Your **group benefits**

An overview of your Great-West Life group benefits plan

CUPE Local 1310 - Simcoe County District School Board

Plan # 172858

THE Great-West Life ASSURANCE COMPANY

Welcome to

Great-West Life

The attached information package provides an overview of the benefits and services included in your group plan. Take some time to review the product summaries to help ensure you're familiar with the coverage available and the services provided under your plan.

We want to connect with you

Great-West makes connecting easier than ever. We've made your plan information accessible any time, from anywhere. Our free, cutting-edge online and mobile services can save you time with features including finding the location of the nearest approved medical service provider, and submitting a claim in a few short steps. Read on to learn about our convenient services that provide you with access to your benefits plan information.

To register for online access to information, go to www.greatwestlife.com. Click *Sign in to GroupNet for Plan Members* and *Register.* *GroupNet* will be available to you one business day after the effective date of your plan.

I want to:	Online	Mobile	Phone	Posted mail	Plan administrator
Register for *GroupNet™ for Plan Members*	●	●			
Submit a claim	●	●		●	
Sign up for Direct Deposit of claim payments	●	●			
Find out what my plan covers	●	●	●		
Find out my personal benefit details – benefit maximums, next appt date for dentist or vision, and more	●	●	●		
Report a change in my coverage – birth, divorce, loss of spouse's coverage, etc.	●				●
Get a paper claim form	●		●		●
Get help completing a claim form			●		●

Connecting with you

Member eClaims

Save time and paper by submitting many of your claims online. Sign in to *GroupNet for Plan Members* at **www.greatwestlife.com**. Make sure you sign up for Direct Deposit and eDetails. Now you're ready to submit claims online. Hold onto your receipts for 12 months. We're committed to protecting your plan and claims submitted electronically are subject to random audits.

Provider eClaims

On-the-spot claims submission at approved providers. Claims will be assessed immediately and your provider will be able to let you know whether the claim is approved, declined or held for review. To view a list of approved providers, go to **www.greatwestlife.com**.

GroupNet Mobile

All the convenience of Great-West's *GroupNet for Plan Members* on your mobile device. Available on your smartphone, use this app to:

- Submit claims online
- Access personal coverage information
- Locate the nearest provider who has access to Provider eClaims through a built-in GPS mapping tool.

DrugHub

Available free for iPhone and iPod touch mobile devices, Great-West's *DrugHub* is a virtual medicine cabinet that lets you:

- Search thousands of medications – ingredients, interactions and side effects
- Set reminders for you and your family to take medications on schedule
- Know when you're running low, when to order refills and more!

Text message

If you submit a claim online and if it's auto-adjudicated, you can receive a text message that advises your claim has been processed and that payment will be deposited into your bank account. To sign up go to *GroupNet for Plan Members – Your Profile – Claim Payment Notification Preferences*.

GroupNet for Apple Watch

One more way you can access your benefits information, any time, anywhere. You can check your coverage balances and claims history, receive claims notifications, access your plan member I.D. cards, and locate approved health care providers using the built-in GPS mapping tool.

To view benefit plan details including coverage, deductibles, claims history and more, sign in to *GroupNet for Plan Members* at *www.greatwestlife.com.*

Need more information?
Call us at the customer services number provided on your card. TTY: 1-800-990-6654 *(Available 7 a.m. to 6 p.m. CST)*

Co-ordination of benefits

If both you and your spouse have coverage under your group insurance plans, you may be able to recover 100% of your expenses.

If the claim is for:		
YOU	1 Submit the claim to Great-West.	2 Submit a claim through your spouse's plan for any amount unpaid by Great-West.
YOUR SPOUSE	1 Submit the claim to your spouse's insurance plan.	2 Submit a claim to Great-West for any amount unpaid by your spouse's insurance plan.
YOUR CHILD	1 Send the claim to the insurance company of the person who has the earlier birth month and day.	2 Submit the unpaid balance to the other insurance company.

THE Great-West Life ASSURANCE COMPANY

www.greatwestlife.com

A tax-free way to pay for additional medical expenses

Healthcare Spending Account

What do sports injuries, allergies and diabetes have in common? Their treatment can leave you with significant out-of-pocket expenses, even with group insurance coverage. That's where a Healthcare Spending Account (HCSA) can benefit you.

What is an HCSA?

An HCSA is like a bank account. You start each plan year with a certain number of credits in your account. Throughout the year, you can use those credits to pay for or top-up coverage for certain health, vision, and dental care expenses not covered by your group benefits plan or provincial health care. They can also be used to cover costs that qualify for a medical expense tax credit under the Income Tax Act.*

For example, you can use HCSA credits to purchase vitamins, hearing aids, eyeglasses, or to top up coverage for your child's braces.

Who can use your HCSA?

Your HCSA covers you, your spouse and your dependants under the following conditions:

- You must be covered for Great-West Life's basic group benefits plan, or by your spouse's plan.
- Your spouse and dependants must be covered for basic health care benefits by your group plan or your spouse's plan.
- If your child isn't eligible for basic health care benefits due to student age restrictions, he or she can still qualify for the HCSA.

Before establishing an HCSA, consult with your independent tax advisor to review your needs and to determine whether an HCSA is appropriate for your particular circumstances.

*For a complete list of expenses that qualify for a medical expense credit, contact your local Canada Revenue Agency district office.

Healthcare Spending Account

Submitting claims

An HCSA only covers the balance remaining after all other insurance plans have paid out. That includes your basic plan, your spouse's plan and your provincial plan. Your first step is to submit your claim to all other sources before the HCSA.

There are specific forms for HCSA claims. Use these forms when you're claiming benefits from your HCSA, or when you're claiming benefits from your basic plan and want any remaining balance to be paid by the account. Forms are available on *GroupNet™ for Plan Members* or from your plan administrator.

You have up to 31 days past the end of the plan year to submit claims for expenses incurred during the plan year. Qualifying expenses are reimbursed out of the remaining HCSA balance for that plan year.

Exclusions

There are some exclusions to HCSA coverage, including:

- Expenses that private insurers aren't legally permitted to cover
- Services and supplies for which there's normally no charge
- Any portion of an expense for services and supplies for which benefits are payable under another group plan or a government plan
- Expenses arising from war, insurrection, acts of terrorism or voluntary participation in a riot.

For a complete list, contact your local Canada Revenue Agency district office.

This brochure highlights the features of the Healthcare Spending Account. The plan provisions are detailed in the Group Contract issued to your plan sponsor by The Great-West Life Assurance Company. The Group Contract is the governing document. If you would like further information about the Healthcare Spending Account, please contact your plan administrator.

THE Great-West Life ASSURANCE COMPANY

www.greatwestlife.com

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Completing the **Healthcare Expenses Statement**

You can use the Healthcare Expenses Statement form to submit claims for the following benefits:

- Healthcare
- Visioncare
- Prescription drugs

The form is divided into four sections:

Part 1: Confirmation, authorization, and signature

This section requires a signature from you that confirms that all information given on the claim form is true, correct, and complete to the best of your knowledge.

Part 2: Plan member information

Information requested in this section identifies you and your group benefits plan.

When accessing this form on GroupNet for Plan Members, information will be pre-filled to the greatest extent possible. Review the information to ensure it is complete and correct.

If any information shown requires a change and/or correction, click on the blue text and edit as appropriate.

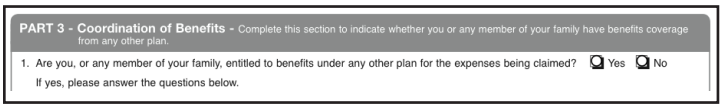
If you are completing this section, provide your Employee ID number, plan number, and plan name. Depending on where you look up the information, the plan number and plan name may be referred to as policy number and name. You can find the information you need on your plan ID card, on the Explanation of Benefits statement, or from your plan sponsor (i.e. employer). If you do not know your division number, leave it blank, as it is not pertinent to your claim submission.

Part 3: Coordination of benefits

The person you are submitting a claim for may be covered under government plans, or the benefits plan of a spouse. This section helps us determine how your claim should be processed depending on your age and circumstances.

Read this section to determine if any of the questions apply to you. If you are claiming for yourself or a family member, and are covered under the benefits plan of a spouse (common law or married), provide the name of your spouse's insurer, and the policy number.

If you or any other family member is covered under a benefits plan other than this Great-West plan, check "Yes" when asked, "Are you or any other member of your family entitled to benefits under any other plan for the expenses being claimed?"



PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ❑ Yes ❑ No

If yes, please answer the questions below.

Part 4: Patient information

Birthdate information is very important when submitting claims for a dependent child who has coverage under both you and your spouse, as the earliest birthdate (month/day, not year) is used to determine whose plan pays for the claim. Information requested in this section identifies the dependants covered under your benefits plan. Complete this section if you are making a claim for one or more of your dependants.

Part 5: Claim details

Information requested in this section provides details about the claim(s) you are making. All original receipts must be attached to each claim submission (receipts will not be returned).

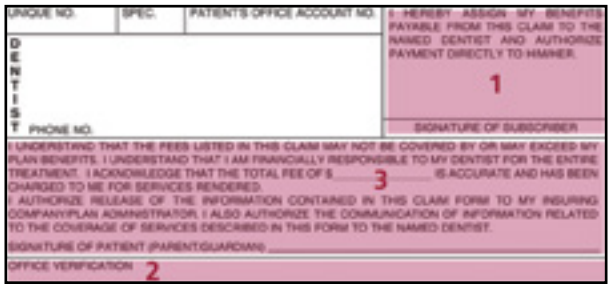
Completing the **Standard Dental Claim Form**

The dental claim form is divided into three sections:

Part 1: Dentist

Either you or your dentist can complete the patient information. Your dentist must complete the remaining information. Please ensure your dentist signs (signature #2) the form once he or she has completed this section.

If you choose to have payment sent directly to your dentist, you must sign where it states, "I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him or her" (signature #1). If this area is not signed, you will receive the payment. You must, in all instances, sign where it states, "I understand that the fees listed in the claim may not be covered…" (signature #3).



Part 2: Employee information

Information in this section identifies you and your group benefits plan.

When accessing this form on *GroupNet for Plan Members*, information will be pre-filled to the greatest extent possible. Review the information to ensure that it is complete and correct.

If any information shown requires a change and/or correction, click on the blue text and edit as appropriate.

If you are completing this section, provide your plan number, employee ID number, division number, and plan name. Depending on where you look up the information, the plan number and plan name may be referred to as policy number and name. You can find the information you need on your plan ID card, on the Explanation of Benefits statement, or from your plan sponsor (i.e. employer). If you do not know your division number, leave this field blank, as it is not pertinent to your claim submission.

Part 3: Coordination of benefits

The person you are submitting a claim for may be covered under a government plan, or the benefits plan of a spouse. This section helps Great-West determine how your claim will be processed depending on your age and circumstances.

Read this section to determine if any of the questions apply to you. If you are claiming for yourself or a family member, and are covered under the benefits plan of a spouse (common law or married), provide the name of your spouse's insurer, and the policy number.

If you or any other family member is covered under a benefits plan other than this Great-West plan, you must check "Yes" when asked, "Are you or any other member of your family entitled to benefits under any other plan?"

If any other family member (other than yourself) is insured under this benefits plan with their own benefits (i.e. are employed by the same employer as yourself), check "Yes" when asked, "Is any member of your family (other than yourself) insured as an employee under this plan?" If you have answered "Yes" to this question, provide your spouse's date of birth.

Birthdate information is very important when submitting claims for a dependent child who has coverage under both you and your spouse; the earliest birthdate (month/day, not year) is used to determine whose plan pays first.

THE Great-West Life ASSURANCE COMPANY

Healthcare Expenses Statement
With Healthcare Spending Account

Benefits to be paid from:
- ❑ Healthcare Plan Only
- ❑ Healthcare Spending Account Only
- ❑ Both

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See PART 9.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - Plan Member Information (1)

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name: CUPE Local 1310 - Simcoe County District School Board

Plan number: 172858

Plan member I.D. number:

Plan Member Name

Last name:

First name:

Plan Member Address

Number and street:

City or town:

Province:

Postal code:

Date of birth: Day: Month: Year:

Language preference: ❑ English ❑ French

PART 2 - Coordination of benefits (2)

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. **Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed?** ❑ Yes ❑ No **If yes, please provide:**

Name of insurance company:

Plan number:

Plan member I.D. number:

If spouse's plan, please provide spouse's date of birth:

Day: Month: Year:

2. **Is treatment required as the result of a motor vehicle accident?** ❑ Yes ❑ No

3. **Is a claim being made for Workers' Compensation Benefits?** ❑ Yes ❑ No

PART 3 - Patient information (3)

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 18 years: Full time student hours per week	Full time student Yes	Full time student No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	Does Patient Reside with Plan Member? No
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑

PART 4 - Prescription drug expenses (4)

For all prescription drug claims

Attach all original receipts.
- **Patient name, date of purchase, drug identification number and drug name.**

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Great-West Life
Healthcare Expenses Statement

PART 5 - Paramedical Expenses 5

For chiropractor, physiotherapist, massage therapist, psychologist, etc.

Attach original receipts. Receipts must indicate the:
- **Patient name, length and type of service and date of service**
- **Healthcare provider's name, address, phone number, designation and professional association**
- **Date last paid by provincial plan (if applicable)**

Provider's name	Type of service	Phone number

PART 6 - Medical Expenses 6

For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis. Receipts must indicate the:
- **Patient name, date of service and description of item purchased**
- **Provider's name, address and telephone number**
- **Provincial plan statement of payment (if applicable)**

PART 7 - Visioncare Expenses 7

Laser eye surgery, glasses, contact lenses and eye exams.

Attach original receipts.
Reason for purchase of lenses? (check all that apply)

❑ **Initial prescription** ❑ **Prescription change** ❑ **Loss or breakage**

❑ **None of the above**

PART 8 - Confirmation, Authorization and Signature 8

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes.

I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I certify that the information given is true, correct and complete to the best of my knowledge.

I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

Plan Member signature X _____

Date: Day | Month | Year

PART 9 - Submitting Your Claim 9

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

London Benefits Payment Office
PO Box 5160 Stn. B
London ON N6A 0C6

THE Great-West Life ASSURANCE COMPANY

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association

Benefits to be paid from:
- ❑ Dentalcare Plan Only
- ❑ Healthcare Spending Account Only
- ❑ Both

Dentalcare Expenses Statement
With Healthcare Spending Account

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. If you wish benefits to be paid directly to the dentist, sign the assignment portion of PART 1 below. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
5. Send to the appropriate Benefit Payment Office for your plan. See PART 7.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - DENTIST INFORMATION - To be completed by Dentist (1)

PATIENT

Last name | Given name

Address | Apt./Suite No.

City | Prov. | Postal code

Unique No. | Spec. | Patient's office account No.

DENTIST

Phone No.

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of subscriber

For dentist's use only, for additional information, diagnosis, procedures, or special consideration.

Duplicate form ❑

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment.

I acknowledge that the total fee of $ _____ is accurate and has been charged to me for services rendered.

I authorize release of the information contained in this claim form to my insuring company/plan administrator. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of patient (parent/guardian)

Office verification

Date of Service Day Month Year	Procedure Code	Intl. tooth Code	Tooth Surfaces	Dentist Fees	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable, e. & o.e. **TOTAL FEE SUBMITTED** $

PART 2 - Claim Details - To be completed by Dentist (2)

Please specify claim details.

1. Is this treatment required as the result of an accident? ❑ Yes ❑ No
   If yes, please provide:
   Date: | Location:
   Explain how accident happened
2. If claim is for a denture, crown, or bridge, is this initial placement? ❑ Yes ❑ No
   If no, give date of prior placement and reason for replacement:
3. If claim is for a denture or bridge, please provide missing tooth number(s):

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Great-West Life
Dentalcare Expenses Statement With Healthcare Spending Account

PART 3 - Plan Member Information 3

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name: CUPE Local 1310 - Simcoe County District School Board

Plan number: 172858

Plan member I.D. number:

Plan Member Name

Last name:

First name:

Plan Member Address

Number and street:

City or town:

Province:

Postal code:

Date of birth: Day | Month | Year

Language preference: ❑ English ❑ French

PART 4 - Coordination of benefits 4

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ❑ Yes ❑ No If yes, please provide:

   Name of insurance company:

   Plan number:

   Plan member I.D. number:

   If spouse's plan, please provide spouse's date of birth: Day | Month | Year

2. Is a claim being made for Workers' Compensation Benefits? ❑ Yes ❑ No

PART 5 - Patient information 5

Complete this section if claim is for spouse or dependant.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 18 years: Full time student hours per week	Full time student Yes	Full time student No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	Does Patient Reside with Plan Member? No
				❑	❑		❑	❑

PART 6 - Confirmation, Authorization and Signature 6

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes.

I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I certify that the information given is true, correct and complete to the best of my knowledge.

I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

Plan Member signature X _____ Date: Day | Month | Year

PART 7 - Submitting Your Claim 7

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

London Benefits Payment Office
PO Box 5160 Stn. B
London ON N6A 0C6