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Group Benefit Plan

your Benefits Solutions People

COLLEGE OF PHARMACISTS OF BC

ADMINISTRATION STAFF

Effective: February 01, 2009

Policy: 250289

GREAT-WEST ONLINE SERVICES FOR PLAN MEMBERS

As a Great-West Life plan member, you can also register for Great-West Online Services for Plan Members at www.greatwestlife.com. This service enables you to access:

- Your benefit details and claims history
- Personalized claim forms and cards
- Extensive Health and Wellness content
- as well as much more;

all within a user friendly environment twenty-four hours a day, seven days a week.

CLAIM SUBMISSION

Claim forms are available from your plan administrator. You may also obtain these forms on-line in the Group Benefits section of the Great-West Life web site located at: www.greatwestlife.com

Your claim form, and any other correspondence about your claim, may be submitted to your employer, or directly to the Benefit Payment Office that will be handling your claim.

Life Claims:

The Great-West Life Assurance Company
Attn: Group Life Claims
60 Osborne Street North
Winnipeg, Manitoba
R3C 3A5

Health and Dental Claims:

The Great-West Life Assurance Company
Attn: Benefit Payments Office
PO Box 4408
Regina, Saskatchewan
S4P 3W7
(800) 957-9777
or
(800) 990-6654
TTY line (for the hearing impaired)

Disability Claims:

The Great-West Life Assurance Company
Attn: Disability Management Services Office
255 Dufferin Avenue - 7th Floor
London, Ontario
N6A 4K1
(519) 435-7229
(866) 325-6413

BENEFIT SUMMARY

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

Employee Basic Life Insurance

$ 30,000 Reducing by 50% at age 65.

Optional Life Insurance

Available in $ 10,000 units to a maximum of $ 200,000 for you or your spouse, subject to approval of evidence of insurability

Accidental Death, Dismemberment and Specific Loss (Principal Sum)

An amount equal to your Basic Life Insurance

Long Term Disability (LTD) Benefits

Waiting period	120 days
Amount	65.3% of the first $ 2,666 of monthly earnings plus 58.8% of the next $ 2,667 of monthly earnings plus 49.1% of the remainder to a maximum of $ 8,000 or 85% of your pre-disability take-home pay, whichever is less. Any amount of LTD Insurance over $ 3,200 is subject to approval of evidence of insurability.
Benefit period	to age 65
Tax Status:	non-taxable

Healthcare

Calendar Year Deductible

-for global medical assistance	none
-for chronic care	none
-for in-Canada ambulance and hospital	none
-for all other healthcare expenses	
-individual	$ 25
-family	$ 25

Reimbursement Level

-for global medical assistance	100%
-for out-of-country care	100%
-for chronic care	100%
-for in-Canada ambulance and hospital	100%
-for in-Canada prescription drugs	80%
-for paramedical expenses	
-for chiropractors	80%
-for physiotherapists	80%
-for psychologists/social workers	80%
-for dieticians	80%
-for podiatrists	80%
-for speech therapists	80%
-for massage therapists	80%
-for acupuncturists	80%
-for naturopaths	80%
-for osteopaths	80%
-for all other healthcare expenses	80%

Basic Expense Maximums

-for in-Canada home nursing care	$ 10,000 for a maximum of 12 months per condition
-for hospital care	semi-private room
-for chronic care	$ 25 per day
-for in-Canada prescription drugs	unlimited
-for hearing aids	$700 every 5 years
-for speech aids	$1,000 lifetime
-for custom-fitted orthopedic shoes and custom-made foot orthotics	$300 every 12 months
-for myoelectric arms	$10,000 per prosthesis
-for external breast prosthesis	1 every 12 months
-for surgical brassieres	2 every 12 months
-for mechanical or hydraulic patient lifters (excluding electric stairlifts)	$2,000 per lifter every 5 years
-for outdoor wheelchair ramps	$2,000 lifetime
-for blood-glucose monitoring machines	1 every 4 years
-for transcutaneous nerve stimulators	$700 lifetime
-for extremity pumps for lymphedema	$1,500 lifetime
-for custom-made compression hose	4 pairs each calendar year
-for wigs for cancer patients	$200 lifetime
-diagnostic x-rays and lab tests	unlimited
-for paramedical expense maximums	
-for chiropractors	$ 500 each calendar year
-for physiotherapists	$ 500 each calendar year
-for psychologists/social workers	$ 500 each calendar year
-for dieticians	$ 500 each calendar year
-for podiatrists	$ 500 each calendar year
-for speech therapists	$ 500 each calendar year
-for massage therapists	$ 500 each calendar year
-for acupuncturists	$ 500 each calendar year
-for naturopaths	$ 500 each calendar year
-for osteopaths	$ 500 each calendar year

Unless prohibited by law, Great-West Life will pay for the portion of the cost that is not payable under a government plan. (Please refer to the Healthcare "Limitations" for Podiatric treatment.)

Out of Pocket Maximum for Quebec Residents

An out-of-pocket maximum is applied to in-province expenses for drugs listed in the Liste de Medicaments Publiee par la Regie de L'Assurance-Maladie du Quebec if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows:

1. reimbursement will be made at 100%
2. no further out-of-pocket amounts will apply

The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec.

Lifetime Healthcare Maximum unlimited

Dentalcare

Payment Basis

The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered. (Specialist charges are limited to the General Practitioner Fees)

Calendar Year Deductible:

-for dental accident coverage	none
-for all other expenses:	
-individual	none
-family	none

Reimbursement Levels

Dental Accident Coverage	100%
Basic Coverage	100%
Major Coverage	50%
Orthodontic Coverage	50%

Plan Maximums

-for dental accident	unlimited
-for basic and major coverage combined	$ 1,500 per calendar year
-for orthodontics	$ 1,500 lifetime

Other Information

Major dental services include the prior extraction limitation.

Basic dental services exclude oral hygiene instruction.

Orthodontic dental services exclude orthodontic services for adults.

Benefit Details

This booklet describes the principal features of the group benefit plan sponsored by your employer, but Group Policy Nos. 250289 and 250789 issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail. Contact your employer if you require any additional information.

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan immediately if you are covered on the effective date of this plan. Otherwise you are eligible after completion of the eligibility waiting period shown below. The waiting period can only be satisfied by continuous employment as an insurable employee, ending on or after the effective date of this plan. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

Basic Life Insurance	3 months
Long Term Disability	3 months
Healthcare	3 months
Dentalcare	3 months
Accidental Death and Dismemberment	3 months

- You must apply for coverage no later than 31 days after you become eligible. If you apply within 31 days of when you are eligible, your coverage takes effect on the date you applied. After 31 days, you must provide evidence of insurability for you and your dependents before you can participate.
- If you do not apply for dentalcare coverage within 31 days of becoming eligible, your benefits may be subject to restrictions*. See the Late Applicant Restrictions section.
- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- You must be employed on a permanent, and non-seasonal basis for at least 20.0 hours each week to join the plan.

Your coverage terminates when your employment ends, 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 employer will provide you with details.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 24 months or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse means a person who is living with the employee in a conjugal relationship.

- Your unmarried children under age 21, or under age 25 if they are full-time students.

  Children under age 21 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 21, or while they are students under 25, and the disorder has been continuous since that time.

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Note: If you are a Quebec resident, full-time students are covered for prescription drug benefits until age 26.

EMPLOYEE BASIC LIFE INSURANCE

You may name a beneficiary for your life insurance and change that beneficiary at any time by completing a form available from your employer. On your death, your employer will explain the claim requirements to your beneficiary. Great-West Life will pay your life insurance benefits to your beneficiary.

- Your life insurance terminates when you reach age 71.
- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.
- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of your insurability, and your application must be approved by Great-West Life. If you or your spouse die within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

You may name a beneficiary for your optional life insurance and change that beneficiary at any time by completing a form available from your employer. On your death, Great-West Life will pay your life insurance to your beneficiary. If your spouse dies you will be paid the amount for which he or she was insured. Your employer will explain the claim requirements.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your spouse will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.
- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.
- Your optional life insurance terminates when you reach age 65. Your spouse's coverage terminates at the same time, or when he or she reaches age 65 or is no longer your spouse, whichever comes first.

Limitation

No benefit is paid for a suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, Great-West Life will pay up to two times the Principal Sum. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days.

Loss	*Amount Payable*
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use

Both arms and both legs (quadriplegia)	2X Principal Sum
Both legs (paraplegia)	2X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

Surgical Reattachment

If you suffer the loss of a limb that is surgically reattached, Great-West Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation

If you die as the result of an accident that is at least 150 kilometres away from your home, Great-West Life will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation less any amounts paid under this plan's global medical assistance benefit.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Great-West Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death, or he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Great-West Life will pay up to 5% of the Principal Sum, or $ 5,000, whichever is less, for each year of full-time post-secondary school enrolment. Great-West Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

No benefits will be paid for tuition expenses incurred before the accident, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Great-West Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's global medical assistance benefit, up to $ 2,000, for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.20 per kilometre travelled.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Great-West Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Great-West Life will pay up to 10% of the Principal Sum, or $ 10,000, whichever is less.

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Great-West Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Great-West Life will pay up to $ 10,000.

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Great-West Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Great-West Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's healthcare benefit, up to $ 10,000 for all home and vehicle modifications combined.

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

Your AD&D insurance terminates when you reach age 71.

Limitations

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide
- Viral or bacterial infections, any form of illness or physical or mental infirmity, or medical or surgical treatment except surgical reattachment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

- To claim benefits for yourself, ask your employer for a claim form. Complete it and return it to your employer.
- If you die accidentally, your employer will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over, and continue until you are no longer disabled as **defined by the policy** or you reach age 65, whichever is earlier. Check the **Benefit Summary** for the benefit amount, benefit period and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury. If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the short term disability or sick leave benefit period, but no later than one year after your disability started.
- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.
- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.
- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.
- Because you pay the entire cost of LTD coverage, benefits are not taxable.
- Your LTD insurance terminates when you reach age 65.

Other Income

Your LTD benefit is reduced by other income to which you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts
- benefits under any Workers' Compensation Act or similar law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan
- benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts
- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other members of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law
- disability benefits under a plan of insurance available through membership in an association
- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, including any increases in Canada or Quebec Pension Plan benefits that take effect after the benefit period starts, would exceed your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Disability that begins before your insurance starts or after it ends.
- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period in which you do not participate or cooperate prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- The scheduled duration of a lay-off or leave of absence.

  This does not apply for any portion of a period of maternity leave during which you are disabled due to pregnancy.
- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any 12-month period during which you do not live in Canada for at least 6 months.
- Any period of confinement in a prison or similar institution.
- Disability arising from war, insurrection, or voluntary participation in a riot.

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Great-West Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your employer for details.

How to Make a Claim

Obtain an Employee Claim Submission Guide (form M4307) from your employer and follow the guide's instructions. Return the completed form to your employer as soon as possible, but no later than 6 months after proof of your claim has been requested.

HEALTHCARE

A deductible may be applied before you are reimbursed. 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.

Covered Expenses

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

- Semi-private room and board in a hospital in Canada

  For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is covered.

  Great-West Life 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 your home province.

- Convalescent care for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care

- The government authorized co-payment for accommodation in a nursing home. Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- Services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse

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

- Chronic care, provided in a hospital, nursing home or for home nursing care, for a condition where improvement or deterioration is unlikely within the next 12 months

- 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 care provision. Drugs which require a written prescription, including oral contraceptives

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

  - 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 when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense.

- 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

- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible

- Diabetic supplies, including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets, when prescribed by a physician

- Blood-glucose monitoring machines prescribed by a physician

- Diagnostic x-rays and lab tests

- 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 treatment by a registered psychologist or qualified social worker

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

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

- Out-of-hospital treatment of nutritional disorders by a registered dietician

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

- Out-of-hospital services of a qualified naturopath

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

- Out-of-hospital services of a qualified acupuncturist

Out-Of-Country Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily 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 is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

- the amount payable under this plan for continued treatment outside Canada, and
- the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

No benefits are paid for:

- any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency
- any subsequent and related episodes during the absence from Canada
- expenses related to pregnancy and delivery, including infant care:
  - after the 34th week of pregnancy, or
  - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.
- expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60 day period, benefits will be extended to the end of the confinement.

- **Non-emergency** care outside Canada is covered for you and your dependents if:

- it is required as a result of a referral from your usual Canadian physician

- it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties
- you are covered by the government health plan in your home province for a portion of the cost, and
- a pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

No benefits will be paid for:

- investigational or experimental treatment
- transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

- 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
- for emergency care only, ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

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 Great-West 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 more than 500 kilometres from home. 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 Great-West 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.
- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for a round trip economy class ticket and for moderate quality lodgings up to $1,500.
- 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. 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. Meal expenses are not covered.

Limitations

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 other than drugs

  - contraception, other than oral contraceptives

- 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 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 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

- 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

The following non-prescription items are not covered:

- Atomizers, appliances, prosthetic devices, or colostomy supplies

- First aid or diagnostic supplies or testing equipment

- Diabetic supplies

- 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

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

- Drugs dispensed by a physician, surgeon, dentist or clinic or by a non-accredited hospital pharmacy

- Any single purchase of drugs which would not reasonably be used within 100 days.

- Any drug which does not have a drug identification number as defined by the Food and Drugs Act, Canada

- 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

- the following drugs when prescribed for a student over age 24 who is your dependent child and you are a resident in Quebec:
  - Drugs or drug supplies not listed in the Liste de Medicaments Publiee par la Regie de L'Assurance-Maladie du Quebec in effect on the date of purchase.
  - drugs or drug supplies received outside Quebec.
- Preventative immunization vaccines and toxoids
- Smoking cessation products
- Drugs used to treat erectile dysfunction

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec*, unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to your employer by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec.*

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec.*

How to Make a Claim

- Out-of-country claims (other than those for Global Medical Assistance expenses) should be submitted to Great-West Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Great-West Life Benefit Payment Office immediately as your Provincial Medical Plan has very strict time limitations.

  Obtain form M5432 (Out-of-Country Statement of Claim) from your employer and, if applicable, the Government Assignment form (all provinces excluding Manitoba) and the Special Government Claim form (British Columbia, Quebec and Newfoundland). Complete these forms, making sure all required information is included. Attach all original receipts and forward the claim to your local Great-West Life Benefit Payment Office. Be sure to retain a copy for your own records.

  Great-West Life will pay all eligible claims including your Provincial Medical Plan portion. Your Provincial Medical Plan will then reimburse Great-West Life for the government's share of the expenses.

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

- For all other Healthcare claims, 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 Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

PREFERRED VISION SERVICES (PVS)

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

Preferred Vision Services (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.

PVS also entitles you to a discount on laser eye surgery obtained through an organization that is part of the PVS network.

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:

- 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
- Arrange for a fitting or eye examination, if needed
- 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 is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

MEDICAL REFERRAL SERVICES CARD
(BEST DOCTORS® SERVICE CARD)

Your medical referral services card is designed to allow you, your dependents and your local physicians or specialists access to the latest technologies, the opinions of world-class specialists, and clinical guidance.

This service can assist with confirming the diagnosis of a covered condition, and can suggest the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

If you or your dependents contract one of the covered conditions, this service can be your connection to valuable medical expertise. The service is provided in respect of the following illnesses:

- acquired immunodeficiency syndrome (AIDS)
- Alzheimer's disease
- blindness
- benign brain tumour
- cancer
- cardiovascular conditions
- coma
- deafness
- kidney failure
- loss of speech
- multiple sclerosis
- major organ transplant
- major trauma. This does not include mental trauma.
- motor neuron disease
- Parkinson's disease
- paralysis
- severe burns
- stroke

Conditions that are not directly related to the listed illnesses and some less serious forms of the covered conditions are excluded. For specific definitions of a covered condition, call the number shown below.

This is a referral service - neither the provider of the referral service nor Great-West Life is responsible for the quality of any treatment that may be received.

How it works

- The person can access all of the medical referral services card services available by calling 1-877-419-BEST (2378) toll free
- The person will be provided with forms that he must complete
- The person's medical file will be reviewed by a team of specialists. This review usually takes 7 to 10 days from the date the person's medical file is received from his physician
- A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person and his physician.

DENTALCARE

A deductible may be applied before you are reimbursed. 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 to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary.** 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.

Frequency limitations or maximums expressed in years refer to 12-month periods and not calendar years.

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 Great-West Life. It is recommended that a person submit a treatment plan to Great-West Life before having dental treatment that will cost $200 or more. Great-West Life will calculate the benefits payable for the proposed treatment, 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 every 36 months

  - limited oral examinations twice a year, 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 twice every 12 months

  - complete series of x-rays every 36 months

  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- Preventive services including:

  - polishing and topical application of fluoride each twice a year

  - scaling, limited to a maximum combined with periodontal root planing of 10 time units every 12 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 every 60 months

  - space maintainers 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 10 time units every 12 months

  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

- Denture maintenance, after the 3-month post-insertion care period, 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

  - resilient liner in relined or rebased dentures, once every 36 months

  - denture repairs and additions and resetting of denture teeth

- denture adjustments, once every 12 months

· Oral surgery

· Adjunctive services

Major Coverage

· Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns

· Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays

Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

· Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. 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

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

· Denture and bridgework maintenance following the 3-month post-insertion period including:

- denture remakes, once every 36 months

- denture adjustments, once every 12 months

- denture repairs and additions, tissue conditioning and resetting of denture teeth

- repairs to covered bridgework

- removal and recementation of bridgework

Orthodontic Coverage

· Orthodontics are covered for children age 6 to 18 years of age when treatment starts

Accidental Dental Injury Coverage

· Treatment of injury to sound natural teeth. The injury must result from an external blow to the mouth. 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

Late Applicant Restrictions

If you do not apply for dentalcare coverage within one month after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic Coverage expenses are limited to $100 during the first 12 months of your coverage
- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage
- No benefits will be paid for Orthodontic Coverage expenses during the first 24 months of your coverage

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any 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, charges for post surgical treatment and periodontal re-evaluations

- 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 alveoplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Expenses covered under another group plan's extension of benefits provision
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided

- Accidental dental injury expenses for injury caused by an object wittingly or unwittingly placed in the mouth, treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private plans are not permitted to cover by law
- Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance 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

Obtain form M445D from your employer. Have your dental service provider complete the form and return it to the benefit payments office as soon as possible, but no later than 15 months after the dental treatment.

CONTACT EMPLOYEE ASSISTANCE PROGRAM

CONTACT is an employee assistance program that provides you and your dependents with access to confidential counselling and information services.

The employee assistance program services are intended to help you address various areas of concern including:

- marital, family and relationship issues
- personal and emotional difficulties
- alcohol and drug abuse
- violence
- work and career-related issues
- bereavement

Other service the program provides are:

- nutritional and weight management counselling
- stress assessment and counselling
- legal assessment and information
- financial assessment and consultation
- trauma response services
- childcare and eldercare assessment and information services
- information regarding home healthcare options and access to your local home care providers

- telephone access to registered nurses for health information, assessment and referral to appropriate medical services

All of the CONTACT services are available to you and your dependents by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English:	1-800-387-4765
For service in French:	1-800-361-5676

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined 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

You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. When you apply for coverage or benefits, we establish a confidential file of personal information. 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.

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
- 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 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, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with us when necessary to administer the plan.

All claims under this plan are submitted through you as plan member. We may exchange personal information about claims with you and a person acting on your behalf when necessary to confirm eligibility and to mutually manage the claims.

The personal information in your file will be kept in offices of Great-West Life or in the offices of an organization authorized by us. You may request to review or correct the personal 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 Life's offices or to our head office at:

The Great-West Life Assurance Company
Attn: Group Compliance
P.O. Box 6000, Winnipeg, MB R3C 3A5

Claims submissions should not be sent to this address. Please use the address on the claims form or contact your plan administrator for details.

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

- **Notice to Quebec Residents Regarding Prescription Drug Coverage**

  The prescription drug plan described in this booklet complies with the minimum requirements of Quebec Bill 33 - An act respecting prescription drug coverage.

This Booklet Contains Important Information And Should Be Kept In A Safe Place Known To You And Your Family

This Plan is underwritten by

THE
GREAT-WEST LIFE
ASSURANCE COMPANY

and arranged by

GREGORY J WYATT

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