CANADIAN BAPTIST

CB Benefits

OPTIONAL
GROUP BENEFIT FLEX PLAN

for retirees

who retire on or after age 55 with at least 10 years of service

BENEFIT DETAILS

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms and the ability to submit certain claims online

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**. To access this service, click on the GroupNet for Plan Members link. 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 benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Healthcare and Health Care Spending Account sections of this booklet
- extensive health and wellness content

Using our GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life:

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

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 156241** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail.

This booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

The Plan is underwritten by

THE Great-West Life ASSURANCE COMPANY

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Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West or Manulife Life as evidence of insurability, subject to certain limitations. You may be charged for such documentation after your first request.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

PROTECTING YOUR PERSONAL INFORMATION

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

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
- preparing regulatory reports, such as tax slips

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 plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

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YOU SHOULD KNOW

Effective Date of Plan –	January 1, 2015
Covered Classes –	Retirees who retire on or after age 55 with at least 10 years of service

IMPORTANT

The coverages described in this group benefits plan are insured under Group Policy Nos. 156241 issued to the Contractholder by Great-West Life. They are available to you if you are included in the covered classes shown above. Only those coverages for which you become covered will apply to you.

Preferred Vision Services (PVS) described in this group benefit plan is a service provided by Great-West Life to its customers through Preferred Vision Services. It does not form part of the contract issued to the Contractholder by Great-West Life.

This booklet is a description of the group benefits at the date shown on the front cover

CONFORMATION WITH LAW

If any provision of this group plan conflicts with any law which applies to individuals shown in the covered classes, the plan will be amended to conform to that law.

COST

You will be advised of the amount of your contribution, if any, when you enroll for the coverage. Cost is subject to change.

WAITING PERIOD

You are eligible for coverage on the date your retirement begins.

The coverages are described in the Benefit Summary and the coverage description pages. Be sure to read these pages carefully. They show when benefits are or are not payable, and outline the conditions, limitations and exclusions that apply to the coverages.

BENEFIT SUMMARY

COVERAGES FOR YOU AND YOUR ELIGIBLE DEPENDENTS

This summary must be read together with the benefits described in this booklet.

Retiree Life Insurance			
Amount	$5,000		
Reduction	Coverage reduces to $2,500 at age 70		
Dependent Life Insurance			
Spouse	$5,000		
Child	$2,000		
Termination	Coverage terminates when you reach age 70		

	BIRCH OPTION	MAPLE OPTION	ELM OPTION
Healthcare			
Deductible	Nil		
Reimbursement Levels			
Global Medical Assistance Expenses	100%	100%	Not covered
Visioncare Expenses	Not covered	100% to limits specified below	Not covered
In-Canada Prescription Drug Expenses			
- dispensing fee portion of the drug charge	100% up to $5	100% up to $5	Not covered
Drug Charge: - Formulary Drug Plan Expenses - Non-Formulary Drug Plan expenses	 70% 50%	 80% 60%	Not covered
- Out-of-pocket maximum	If out-of-pocket drug expenses exceed $1,000 (per person) in a calendar year, eligible drug expenses will be reimbursed at 100% for the remainder of the calendar year		Not covered
All Other Expenses	70%	80%	Not covered

	BIRCH OPTION	MAPLE OPTION	ELM OPTION
Basic Expense Maximums			
Ambulance (including air ambulance)	Included		Not covered
Home Nursing Care	$5,000 every 3 calendar years.		Not covered
Home Nursing Care Limit	Beginning on your 65th birthday, the maximum is limited to a lifetime maximum of $5,000, reduced by the amount paid during the previous 3 calendar years		Not covered
Drugs Used To Treat Erectile Dysfunction	$1,200 each calendar year		Not covered
Hearing Aids	$300 every 4 years		Not covered
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	$300 each calendar year		Not covered
Myoelectric Arms	$10,000 per prosthesis		Not covered
External Breast Prosthesis	1 initial prosthesis and 1 replacement every 2 calendar years		Not covered
Surgical Brassieres	2 each calendar year		Not covered
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years		Not covered
Outdoor Wheelchair Ramps	$2,000 lifetime		Not covered
Blood-glucose Monitoring Machines	1 every 4 years		Not covered
Insulin Infusion Pumps	$5,000 per pump once every 5 years		Not covered
Insulin Jet Injectors	$1,000 lifetime		Not covered
Transcutaneous Nerve Stimulators	$700 lifetime		Not covered
Extremity Pumps for Lymphedema	$1,500 lifetime		Not covered
Custom-made Compression Hose	2 pair each calendar year		Not covered
Wigs			
- for cancer patients	$100 lifetime		Not covered
- for alopecia totalis	$250 lifetime		Not covered
Diagnostic Supplies	Included		Not covered
Accidental Dental Injury	Included		Not covered

	BIRCH OPTION	MAPLE OPTION	ELM OPTION
Paramedical Expense Maximums			
Acupuncturists	Not covered	$200 each calendar year	Not covered
Chiropractors	Not covered	$200 each calendar year	Not covered
Physiotherapists	Not covered	Unlimited	Not covered
Massage Therapists	Not covered	$200 each calendar year	Not covered
Naturopaths	Not covered	$200 each calendar year	Not covered
Osteopaths	Not covered	$200 each calendar year	Not covered
Podiatrists	Not covered	$200 each calendar year	Not covered
Psychologists/Social Workers	Not covered	$200 each calendar year	Not covered
Speech Therapists	Not covered	$200 each calendar year	Not covered
Occupational Therapists	Not covered	Not covered	Not covered
Visioncare Expense Maximums			
Glasses, Contact Lenses and Laser Eye Surgery	Not covered	$150 every 24 months	Not covered
Lifetime Healthcare Maximum	$100,000	$100,000	Not covered

	BIRCH OPTION	MAPLE OPTION	ELM OPTION
Health Care Spending Account			
You only	$350	Not covered	$1,000 with at least 20 years of service at retirement - Increasing by $250 per year of service over 20 years - Further increasing by $250 per year of service over 30 years
You + dependents	$700	Not covered	

DEFINITIONS

The following definitions apply throughout this group benefit plan unless a term is defined differently within a specific coverage for the purposes of that coverage.

BENEFITS means any amounts which become payable under a coverage.

CALENDAR YEAR means January 1 through December 31.

CONTRACT means Group Insurance Policy No. 156241.

CONTRACTHOLDER means Canadian Baptist Ministries in its capacity as the Policyholder of Group Insurance Policy No. 156241.

DEDUCTIBLE is the amount of eligible charges shown in the Benefit Summary which must be paid by or on behalf of a covered person in any calendar year before reimbursement will be made under a coverage. There is no deductible under this plan.

DEPENDENT CHILD means your unmarried children under age 22 or under age 25 if they are full-time students.

Children under age 22 are not covered if they are working more than 30 hours a week, unless they are full-time students.

Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 22 or while they are students under 25, and the disorder has been continuous since that time.

ELIGIBLE DEPENDENT means your spouse and dependent children.

EMPLOYER means the Contractholder and any of its affiliated or associated employers and churches as defined by the Contractholder which have been approved by Great-West Life for inclusion under the contract.

GREAT-WEST LIFE means The Great-West Life Assurance Company.

MEMBER/PLAN MEMBER is a former employee participating in this group insurance plan.

PHYSICIAN means a person, other than an insured or a member of the insured's family, who is a licensed medical doctor in the province where the medical care is received and who gives medical care within the scope of that license.

PROVINCE or PROVINCIAL refers to any province or territory of Canada.

REIMBURSEMENT LEVEL is the percentage of eligible charges shown in the Benefit Summary, which will be reimbursed under a coverage after satisfaction of the deductible.

RETIREE means those who retire on or after age 55 with at least 10 years of service and were insured under the employer's benefit program the day before you retired.

SICKNESS means disease or illness.

SPOUSE means your legal, common-law or former spouse.

A common-law spouse is a person who has been living with you in a conjugal relation for at least 36 months, or if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

A former spouse means your divorced or ex-common-law spouse for whom insurance protection for some of the benefits available under the employer's benefit program is mandated by court order.

YEARS OF SERVICE: Completed continuous years of service from start date of employment.

YOU refers to the retiree of the employer as shown in the covered classes on the You Should Know page.

INFORMATION ABOUT YOUR FLEX PLAN

- You have the ability to select a benefit plan upon retirement however if you opt out at retirement there is no option to opt in unless you experience a life event change. You must notify your plan administrator within 6 months of the life event.

- If you experience a life event during a plan year that affects your coverage needs, you may make changes to your benefit options that directly relate to your status change. Any of the following is considered a life event:

  - acquiring your first dependent (spouse or child)
  - acquiring a spouse if you have child coverage only
  - involuntary loss of similar coverage through your spouse's group benefit program (for example, because of a change in your spouse's employment status)
  - death of your spouse or only child
  - your spouse or only child ceasing to qualify for coverage (for example, through divorce or your child's attainment of a limiting age – see Dependent Coverage in this booklet)

Note: See your plan administrator for details no later than 31 days after a life event occurs. Certain conditions apply.

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your retirement begins.

- Increases in benefits while you or your dependents are in hospital will not become effective until you or your dependents are released from hospital.

Your coverage terminates when you are no longer eligible, you stop paying the required premiums, or the policy terminates, whichever is earliest.

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

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

SURVIVOR BENEFITS

If you die while your coverage is still in force, the health benefits for your dependents will be continued with no premium required for a period of 3 months, after which time coverage can continue with premium payment.

WHEN YOU HAVE A CLAIM

RETIREE LIFE INSURANCE

To submit a Retiree Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your plan administrator.

Documents necessary to submit with the form are listed on the form.

TO MAKE A HEALTH CLAIM

Claims for expenses incurred in Canada, for paramedical services and visioncare, may be submitted 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 Great-West Life as soon as possible, but no later than 6 months after you incur the expense.

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

For all other Healthcare claims, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your employer. Complete this form making sure it shows all required information.

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

For drug claims, your employer 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 assess and take action if needed prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

When your coverage ends, return your direct pay drug identification card to your employer.

TO MAKE A HEALTH CARE SPENDING ACCOUNT 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.

Any claim against the HCSA must be submitted on a claim form. For dental claims, use form M5429A or form M445D (HCSA), and for all other claims, use form M5431A or form M635D (HCSA).

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

- 3 months after the end of the year in which the expenses are incurred
- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

GENERAL INFORMATION

CLAIM RULES

PROOF OF LOSS

The time limits for submitting proof of loss under a coverage are described in the applicable coverage description page.

Failure to furnish any such proof within the time required will not invalidate or reduced any such claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

PHYSICAL EXAMINATION

Great-West Life, at its own expense, will have the right and opportunity to have any covered person, whose injury, sickness or treatment is the basis of a claim , examined by a physician or dentist designated by Great-West Life when and as often as it may reasonably be required during the period of a claim under the contract.

LEGAL ACTION

No action at law or in equity will be brought to recover under the contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the contract.

OVERPAYMENT OF BENEFITS

Nothing in this group benefit plan will prevent Great-West Life from recovering any overpayment of benefits from the person or organization to whom such payment has been made, irrespective of the cause of such overpayment.

*The “other plans” may include employment-related group contracts, individual or group travel or health policies, credit card coverages or any other private insurance source.

COORDINATION OF BENEFITS

Healthcare benefits are coordinated when other similar coverage is available.

Government Plans

When reimbursement is available under a government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other coordination provisions. It is subject to any applicable deductible, reimbursement level, and maximum under this plan.

Government plans are plans that are legislated, funded, or administered by a government. Group plans for government employees are not included.

Group Plans

The amount payable is reduced when this plan is secondary to another group plan. The reduction is the amount by which total payments under all group plans would exceed eligible expenses. An eligible expense is that portion of a customary charge for reasonable treatment for which overage is provided under this plan.

When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum.

Group plans are plans that are available only to members of particular groups and not to the general public. Student accident plans are not considered group plans.

A secondary plan is one that determines its benefits under another plan.

Employee Coverage

A plan determines its benefits first if it covers the person as an employee. If you are covered as an employee under more than one plan, the plans are prioritized in the following order:

1. the plan covering you as an active, full-time employee;
2. the plan covering you as an active, part-time employee;
3. the plan covering you as a retiree.

Dependent Coverage

A plan is secondary if it covers the person as a dependent. If the person is covered as a dependent of more than one person, the plans are prioritized in the following order:

1. the plan covering the person as a dependent spouse;
2. the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year;
3. the plan covering the person as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

If the parents are separated or divorced, the plans under which benefits for the child are determined are prioritized in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

Benefits Paid Under Another Plan

If benefits have already been paid under another group plan, this plan is automatically secondary.

Prorated Benefits

If these rules do not establish an order of benefit determination or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before coordination.

Coordination With This Plan

Coordination of benefits will also take place within this plan if:

1. a person is covered as both a retiree and a dependent under this plan; or
2. a person is covered as a dependent of two retirees under this plan.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

RETIREE LIFE INSURANCE

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

DEPENDENT LIFE INSURANCE

If one of your dependents dies, Great-West Life will pay you the dependent life insurance benefit. Your employer will explain the claim requirements.

- Your dependent life insurance terminates when you reach age 70 or when you no longer have eligible dependents, whichever comes first.

CONVERSION PRIVILEGE

If your spouse's insurance terminates on or before his or her 71st birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your plan administrator for details.

HEALTHCARE

DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) "Convalescent hospital" or "chronic care facility" means an extended care facility such as a sanatorium or skilled nursing home or a special wing or ward of a hospital, which has a transfer agreement with the hospital.
(2) "Hospital" means 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 provides continuous 24-hour nursing by graduate registered nurses.
(3) "Medical emergency" is a sudden, unexpected injury or an acute episode of disease.
(4) "Physician" means a person, other than an insured or a member of the insured's family, who is a licensed medical doctor in the province where the medical care is received and who gives medical care within the scope of that license.
(5) "Customary charges" are the lowest of:
    (a) representative prices in the area where the treatment was provided.
    (b) prices shown in any applicable professional association fee guide, and
    (c) maximum prices established by law.

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

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.

You are only covered for Healthcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

COVERED EXPENSES

- Ambulance transportation, including air ambulance, to the nearest centre where adequate treatment is available

- Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse

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

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided 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 contraceptive drugs and products containing a contraceptive drug

  - 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.

Covered drugs consists of:

- those drugs listed in the National Formulary or Special Authorization (SA) drug list established by the pharmacy benefits manager in effect on the date of purchase,

- diabetic supplies, and

- all other eligible “non-formulary” drugs

Unless medical evidence is provided to Great-West Life that indicates why a drug is not to be substituted, Great-West Life can limit the covered expense to the cost of the lowest priced interchangeable 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.

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

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

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

- Blood-glucose monitoring machines prescribed by a physician

- External insulin infusion pumps prescribed by a physician

- Needleless insulin jet injectors prescribed by a physician

- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

  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

  No benefits are paid for:

  - accidental damage to dentures

  - dental treatment completed more than 12 months after the accident

  - orthodontic diagnostic services or treatment

- 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 treatment of movement disorders by a licensed physiotherapist
- 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 foot disorders, including diagnostic x-rays, by a licensed podiatrist
- 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

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

Other Services and Supplies

Great-West Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

LIMITATIONS

Great-West Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Great-West Life.

Great-West Life can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

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

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance 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
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Great-West Life to be a covered service or supply
- 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 Great-West Life would have paid benefits 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
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
- Visioncare services and supplies required by an employer as a condition of employment

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
- Fertility drugs
- 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 administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Great-West Life maintains a limited list of services and supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the Great-West Life website as follows:
http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Great-West Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Great-West Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Great-West Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Great-West Life at its discretion. Expenses claimed under this provision must be pre-authorized by Great-West Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Great-West Life has recommended or approved health case management, Great-West Life can require that a service or supply be purchased from or administered by a provider designated by Great-West Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Great-West Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Great-West Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Great-West Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Great-West Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Great-West Life requires participation in, Great-West Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

PREFERRED VISION SERVICES (PVS)

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network provider.

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

1. Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program

2. Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed

3. Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery

4. Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

HEALTHCARE SPENDING ACCOUNT BENEFITS (HCSA)

A Healthcare 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. Your employer will establish the credits for your account prior to each plan year. The credits are based on the option you select as outlined in the **Benefit Summary**. 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. Credits are available for covered expenses incurred in a plan year. Unused credits at the end of any plan year are rolled over to your account for covered expenses incurred in the following plan year. If they are not used by the end of that year, they are automatically forfeited.

The maximum annual payment available under your account consists of the amount of credit directed to it at the beginning of the plan year plus any unused amount from the previous year.

ELIGIBILITY

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health benefits under the Birch or Elm plan. In addition to the dependents eligible for coverage under your basic 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 basic health coverage terminates, when you elect to discontinue coverage (at any plan enrolment date) or when your employer discontinues the plan.

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

COVERED EXPENSES

The Income Tax Act (Canada) governs the types of expenses that can be reimbursed under the HCSA. Coverage is provided for those expenses that qualify for a medical expense tax credit. For a complete list of covered expenses, contact your Canada Revenue Agency District Office and ask for Income Tax Interpretation Bulletin IT-519R.

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.

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