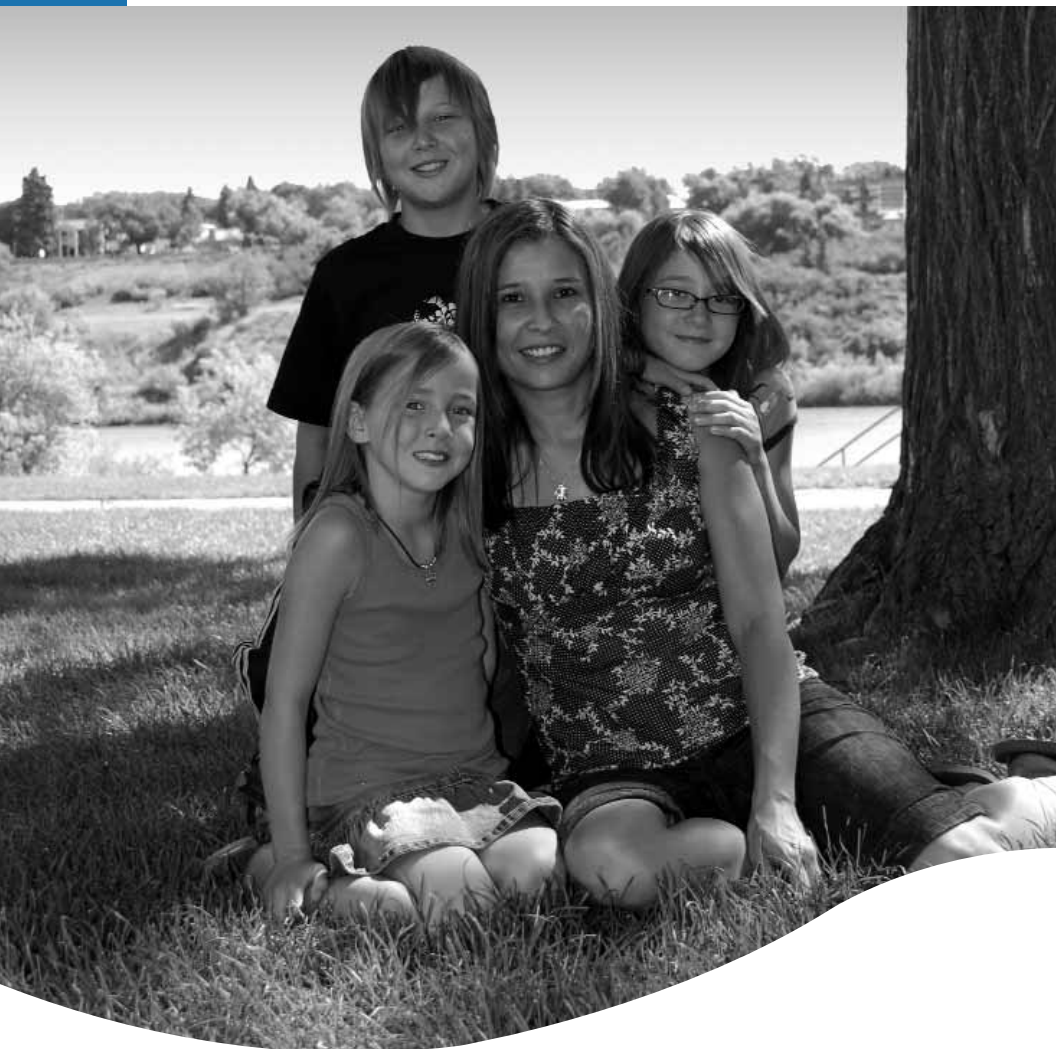


Health Benefits Information

for Saskatchewan Teachers and Their Families



Members'
Health Plan

July 2009

Your Plan Information

Plan Document number:

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Member Identification number:

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This summary contains general information only. In the event any discrepancy or misunderstanding in interpretation should arise, the applicable Plan documents are the final authority concerning the administration of the Plan.

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Introduction

The STF Members' Health Plan provides Saskatchewan teachers with coverage for prescription drugs using a Prescription Drug Card, extended health care benefits, out-of-country emergency benefits, eye examinations and vision care services and supplies.

The Plan came into effect April 1, 2001 in accordance with the Provincial Collective Bargaining Agreement between the boards of education, the Government of Saskatchewan and the teachers of Saskatchewan.



Members are not responsible for paying any premiums to the Plan. Funding for the Plan is set at a fixed percentage of teachers' payroll and comes from the Government of Saskatchewan. As per the terms of the Agreement, the STF is responsible for the design and administration of the program.

Updates to this booklet, general information, newsletters, claim forms, enrolment forms and information change forms can be downloaded from our website at www.stf.sk.ca.

Inquiries

General inquiries (including questions regarding eligibility, commencement and termination of coverage, and Prescription Drug Cards) and vision care claims:

STF Members' Health Plan

PO Box 1944 Stn Main

Saskatoon SK S7K 3S5

Tel: 1-800-667-7762 or 373-1660 in Saskatoon

E-mail: health@stf.sk.ca

Prescription drug, extended health care and out-of-country emergency claims:

Great-West Life

Tel: 1-800-957-9777 or 204-942-3589

Please provide **Plan Document number 51585** and your **Member Identification Number** (see page 6) when calling Great-West Life to make an inquiry. You can also register on Great-West Life's secure access GroupNet for Plan Members to check on the status of your prescription drug and extended health care claims. Go to www.greatwestlife.com and follow the instructions to register on GroupNet. When making inquiries to the STF Members' Health Plan office, you need only provide your Member Identification Number.

Your Plan Information

Plan Document number:

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Member Identification number:

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Rights & Responsibilities

STF Members' Health Plan Administration

The STF

The Saskatchewan Teachers' Federation is the administrator of your Health Plan. STF Members' Health Plan staff are here to help you determine whether you are eligible for benefits, what expenses are covered under your Plan, how to complete your claim forms, and to provide you with information and answer questions about your benefits. They are also responsible for the adjudication of claims and administration of the vision care component of the Plan.

Great-West Life

Great-West Life adjudicates all prescription drug, extended health care and out-of-country emergency benefits. All of these benefits are self-insured by the STF and covered by a master plan document issued by Great-West Life. Please note that in the case of any inconsistency between the master plan document and what appears in this booklet or on the STF website at www.stf.sk.ca, the terms of the plan document will prevail.

Your Rights

Your Claim File and Right to Privacy

The STF Members' Health Plan collects personal information relevant to your insurance coverage including your name, address, teaching certificate number, social insurance number, birth date and dependant information. This information is secured and may be shared within the STF Members' Health Plan and with Great-West Life in order to set up a claim file for you, maintain our databases and provide health care and other related services to you.

We collect this information from you in order to identify you and provide you with your unique Member Identification Number to protect both you and the Plan from error and fraud, to meet your service needs and to comply with legal requirements. The purpose of your claim file is to permit the STF Members' Health Plan and Great-West Life to administer all health and financial services provided to you and to keep

information specific to the STF Members' Health Plan and Great-West Life's business relationship with you. This includes the following:

- Underwriting and financial reporting (e.g., claim history is summarized at renewal and the next year's rates are calculated based on the experience of the group).
- Claims adjudication and management (e.g., claim history is accessed to determine whether a benefit maximum is in place and whether that maximum has been met).
- Internal and external audits (e.g., random claim audit for payment accuracy. This would compare the information on a claim form to the electronic record of the payment).
- Preparation of regulatory and statutory reports (e.g., reports that may be required by provincial statute).

Access to your specific claim information is restricted to personnel from the STF Members' Health Plan, Great-West Life and/or its claims agents, and any person or organization that has relevant information about you or your dependants to exchange information needed for processing your claims.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be in writing and may be sent to the STF Members' Health Plan.

Your Responsibilities

Enrolment

Each time you sign a new contract of employment a new Enrolment Form must be completed and submitted to the STF Members' Health Plan. Your school division must complete a section of the form to verify your employment. You must then complete the remainder of the form and submit the form to the STF. The information on your form will be used to determine if you and your dependants are eligible for any or all benefits and the period of eligibility.

Member Identification Number & Prescription Drug Card

Your 10-digit Member Identification Number is assigned to you when you are first enrolled in the Plan. This number is unique and will be required every time you make an inquiry or submit a claim. You must include your number on all correspondence to ensure accurate, efficient and confidential service. Your number is found on your Prescription Drug Card, or if you are a teacher on a temporary contract, you will be sent a letter confirming your enrolment along with your Member Identification Number.



When your coverage terminates, you will no longer be able to use your Prescription Drug Card. This is effective immediately upon your termination date. Please destroy or return your cards to the STF Members' Health Plan upon termination of employment. If you return to teaching and satisfy the eligibility requirements and submit the required Enrolment Form, a new card will be sent to you.

Information Changes

It is critical to maintain accurate and current records for you and your dependants to ensure timely adjudication of your claims. You must notify the STF Members' Health Plan if there is a change in your personal or contract status and/or dependant information by completing an Information Change Form. You may be requested to provide supporting evidence of the change including, but not limited to, custody agreements and verification of student, dependant or marital status.

Board of Trustees

The STF Members' Health Plan Board of Trustees is comprised of eight members appointed by the STF provincial Executive:

- The chairperson.
- Five members from the general membership of the Federation.
- Two administrative staff members.

Plan personnel serve in an advisory capacity to the Board as necessary. This includes, but is not limited to, the Plan Manager and support staff.

The chairperson is appointed by the Executive for a three-year term, as are the members appointed from the general membership of the Federation. The Executive may deviate from this in filling initial appointments and filling unexpected vacancies and to allow for the continuity of membership on the board. The chairperson and other members appointed by the Executive may be re-appointed. The board shall name one of its members as vice-chairperson who, in the absence of the chair, will assume that role.

Eligibility, Commencement & Termination of Coverage

Eligibility

You are eligible to participate in the STF Members' Health Plan if you meet the qualification of the Plan on or after April 1, 2001.

You are eligible to participate if you have completed **20 full or partial days of teaching service** (known as the qualification period), and:

- You are a teacher employed under a continuous, replacement or temporary contract with a board of education or a conseil scolaire pursuant to Section 200 of *The Education Act, 1995*.
- You are a member of the Saskatchewan Teachers' Federation employed as a teacher in an independent school that receives operating funding from the provincial ministry responsible for Pre-K to 12 education, provided that the teachers in the school are not members of any trade union and are not covered by any other collective bargaining agreement.

Substitute teachers are not eligible for coverage under the Plan.

Coverage is extended to members of this Plan who are in receipt of **disability benefits** from the STF Income Continuance Plan and/or the Saskatchewan Teachers' Disability Benefits Plan.

In no case will benefits under the STF Members' Health Plan extend beyond the member's 65th birthday, unless the person returns to teaching pursuant to Section 200 of *The Education Act, 1995* and qualifies for eligibility under this Plan.

Coverage is also extended to members of this Plan during a school board-approved leave of absence.

Commencement

After you have completed the 20-day qualification period, your coverage will be applied retroactively to the first paid teaching day of your contract. Please note that a qualification period (completion of 20 full or partial days of teaching service) will

be required for each new contract if there has been a break in service of more than 120 days.

You and your eligible dependants will be covered as soon as your coverage becomes effective. Changes in your benefits while you are covered by this Plan will become effective as long as you continue to satisfy the eligibility requirements.

Teachers who were formerly employed under a temporary contract and who enter into any other type of contract will become eligible for benefits on the first teaching day of the new contract.

Termination of Coverage

Your coverage terminates when your employment ends, you no longer are eligible, you no longer are a teacher as defined by *The Education Act, 1995*, or the Plan terminates, whichever is earliest. Teachers employed on temporary contracts cease to be eligible for benefits at midnight on the last teaching day of the contract. Teachers who superannuate cease to be eligible for benefits on the day of superannuation.

Extended Coverage

When your employment as a teacher terminates, coverage is extended under the Plan only under the following circumstances:

- If you are employed under a continuous or replacement contract that terminates June 30 (or the last teaching day of the school year), and enter into a like contract of employment on the next paid teaching day, you are entitled to retroactive benefits.
- If you have superannuated and you return to teach under a continuous, replacement or temporary contract, you are eligible for benefits only for the duration of your contract commencing on the first teaching day and terminating on the last teaching day. If there is a break in service of more than 120 days from your superannuation date to the date you return to teach, you will be required to satisfy the qualification period (completion of 20 full or partial days of teaching service).
- If you are in receipt of disability benefits from either the STF Income Continuance Plan or The Saskatchewan Teachers' Disability Benefits Plan, you are eligible for benefits provided you maintain a valid Saskatchewan teaching certificate. Benefits will not extend beyond your 65th birthday.

Other Health Insurance

If your coverage under this Plan is terminating for any of the reasons stated in this booklet, including superannuation, you can apply for private coverage offered by other insurance companies. In most cases, you will need to provide evidence of insurability. Evidence of insurability is an application process in which you provide medical information regarding the condition of your health. This may be required when you enrol in, or add dependants to coverage.

You are eligible to apply for group health benefits through the Superannuated Teachers of Saskatchewan (STS) **within 60 days after superannuation** without having to provide evidence of insurability. Great-West Life offers *Plan Direct*, with five plan options, to Canadian residents covered by the provincial plan in their home province between the ages of 50-75 and who were members of a Great-West Life group plan within the past 60 days. Evidence of insurability is not required for former members of the STF Members' Health Plan if they meet this qualification.

If you are interested in purchasing health insurance coverage when your coverage terminates under this Plan, you should first work through your personal health needs with a financial security advisor. You can also contact the STS at 306-373-3879 or Great-West Life at 1-800-565-4066 or any other insurance company for information on individual health insurance products.

Dependant Coverage

Definitions

For the purpose of the STF Members' Health Plan, **a dependant is defined as:**

- Your eligible spouse (legal or common-law) and dependent child(ren) (natural, adopted or stepchildren). If you are the legal guardian of a child who does not meet the definition as stated, please contact the STF Members' Health Plan. We will request some additional information from you to determine whether the child may be eligible for benefits.

Eligible spouse means:

- Your legal spouse or the person who has cohabited continuously with you in a spousal relationship for at least 12 consecutive months.

Eligible dependent children means:

- Your unmarried children under age 21, living with you, and solely dependent upon you for support. Children under age 21 are not covered if they are working more than 30 hours per week, unless they are full-time students.
- Your unmarried children age 21 and older, but under age 26, dependent upon you for support and in full-time attendance at an accredited post-secondary college or university.
- Children who are incapable of supporting themselves because of physical or mental disability are covered without age limit if the disabling condition begins before they turn age 21, or while they are students under age 26, and the disabling condition has been continuous since that time.

Verification of Eligibility

For dependent children who are age 21 and older, but under age 26 and in full-time attendance at an accredited post-secondary college or university:

- A completed verification of student status, signed by the registrar of the institution your dependant attends, must be sent to the STF Members' Health Plan either before, or immediately following, your dependent child's 21st birthday.
- The verification must indicate the student's full name and the start and end date of classes, and must confirm that the student is in full-time attendance.
- The STF Members' Health Plan accepts only the **original** document.
- Confirmation of your dependant's continued enrolment each year is required to maintain coverage.
- Coverage under the Plan begins on the **first day** of classes unless your dependent child has been a full-time student during the past academic term and is continuing full-time studies in the fall. Coverage is then extended throughout the summer without break into the fall academic term.
- There are certain situations when your dependant may not be eligible for continued coverage under the Plan. If your child is convocating or graduating from a full-time program of study, benefits will cease on the last day of the month in which your child convocates or graduates. If your child is attending a post-secondary institution under an apprenticeship program, please contact the STF Members' Health Plan for specific information.

For dependent children who are incapable of supporting themselves because of physical or mental disability:

- You may be asked to provide detailed medical information when the child turns 21 to support eligibility for continued coverage under the Plan. Your dependant's coverage terminates when your coverage terminates or your dependant no longer qualifies, whichever is earlier.

Your Responsibilities

Eligibility

This Plan covers you and your dependants only if you are covered under a provincial health plan and have residence status in your home province.

Change of Information

It is critical to maintain accurate and current records for you and your dependants to ensure timely adjudication of your claims. You must notify the STF Members' Health Plan if there is a change in your personal or contract status and/or dependant information by completing an Information Change Form. You may be requested to provide supporting evidence of the change including, but not limited to, a letter from your school board approving a leave of absence, custody agreements, verification of student status, verification of dependant status, and/or change in marital status.

Send this completed form, along with all required supporting documents attached, to:

STF Members' Health Plan
PO Box 1944 Stn Main
Saskatoon SK S7K 3S5

Inquiries

Contact the STF Members' Health Plan at 1-800-667-7762 or 373-1660 in Saskatoon, or e-mail health@stf.sk.ca.

Survivor Benefits

If a member of the STF Members' Health Plan dies while his or her spouse and dependent children are insured under this Plan, coverage for the spouse and dependent children will continue to the earlier of:

1. The date they cease to be eligible dependants.
2. Six months after the member's death.

If a member's child is born after his or her death, the child is considered to be an insurable dependant.

Survivor benefits are paid to the surviving spouse. If there is no surviving spouse, benefits are paid as follows:

1. For a child who meets the definition of eligibility and who has reached the age of majority, to him or her.
2. For a minor child who meets the definition of eligibility, to his or her legal guardian.

Coordination of Benefits

It is important that your plan pays only for benefits for which it is responsible. This is done through a process called Coordination of Benefits.

Definition

Coordination of Benefits is a group health insurance policy provision designed to eliminate duplicate payments and determine the order for payment of benefits when there is coverage provided under another plan. Benefit payments may be coordinated with the benefits provided by any other plan to provide up to 100 per cent of **eligible** expenses, as long as the total amount received from all sources does not exceed the amount of the actual expenses incurred.

Health care benefits for you and your dependants (spouse and dependent children) will be directly reduced by any amount payable under a government plan. When reimbursement is available under a government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other coordination provisions. It is subject to any applicable deductibles, reimbursement levels and maximums under this Plan.

No payment is provided by this Plan for any portion that is covered or funded by Saskatchewan Health, Workers' Compensation Board (WCB), Saskatchewan Government Insurance (SGI), Saskatchewan Aids to Independent Living (SAIL), or any other government programs and benefits provided in Saskatchewan, or in your province of residence, if other than Saskatchewan.

If you and your dependants are entitled to benefits for the same expenses under another group plan, or as both a member and dependant under this Plan, or as a dependant of both parents under this Plan, benefits will be coordinated so that the total benefits from all plans will not exceed eligible expenses.

For example, the Plan covers four pairs of compression hose in a calendar year. If you purchased five pairs of compression hose; you can claim 80 per cent of four pairs at reasonable and customary charges under the STF Members' Health Plan. After coordination of benefits, 20 per cent, or the balance, is paid under the secondary plan. Let's say the secondary plan also covers four pairs of compression hose in a calendar year. That plan would pay 20 per cent of the eligible four pairs of compression hose, not five pairs, as only four pairs are eligible in a calendar year for both plans. The member pays the entire cost of the fifth pair of hose as it is not eligible under either plan.

Another example may be for a benefit like massage therapy where there is a dollar maximum in a calendar year. You are covered under your plan at 80 per cent to a maximum of \$400 per calendar year. Each time you claim, you can submit the 20 per cent that you were not reimbursed under the primary plan to the secondary plan. Once you have reached the \$400 maximum under your plan, the secondary plan would reimburse up to the maximum amounts as stated in that policy.

Remember, the coordination of benefits provision means that a plan can only pay up to what it would have paid had it been the only plan and no more than 100 per cent of eligible charges.

Your Responsibilities

You and your spouse must first submit your own claims through your own group plan. If you are **both members of the STF Members' Health Plan**, you may elect to automatically coordinate benefits so that the total of eligible expenses are calculated first as a member and secondly as a dependent spouse at the same time. If you are using your prescription drug cards, your pharmacist may electronically coordinate benefits for you.

If you are submitting the balance of ineligible expenses to another plan, you must include the original explanation of benefit (itemization of expenses) that you receive from the STF Members' Health Plan or Great-West Life. This allows the other insurance carrier to calculate the balance of eligible expenses and reimburse you properly for the claims incurred.

Remember to include copies of receipts and bills when submitting claims for coordination of benefits, as well as retaining the same for your own files.

Claims for dependent children must be submitted to the plan of the parent who has the earlier birthday in the calendar year (the year of birth is not considered), either when the parents are cohabiting or when there is a shared custody arrangement in

the event of separation or divorce. However, if you are separated or divorced, and have full custody of any dependent children, the plan that will pay benefits for your children will be determined in the following order:

- The plan of the parent with custody of the child.
- The plan of the spouse of the parent with custody of the child.
- The plan of the parent without custody of the child.
- The plan of the spouse of the parent without custody of the child.

Please ensure you advise the STF Members' Health Plan if you separate or divorce so that the correct order for payment of benefits can be determined. If the Plan is not advised, it is assumed that the Plan will pay first to the plan of the parent who has the earlier birthday in the calendar year.

You may submit a claim to the plan of the other spouse for any amount that is not paid by the first plan. Payment will be made to the plan of each person, regardless of who incurred the total cost. The STF Members' Health Plan cannot pay benefits to any individual or organization other than the covered member under whose plan the claim is being submitted.

Submitting Your Claim

Please note that you have 15 months from the date the expense is incurred to submit your claim for consideration, with the exception of out-of-country claims, which have a different claims submission period applicable in each province.

Claim Forms

Extended Health Care Drug Claim Forms are used to submit claims for extended health care claims and for occasions when a Prescription Drug Card cannot be used (e.g., you are submitting a claim under the Coordination of Benefits provision, you do not have your card, you are out of the country, or you are employed under a temporary contract).

Vision Care Claim Forms are completed when you are submitting a claim for an eye examination or for vision care services and supplies.

Out-of-country statement of claim forms and provincial government assignment forms are completed when you have a claim for out-of-country expenses for which you did not use Global Medical Assistance (see page 33).

All claim forms can be obtained by downloading and printing from the STF website, www.stf.sk.ca, or by calling the STF Members' Health Plan. Claim forms are subject to change; please ensure you have the most up-to-date claim form.

Your Responsibilities

You must ensure your claim form is fully completed and that you have provided all the information required, including your Member Identification Number. This number is assigned to you when you first enrol in the Plan and you must indicate this number on your claim form so we can enter your claim information accurately and quickly. Your claim will be returned to you to provide your Member Identification Number if it is not clearly written in the space provided. You can find your 10-digit Member Identification Number on your Prescription Drug Card shown on page 6.

Teachers employed on a temporary contract do not receive prescription drug cards. Instead, you must submit your drug claims on an Extended Health Care Drug Claim Form. You will find your unique Member Identification Number on your confirmation of enrolment letter you receive from us when you enrol in the Plan.

All claims must be accompanied by the appropriate original, itemized receipts and documentation required to process your claim. In order to consider your claim, payment must have been made, in full, for each service provided. Make sure you enclose all medical information, including letters of referral and pertinent medical information, including the medical necessity for the prescribed item. Your claim may be denied if information is missing. In some cases Great-West Life may adjudicate claims based on the pick-up date of supply. These situations are handled on a case-by-case basis. If you are uncertain what documentation is needed to complete your claim submission, please contact the STF Members' Health Plan, or Great-West Life, prior to mailing in your claim.

Photocopies, credit card and/or cash register receipts are not acceptable and your claim will be returned to you in order for you to provide the original documentation requested. The STF Members' Health Plan does not provide for assignment of benefit to providers or reimbursement for services not paid in full. All receipts and documentation become part of our records and will not be returned to you. Your explanation of benefit (itemization of expenses) is provided to you for income tax purposes and for coordination of benefits with other insurance carriers.

Prescription Drugs and Extended Health Care Claims

Submitting Your Claim

Under certain situations, such as purchasing drugs when you are travelling outside the country, or when you are filling a prescription at a non-participating pharmacy, or you are employed under a temporary contract, you will be required to pay upfront for your prescription. For these types of drug claims, as well as any extended health care or prescription drug claims from another group benefit plan submitted for coordination of benefits, you will have to make a claim for reimbursement.

Please note that you have **15 months from the date the expense is incurred** to submit your claim for consideration.

When claiming extended health care or prescription drug benefits, please complete one Extended Health Care Drug Claim Form for all family members for whom you are claiming expenses. Send this completed form, along with **all original receipts and bills** attached, to:

STF Members' Health Plan
PO Box 1944 Stn Main
Saskatoon SK S7K 3S5

Please be sure to keep a copy of your claim for your own records.

Processing and Payment

If any of the requested information on the STF Members' Health Plan Extended Health Care Drug Claim Form is missing or incorrect, your claim will be returned to you for completion.

All eligible charges for your claim will be paid to you by Great-West Life. An itemized explanation of your benefits will accompany your cheque. This record should be kept for income tax purposes.

Inquiries

Contact Great-West Life at 1-800-957-9777. Please provide the **Plan Document number 51585** and your **Member Identification Number** when calling to make an inquiry.

Eye Examination and Vision Care Services and Supplies Claims

Submitting Your Claim

Vision care services and supplies must be submitted for consideration for eligible charges **within 15 months** of the date of service.

When claiming vision care benefits, you must fill out and submit the STF Members' Health Plan Vision Care Claim Form **for each family member** for whom a claim is made. Please note that there is a section on the claim form that must be completed by your provider if your receipts do not clearly break down all information required for your vision care services and supplies. The reverse of your vision care claim form contains detailed instructions on information required to complete your claim.

Send your completed form(s), along with **all original receipts and bills** attached, to:

STF Members' Health Plan
PO Box 1944 Stn Main
Saskatoon SK S7K 3S5

All bills and receipts are part of our records and will not be returned. Please **retain copies** of all your bills and receipts.

Processing and Payment

If any of the requested information on the STF Members' Health Plan Vision Care Claim Form is missing or incorrect, your claim will be returned to you for completion.

All **eligible** charges for your claim will be paid to you by the STF Members' Health Plan. An itemized explanation of your benefits will accompany your cheque. This record should be kept for income tax purposes.

Inquiries

Contact the STF Members' Health Plan at 1-800-667-7762 or 373-1660 in Saskatoon, or e-mail health@stf.sk.ca. Please provide your **Member Identification Number** when calling to make an inquiry.

Out-of-Country Claims

Submitting Your Claim

Out-of-country claims must be submitted within a certain time period that varies by province of residence. Please remember that these time restrictions are subject to change.

In Saskatchewan, out-of-country claims, other than those for Global Medical Assistance expenses (see page 33), should be submitted for consideration of eligible charges within six months of the date of service. This strict time limitation is determined by the Saskatchewan Provincial Health Plan and is subject to change.

Other provinces' dates may be different, so please be aware of these time limits and submit your claim as soon as possible after the date of service.

When claiming out-of-country care benefits, you must fill out and submit three forms:

1. Statement of Claim Out-of-Country Expenses
2. Schedule A: Assignment of Payment
3. Schedule B: Authorization to Provide Medical Information

If you reside outside Saskatchewan, you will have to obtain and submit the out-of-country statement of claim and, if applicable, the government assignment and authorization to provide medical information forms, from your home province (in all provinces except Manitoba). You need to obtain a special government claim form if you reside in British Columbia, Quebec, or Newfoundland.

Send the applicable, completed forms, along with **all original receipts and bills** attached, to:

Great-West Life
Attention: Out-of-Country Claims Department
PO Box 6000
Winnipeg MB R3C 3A5

Please be sure to keep a copy of your claim for your own records.

Processing and Payment

If any of the requested information on the required forms is missing or incorrect, your claim will be returned to you for completion.

All **eligible** charges for your claim will be paid, including the portion that is covered by your provincial medical plan. Your provincial medical plan will then reimburse Great-West Life for their share of the expenses, except for those provinces requiring you to mail your claim directly to their plan first (i.e., Manitoba, Yukon, Northwest Territories and Nunavut).

Inquiries

To verify the claims submission period applicable in your province or if you require assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Unit at 1-800-957-9777.

Benefit Summary

This summary must be read together with the benefit details section of this booklet (page 27). Benefit deductibles and benefit maximums, along with reasonable and customary charges apply individually to each eligible family member. Please also see the section on Coordination of Benefits if you are coordinating eligible expenses under two, or more, plans.

A Reasonable and Customary (R&C) charge is the maximum amount that an insurance company determines is a fair reimbursement level, based on their pool of claims for that benefit in a particular geographic location, practitioner fee schedules and interaction with plan sponsors and other insurance companies.

Extended Health Care

Deductibles

In-Canada Prescription Drug Expenses	\$8 per prescription
All Other Extended Health Care Expenses	Nil

Reimbursement Levels (see pages 24-25 for benefit maximums)

In-Canada Prescription Drug Expenses	
• Base: National Formulary drug expenses; vaccines; fertility; erectile dysfunction and smoking cessation drug expenses; and all diabetic supplies listed under prescription drug benefit	100%
• Supplementary: Special Authorization (SA) Drug Expenses	75%
Extended Health Care Expenses	
• Ambulance, Hospital, Private Duty Nursing, Medical Travel in Canada, Global Medical Assistance, Out-of-Country Care	100%
• All Other Extended Health Care Services and Supplies	80%

Basic Expense Maximums	
Hospital	Semi-private room
Nursing	\$25,000 every 3 years (page 28)
Chronic Care	\$20 per day to a maximum of 90 days (page 28)
Medical Travel in Canada (referral)	\$2,000 lifetime (page 30)
In-Canada Prescription Drugs	Included (page 34)
Hearing Aids	\$750 every 5 years (page 28)
Out-of-Country (referral non-emergency)	\$50,000 lifetime (page 31)
Orthopedic Shoes and Orthotics	\$500 each calendar year (custom-made) with referral by approved provider (page 28)
External Breast Prosthesis	1 (per side) every 12 months
Surgical Brassieres	2 every 12 months
Mechanical or Hydraulic Patient Lifters (excluding stair lifts)	\$2,000 per lifter (electric) once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines	1 every 4 years (page 29)
Transcutaneous Nerve Stimulators (TENS)	\$700 lifetime (prescribed by a physician)
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	4 pairs (graduated compression, custom-made and custom-fitted) each calendar year with physician referral
Hairpieces	\$200 lifetime (page 28)
Certain prescription drugs and drug supplies covered under Prescription Drug Expenses (page 36)	
Diabetic supplies	\$1,500 each calendar year

Vaccines	\$100 each calendar year
Fertility drugs	\$2,500 lifetime
Smoking cessation drugs requiring prescription	\$500 lifetime
Erectile dysfunction drugs	unlimited

Paramedical Expense Maximums (page 29)

Audiologist	\$400 each calendar year
Chiropractor	\$400 each calendar year
Physiotherapist/Athletic Therapist	\$400 each calendar year
Podiatrist	\$400 each calendar year
Naturopath	\$400 each calendar year
Osteopath	\$400 each calendar year
Psychologist/Social Worker	\$400 each calendar year
Speech Therapist	\$400 each calendar year
Massage Therapist	\$400 each calendar year
Acupuncture	\$400 each calendar year
Dietician	\$400 each calendar year
Occupational Therapist	\$400 each calendar year
Lifetime Health Care Maximum	Unlimited

If you have an inquiry concerning your claim, please contact:

Great-West Life
1-800-957-9777 or 204-942-3589

Please provide your **Plan Document number 51585** and your **Member Identification Number** (see page 3) when calling to make an inquiry.

Eye Examinations and Vision Care Services and Supplies

Deductibles

Eye Examination	Nil
Vision Care Services and Supplies	Nil

Reimbursement Levels

Eye Examinations	100%
Vision Care Services and Supplies	100%

Maximums (page 38)

Eye Examination – you, your spouse, covered dependants to age 21 but under age 26	one every 24-consecutive month period \$85 maximum
Eye Examination – dependent children under age 21	one every 12-consecutive month period \$85 maximum
Eye Examination – disabled dependent children age 21 years or older	one every 24-consecutive month period \$85 maximum
Vision Care Services and Supplies	\$300 per insured family member every 24-consecutive month period

Benefit Details

This section describes the major features of your Group Benefit Plan sponsored by the Saskatchewan Teachers' Federation, but **Plan Document 51585 and the Vision Care Services and Supplies Plan Document are the governing documents**. If there are variations between the information in the booklet and the provisions of the Plan Documents, the Plan Documents prevail. Contact the STF Members' Health Plan Administrator if you require any additional information.

Extended Health Care

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to combinations of various plan **maximums, deductibles, co-insurance, reasonable and customary charges and frequency** limits. Check the benefit summary for this information or contact the STF Members' Health Plan. Covered expenses and limitations apply individually to each eligible, enrolled family member.

The Plan covers the following services and supplies if they are not covered under your provincial government plan and provincial law permits coverage. 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.

Situations may arise when further information is required to assess your claim. You may be asked to have your health care provider send in additional information and to confirm the medical necessity for the prescribed item.

Covered Expenses

- Ambulance transportation, including air ambulance services, to the nearest centre where adequate treatment is available, and where a licensed ambulance company provides services.
- Semi-private room and board in a hospital in Canada. A hospital is an institution that is legally termed a hospital, is open at all times, offers in-patient accommodation, has a staff of one or more physicians available at all times, and continuously provides 24-hour nursing by graduate registered nurses.

- Hospital care is described as:
 - Acute care for active intervention required to diagnose or manage a condition that would otherwise deteriorate.
 - Convalescent care for a condition that will significantly improve as a result of the care and that follows a three-day confinement for acute care.
 - Palliative care for the relief of pain in the final stages of a terminal condition.
- Out-of-province outpatient charges not covered by the government health plan in your home province.
- 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.
- 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 as prescribed by a physician. Care provided does not include homemaking or companionship duties. Charges will not be considered for services provided in hospital, or when the nurse normally resides in the patient's home. **To establish the amount of coverage available under this benefit, the member must apply for a pre-care assessment.**
- Rental or, at the Plan's discretion, purchase of a manual wheelchair, or a standard hospital bed. When deemed necessary, an electric wheelchair may be substituted. These charges will be allowable only if approved and prescribed by a physician.
- Rental or, at the Plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician.
- Charges for the initial placement of a non-myoelectric limb and artificial eyes.
- Custom-made foot orthotics and custom-made orthopedic shoes prescribed by an approved health care provider and specifically designed and molded for the patient's foot. Custom-fit and modifications to existing or new orthopedic shoes are not eligible. Birkenstocks, Finn Comfort, Rockport, Nike, etc. are not eligible. This benefit includes the biomechanical assessment and casting fee.
- Hearing aids, tubing and ear molds provided at the time of purchase, excluding replacement batteries and routine maintenance.
- Hairpieces, prescribed by a physician following chemotherapy or surgery requiring the head to be shaved.

- Diabetic supplies: novolin-pens or similar insulin injection devices using a needle, insulin infusion sets, not including infusion pumps, bloodletting devices including platforms but not lancets. Lancets are covered under prescription drugs (see diabetic supplies covered under base prescription drugs, page 36).
- Blood-glucose monitoring machines.
- Diagnostic x-rays and tests, when not covered under your provincial government health plan.
- Ostomy supplies including irrigation sets, bags, deodorants, pads, adhesives or skin creams when not covered under your provincial government health plan.
- Out-of-hospital services of a licensed, certified or registered audiologist.
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed, certified or registered chiropractor.
- Out-of-hospital treatment of movement disorders by a licensed, certified or registered physiotherapist/athletic therapist.
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays by a licensed, certified or registered podiatrist.
- Out-of-hospital treatment of speech impairments by a licensed, certified or registered speech therapist.
- Out-of-hospital services of a licensed, certified or registered osteopath, including diagnostic x-rays.
- Out-of-hospital services of a licensed, certified or registered naturopath.
- Out-of-hospital services of a licensed, certified or registered psychologist/social worker.
- Out-of-hospital services of a licensed, certified or registered massage therapist.
- Out-of-hospital services of a licensed, certified or registered acupuncturist.
- Out-of-hospital treatment of nutritional disorders by a licensed, certified or registered dietician.
- Out-of-hospital services of a licensed, certified or registered occupational therapist.

Licensed, certified or registered means licensed, certified or registered to practice the profession by the appropriate licensing, certification or registration authority of the jurisdiction in which the care and/or services are provided or, where no such authority exists, possessing a certificate of competency from the professional body that establishes professional standards of competency and conduct.

Medical Travel in Canada

The Plan will pay for the following expenses when accompanied by supporting documentation and receipts, if you or your dependants are referred away from home by your doctor for treatment by another physician within your own province, or elsewhere in Canada, and the round trip distance is 1,000 kilometres or more.

- Travelling expenses for the person requiring the treatment and one companion if recommended by the attending doctor. Benefits are limited to either round trip economy class travel or automobile fuel expenses. Taxicab, car rental charges and automobile repair charges are not covered.
- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred. Telephone and meal expenses are not covered.

Transportation and lodging expenses associated with in-Canada medical travel are limited to a maximum of \$2,000 in a person's lifetime.

In order to assess a claim for Medical Travel in Canada you must submit, in addition to receipts for travel and lodging, confirmation from your physician of:

- The nature of the patient's medical condition.
- Written referral to another physician for treatment.
- The nature of the treatment provided.
- That if charges are claimed for a companion, a physician's written recommendation that the patient is to be accompanied.

Out-of-Country Care

Emergency Care

Emergency care outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependants are temporarily outside Canada for vacation, business or education purposes. The health care coverage provided under this Plan is intended for people who live in Canada and who are covered by the government health plan in their 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 defined as 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.
- The amount payable under this Plan for comparable treatment in Canada plus the cost of return transportation.

Limitations

No benefits will be paid for:

- Any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management, or follow-up care of the condition originally treated as an emergency.
- Any subsequent and related episodes during the same absence from Canada.
- Expenses related to pregnancy and delivery, including infant care:
 - After the 34th week of pregnancy.
 - 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, excluding members and covered dependants who are students in full-time attendance at a recognized post-secondary educational institution outside Canada. If you or your dependant is confined to hospital at the end of the 60-day period, benefits will be extended to the end of the confinement.

Non-Emergency Care

Non-emergency care outside Canada is covered for you and your dependants 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.
- A pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

The maximum amount payable for non-emergency care is \$50,000 in a person's lifetime.

Limitations

No benefits will be paid for:

- Investigational or experimental treatment.
- Transportation or accommodation charges.

Covered Expenses

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 when you or your dependant is covered.
- Medical supplies provided during a covered hospital confinement.
- Paramedical services provided during a covered hospital confinement.
- Hospital outpatient services and supplies.
- Medical supplies provided out-of-hospital if they would have been covered in Canada.
- Prescription Drugs.
- Out-of-hospital services of a professional nurse, if prescribed by a physician.
- 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 that 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 dependants are travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You and your dependants 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 on an in-patient basis for more than seven days while travelling alone. Benefits will be paid for moderate quality lodgings up to \$1,500 and for a round trip economy class ticket. Benefits payable for moderate quality accommodation includes telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.
- If you or your dependant 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 dependant's medical condition, to a maximum of \$1,500.
- The cost of comparable return transportation home for you or your dependant and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependant 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 home of the deceased.
- Return transportation home for minor children travelling with you or a dependant that are left unaccompanied because of your or your dependant's hospitalization or death. Return of round trip transportation for an escort for minor children is also covered when considered necessary.
- Costs of returning your or your dependant's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependant 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.

Please refer to Great-West Life's brochure Global Medical Assistance, for additional details.

Prescription Drugs

Your Prescription Drug Card

Upon your approved enrolment in the STF Members' Health Plan, you will receive a personalized Prescription Drug Card. This card is accepted at almost every pharmacy in Canada and provides a convenient method to access your STF Members' Health Plan prescription drug benefits.

- You do not need to fill out any claim forms. Your pharmacist can electronically file your claim and coordinate benefits between you and your spouse's plans.
- You receive your prescription immediately and in most cases your out-of-pocket expenses are reduced.

Spouse and Dependant Cards

Your spouse and dependent children over age 21 and under age 26 will receive their own cards to use. Dependent children under the age of 21 will not be issued a card of their own except if they are enrolled in a post-secondary institution in another province. In that instance, you will be required to request an individual card to be issued to your dependent child for the period of their enrolment.

Temporary Contract Teachers

Teachers on temporary contracts do not receive Prescription Drug Cards. If you are on a temporary contract you must pay for your prescriptions up front and submit receipts for reimbursement using the Extended Health Care Drug Claim Form.

Lost or Stolen Cards

If your card has been lost or stolen, contact the STF Members' Health Plan immediately at 1-800-667-7762. We will arrange to cancel your card and issue a new one. If you find your card after it has been cancelled, please destroy or return it to the STF Members' Health Plan.

Using Your Card

You must **present your card at the same time you present your prescription** to your pharmacist. You may be asked to provide your, or your dependant's, date of birth, which will be verified electronically with your prescription information.

Health Assure Check

Before your prescription is filled, a Health Assure check will be done on your drug claim history to assist the pharmacist in identifying any drug interaction warnings, limits on quantity of medication, therapeutic duplication and duration of therapy. Depending on the outcome of this check, the pharmacist may refuse to dispense the prescribed drug and further consultation with your physician may be necessary to have the proper medication prescribed.

National Formulary

The goal of a managed-care drug benefit is to provide you with high quality medications along with a cost-effective approach to health care. The National Formulary is a comprehensive list of medically- and cost-effective medications. The National Formulary includes the majority of the most commonly prescribed medications. Coverage is also provided for certain prescription drugs and drug supplies at specific calendar year and lifetime maximums. These drugs are eligible for 100 per cent coverage, subject to your \$8 per prescription deductible, and any Plan maximums and reasonable and customary charges.

Special Authorization Drugs

A limited number of Special Authorization drugs (drugs that can be prescribed if a similar medication prescribed for you has not been effective) are covered at 75 per cent. You are responsible for 25 per cent of the cost of these drugs, plus your \$8 per prescription deductible, and any Plan maximums and reasonable and customary charges. Exception drug status under a provincial formulary does not qualify as special authorization for drug coverage. The prescribed drug must be eligible under the National Formulary to be considered.

Generic Drugs

If a generic drug is available, and your doctor has not indicated “no substitution” for the drug prescribed, the generic product will be dispensed and the Plan will cover only up to the cost of the lowest price generic substitute if the prescribed medication is eligible for coverage. If your doctor has requested “no substitution” the brand name medication will be dispensed and the Plan will cover the cost of the brand name drug if it is eligible for coverage.

Non-Participating Pharmacy

When you purchase your drugs at a non-participating pharmacy or a pharmacy that does not have the capability to process electronic prescription drug claims, or you

forget your card, or you are outside the country, you will be required to pay the full price of the prescription drug and the Health Assure check will not be available. You will be required to complete a paper claim form to receive reimbursement for your expenses.

Saskatchewan Special Support Program

If you are a Saskatchewan resident, you are eligible to have a portion of your prescription drug expenses paid for by the provincial government under the Saskatchewan Special Support Program (SSP). The program works together with your Plan to ensure you have affordable access to covered drugs. This Plan covers your eligible prescription drug expenses up to the level of your family deductible under the SSP program. For purposes of the SSP, each dependent child age 18 and over is considered to be a single family unit. Once this deductible is reached, the SSP assumes responsibility for a portion of your prescription drug expenses. The only way to ensure you can utilize this coverage is by submitting an application to the SSP. Applications are available at your pharmacy or online at www.health.gov.sk.ca.

When your drug claims reach a designated dollar amount in a calendar year, you will receive a letter from Great-West Life Drug Services requesting you to apply to the SSP. After you apply, the SSP will send you a letter confirming eligibility and the deductible amount. When you receive this notification, please send Great-West Life a copy to ensure your claims are paid accurately and without interruption. For more information, contact the Plan office. You can also contact the SSP directly at 787-3317 in Regina, or toll free at 1-800-667-7581.

Covered Expenses

Covered drugs and drug supplies are categorized as either base drugs or supplementary drugs under the National Formulary for benefit payment purposes.

The National Formulary base drugs consist of:

- Those drugs listed in the Emergis Inc. National Formulary in effect on the date of purchase.
- Diabetic supplies, limited to syringes, disposable needles for use with non-disposable insulin injection devices, test strips and lancets. The maximum amount payable for diabetic supplies including syringes and lancets is \$1,500 in a calendar year.
- Vaccines to a maximum of \$100 each calendar year.
- Fertility drugs limited to \$2,500 lifetime.

- Smoking cessation drugs requiring a prescription limited to \$500 lifetime.
- Erectile dysfunction drugs with no limitations.

The National Formulary supplementary drugs consist of:

- Those drugs listed in the Emergis Inc. Special Authorization (SA) list in effect on the date of purchase.

Limitations

- Unless your doctor has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the Plan will cover only the cost of the lowest priced equivalent generic drug.
- For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and co-insurance you are required to pay under that plan.
- Any single purchase of drugs which would not reasonably be used within 90 days.
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy.
- Drugs dispensed during treatment as an inpatient or an outpatient in a hospital.
- Allergy extracts.
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.

Eye Examinations and Vision Care Services and Supplies

All vision care services and supplies will be reimbursed at the level shown in the Benefit Summary. Benefits may be subject to combinations of various Plan maximums, deductibles, co-insurance, reasonable and customary charges and frequency limits. Check the benefit summary for this information or contact the STF Members' Health Plan for further information.

Covered expenses and limitations apply to each individual covered family member. Frequency limitations (i.e., consecutive 12- or 24-month periods) apply from the date of purchase of the service or supply. The frequency limit does not apply from your effective date of coverage. The date of purchase is the date the service or supply was paid for, in full.

For example, if you had and paid for a \$95 eligible eye examination on July 1, 2008 and ordered eligible vision care services and supplies in the amount of \$300 but paid for them on July 8, 2008, your claim would be adjudicated as follows:

Eye Examination: \$85 reimbursed as maximum payable under the Plan has been met for the 24-month period. Member may claim again for an eligible eye examination after July 1, 2010.

Vision Care Services and Supplies: \$300 reimbursed as maximum payable under the Plan has been met for the 24-month period. Member may again claim for eligible vision care services and supplies after July 8, 2010.

If you would like to confirm the date you will again be eligible for eye examination and vision care services and supplies, or would like to confirm coverage still available in the current 12-month or 24-month period, contact the Plan office at 1-800-667-7762 or 373-1660 in Saskatoon, or e-mail health@stf.sk.ca. A Vision Care Report will be mailed to you that clearly indicates the date(s) you and your eligible spouse and dependent children are eligible for coverage, as well as coverage still available. **The Plan office does not provide this information over the telephone.**

The Plan covers the following services and supplies if they are not covered under your provincial government plan and provincial law permits the Plan to cover them. 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.

Eye Examinations

Covered Expenses

- One complete eye examination is covered every consecutive 24-month period for you and your spouse if no cost is covered by any government plan.
- One complete eye examination is covered every consecutive 24-month period for each dependent child age 21 or older, but under age 26 if in full-time attendance at a recognized post-secondary institution if no cost is covered by any government plan.
- One complete eye examination is covered every consecutive 12-month period for each dependent child under age 21, if no cost is covered by any government plan.
- One complete eye examination is covered every consecutive 24-month period for each disabled dependant age 21 or older provided no cost is covered by any government plan.

A licensed optometrist or ophthalmologist must perform the eye examination. A complete eye examination is defined as an examination that includes case, visual and medical history, a thorough assessment of visual needs, binocular vision and sensory status, refraction, intraocular pressure testing (glaucoma), ocular motility assessment and a complete ocular health evaluation.

Vision Care Services and Supplies

The Plan covers vision care services and supplies for you and each of your dependants every consecutive 24-month period if:

- The service or supply rendered was prescribed by a licensed optometrist or ophthalmologist and provided by a qualified optician.
- The service or supply rendered was purchased while you or your eligible family members are covered under this benefit.
- You and your dependants are eligible for coverage.

Covered Expenses

- Prescription Lenses.
- Contact lenses.
- Eyeglass frames.

- Surgery to correct visual acuity (laser surgery).
- Repairs, including soldering charges, temples and fronts, rimlon wires (nose pads and temple tips are not eligible when submitted alone).
- Services and supplies in conjunction with visual training and therapy to treat a medical condition of the eye not covered under the member's provincial health plan and performed in the office of a licensed optometrist or ophthalmologist.

Limitations

Ineligible charges include, but are not limited to:

- Any eye examination that is not a complete eye examination
- Sunglasses, whether prescribed or not, or any tinted prescription glasses with other than a No. 1 or No. 2 tint.
- Safety glasses, whether prescribed or not.
- Reading glasses, whether prescribed or not.
- Glasses and services and supplies for sport or recreational use.
- Consultation fee for contact lenses evaluation, custom-fitting fees, contact lenses training, follow-up examinations and service plans relating to contact lenses.
- Magnifying glasses.
- Any options added to basic lenses for cosmetic purposes, or any other services and products provided principally for cosmetic purposes.
- Treatment or examinations paid for by any government plan or program, or for which the member is entitled to obtain without charge.
- Automated visual fields, retinal photographs, colour vision analysis and dilated fundus examinations, when not part of a complete eye examination.
- Computer-assisted home therapy programs.
- Charges that are not medically necessary, including time spent travelling, broken appointments, transportation costs or advice given by telephone or by any other means of communication.
- Nose pads and temple tips when submitted alone.
- Charges that are in excess of reasonable and customary charges.

Preferred Vision Services (PVS)

Preferred Vision Services (PVS) is a service provided to you at no extra cost.

Preferred Vision Services (PVS) entitles you to a discount on a wide selection of quality eyewear and vision care services when you purchase these items from a PVS network optician or optometrist. You can use the PVS network as often as you wish to purchase services and eyewear for yourself and your dependants at a reduced cost. You can submit your expenses to the Plan for reimbursement up to the maximums established.

Shopping for eyewear through PVS:

- **Call the PVS Information Hotline at 1-800-668-6444** or visit the **PVS website at www.pvs.ca** for information about PVS locations and the program.
- Arrange for a fitting or eye examination, if needed.

Select your eyewear and pay the reduced PVS price. Retain your receipts and submit your claim for vision care to the STF Members' Health Plan for consideration of eligible charges.

General Plan Limitations

No benefits will be paid for:

- Expenses private insurers are not permitted to cover by law.
- Services or supplies not listed as covered expenses.
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage.
- Medical examinations for the use of a third party.
- Obtaining further medical information regarding claims for covered expenses, or any expenses incurred for the completion of claim forms.
- Charges for which the carrier is not permitted by law/legislation to cover. Any changes to provincial legislation or government health insurance plans will not automatically result in a change of coverage provided under this Plan.
- Services or supplies the insured person obtains or is entitled to obtain under any government plan.
- The failure of an insured person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to a government plan to which they are entitled. If the insured person is not a member of a government plan by reason of having “opted-out,” or for any other reason is not a member of a government plan, the insured person will be deemed, for the purposes of this Plan, to be a member of the government plan.
- Extra charges that may result due to the physician opting-out of the government health insurance plan.
- Services or supplies that do not represent reasonable treatment or the least expensive appropriate treatment.
- Services or supplies that are not medically necessary.
- Charges in excess of the specific limitations and maximum amounts described in the Benefit Summary, including combinations of various Plan maximums, deductibles, co-insurance, reasonable and customary charges and frequency limitations.
- Experimental or investigational treatment not generally accepted by the medical community or involving therapies not prescribed or paid for under provincial or federal medical reimbursement plans.
- Treatment not recognized under Canada Revenue Agency bulletins that define the parameters of a private health services plan.

- Any sickness or bodily injury occurring in the course of employment if you or your dependant is eligible for coverage through *The Workers' Compensation Act* in your province of residence.
- Charges in connection with general health exams.
- Services or supplies associated with:
 - Treatment performed only for cosmetic purposes.
 - Recreation or sports only, rather than with other daily living activities.
- Any care, service or supply in connection with a change in gender.
- Charges for any method of contraception other than covered drugs.
- The renovation or alteration in any physical way to an insured person's residences, vehicles or place of business, including the filtration or purification, whether mechanical or electronic, of air, water or other environmental factors.
- The repair or alteration of any prosthetic device incurred after the initial placement and fitting, or charges incurred due to the replacement of any prosthetic device unless the replacement is due to a change in the insured person's physical condition.
- Private or semi-private room charges in an acute care hospital where the type of care is primarily custodial care or while awaiting admission to a custodial care facility.
- Private duty nursing care provided in hospital, or when a nurse normally resides in the patient's home.
- The purchase of a myoelectric controlled prosthetic. However, an amount equal to the reasonable and customary charges for the initial placement of a non-myoelectric prosthetic device will be considered.
- Any self-inflicted sickness or injury, while sane or insane.
- Sickness or bodily injury resulting from insurrection or war (declared or not), any related act, or participation in any riot.
- 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 Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province. This limitation does not apply to Global Medical Assistance.

Notes



Members'
Health Plan

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