home** – In case of death, preparation and transportation of the deceased home
- **Return of minor children to 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
- **Vehicle return** – 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.

How to Access Travel Assistance – Your Benefits Card

Your benefits card lists the toll-free numbers to call in case of an emergency, while travelling outside your province. The toll-free numbers will put you in touch with the international travel assistance organization.

Your benefits card also lists your plan and identification numbers, which the travel assistance organization needs to confirm that you have Travel Assistance coverage.

If you do not have a benefits card, please contact Great-West Life. You can also print a copy of your benefits card from Great-West Life's GroupNet for Plan Members online site, or access the information using Great-West Life's mobile app (for more information, see the section Great-West Life Online).

What Happens When...

Change in Family Status

When You Can Increase Coverage

When certain life events occur, you are eligible to increase your coverage from single to family to reflect the change in your family status, provided you request the increase within 31 days of the life event. The following changes in family status qualify for an increase in coverage:

- marriage (legally married or common-law)
- birth or adoption of a **child**
- loss of coverage under your **spouse**'s benefits program

When You Can Decrease or Cancel Coverage

You may decrease your coverage from family to single or cancel it at any time, for any reason.

What You Need to Do

Consider Your Benefit Options

When a change in your family status occurs, consider whether your current benefit coverage continues to meet your needs and ensure that the necessary updates have been made to Coughlin & Associates Ltd.'s files. Here are some of the actions you may have to take:

- change your address or add or delete a **dependent**
- change from family to single coverage or vice versa
- update your coordination of benefits information if you or a **dependent** have lost or gained coverage under your spouse's plan
- update your **dependent** information

Advise Coughlin & Associates Ltd.

If you are increasing your coverage, you must contact Coughlin & Associates Ltd. **within 31 days** of the life event to register the change.

For all other changes, you should contact Coughlin & Associates Ltd. as soon as possible.

Death

What Happens to Your Coverage

When you die, coverage for your **dependents** may continue, at no cost to your **dependents**, until your **dependents** become eligible for similar coverage elsewhere.

Coverage will end earlier if:

- your **dependents** no longer meet the definition of **dependent**
- the group contract terminates

In specific circumstances, **extension of benefits** may apply to certain health expenses that are incurred after your coverage ends.

How It Works

Your executor or survivor should contact Coughlin & Associates Ltd. as soon as possible after your death. Coughlin & Associates Ltd. will provide your executor or survivor with all the information and forms needed to maintain benefits, if applicable.

Reach Age 65

What Happens to Your Coverage

Your drug coverage ends at the end of the month in which you reach age 65, but coverage continues for your **spouse** until the last day of the month in which your **spouse** reaches age 65 and continues for your **children** until they are no longer eligible. When your drug coverage ends, you and your **dependents** will no longer be able to use your pay-direct benefits card for drug expenses. You can keep your benefits card as a quick reference for your plan and identification numbers and Great-West Life's contact information.

Some provincial health plans cover prescription drugs after age 65. For more details, speak to your pharmacist.

Claims

Your Pay-Direct Benefits Card

Great-West Life provides you with a plastic pay-direct benefits card when you enrol in the Health Plan. Your **spouse** and **children** over age 18 will also receive a benefits card.

To fill a prescription for covered **drug** expenses:

- present the benefits card to the pharmacist at the time of purchase
- Great-West Life reimburses the pharmacist directly for the eligible amount and you pay any amounts that are not covered under the benefit

You will be required to pay the full cost of the prescription at the time of purchase if:

- you cannot locate a participating pay-direct drug pharmacy
- you do not have your benefits card with you
- the prescription is not payable through the benefits card system
- you are not eligible for a benefits card

If you paid the cost of the prescription, you must submit a claim to Great-West Life to receive reimbursement. See the sections Online Claims and Paper Claims for how to submit a claim.

Online Claims

If you register for Great-West Life's GroupNet for Plan Members online secure site and for direct deposit, you will be able to submit a number of claims online and receive your reimbursement faster. To register, go to www.greatwestlife.com and click on GroupNet for Plan Members. Then follow the links to register.

Once your access has been set up, complete the online form with the details of the service or expense; you don't need to send your receipts. Great-West Life assesses your claim and deposits your payment to your bank account and sends you an email notifying you of the payment. You are responsible for keeping your original receipts for 12 months following the date you submitted your claim online, in case Great-West Life later requests them as part of an audit.

You can also submit claims using Great-West Life's mobile app. For more information, see the section Great-West Life Online.

You have six months from the date an expense is incurred to submit the claim online or using the mobile app. After six months, the expense can only be submitted using a paper claim form.

Paper Claims

To submit a claim, you must complete a *Healthcare Expenses Statement* form, except when claiming for physician or hospital expenses incurred outside your province of residence. If you paid for an out-of-province or out-of-country expense because you did not contact the Travel Assistance provider, you must complete a *Statement of Claim Out-of-Country Expenses* form. Claim forms are available from the Great-West Life site, or you can contact Coughlin & Associates Ltd. to request a form.

Claims for out-of-Canada expenses should be submitted to Great-West Life as soon as possible after the expense is incurred, as your provincial medical plan has very strict time limitations for reimbursements. The Great-West Life plan will pay all eligible claims including the provincial medical plan portion. The provincial medical plan will then reimburse the Great-West Life plan for the government's share of the expenses. For these expenses, you must complete a *Statement of Claim Out-of-Country Expenses* form and, as required, the Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention. Travel Assistance provides a claims payment service that arranges for the payment of most expenses on behalf of the covered person. See the About Travel Assistance section under Health Plan for more information.

For paramedical practitioner services, such as massage therapy and physiotherapy, please ensure that the practitioner's licence number is on the receipt. Having the practitioner include their registration or licence number will allow for faster payment of your claim.

If you incur ambulance expenses, you are responsible for paying the invoice then submitting a paper claim to Great-West Life for reimbursement.

To avoid any delays in processing your claim, be sure that all sections of your claim form are complete and that your receipts are attached. Remember, always provide your plan number and your identification number. Your plan number can be found in the Benefits Summary, located at the front of this booklet. Your benefits card shows your identification number. It is important to indicate if you have benefits under another plan, such as your spouse's plan. If this information is not included, your claim cannot be processed. See the section Coordination of Benefits for more information.

Staple receipts and any other required documentation to your claim form before mailing. For **drugs**, be sure to include the pharmacy receipt. Be sure to keep a copy for your records.

If you're claiming expenses for a **spouse** or **child**, be sure to show their name and relationship to you, and show the name of your **spouse's** plan sponsor or employer or your **child's** post secondary institution if your **child** is an over-age **dependent**.

Deadline

Claims for expenses incurred in the prior year must be received by Great-West Life by June 30 of the current year, if they are to be considered for reimbursement.

However, when your coverage ends, all claims must be received by Great-West Life no later than 90 days from the termination date.

Prior Authorization

Expensive **drugs** or **drugs** that have a high potential for misuse require prior authorization from Great-West Life before they can be reimbursed. In most cases, your doctor will know if the **drug** being prescribed requires prior authorization. To receive the eligible reimbursement, you must submit a prior authorization form to Great-West Life. The form will need to be completed by you and your doctor and will provide confirmation that the **drug** is being used for its intended purpose.

For information on prior authorization, contact Great-West Life, or check Great-West Life's prior authorization drug list located on the Great-West Life site.

Submitting a Treatment Plan for Private-Duty Nursing Services

Great-West Life suggests that a detailed treatment plan be submitted with cost estimates before private-duty nursing services begin. Great-West Life will then advise you of any benefit that will be covered.

Coordination of Benefits

If you or your **dependents** are also covered for similar benefits under another plan, Great-West Life will take this into account when determining the amount of expenses payable. This process is known as coordination of benefits. It allows for reimbursement of covered expenses from all plans, up to a total of 100% of the actual expense incurred.

Order of Benefit Payment

A variety of circumstances will affect which plan is considered the primary carrier (that is, responsible for making the initial payment toward the eligible expense), and which plan is considered the secondary carrier (that is, responsible for making the next payment).

If the other plan does not provide for coordination of benefits, it will be considered as the primary carrier, and will be responsible for making the initial payment toward the eligible expense.

If the other plan does provide for coordination of benefits, submit claims in the order listed below.

For Claims Incurred by You or Your Spouse

- submit claims first to the plan insuring you or your **spouse** as an employee/member, then to the plan insuring you or your **spouse** as a dependent
- in situations where you or your **spouse** have coverage as an employee/member under more than one plan, submit claims:
  - first to the plan where the person is covered as an active full-time employee
  - then to the plan where the person is covered as an active part-time employee
  - then to the plan where the person is covered as a retiree
  - then to the plan insuring you or your **spouse** as a dependent

For Claims Incurred by Your Child

- submit claims first to the plan covering the parent whose birthday is earlier in the calendar year (month/day). If both parents have the same birthday, submit claims first to the plan covering the parent whose first name begins with the earlier letter in the alphabet
  - however, if you and your spouse are separated or divorced, the order in which you submit claims depends on your custody arrangement
    - **for joint custody**, submit claims:
      - first to the plan of the parent with joint custody of the **child** whose birthday (month/day) occurs earlier in the calendar year, regardless of age
      - then to the plan of the other parent with joint custody
      - then, if applicable, to the plan of the (new) spouse of the parent whose birthday (month/day) occurs earlier in the calendar year (i.e. if this parent remarries or has a common-law spouse, the new spouse's plan will pay benefits for the **child**)

  - then, if applicable, to the plan of the (new) spouse of the other parent (i.e. if this parent remarries or has a common-law spouse, the new spouse's plan will pay benefits for the **child**)
  - if both parents with joint custody have the same birthday, submit claims first to the plan covering the parent whose first name begins with the earlier letter in the alphabet
- **for single custody**, submit claims:
  - first to the plan of the parent with single custody of the **child**
  - then, if applicable, to the plan of the (new) spouse of the parent with single custody of the **child** (i.e. if the parent with custody of the **child** remarries or has a common-law spouse, the new spouse's plan will pay benefits for the **child**)
  - then to the plan of the parent not having custody of the **child**
  - then, if applicable, to the plan of the (new) spouse of the parent not having custody of the **child** (i.e. if the parent without custody of the **child** remarries or has a common-law spouse, the new spouse's plan will pay benefits for the **child**)

If the order of benefit payment cannot be determined from the above, the benefits payable under each plan will be in proportion to the amount that would have been payable if coordination of benefits did not exist.

If the covered person is also covered under an individual travel insurance plan, submit the claim first in the order described in this section and then to the individual travel insurance plan.

Submitting a Claim

To submit a claim when coordination of benefits applies, refer to the following guidelines:

- determine which plan is the primary carrier and which is the secondary carrier (as outlined in Order of Benefit Payment)
- submit all necessary claim forms and – if you are submitting a paper claim – submit original receipts to the primary carrier
- keep a photocopy of each receipt
- once your claim has been settled by the primary carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and a copy of the receipts to the secondary carrier for further consideration of payment, if applicable

Payment of Claims

Once your claim has been processed, Great-West Life will send an explanation of benefits to you.

If you submit a paper claim, you should receive settlement of your claim within 15 working days from the date of submission to Great-West Life. If you use online claims, you should receive settlement within 7 working days. If you have not received payment or if you have any questions about the explanation of benefits, contact Great-West Life.

Advance Supply Limitation

Payment of any eligible expenses that may be purchased in large quantities will be limited to the purchase of up to a three-month supply at any one time, except for eligible **drug** expenses.

Drug Expenses

The maximum quantity of **drugs** or medicines that will be payable for each prescription will be limited to the lesser of the following:

- the quantity prescribed by the physician or dentist
- a 34-day supply

A quantity of up to a 100-day supply may be payable in long-term therapy cases, where the larger quantity is recommended as appropriate by the physician and the pharmacist.

Contacts and Resources

Great-West Life

▪ for details on claims or coverage ▪ to request a replacement benefits card ▪ to obtain a claim form	1-855-360-4415 1-800-990-6654 (for the deaf or hard of hearing) www.greatwestlife.com Have your benefits card handy when visiting the site or calling Great-West Life for coverage and claims information. This card includes the plan and identification numbers needed to access information on your coverage and claims.

Mailing Your Claim Forms

English Claims	French Claims
Great-West Life London Benefit Payments PO Box 5160 Station B London, ON N6A 0C6	Great-West Life Montréal Benefit Payments CP 8825 Succursale Centre-Ville Montréal, QC H3C 4K9

Great-West Life Online

Your claims are easy to manage when you register to use Great-West Life's GroupNet for Plan Members online secure site. Once you've registered, you can:

- get access to personalized information about your coverage
- submit many of your claims online
- track your claims and review your claims history
- arrange for direct deposit for claims reimbursement

Great-West Life's GroupNet for Plan Members site also provides you with access to:

- a copy of your benefits card, which you can print directly from the site
- personalized claim forms for paper claim submissions
- extensive health and wellness content

Visit www.greatwestlife.com or call Great-West Life at 1-855-360-4415 for more information about registering.

GroupNet Mobile App

By downloading Great-West Life's GroupNet Mobile app, you can access certain features of GroupNet for Plan Members from your mobile device to:

- submit many of your claims online
- access personalized coverage information about benefits, claims and more
- view benefits card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

GroupNet Text

GroupNet Text gives you immediate information specific to your benefits by allowing 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.

Coughlin & Associates Ltd.
Groups Administration Department

▪ to change your address, coverage or beneficiary designation ▪ for information on the rates and premiums you pay ▪ to obtain a claim form	1 888-613-1234 613 231-2266 (in the Ottawa region) admininquiries@coughlin.ca 466 Tremblay Road Ottawa, ON K1G 3R1

Glossary

Child

Your or your spouse's unmarried, natural, legally adopted, step or foster children who are residents of Canada and:

- under age 21
- under age 25, if they are full-time students studying within Canada or outside Canada at an accredited institute of learning and depend on you for support
- of any age, if mentally or physically disabled and incapable of self-sustaining employment and totally dependent on you for support, provided the disability began before they reached age 21 or while they were full-time students under age 25, and the disability has been continuous since then

Deductible

The amount of eligible expenses that you are responsible for (you must pay out-of-pocket) before Great-West Life will pay benefits.

Dependent

See definitions of Child and Spouse.

Drugs

Medications that have been approved for use by the Government of Canada and have a drug identification number.

If your eligible dependent is confined to hospital on the date coverage would normally end (for any reason other than contract termination), reimbursement will be made under the Health Plan for expenses incurred due to hospital confinement, until the earliest of the following events:

- the 90th day following the date coverage would normally end
- the date this policy terminates
- the date hospital confinement is no longer necessary

Immediate Family Member

You or your spouse, or your or your spouse's child, parent, brother or sister.

Note: Your or your spouse's parent, brother or sister are not eligible for coverage under the benefit plans outlined in this booklet, except for specific coverage under Travel Assistance. See Child and Spouse for who is eligible for coverage under the benefits program.

Medically Necessary

Broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Reasonable and Customary

The plan covers customary charges for 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.

Service

Service with the City starting from your last date of hire and including any periods of authorized leave of absence.

Spouse

The person of either sex who is your legal spouse or with whom you have been living in a role like that of a marriage partner continuously for at least 12 months and who is a resident of Canada. Only one spouse is eligible for coverage.

Stable

For out-of-province or out-of-Canada coverage, stable means that the covered person has not in the 90 days before the departure date of the trip outside their province of residence:

- been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination

- experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the covered person has been seen by a medical professional in relation to the symptoms
- been prescribed or recommended a change in treatment or medication related to the medical condition by a physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition
- been admitted to or treated at a hospital for the medical condition

In addition, the covered person did not have future medical appointment(s) planned with respect to an undiagnosed medical condition and did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition.