CBC/RADIO-CANADA HEALTH PLAN & TRAVEL ASSISTANCE

March 2019

CBC Radio-Canada

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The Health Plan helps with medical expenses, supplementing your provincial/territorial plan coverage. The Health Plan includes **Travel Assistance** when you travel for CBC/Radio-Canada business or for pleasure; go to GroupNet for plan members to obtain a copy of the card or of the Travel Assistance Summary.

About Great-West Life

Great-West Life Assurance Company provides administrative services only for the Health Plan & Travel Assistance under plan number **51089**.

Your coverage includes a pay-direct drug card. With your drug card, eligible drug expenses are reimbursed automatically when you fill your prescription at the pharmacy.

For claims and coverage inquiries, contact Great-West Life at **1-877-340-9082** or visit GroupNet for plan members. If you are calling from outside North America, please call (204) 946-1190 collect, and ask to speak to a customer service representative in the Out-of-Country Claims Department.

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at www.greatwestlife.com/login. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your pay-direct drug card and personalized claim forms
- your benefit details, claims history and claim status
- online claim submission for many of your health benefits
- confirm if your prescription drug will be covered with Drug Search
- add or remove your dependents

Expatriates

If you are an expatriate employee, please refer to Appendix III in the CBC/Radio-Canada Expatriate Program document for additional information on some specific benefits provisions for expenses incurred outside Canada, as well as how to contact Great-West Life, during your assignment.

Coverage

The Health Plan covers the medical services and supplies listed in this section.

All of the following conditions must be met:

- You must participate in the Health Plan. If your spouse or child incurred the expense, you must have family coverage.
- The expense must be reasonable and customary and medically necessary.
- Claims for expenses eligible under provincial or territorial health care plans or programs must be submitted to the governmental entity before being submitted under the Health Plan.
- The medical service or supply must be prescribed by a person legally authorized to prescribe in Canada.

The Health Plan covers:

- Eligible expenses incurred in Canada while temporarily out-of-province if these expenses were incurred as a result of an emergency or a sudden unexpected illness and provided the expenses would have been covered by your provincial health care plan had they been incurred in your province of residence.
- If you have dependents studying outside your province of residence, make sure their provincial coverage is maintained, since the Health Plan covers only emergency, unexpected medical services.
- Eligible expenses incurred in Canada, outside your province of residence, for reasonable and customary treatment that is not readily available in your province of residence and that a portion of the treatment is paid by the provincial health care plan had the treatment been rendered in your province of residence. The Health plan would be the second payer, if there is a portion left over to pay.
- Coverage is provided for you or your eligible dependents in the event of a sudden and unexpected medical emergency or acute illness or injury that occurs while temporarily traveling outside Canada for business or on vacation. All claims are subject to plan provisions, including coinsurance, maximums, and deductibles.
- There is no lifetime maximum for out-of-the country expenses.

Each benefit year runs from January 1 to December 31.

Drug expenses	All other eligible expenses (Vision care, Medical services and supplies)
The Health Plan pays **100% of the drug or of the least expensive generic equivalent of a brand name drug**, if available.	The Health Plan pays **100% unless specified otherwise**.
Deductible	
You pay a deductible of $5 for each drug that is prescribed up to $150 per person per calendar year.	You pay $75 per covered person, for all services combined, up to $100 for the entire family per calendar year, except for a semi-private hospital room.

Save at Costco pharmacies

Dispensing fees and prescription costs can vary from one pharmacy to the other. Great-West Life and Costco Wholesale have an arrangement under which members of participating plans pay lower-than-average prescription drug costs when they fill their prescriptions at a Costco pharmacy:

• If you get your prescription filled **with your drug card** at Costco pharmacies the **$5 deductible will be waived**.

• Depending on your province of residence, you may also be able to buy your prescription drugs online at www.costcopharmacy.ca and benefit from the same low prices. There are no shipping fees.

Note:

• A Costco membership is not required to purchase prescription drugs at their pharmacy.

• **This program is not available in the province of Québec.**

Prescription drugs

The Health Plan covers medication that legally requires a physician's (M.D.) prescription, is listed under the Telus Complete Managed Formulary** and is dispensed by a licensed pharmacist, or other person entitled by law to dispense it, including the following:

- insulin, self-injection syringes and insulin-related supplies (disposable needles for use with non-disposable insulin injection devices, sensors for flash glucose monitoring machines, lancets and test strips),
- limited over-the-counter medication judged by Great-West Life to be life-sustaining,
- injectable drugs***,

- oral contraceptives,
- smoking cessation: Up to $500 lifetime or, in Québec, up to RAMQ's calendar year maximum, and
- fertility drugs.

**As new drugs become eligible, only those recommended by an independent board of professionals and approved by TELUS Health will qualify for coverage. TELUS Health is the largest Health Benefit Manager in Canada and offers electronic claims processing services for the largest insurer in the country, including Great-West Life. To find out if a specific prescription drug will qualify for reimbursement under the Health Plan, please consult the Drug Search on the GroupNet for Plan Members. Or contact Great-West Life.

***Injectable drugs administered by a physician are covered to a maximum of $15 towards the total cost of all drugs/injections provided on a single date of service at a clinic or doctor's office. If there are multiple drugs/injections provided during the same date of service, only $15 will be reimbursed. Additional fees charged for the administration of these drugs are not covered.

Pre-authorization

Certain prescription drugs require pre-authorization. Please go to GroupNet for Plan Members for the listing of the prior authorization drugs or contact Great-West Life.

Coverage of generic versus brand-name drugs

Reimbursement of prescription drugs will be based on the cost of the lowest-cost generic alternative of the prescribed drug (if there is one) unless there is a medical reason that would prevent the use of a generic drug as attested by the patient's doctor.

If there is a medical reason why the patient cannot take the generic equivalent of the brand-name drug, the patient and the patient's doctor must complete and send to Great-West Life the *Request for Brand Name Drug Coverage* form. Great-West Life will assess the request and send a letter indicating if the request for brand-name drug coverage has been approved. The form is available on the Great-West Life website or by contacting Great-West Life by phone.

If there is no medical reason preventing you from using the generic equivalent of the brand-name drug prescribed, but you choose to ask for the brand-name drug, the Health Plan will pay the cost of the lowest-cost generic alternative and your share of the cost will increase accordingly.

Pay-direct drug card

Always use your pay-direct drug card when paying for any prescription drugs or eligible diabetic supplies (such as syringes, needles, test strips and lancets). Great-West Life will reimburse eligible expenses to the pharmacist directly and you only pay your share of the cost of each prescription.

If you don't have the card with you, you need to know the information printed on the drug card in order for the claim to be processed electronically. Using the card will allow the pharmacist to electronically verify your eligibility and know if this drug is covered under the Plan.

When you go to a pharmacy to fill a drug prescription, the cost includes the cost of the drug itself and a dispensing fee, which is the amount pharmacies charge for their professional services to fill the prescription. When using the drug card, price limits established through the drug card system will be applied on the cost of the drug and the dispensing fee that the pharmacy can charge. The pharmacy cannot charge more than those limits.

If you don't use your drug card when purchasing a prescription, the pharmacist may charge you more than the established price and you may end up paying more because there is no way to monitor and verify that the amount charged by the pharmacist does not exceed the drug and dispensing fee limits. Therefore, when you submit your paper claim to the Great-West Life for reimbursement, it will be assessed and paid based on the price limits established through the drug card system and **you may end up paying more out of pocket than you would have, had you used the drug card to purchase your prescription.**

You will not receive a plastic card:

- To obtain a copy of the card, you will need to go to GroupNet for plan members: www.greatwestlife.com/login under "Forms & Cards" to print a drug card.
- You will need to open an account on GroupNet for Plan Members www.greatwestlife.com/login.

Note: It may take up to 30 days after the start of your coverage for Great-West Life to set-up your file. Once that has been done, you will be able to open a GroupNet for Plan Members account. If you purchase prescription drugs in this period, you will need to pay for them up front and submit a paper claim to Great-West Life. You may want to wait to open a GroupNet for Plan Members account and submit your claim online.

Prescription drug quantities/limits

The quantity of medication that can be dispensed will vary depending on whether the medication is considered to be an acute or a maintenance medication.

- **Acute medications**, which include antibiotics and pain medications, are usually prescribed to treat one-time or short-term conditions. When you use the pay-direct drug card, you will be reimbursed up to a 34-day supply of these drugs, as prescribed by a physician. If you are taking an acute medication on a regular basis, you can request to increase the 34-day supply limit to a 100-day supply by sending an email, writing or calling Great-West Life. The reason for the request will need to be provided. Great-West Life will note the new limit for that drug in their system, and the next time your prescription for this drug is filled, your pharmacist will be able to dispense the quantity your physician prescribed. Otherwise, if you purchase more than the recommended 34-day supply, you will have to submit a claim to Great-West Life to be reimbursed for the difference.
- **Maintenance medications** are usually prescribed to treat chronic or long-term conditions, such as high blood pressure and high cholesterol; therefore, these drugs are used on a long-term basis. When you use the pay-direct drug card, you will be reimbursed up to a 100-day supply of these drugs, as prescribed by a physician.

All other eligible expenses (Medical services and supplies)

Great-West maintains a list of services and supplies that require prior authorization. Prior authorization is intended to help ensure that price being charged and treatment are reasonable. Contact Great-West Life for an estimate of what will be reimbursed.

A claim for a service or supply that was purchased from a provider that is not approved by Great-West may be declined. The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

Eligible expenses:

The Health Plan pays 100% of eligible expenses exceeding what the provincial plan covers, up to certain maximums **unless specified otherwise.** Please contact Great-West Life for more details on medical supplies not listed in this table.

See section Claim Submission Guidelines for more information on submission requirements.

Alcoholism and drug addiction treatment	• If your provincial or territorial health plan covers the treatment in a recognized centre: $150/day (for room accommodation), up to 30 days. • If your provincial or territorial health plan does not cover any treatment cost in a recognized facility: $30/day (for room accommodation, up to 30 days. • Lifetime maximum: A total of 30 days for each covered person.
Ambulance	Licensed ground or air ambulance to the nearest centre where essential treatment is available.
Breathing machines	Breathing machine (includes Continuous Positive Airway Pressure machine (CPAP), Nasal Constant Positive Airway Pressure machine (NCPAP) and Automatically Adjusting Positive Airway Pressure machine (APAP). • Rental or purchase, as approved by Great-West Life. • See section Claim Submission Guidelines.
Graduated compression hose	• Benefits will be determined according to the compression factor of the hose, which is measured in millimeters of mercury (mmhg), compression factor of at least 15 mmhg. • Limit of 4 pairs per calendar year. • See section Claim Submission Guidelines.
Diabetic supplies	If you are insulin-dependent: • one external infusion pump in any five-year period, • one needleless insulin jet injector per lifetime,

	• blood glucose monitoring devices, • Flash glucose monitoring devices (FGMs).
Dental treatment	• The Health Plan pays dental work to your natural or artificial teeth as a result of an accidental injury, the Health Plan (not the Dental plan) will cover the reasonable and customary expenses at 100% for out-of-hospital dental treatment. • Treatment is completed within six months of the accident.
Hearing aids	• Must be prescribed by a physician, or an ear, nose, and throat specialist. • The Health Plan pays up to $500/ear/60-month period.
Hospital Beds	• Standard hospital bed (including maintenance and replacement) • Rental or purchase, as approved by Great-West Life.
Hospitalization	Hospital services and supplies provided on an out-patient basis that the provincial plan does not cover. Semi-private room in a general or convalescent hospital: • The Health Plan pays 100% (above what the provincial plan plays for ward accommodation). Private room in a convalescent hospital: • The Health Plan pays 100% of difference in cost between semi-private and private room, up to 120 days per calendar year. • You pay any cost after 120 days. Private room in a general hospital: • The Health Plan pays up to 12$/day for the difference in cost between semi-private and private room. • You pay any amount over 12$/day. Hospitalization and related services and supplies, above provincial health care coverage, including care in a convalescent hospital, to a maximum of 120 days in any one benefit year, provided that the hospitalization is recommended by a doctor and follows a hospitalization of at least three days in an acute treatment hospital for the same condition: • the difference between charges for standard ward and semi-private accommodation, and • out-patient supplies and services not covered by the provincial plan.
Hospital and medical	Eligible expenses incurred while in **another Canadian province or outside of the country**, provided that some portion of the expense is

expenses outside the province of residence or outside of the country	payable by the provincial plan or would be eligible under the provincial plan if incurred in the province of residence, subject to Great-West Life's evaluation, for • emergency hospitalization and medical services while temporarily out-of-province or outside of the country on business, vacation or for furthering education, and • hospital charges and medical expenses for treatment not readily available in the patient's province of residence. The Health plan does **not cover** the expenses incurred outside Canada for: • non-emergency or follow-up care after the initial emergency treatment, • non-emergency and/or ongoing care of a condition for which the patient was receiving treatment in Canada, or treatment/tests the patient could reasonably anticipate would be required while outside Canada even if they were deemed urgent, • pregnancy-related and/or delivery-related expenses after the 34th week of pregnancy, or at any time prior to the 34th week if the patient's Canadian doctor considers the pregnancy high risk, • continued medical care following an emergency outside Canada if the patient's medical condition permits a return to Canada for treatment, and • any expenses incurred outside your province/territory of residence when you were not covered by your provincial/territorial health plan.
Medical supplies	Splints, trusses, braces with rigid supports (excluding lumbar supports unless they are constructed with rigid supports), crutches or casts.
Orthopedic shoes	• Must be prescribed by a physician, orthopedic surgeon, podiatrist or chiropodist (patient's medical condition must be provided on the prescription). • Must be custom-made orthopedic shoes or sandals (including sandalthotics) specially constructed for the patient or orthopedic shoes that have been custom-fitted for the patient. • Orthopedic shoes or sandals that are purchased to accommodate an orthotic are not covered. • Mass-produced, brand name orthopedic shoes or sandals are not eligible for reimbursement unless they were custom-fitted for the patient.

	• Limited, for adults, to one pair every 12 consecutive months or limited to the repair and modification to existing orthopedic shoes in the same 12 consecutive months period. • Reasonable and customary for dependent children under age 18. • See section Claim Submission Guidelines.
Orthotics	• Must be prescribed by a physician, orthopedic surgeon, podiatrist, or chiropodist (patient's medical condition must be provided on the prescription). • Must be custom designed and made for the patient. • See section Claim Submission Guidelines.
Paramedical services (no doctor's prescription needed)	The Health Plan pays 100%, up to $500 per person each calendar year for each type of practitioner: • chiropractors • osteopaths • podiatrists or chiropodists • naturopaths • acupuncturists Cost of laboratory tests or X-rays are included in the $500 maximum per type of specialist if within their scope of practice. For podiatrist: if the services were paid in part by Ontario or Alberta health, the Health Plan & Travel Assistance will cover only once the provincial max is reached.
Paramedical services (doctor's prescription needed)	The Health Plan pays 100% - No maximum reimbursement: • physiotherapists and athletic therapists The Health Plan pays 100%, up to $500 per person each calendar year: • massage therapists The Health Plan pays 90% - No maximum reimbursement: • psychological services The service must be provided by a registered psychologist. A recommendation from a CBC/Radio-Canada EAP Resource Centre is accepted for psychological services. The Health Plan pays 90%,up to $500 per person each calendar year: • Speech therapist

	Doctor prescription: You will need your prescription renewed annually for ongoing treatment. Your prescription is valid for a 12-month period if your treatment starts within the first six months following the prescription date; otherwise, you will have to obtain a new one. Your prescription is also valid for 12 months if treatment has not been interrupted for six months or more.
Private-duty nursing	• The Health Plan pays 100% - No maximum reimbursement. • See section Claim Submission Guidelines.
Prosthetic appliances/supplies	Artificial limbs or eyes and other prosthetic devices required after surgery, including repair and replacement (excluding myoelectrical limbs), once any government assistance plan maximums have been reached.
Tens machines (Transcutaneous electrical nerve stimulators)	• Approval by Great-West Life is recommended. • Must be prescribed by a physician to relieve chronic pain (patient's medical condition must be provided on the physician's prescription including confirmation that the condition is chronic). • Limited to 1 machine per 5 years. • See section Claim Submission Guidelines.
Travel Assistance	• Emergency travel assistance for you during CBC/Radio-Canada business or for you and your covered dependents during personal travel anywhere in the world, or more than 500 kilometers from your place of residence within Canada. • Emergency medical assistance includes a 24-hour help line, medical advisors, medical evacuation, help in locating health care, and much more. • Travel Assistance Card and Travel Assistance Summary are available on Groupnet: www.greatwestlife.com/login.

Vision care	Eye exams:
	• One per person each calendar year.
	Prescription glasses or contact lenses:
	• $240 per person every 24 months.
	• The 24-month maximum reimbursement period:
	  ○ begins on the date you purchase your glasses or contact lenses; and
	  ○ expires exactly two years later.

Wheelchairs	• Standard wheelchair (including maintenance and replacement).

	• Rental or purchase, as approved by Great-West Life.
Wigs	• Must be a permanent hair loss as a result of any injury or disease, or for temporary hair loss as a result of medical treatment for any disease. • Must be prescribed by a physician (patient's medical condition must be provided on the physician's prescription). • Up to $200/lifetime.

Exclusions and limitations

Most diagnostic services performed in a private clinic are not covered as these services are covered by your provincial government health plan and will not be reimbursed. Some diagnostic services may be covered, contact Great-West Life before incurring any expenses.

Health benefits are not paid when the patient is not under the continuing care of a physician. Benefits are not paid for supplies and services:

- received before the person was covered by this plan,
- that do not represent reasonable treatment,
- associated with recreation or sports rather than with other daily living activities or extra medical supplies that are spares or alternates,
- covered by any government plan, including provincial health care, workers' compensation or provincial automobile insurance, or for which a government plan prohibits payment,
- generally provided without cost, or that the person would not have had to pay in the absence of this insurance,
- provided by a government hospital, unless you are required to pay for such services,
- provided by CBC/Radio-Canada, a mutual benefit association or any employee group,
- required as a result of an injury or disease resulting from voluntary participation in a war or any act of war, civil disorder, riot or insurrection.

In addition, no benefits are paid for the following:

- any injury sustained as a result of or in the course of any employment other than with CBC/Radio-Canada,
- expenses private insurers are not permitted to cover by law,
- services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Travel Assistance,
- services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province,

- a disability that the covered person chooses not to have treated by a doctor,
- treatments received while in the services of any armed forces,
- hospital services primarily provided for chronic or custodial care, unless specifically covered as an eligible expense,
- cosmetic surgery or treatment, except as a result of a dental accident,
- doctors' mileage or travel time, transportation costs, or consultations by telephone or other means,
- pregnancy tests or routine medical checkups,
- hearing test, laser eye surgery, non-prescription sunglasses or safety glasses,
- missed appointments, completion of forms or medical examinations for the use of a third party,
- medication prescribed or dispensed without respecting federal or provincial regulations, or services performed by unqualified practitioners,
- delivery charges or your mileage/travel expenses for treatment,
- preventative vaccines and immunization products,
- consultation with a social worker, or
- drugs for erectile dysfunction.

Claims

For all expenses other than prescription drugs and eligible diabetic supplies, submit a paper claim to Great-West Life or an e-claim via GroupNet for Plan Members.

Submit claims as soon as you can. The Health Plan will not pay claims submitted more than 15 months after the expense is incurred.

Claim Submission Guidelines

When you submit a claim be sure to include the invoice from the clinic or medical supply store where you received the services. To ensure there are no delays in the processing of your claim, the invoice must include the following:

- provider’s name, designation, address and phone number,
- name of the patient who received the service or supply,
- type of service (i.e., massage) or supply (i.e., brace),
- date the expense was incurred*, and
- total charge for the expenses and/or a breakdown of the charges for multiple items/services.

*Note: The incurred date for medical services is the date you received the service. The incurred date for medical equipment or supplies is the date you picked up or received the equipment or supplies.

Prescription Requirements

When you submit a claim for a medical expense that requires a prescription, ensure the prescribing physician indicates the medical condition for which the medical device or service is being prescribed, on the prescription. A medical condition can be a disease, illness or injury. A prescription that only indicates symptoms (i.e., knee pain, ankle swelling) or a medical device (i.e., orthotics, wheelchair) is not an acceptable prescription. These prescription rules apply to any medical device or service that requires a prescription.

Special claim submission requirements

This section provides an outline of special claim submission requirements depending on the medical expense, along with a completed claim form and invoice, additional information may be necessary. Claims for medical expenses listed below require more information:

Expenses outside of Canada:

Make a claim to Great-West Life for all expenses. Great-West Life can reimburse you in full for eligible out-of-country expenses and obtain reimbursement of the provincial portion if you complete a designation form. Contact Great-West Life for details immediately after the expenses have been incurred because certain provincial or territorial plans have very strict time limits. Any delays in making a claim can potentially impact coverage available to you by both the province and Great-West Life.

Expenses outside your province or territory:

Submit a claim and related receipts to your provincial or territorial plan and keep copies. Once the province has assessed and paid your claim, send a complete claim form, a provincial statement of payment, as well as duplicate receipts to Great-West Life for assessment.

Graduated compression hose:

When submitting a claim for graduated compression hose, include the following information:

- prescription from a physician indicating the patient's medical condition,
- detailed invoice,
- the compression factor of the hose, and
- brand name and model number of the compression hose.

If the claim is for custom-made compression hose, along with the details listed above, include the following:

- explanation from the patient's physician explaining why stock-item compression hose can't be used by the patient, and
- copy of the order form from the lab.

Custom-made orthotics:

When submitting claims for custom made orthotics, include the following information:

- prescription from the physician, orthopedic surgeon, podiatrist, or chiropodist indicating the patient's medical condition,
- detailed copy of the biomechanical assessment/examination,
- details of the casting technique used to acquire an anatomical model of the patient's foot,
- date the orthotics were dispensed to the patient, and
- invoice providing the name, address, and phone number of the clinic or provider along with a list of all charges.

Custom-made orthopedic shoes:

When submitting claims for custom made orthopedic shoes, include the following information:

- prescription from the physician, orthopedic surgeon, podiatrist or chiropodist indicating the patient's medical condition and an explanation why stock-item orthopedic shoes can't be used by patient,
- details of the casting technique used to acquire an anatomical model of the patient's foot,
- details of the fabrication process and materials used to make the shoes, and
- invoice providing the name, address, and phone number of the dispensing clinic or provider along with a list of all charges.

Breathing machines:

When submitting claims for breathing equipment, including continuous positive airway pressure machines (CPAPs), include the following information:

- prescription from the patient's attending physician indicating the patient's medical condition,
- copy of the patient's sleep study, and
- invoice providing the name, address, and phone number of the dispensing clinic or provider along with a list of all charges.

Specialized Breathing Equipment: for breathing equipment such as Bi-PAP or V-PAP machine, in addition to the above, please include an explanation from the patient's physician explaining why a standard CPAP or APAP machine can't be used by the patient.

Private duty nursing - Service for foot care and blood work:

When submitting claims for foot care or blood work performed by a nurse, include the following information:

- prescription from the patient's attending physician indicating the patient's medical, condition, and
- itemized invoice that includes the following information:

- name, address, and phone number of the nursing agency providing the service,
- name, designation and registration number of the nurse(s) providing the service,
- dates of service, and
- total cost for the visit.

Private duty nursing - In-home nursing care:

To qualify for in-home private duty nursing, a Nursing Care Health Assessment Form must be completed by the patient's attending physician and the patient's home care coordinator. Forms E1083A can be obtained from Great-West Life's website: https://www.greatwestlife.com/content/dam/gwl/documents/E1083A-FINAL.pdf or by calling GWL at 1-877-340-9082.

When submitting claims for in-home nursing care, please submit an itemized invoice that includes the following information:

- name, address and phone number of the nursing agency providing the service,
- name, designation, and registration number the nurse(s) providing the service,
- dates of service,
- number of hours,
- cost per hour,
- total cost, and
- nurse's signature.

Reimbursement under more than one plan

If you and your spouse are covered by more than one health care plan, you can claim benefits under both plans and you may receive reimbursement of up to 100% of your eligible expenses. Here's how you can coordinate benefits:

For expenses incurred by…	Submit your claim to...
You	❶ This Health Plan ❷ Then, to your spouse's plan, if a balance remains
Your spouse	❶ Your spouse's plan ❷ Then to this Health Plan, if a balance remains
Your dependent children	❶ The plan of the parent whose birthday falls earlier in the year ❷ Then to the plan of the other parent, if a balance remains

If you are separated or divorced various plans might cover your children's eligible expenses. The plan that will pay benefits will be determined in the following order, assuming family coverage was chosen for all plans:

For expenses incurred by your dependent children if you…	Submit your claim to…
Are separated or divorced with custody of your covered children	❶ The plan of the parent with custody of the child ❷ Then, the plan of the spouse of the parent with custody of the child, if a balance remains ❸ Then, the plan of the parent without custody of the child, if a balance remains ❹ Then, the plan of the spouse of the parent without custody of the child.
Have joint custody of your children	❶ The plan of the parent with joint custody with the earlier birth date (based on date and month) ❷ Then, the plan of the other parent with joint custody, if a balance remains ❸ Then, the plan of the spouse of the parent in #1, if a balance remains ❹ Then, the plan of the spouse of the parent in #2.

Legal Actions

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within 12 months from the date Great-West Life completed the initial assessment of the claim or predetermination. 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 overpaid you are responsible for repayment within six months. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

This booklet summarizes the main provisions of the Health Plan & Travel Assistance in effect as of March 2019. Actual benefits will be determined by the terms of the group plan document with Great-West Life, which will govern in case of any discrepancy. For additional information, contact Great-West Life.

The Health Plan is reviewed regularly and coverage may be adjusted at any time.