

Group Benefit Plan



Great-West Life
your Benefits Solutions People



CONVENTION of Atlantic Baptist Churches
CONVENTION des Eglises Baptistes de l'Atlantique

Retirees Without Drug Coverage

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

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website www.greatwestlife.com.

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.

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 certain healthcare claims and all dental claims
- extensive health and wellness content

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-800-957-9777.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 160885** and **Plan Document No. 57198** issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policy or plan document, the policy or plan document will prevail.

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

The Plan is administered by



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 benefit plan under which you are covered. This includes many tasks, such as:

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

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit 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.

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

Liability for Benefits

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby your employer will have full liability for Healthcare (except Global Medical Expenses) and Dentalcare benefits outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

TABLE OF CONTENTS

	Page
Benefit Summary	1
Commencement and Termination of Coverage	5
Dependent Coverage	6
Healthcare	7
Preferred Vision Services (PVS)	17
Dentalcare	18
Coordination of Benefits	24
Diagnostic and Treatment Support Services (Best Doctors [®] Service)	25

Benefit Summary

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

Healthcare

Covered expenses will not exceed customary charges

Deductible Nil

Reimbursement Levels

Physiotherapists 80%
All Other Expenses 100%

Basic Expense Maximums

Home Nursing Care \$10,000 for a maximum of 12 months per condition
Hearing Aids \$600 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics
- Dependent Children Under Age 18 \$150 each calendar year
- All Others \$150 every 2 calendar years

Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	\$250 each calendar year
Wigs for Cancer Patients	\$200 each calendar year
Intrauterine Devices (IUDs)	\$75 every 24 months
*Medical Prosthesis including but not limited to: External Breast Prosthesis, Surgical Brassieres, Prosthetic Limbs, Eyes, Gloves and Stump Socks	\$10,000 lifetime

*Certain frequency limitations apply, contact your Great-West Life administrator for details.

Paramedical Expense Maximums

Acupuncturists	\$500 each calendar year
Chiropractors	\$500 each calendar year
Massage Therapists	\$500 each calendar year
Naturopaths	\$500 each calendar year
Homeopaths	\$500 each calendar year
Osteopaths	\$500 each calendar year
Physiotherapists	\$1,000 each calendar year
Occupational Therapists	\$500 each calendar year
Podiatrists	\$500 each calendar year
Psychologists/Social Workers	\$750 each calendar year
Speech Therapists	\$500 each calendar year

Visioncare Expense Maximums

Eye Examinations	
- dependent children under age 18	1 every calendar year to a maximum of \$90 every calendar year
- all others	1 every 2 calendar years to a maximum of \$90 every 2 calendar years
Glasses and Contact Lenses	
- dependent children under age 18	\$200 every calendar year
- all others	\$200 every 2 calendar years

Lifetime Healthcare Maximum Unlimited

COMMENCEMENT AND TERMINATION OF COVERAGE

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

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

You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Great-West Life, you and your dependents may be required to provide evidence of good health acceptable to Great-West Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

- 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 or the plan terminates, whichever is earlier.

- Your dependents' coverage terminates when your coverage 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 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.
- 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.

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.

Except to the extent otherwise required by law, your coverage for Global Medical Assistance (GMA) terminates when you reach age 70.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Home nursing services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, when services are provided in Canada, but only if the patient requires the specific skills of a trained nurse

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

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

- Rental or, at the plan's discretion, purchase of certain medical supplies and appliances including but not limited to transcutaneous electric nerve stimulators, blood glucose monitoring machines, wheelchairs, insulin pumps and home accessories, when prescribed by a physician to a combined maximum of \$10,000 lifetime. For specific details contact your Great-West Life plan administrator.
- 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, including insulin, syringes, Novolin pens, testing supplies and insulin infusion sets, when prescribed by a physician
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan
- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays

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

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

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.

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

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

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to \$1,500 and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of \$1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation
- In case of death, preparation and transportation of the deceased home
- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of \$1,000. 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.

Out-Of-Country Emergency Care

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

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

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

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

Limitations

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

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

In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment
- Drugs, except as provided under Out-of-Country Emergency Care
- 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 oral contraceptives and intrauterine devices (IUDs)

- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province

This limitation does not apply to Global Medical Assistance

- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

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 Out-of-Country Claims Department immediately as your Provincial Medical Plan has very strict time limitations.

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

If you are a resident of the Territories, you must submit your out-of-country claims to your territorial government for processing before submitting the claim to Great-West Life. When you receive your Explanation of Benefits back from the territory, please send the following to the Great-West Life Out-of-Country Claims Department (be sure to keep copies for your own records):

- a copy of the payment from your territory
- a completed Statement of Claim Out-of-Country Expenses form (form M5432)
- all required information
- copies of all original receipts

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

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

- Claims 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.

Claims must be submitted to Great-West Life as soon as possible, but no later than 15 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 Healthcare claims not submitted online, 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.

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:

- 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, an eye examination, a hearing assessment or a hearing test, 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 or the hearing aid is purchased, or at the initial consultation for laser eye surgery
- 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.

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.

Treatment Plan

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

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
 - one complete oral examination every 36 months
 - limited oral examinations twice every 12 months, 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
 - temporomandibular joint (TMJ) x-rays to a maximum of 4 films every 12 months
- Preventive services including:
 - polishing and topical application of fluoride each twice every 12 months
 - scaling, limited to a maximum combined with periodontal root planing of 6 time units every 12 months

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

 - oral hygiene instruction once in a person's lifetime
 - pit and fissure sealants on bicuspid 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

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

 - TMJ, periodontal and myofacial appliances – 1 maxillary and 1 mandibular of each appliance every 24 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
- Oral surgery
- Adjunctive services

Accidental Dental Injury Coverage

- 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

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, 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 alveoloplasty or gingivoplasty performed in conjunction with extractions
- Hypnosis or acupuncture
- Crowns (other than prefabricated crowns), bridgework, dentures or repairs to bridgework or dentures
- Orthodontic treatment
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over
- Vertical dimension correction
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- For dentalcare claims submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Claims must be submitted to Great-West Life as soon as possible, but no later than 15 months after the dental treatment.

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 dentalcare claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

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.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

This service is designed to allow you, your dependents and your attending physician or specialists access to the expertise of world-class specialists, resources, information and clinical guidance.

If you or your dependents are diagnosed with a serious medical condition for which there is objective evidence, or if your physician or you or your dependent suspect you have this condition, you can access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a medical condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- You or your dependent can access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- You will be connected with a member advocate who will be dedicated to your case and will provide support through the process. The member advocate will take the necessary medical history and answer your questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information and questions, the member advocate determines the optimal level of service for you or your dependent.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet your health needs. They can also help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of your medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to you and your physician. On average, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.
- If you decide to seek treatment by a different physician, the member advocate can help identify the specialist best qualified to meet your specific medical needs. Expenses incurred for travel and treatment are not covered by this service.
- If you decide to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also access hospital and physician discounts, arrange for forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.

Note: These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.