Welcome Plan

Basic health insurance for temporary, new and returning Canadian residents

Welcome Plan

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Important Notice
This is not a contract. Actual terms and conditions are set out in the policy issued by Great-West upon application approval. The policy contains important information concerning terms, conditions, limitations, exceptions and exclusions. Please read carefully upon receipt.

Welcome Plan Coverage

Coverage under the Welcome Plan takes effect on the latest of the following dates, providing you are **actively at work**:

- the date your coverage begins under the plan sponsor's (your employer's) supplementary health plan,
- the effective date of the Welcome Plan or
- the date you meet any applicable ***evidence requirements***. If you have dependants covered under the Welcome Plan, their coverage begins on the date they qualify for coverage under the plan sponsor's supplementary health plan.

> ***Actively at work*** *means you are fully capable of performing your regular duties, and you are either working where your plan sponsor requires you to work, or you are absent due to vacation, weekends, statutory holidays or shift variances.*
>
> ***Evidence Requirements****: If you apply for coverage more than 31 days after the date you first qualify for coverage, you may have to provide medical evidence showing that you meet certain health requirements before your coverage is approved.*

The Welcome Plan covers healthcare services and supplies required for treatment of disease or injury, when treatment is:

- accepted by the Canadian medical profession,
- proven to be effective, and
- of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Great-West has full responsibility for the assessment of a person's entitlement to benefits.

Under the Welcome Plan, the following coverage is provided:

Ambulance Services

Ambulance services, including air ambulance services, are covered if they are provided by a licensed ambulance company. Transportation must be to the *nearest* medical centre where essential treatment is available. If the patient is transported to a farther medical centre, benefits will be based on the cost for transportation to the nearest centre where treatment was available.

Physician Services

Physician services are covered when they are provided in the physician's office, the patient's home, or in a ***hospital*** or other treatment facility. Coverage is provided for:

- diagnosis and treatment, including X-ray procedures and the administration of anaesthetics, and
- annual health examination.

> ***Hospital*** *refers to an institution that:*
>
> - *Is legally termed a hospital,*
> - *Is open at all times,*
> - *Offers in-patient accommodation,*
> - *Has a staff of one or more physicians available at all times, and*
> - *Continuously provides 24-hour nursing by graduate registered nurses.*

The following hospital in-patient services are covered:

- hospital accommodation in a standard ward, including meals.
- drugs prescribed by a physician.
- use of operating and delivery rooms, radiotherapy facilities, and respiratory equipment, including anaesthetic and surgical supplies.
- X-ray and laboratory services.
- nursing services.
- occupational therapy, speech therapy and physiotherapy, if prescribed by a physician.
- services of other hospital employees, such as nursing assistants.
- a home visit, use of the hospital's home renal dialysis equipment and home hyperalimentation equipment, including supplies and medications, if prescribed by a physician.

Hospital Outpatient Services

The following hospital outpatient services are covered when the treatment is prescribed by a physician and performed in a hospital:

- X-ray and laboratory services.
- use of radiotherapy, physiotherapy, occupational or speech therapy facilities.
- use of operating rooms, including anaesthetic and surgical supplies.
- nursing services.
- drugs prescribed by a physician and administered in the hospital.
- meals provided by the outpatient department during a treatment program.

Dental Services

Dental services are covered if:

- the patient is at risk medically,
- the services are performed by a dentist in a hospital operating room, and
- the services represent treatment recognized by the Canadian Dental Association.

Out-of-province Emergency Care

Out-of-province emergency care is covered when it is required as a result of a ***medical emergency*** arising while the patient is outside his/her province or territory of residence, but inside Canada.

This provision covers the same expenses that would have been covered if they had been incurred in the patient's province or territory of residence.

> ***Medical emergency*** *refers to a sudden, unexpected injury or an acute episode of disease.*

Out-of-country emergency care is covered when it is required as a result of a medical emergency arising while the person is outside Canada.

This provision covers the same expenses that would have been covered if they had been incurred in the person's province or territory of residence.

Out-of country emergency care benefits are limited to:

- $400 per day for hospital in-patient services.
- $200 per day for hospital outpatient services.
- 15% of the total submitted amount for physician services.

Benefits will not be paid for expenses incurred more than 60 days after the date of departure from Canada. If the patient is confined to a hospital at the end of the 60-day period, benefits will be extended to the end of the confinement.

Home Nursing Care

Home nursing care is covered if it:

- requires the skill and training of a professional nurse, and
- is provided by a ***professional nurse*** who is not a member of the patient's family.

*A **professional nurse** is a graduate registered nurse, licensed practical nurse, or registered nursing assistant.*

Coverage is limited to the minimum number of hours and level of skill required to provide each essential nursing service. Applicable licensing restrictions will be recognized in determining the level of skill needed.

Home nursing care is limited to a maximum of $5,000. Reinstatement of the maximum will be considered if:

- the patient has not required home nursing care in the previous six months, or
- care is required for a condition ***not related*** to the previous condition(s) that required home nursing care.

Before beginning home nursing, you should apply for a pre-care assessment. The pre-care assessment, provided by Great-West, will identify:

- the type of nurse that will be covered,
- the number of hours to be covered per day or week, and
- the estimated duration of coverage.

To request a pre-care assessment, submit a letter from the attending physician containing the following information:

- a description of the patient's current medical condition and prognosis
- a list of the required nursing services and their frequency
- an indication of the level of skill required to perform the required services, (i.e. a graduate registered nurse, licensed practical nurse, registered nursing assistant, or other practitioner)
- the number of hours of care required per day or week, and
- an estimate of the length of time care will be required.

Conditions are considered related when they exist simultaneously, or they arise from the same or related causes.

Laboratory services provided outside of a hospital are covered when authorized by a physician and performed in a licensed laboratory.

X-ray Procedures

X-ray procedures provided outside of a hospital are covered when authorized by a physician.

Eye Examinations

Eye examinations are covered if they are performed by a licensed ophthalmologist or optometrist. Benefits are limited to one examination every 12 months for dependants under age 19, and one examination every 24 months for any other person.

If eye examinations are covered under the plan sponsor's supplementary health plan, they will not be covered under your Welcome Plan.

Amount Payable

- The Welcome Plan pays 100% of ***covered expenses*** that are ***incurred*** while the patient is insured.
- There is no deductible applied.
- The maximum amount payable per individual is $1,000,000 per lifetime.

Some supplies and services covered under the Welcome Plan are subject to specific maximums over specific periods of time. Please review the appropriate section of this booklet to determine if a maximum applies to your situation.

Exclusions

Benefits will not be paid for:

- expenses incurred in a private health care facility, except on the written referral of the person's physician.
- services or supplies received outside Canada, on a non-emergency basis.
- organ transplants, whether expenses are incurred as a donor or a recipient.
- expenses arising from war, insurrection or voluntary participation in a riot.
- services or supplies associated with recreation or sports rather than with other regular daily living activities.
- services or supplies associated with treatment for cosmetic purposes only.
- fertility or weight control treatments or related drugs.
- expenses incurred after coverage terminates except as provided under the extension of benefits provision (see below).

Covered expenses *are the lesser of actual expenses or customary charges for the covered services and/or supplies.*

Expenses are incurred when the patient receives them.

Claims information

Claims must be submitted within fifteen months after services or supplies are provided.

To Make a Claim

1. Ask your plan sponsor for a claim form or visit www.greatwestlife.com
2. If you are submitting claims for more than one member of your family, complete a separate claim form for each member.
3. Submit all original receipts attached to a completed claim form to:

The Great-West Life Assurance Company
Individual Health Unit PO Box 6000 Winnipeg MB R3C 3A5

NOTE: Great-West pays the provider of the service directly unless you supply proof that you have already paid the provider, satisfactory to Great-West.

Coordination of Benefits

If you or one of your dependants is entitled to benefits for the same expenses under another group plan or as both an employee and a dependant under the Welcome Plan, benefits will be coordinated so the total benefits from all plans will not exceed expenses.

Claims Inquiries

To verify expense eligibility or inquire about a claim, call toll-free 1-866-430-2863 or email individual.health@gwl.ca.

Protecting your personal information

At Great-West, we recognize and respect every individual's right to privacy. When you apply for coverage or benefits, we establish a confidential file of your personal information.

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

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

We limit access to information in your file to Great-West staff or persons authorized by Great-West who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Great-West, your health care provider, other insurance and reinsurance companies, and your plan administrator may also exchange information when the information is necessary to administer the group benefit plan.

The information in your file will be kept in the offices of Great-West or in the offices of an organization authorized by Great-West. You may review and correct the information in your file. A request to review or correct your file should be made in writing and may be sent to any of Great-West's offices or to our head office at:

The Great-West Life Assurance Company
Attn: Personal Information Officer PO Box 6000 Winnipeg MB R3C 3A5

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

Termination of Coverage

Your coverage will end on the earliest of the following:

- the date your coverage under the plan sponsor's supplementary health plan ends.
- the date you obtain coverage under a federal or provincial government plan.
- the due date of the first premium, to which you have not made the required contribution, if any.
- the date the Welcome Plan terminates.

Extension of Benefits

If you or a dependant is confined to a hospital when coverage ends, benefits will be paid for that person until the earliest of the following dates:

- the date hospital confinement ends,
- six months after coverage terminates, or
- the date the person becomes eligible for similar coverage under another plan.

Extended benefits are limited to expenses that would have been payable if coverage had not terminated.

Survivor Benefits

If you die while your coverage is still in force, benefits will be continued for your surviving dependants. See the plan sponsor for details.

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