# My group benefit plan

canada life

For doctors. For health. For you.
Doctors Nova Scotia

**Members**

The information provided in the booklet is intended to summarize the provisions of Plan Document No. 58972. If there are variations between the information in the booklet and the provisions of the plan document, the plan document will prevail to the extent permitted by law.

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

**The Plan is administered by**


**This booklet was prepared on: July 13, 2021**

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

## BENEFIT DETAILS

As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

### Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- news releases
- contact information
- online claims submission

### GroupNet for Plan Members

As a Canada Life plan member, you can register for GroupNet™ for Plan Members at www.canadalife.com or on the GroupNet Mobile app. To register, click “Sign in”. From there, click “GroupNet for plan members”, then follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

With GroupNet and GroupNet Mobile you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

**Canada Life's Toll-Free Number**

To contact a customer service representative at Canada Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777.
- for assistance with your Health Care Spending Account, please call 1-877-883-7072.

**Customer complaints**

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON  N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

**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 two years after the denial. 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, or within a longer period if agreed to by your employer. 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.

**Quebec Time Limit for the Payment of Benefits**

Where Quebec law applies, benefits will be paid in accordance with the terms set out in this plan within 60 days following receipt of the required proof of claim.

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## ELIGIBILITY

All members of Doctors Nova Scotia may be eligible to join the health and dental plan without providing satisfactory evidence of good health during the 60-day period after they have been a full member for 6 months (including when membership dues were paid through PARI-MP and DMSS).

### Late applicant

Any member who wishes to join the plan after the 60-day period must provide satisfactory evidence of good health.

### Who is eligible?

All new members who want to join the health and dental plan must be a member of the association for 6 months before being eligible.

### Eligibility criteria

Single, family, senior single and senior family plans are available to members who meet the following criteria:

### NS residents

Physicians whose principal residence as defined by Canada Revenue Agency is Nova Scotia.

### Transfer from another plan

Members who currently have a comparable plan may elect to transfer their benefits to the association's Extended Health and Dental Plan. Canada Life will determine eligibility.

### Outside of NS members

Physicians who provide full-time patient care in Nova Scotia but report their residence address outside Nova Scotia may appeal to the Board of Trustees, on a case-by-case basis, to be eligible to apply for the Extended Health and Dental Plan. The board of Trustees' decision regarding the appeal is final.

**Eligible dependents**

- Legal spouse
- The person publicly acknowledged by you as your spouse who has cohabited with you continuously for a period of at least 12 months
- A stepchild, legally adopted child, or natural child of yourself or your spouse (excluding a foster child) who is under 21 years of age and not employed for more than 20 hours a week
- Unmarried children under 25 years of age while attending college, university or other accredited educational institution as full-time students, provided there is no mandatory student program in effect or available offering the same or similar coverage
- A child 21 years of age or older who by reason of mental or physical disability is incapable of self-sustaining employment and is totally dependent upon you for support and provided such child was covered under this plan prior to age 21

**Evidence of health**

Satisfactory evidence of good health isn't required if application is made within 60 days of first becoming eligible. If coverage isn't applied for within this 60-day period, evidence may be requested for the member and his/her dependents, before benefits commence.

The cost of obtaining satisfactory evidence of good health is to be provided at your own expense.

**Coordination of benefits**

If you receive coverage from more than one insurance company, benefits will be coordinated so that the amount payable under both policies does not exceed 100 per cent of the actual expenses incurred. If you are the person name on the member identification card, submit your claim to Canada Life. Once the claim has been processed, any balance can be claimed with the other insurance company under which you are covered.

If the claim is for your spouse, and he/she has coverage elsewhere, submit the claim to that insurance company first. If your plan also covers your spouse, you can claim the remaining balance from Canada Life.

Claims for dependent children who are covered under both policies should be submitted first to the insurance company of the parent whose birth date is earlier in the calendar year. For example, the member was born on June 1st, 1968 and the spouse was born June 18th, 1962, the claims for the children would fall under the member. It is the birth ”day” that is used, not the birth year.

Canada Life requires a copy of the payment statement or summary from the other insurance company and a copy of your receipt in order to pay any eligible balance.

**Termination**

Benefits cease with the termination of your membership to the association, or failure to meet eligibility requirements, with the exception of a surviving spouse who continues to pay full premiums and continues to reside in Nova Scotia.

**Conversion privilege**

If you terminate participation in the health and dental plan, you may convert to an Individual Health and Dental plan issued by Canada Life provided that application is made within 31 days following your date of termination.

**Eligibility**

- You and your dependents will be covered as soon as you become eligible.

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you may apply for coverage under this plan. If you do not apply within 60 days of loss of such coverage, or you were previously declined for coverage by Canada Life, you and your dependents may be required to provide evidence of good health acceptable to Canada Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

Your coverage terminates on the last day of the month in which your membership with Doctors Nova Scotia ends, or when you are no longer eligible, or the plan terminates, whichever is earliest.

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

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See Doctors Nova Scotia for details.

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

**Survivor Benefits**

If you die while your coverage is still in force, the health and dental benefits for your spouse will be continued for their lifetime, on a premium-paid basis, or until they no longer qualify, whichever happens first. Nova Scotia resident status applies.

## HEALTHCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown below and may be subject to plan maximums and frequency limits.

| | |
|---|---|
| Out-of-Country Emergency Care (including drugs), Visioncare, Accidental Dental Treatment and Global Medical Assistance Expenses | 100% |
| In-Canada Hospital Expenses and External Insulin Infusion Pump | 50% |
| In-Canada Prescription Drug Expenses | |
| - fertility drugs | 50% |
| - diabetic supplies | 80% |
| - all other in-Canada prescription drug expenses | 100% |
| All Other Expenses | 80% |

**The following details must be read together with the benefits described in this booklet.**

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

**Ambulance, Hospital and Nursing Care**

- Ambulance transportation to the nearest centre where adequate treatment is available

- Emergency transportation - Charges for emergency transportation by air, rail or water from an area not serviced by regular licensed professional ground ambulance to the nearest hospital or other medical facility capable of providing the required care when the urgency of the situation requires that only such form of transportation will be adequate. Coverage includes the cost of return transportation for a registered nurse when it is medically necessary for a registered nurse to accompany the person, to a maximum of $1,000 per incident

- Hospital or home nursing care if it represents acute, convalescent, or palliative care.

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

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

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

  - Preferred accommodation in a hospital is covered when provided in Canada.

    For hospital accommodation, the plan covers the difference between the hospital's semi-private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered.

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

**Limitation**

Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- The plan covers home nursing services of a registered nurse, a registered practical nurse if the person is a resident of Ontario or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada. Coverage is limited to 80% of the first $10,000 of covered expenses, 50% of the remainder, to a maximum of $13,000 each calendar year.

  Nursing care is care that requires the skills and training of a professional nurse, and is provided by a professional nurse who is not a member of the patient's family.

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

- Personal care services of a personal care worker, who is not a member of your family, when services are provided in Canada, but only if the patient

  - requires the specific skills of a trained personal care worker, and

  - is foot care prescribed by a physican and provided by a professional nurse in home

  A personal care worker offers essential services such as bathing, dressing, toileting, feeding and mobilization. Home personal care is limited to 4 hours per day. No benefits are paid for custodial care, housekeeping, meal preparation, shopping, transportation or respite care for a family member.

**In-Canada Prescription Drugs (for members, dependents and survivors under age 65 only)**

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

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives

  - Drugs used to treat erectile dysfunction, to a maximum of $250 each calendar year

  - Fertility drugs, to a maximum of $3,000 lifetime

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

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

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

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

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

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

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

**Save on out-of-pocket expenses**

- At a regular pharmacy, you pay a $20 deductible. At a Costco pharmacy, you only pay a $15 deductible.

**Medical Supplies and Equipment**

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

  - medical supplies:
    - feeding alimentation systems to a maximum of $200 each calendar year
    - intrauterine devices (IUDs) limited to one each calendar year
    - peptamen jr. (nutritional formula/food supplements)
    - diabetic supplies including Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets (lancets are covered under prescription drugs), battery caps, syringes, insulin pump supplies, infusion sets, automatic pressurized insulin injectors and testing materials
    - ostomy appliances, irrigating sets and pouches but not including deodorants, pads adhesives, skin creams or other supplies
    - wigs for cancer patients to a maximum of $500 every 2 calendar years
    - custom-made compression hose to a maximum of 2 pairs each calendar year
    - trusses and splints

- medical prosthesis ($10,000 lifetime maximum):
  - breast prosthesis one per breast every 2 calendar years
  - surgical brassieres to a maximum of 2 every 12 months
  - intra-ocular lenses to a maximum of $200 per eye lifetime
  - prosthetic limbs
  - myoelectric arms to a maximum of $10,000 per prosthesis
  - prosthetic eyes
  - intra-ocular lens implants to a maximum of $200 per eye lifetime
  - glove for passive hand purchase
  - stump socks
  - braces

- medical equipment ($10,000 lifetime maximum combined with breathing equipment):
  - standard wheelchairs, excluding repairs. If an electric wheelchair is provided, the plan will pay up to the cost of a standard wheelchair
  - standard hospital beds, bed rails, trapeze bars and traction apparatus
  - elevated toilet seats and shower chairs
  - tube feeding pumps and pump sets
  - non-union bone stimulators
  - prone standers
  - mechanical or hydraulic patient lifters to a maximum of $2,000 per lifter once every 5 years
  - external insulin infusion pumps to a maximum of $2,500 per pump once every 5 years
  - crutches, canes, walkers and parapodiums
  - blood glucose monitoring machines to a maximum of 1 every 4 years
  - flash glucose monitoring machines
  - continuous glucose monitoring machines, including sensors and transmitters to a maximum of $4,000 each calendar year
  - blood pressure monitors
  - transcutaneous nerve stimulators for the control of chronic pain to a maximum of $700 lifetime

    - extremity pumps for lymphedema or severe postphlebitic syndrome to a maximum of $1,500 lifetime
    - breast feeding pumps
    - kangaroo pump limited to one every 5 calendar years
    - cervical supports

  - breathing equipment ($10,000 lifetime maximum combined with medical equipment) including:
    - oxygen supplies
    - intermittent positive pressure breathing machines
    - continuous positive airway pressure machine
    - apnea monitor for respiratory dysrhythmias
    - mist tens and nebulizers
    - chest percussors, drainage boards and sputum stands
    - suction pumps
    - tracheostoma tubes

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician, each limited to a maximum for:

  - dependent children under age 18, $150 each calendar year

  - all others, $150 every 2 calendar years

  Shoes purchased to accommodate orthotics or comfortable walking shoes, such as Nike, Birkenstock, Brooks, Rockport, etc. are not covered

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician, to a maximum of $1,500 every 5 calendar years

- Phonic ear auditory system when required for language development or classroom use for dependent children only, to a maximum of $1,000 lifetime

- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible, to a maximum of $1,000 lifetime

- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

**Accidental Dental Treatment**

- Treatment of injury to sound natural teeth. A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

  **Limitations**

  No benefits are paid for:

  - accidental damage to dentures

  - dental treatment completed more than 180 days after the accident. This requirement is waived if a medical condition or the dependent child's age delays treatment beyond 180 days

**Paramedical Practitioners – limited to a maximum of $600 each calendar year per practitioner**

- Out-of-hospital services of a qualified acupuncturist

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

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

- Out-of-hospital services of a licensed naturopath

- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays

- Out-of-hospital treatment of movement disorders by a licensed physiotherapist

- Out-of-hospital treatment by a qualified occupational therapist

- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist

- Out-of-hospital services of a qualified chiropodist

- Out-of-hospital treatment by a registered psychologist or qualified social worker

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

**Visioncare**

- Eye examinations, including refractions, (once every 24 months; once every 12 months for dependent children under age 18) when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

- Glasses, contact lenses and laser eye surgery required to correct vision when provided by a licensed ophthalmologist, optometrist or optician, to a maximum of $200 every 24 months ($200 every 12 months for dependent children under age 18)

- Contact lenses when the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses, to a maximum of $250 every 24 months

**Global Medical Assistance Program**

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

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

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

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

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

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

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

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

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

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  **Limitation**

  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.

**Limitation**

Meal expenses are not covered.

**Out-Of-Country Emergency Care**

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

A medical emergency for members under age 65 is a sudden injury or a sudden illness or acute episode of disease.

A medical emergency for members age 65 and over is a sudden, unexpected injury or a sudden, unexpected illness or acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

    - treatment by a physician
    - diagnostic x-ray and laboratory services
    - hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
    - medical supplies provided during a covered hospital confinement
    - paramedical services provided during a covered hospital confinement
    - hospital out-patient services and supplies
    - medical supplies provided out-of-hospital if they would have been covered in Canada
    - drugs
    - out-of-hospital services of a professional nurse
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada

**Limitations**

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

No benefits are paid for expenses incurred more than 180 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 180-day period, benefits will be extended to the end of the confinement.

**Limitations**

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

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - contraception, other than oral contraceptives and intrauterine devices (IUDs)
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care in a hospital or nursing home
- Visioncare services and supplies required by an employer as a condition of employment
- Safety glasses

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 100 days
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Anti-obesity drugs

**How to Make a Claim**

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

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from Doctors Nova Scotia. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

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

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

- **You may submit all Healthcare claims online**. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

- **We also accept paper claims for all Healthcare expenses.** Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from Doctors Nova Scotia. Complete this form making sure it shows all required information.

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

- **Drug claims**

  Doctors Nova Scotia will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

## DENTALCARE

The plan covers customary charges to the extent they do not exceed the dental fee guide in effect in your province of residence on the date treatment is rendered. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

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

| | |
|---|---|
| Deductible | Nil |
| Reimbursement Levels | |
| - Basic Coverage | 80% |
| - Major Coverage | 50% |
| - Orthodontic Coverage | 80% |
| Maximums | |
| - Orthodontic Treatment | $2,000 lifetime |
| - All Other Treatment | $1,500 each calendar year |

**Treatment Plan**

Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

**Basic Coverage**

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination once every 24 months
  - limited oral examinations once every 9 months (twice every 12 months for dependent children under age 21), except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations once every 9 months (twice every 12 months for dependent children under age 21)
  - unmounted diagnostic casts
  - complete series of x-rays or panoramic x-rays once every 24 months
  - bite-wing x-rays, limited to a combined maximum of 4 films every 9 months
  - extra-oral x-rays, limited to a combined maximum of 4 films every 9 months
  - occlusal x-rays, limited to a combined maximum of 4 films every 9 months
  - intra-oral x-rays, except bite-wings, to a maximum of 15 films every 36 months. Services provided in the same 12 months as a complete series are not covered
  - cephalometric x-rays, limited to a combined maximum of 5 films every 24 months
  - temporomandibular joint x-rays, limited to a maximum of 4 films every 9 months

- Preventive services including:

  - polishing and topical application of fluoride each once every 9 months (twice every 12 months for dependent children under age 21)

  - scaling, limited to a maximum combined with periodontal root planing of 8 time units every 9 months

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

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

  - space maintainers when provided for missing central and lateral teeth including appliances for the control of harmful habits

  - finishing restorations

  - interproximal disking

  - recontouring of teeth

- Minor restorative services including:

  - caries, trauma, and pain control

  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan

  - retentive pins and prefabricated posts for fillings

  - prefabricated crowns for primary teeth

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

- Periodontal services including:
    - root planing, limited to a maximum combined with preventive scaling of 8 time units every 9 months
    - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
    - periodontal re-evaluations
- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 36 months
    - denture rebases for dentures at least 2 years old, once every 36 months
    - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
    - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- Oral surgery
- Adjunctive services:
    - consultation with a member of the profession
    - written and/or telephone report
    - consultation and/or participation during an autopsy

**Major Coverage**

- Crowns, including complicated crowns

- Onlays, inlays, gold foil restorations and veneers

  Replacement crowns, onlays, inlays, gold foil restorations and veneers are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Dentures and bridgework, including overdentures, implants and implant-retained appliances, when required to replace one or more extracted teeth. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

  The following specialized appliances are covered:

  - equilibrated and gnathological dentures
  - dentures with stress breaker, precision and semi-precision attachments
  - partial overdentures

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

- Appliance maintenance following the 3-month post-insertion period including:
    - denture remakes, once every 36 months
    - tissue conditioning
    - bridgework repairs
    - removal and recementation of bridgework
    - removal and reinsertion of implant-retained appliances for repair
    - resilient liner in relined or rebased dentures, once every 36 months

**Orthodontic Coverage**

- Orthodontics are covered for children age 6 to 18 when treatment starts

**Limitations**

If you do not apply for dentalcare coverage within 60 days after you become eligible, no benefits will be paid for expenses during the first 6 months of your coverage, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect.

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation and charges for post surgical treatment

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

- Hypnosis or acupuncture

- Veneers for cosmetic purposes, recontouring existing crowns and staining porcelain

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

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

- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare

- Expenses private benefit plans are not permitted to cover by law

- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

- Congenital defects or developmental malformations in people 19 years of age or over

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

**How to Make a Claim**

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from Doctors Nova Scotiaand have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after the dental treatment.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from Doctors Nova Scotia. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

## HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

A Health Care Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Doctors Nova Scotia will establish the credits for your account prior to each plan year.

These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

### HCSA Benefit

The health care spending account (HCSA) benefit is $300 per year, per plan subscriber. The plan subscriber may claim expenses for the whole family up to $300.

### Eligibility

You and your dependents are eligible for HCSA credits through Doctors Nova Scotia if you are covered for basic health care benefits or basic dental care benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your group health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the *Income Tax Act* (Canada).

### Termination

Your HCSA coverage terminates when your group health plan coverage terminates or when Doctors Nova Scotia discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

**Covered Expenses**

Coverage is provided for those expenses:

- that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time, or
- that Canada Life deems to be eligible medical expenses under a private health services plan, as defined by the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Canada Life toll-free at 1-877-883-7072.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

Credits are available for covered expenses incurred in a plan year (January to December). Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan year, they are automatically forfeited.

The maximum annual payment available under your account will consist of the amount of the credit directed to it for the plan year plus any unused amount from the previous year.

**Limitations**

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

**How to Make a Claim**

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Claims against the HCSA may be submitted on a claim form. Claims for paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

- To submit claims using a claim form, use form M445D (HCSA) for dental claims, and form M635D (HCSA) for all other claims
- To submit claims online, you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

Claims against the HCSA must be submitted to the Canada Life Benefit Payment Office before the earliest of the following:

- Claims incurred by December 31st must be submitted no later than March 31st. Claims submitted and received by Canada Life after March 31st will not be paid.

- If you haven't claimed a service within the calendar year and would like to, there is a 90 day grace period to process claims from the previous year. Canada Life must receive your claim before the end of March.

- The date the HCSA contract terminates, if it terminates because Doctors Nova Scotia fails to make a required payment

- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

## PROTECTING YOUR PERSONAL INFORMATION

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

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

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and 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 Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

**Notice of Liability for Benefits**

Doctors Nova Scotia has entered into an agreement with The Canada Life Assurance Company whereby the benefits outlined in this booklet are uninsured and Doctors Nova Scotia has liability for them.

This means that the benefits are:

- an unsecured financial obligation and are payable from Doctors Nova Scotia's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts Doctors Nova Scotia from the requirements under the Financial Institutions Act (British Columbia).

If Quebec law applies, any uninsured benefit is not under the supervision and control of the Autorité des marchés financiers.