



Your Group Benefits Booklet

Sault Area Hospital

OPSEU Members other than Members who were certified on December 19, 2011

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99173

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SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

MEDAVIE BLUE CROSS™

Welcome to your Group Benefits Plan

Your group benefits coverage provides you with the peace of mind that you and your family are protected today and in the future, for health and medical expenses not available through the coverage provided by government.

In this plan, drug, extended health care and dental benefits are self-insured by the Sault Area Hospital and are administered by Medavie Inc.

Medavie Inc. (also known as Medavie Blue Cross) will be referred to as "Blue Cross" for convenience of reference.

Blue Cross has been a trusted health services partner for individuals, employers and governments across Canada for over 75 years. Our core purpose is to help improve the health and well-being of people and their communities.

Our commitment to service, innovative solutions and technological expertise mean you can rest easy because at Blue Cross, we're always there for you.

About this Booklet

This booklet, together with your identification card, contains important information about your group benefits coverage. You should keep them in a safe place for future reference.

This booklet summarizes the important features of your group benefits coverage. It is prepared as information only, and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefits coverage are described in the group plan held by your employer. In the event of a difference of wording of the group plan, the group plan will prevail, to the extent permitted by law.



Helpful Tip

Take a tour in the Member Centre section at www.medaviebc.ca

Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.
- **Coverage Details:** Contains important information regarding the eligibility requirements for your group benefits coverage. This includes when your coverage begins and ends, plus other useful information to help you take advantage of the coverage available to you.
- **Rights and Responsibilities under the Plan:** Outlines your responsibilities under the group plan (such as your responsibility to notify your employer upon change in status) and your rights (for example your right to privacy).
- **How to Submit a Claim and Obtain More Information:** Provides additional information on how you can submit claims and obtain more information regarding your coverage.
- **Helpful Tips:** Throughout this booklet we provide useful tips to help you better understand and get the most out of your group benefits.

Medavie Blue Cross Mobile App

Submit a claim, access an electronic version of your ID card, check coverage, find a health professional in your area, and much more! Visit www.medaviebc.ca/app for more information or to download the app.

TABLE OF CONTENTS

Summary of Benefits 1
Key Terms 6
Coverage Details 10
Drug Benefit 14
Extended Health Care 18
Dental Benefit 24
Health Spending Account (HSA) Benefit 29
Rights and Responsibilities Under the Plan 33
How to Obtain More Information 36
Additional Resources and Member Services 38

Summary of Benefits

Drug Benefit

Deductible	$22.50 Participant/$35 family per calendar year, combined with Extended Health Care
Reimbursement Level	100%
Dispensing Fee Maximum	$11.99/prescription
Method of Payment	Pay Direct
Days Supply	100-days maximum supply (1-month supply may apply to some drugs)
Drug Formulary	
Specialty High Cost Drugs	Managed Formulary
All Other Eligible Drugs	Open Formulary
Plan Management Features	
Substitution Provision	Mandatory Generic Substitution
Quebec Pharmacy Pricing Controls	Usual, Customary and Reasonable applies
Additional Benefit Modules	**Benefit Maximum**
Glucose Monitoring Systems	Included
Fertility Drugs	Included
Varicose Vein Injections	$40/visit
Vaccines (including injection service when administered by a pharmacist)	Included
Injectable Vitamins	Included
Termination	When the Member reaches age 70 or retires

Summary of Benefits

Extended Health Care

Deductible	
Hospitalization	None
Lenses/Frames/Contact Lenses/Laser Eye Surgery	None
All Other Extended Health Care	$22.50 Participant/$35 family per calendar year, combined with Drug Benefit

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Private
Convalescent Care/Physical Rehabilitation (combined)	100%	$20/day to a maximum of 180 days/calendar year	
Chronic Care	100%	$3/day to a maximum of 120 days/calendar year	
Private Hospital/Homewood Health Centre/The Centre for Addiction and Mental Health (CAMH) (combined)	100%	$10/day to a maximum of 120 days/calendar year	
Medical Services and Supplies			
Ambulance Transportation	100%	See benefit details	
Nursing Care	100%	See benefit details	
Health Practitioners:		**Maximum per calendar year**	
Mental Health Practitioners (Psychologist/Social Worker/ Psychotherapist (combined))	100%	$800	
Chiropractor	100%	$450 (including 1 X-ray)	
Speech Therapist	100%	$200	
Physiotherapist	100%	$450	
Massage Therapist	100%	$450	

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 calendar years for approved purchase
Insulin Pump*	100%	1/4 calendar years
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment		
Glucometer	100%	$700/lifetime
Pressurized Insulin Injector/Insulin Dosing System (combined)	100%	$200/calendar year
Hearing Aids	100%	$300/36 consecutive months
Custom Orthopedic Shoes	100%	1 pair/calendar year to a maximum of $3,000/pair
Prefabricated Orthopedic Shoes	100%	2 pairs/calendar year
Orthopedic Shoe Supplies/Repairs and Adjustments (combined)	100%	$200/calendar year
Custom Made Foot Orthotics	100%	2 pairs/calendar year
Diagnostic Tests	100%	$1,000/calendar year
Other Medical Services and Supplies	100%	See benefit details
Accidental Dental	100%	Predetermination of claim required
Vision Care		
Eye Examination	100%	$100/24 consecutive months
Lenses/Frames/Contact Lenses/ Laser Eye Surgery (combined)	100%	$450/24 consecutive months
Contact Lenses/Intraocular Lenses for Cataract Surgery (combined)	100%	1 lens/eye/lifetime
Termination	When the Member reaches age 70 or retires	

*Pre-authorization required.

Summary of Benefits

Dental Benefit

Deductible	None
Fee Guide Schedule	Current year/Province of Member's residence (Specialist fees paid at General Practitioner rate)

	Reimbursement Level	Benefit Maximum
Preventive Care	100%	Unlimited
Oral Exam and Diagnosis		
Recall oral exams		1/9 consecutive months
Preventive Treatment		
Polishing of teeth		1/9 consecutive months
Fluoride treatment		1/9 consecutive months
Basic Care	100%	Unlimited
Endodontic Services		Included
Periodontic Services		Included
Major Restoration	50%	
Extensive Restorations, other Restorative Services and other Prosthodontic Services		$2,500/calendar year
Dentures		$1,000/calendar year
Orthodontic Services	50%	$2,500/lifetime

Lowest Cost Alternative Benefit	Inlays and crowns
Termination	The first day of the month following the date the Member reaches age 65 or the first day of the month following the date the Member retires

Summary of Benefits

Health Spending Account (HSA) Benefit

Health Spending Account is available to Members who have chosen Health Benefit coverage in this policy.	
Method of Payment	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member)
Credit Allocation Frequency	Annually
Benefit Details	
Policy Year	January 1st to December 31st
Carry Forward Type	Credit Carry Forward
(CRA) Dependent Coverage	Yes
Grace Period	
Active Members	90 days
Terminated Members	90 days
Termination	When the Member reaches age 70 or retires

You and Your Dependents

Throughout this booklet several key terms are used to refer to you and your Dependents:

- the terms that may refer to you are: Employee, Member and Participant;
- the terms that may refer to your Dependents are: Dependent, Spouse, Child and Participant.

Employee: A person who:

- resides in Canada; and
- works a minimum of 37.5 hours per week for the employer.

Member: An Employee who is eligible and approved for coverage under this plan.

Dependent: Your Spouse or Child.

Spouse: A person who:

- resides in Canada; and
- meets one of the following criteria:
  - is legally married to the Member;
  - is in a civil union with the Member as defined by the Civil Code of Quebec; or
  - is living with the Member in a conjugal relationship.

The Spouse must be designated by the Member on their application for coverage. Only one person may be covered as a Spouse at any one time.

Child: A person who:

- resides in Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
  a) is under age 21;
  b) is under age 25 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

A Child is considered to be mentally or physically disabled for the purposes of this definition if they are incapable of engaging in any substantially gainful activity and are financially reliant on the Member or Spouse for care, maintenance and support due to this disability. Blue Cross may require the provision of written proof of a Child's disability as often as is reasonably necessary.

Participant: The Member or one of the Member's Dependents who has been approved for coverage under this plan.

Helpful Tip

You are responsible for enrolling your Dependents under the plan when they become eligible.

In addition, you are responsible for removing them when they no longer meet the definitions outlined here.

You can update your family or Dependent status by filling out and submitting a change form, available through our website.

Helpful Tip

A Member, Spouse and Child are all Participants under the plan.

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

- is violent in nature;
- arises solely from external means;
- causes bodily injury to the Participant directly and independently of all other causes; and
- is unintended by the Participant.

The resulting injury to the Participant must be certified by a physician.

Actively at Work: Employees are Actively at Work on a specified day if they report for work at their usual place of employment and are able to perform the regular duties of their occupation, according to their regular work schedules.

Employees who are not required to report for work on a specified day due to holidays, shift variances, vacations or weekends are still considered to be Actively at Work if they could have reported for work and performed the regular duties of their occupation on that day.



Helpful Tip

One of the eligibility requirements for coverage is that you be Actively at Work.

Activities of Daily Living: The following 6 activities:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting: getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel continence: managing bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: moving in and out of a bed, chair or wheelchair; and
- Feeding: consuming food or drink that already have been prepared and made available.

Approved Provider: A provider of health care services or supplies who has been approved by Blue Cross to provide specific Eligible Expenses.

Deductible: The amount of Eligible Expenses that the Participant must pay before Blue Cross will reimburse any Eligible Expenses.

The Deductible amount applies once per calendar year or per prescription drug, as specified in the Summary of Benefits. However, Eligible Expenses incurred during the last 3 months of a calendar year that totally or partially met the Deductible for that year may be used to reduce the Deductible for the following calendar year.

Eligible Expenses: Charges incurred by the Participant for health care services and supplies that are:



Helpful Tip

Important: Blue Cross will only reimburse health expenses meeting these Eligible Expenses criteria.

- Medically Necessary;
- Usual, Customary and Reasonable;
- recommended or prescribed by a physician or Health Practitioner who:
  - does not normally reside in the Participant's home;
  - is not the Participant's Family Member; and
  - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant's home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the plan is in effect, unless otherwise specified.

Health care services and supplies that Participants prescribe, render or dispense to themselves are not Eligible Expenses.

An Eligible Expense is considered to be incurred on the date the service or supply was received by the Participant. Reimbursement for Eligible Expenses incurred outside of Canada will be limited to the amount that would have been reimbursed if the expense had been incurred in the Participant's province of residence, unless the benefit is restricted to in Canada only.

Where more than one form of Treatment exists, Blue Cross has the right to base its payment for Eligible Expenses on the lowest cost alternative if Blue Cross, in consultation with its health care consultants, deems the alternative Treatment to be appropriate and consistent with good health management.

Helpful Tip

Family member refers to a Participant's:

- spouse or common law partner;
- parent and parent's spouse or common law partner;
- children and spouse's or common law partner's children;
- brothers and sisters;
- grandchildren; or
- grandparents.

Experimental or Investigative: Any treatment, procedure, facility, equipment, drug or drug usage that, in the opinion of Blue Cross after consultation with its health care consultants:

- is not Medically Necessary;
- lacks sufficient published data to establish its medical effectiveness or safety for the purpose for which it is being provided or prescribed; or
- is not recognized as the standard of care in current prescribing guidelines or practice setting protocols.

Health Practitioner: A health care practitioner who is a registered member of their regulatory body (if applicable) and practices within the limits of their authority as established by law. If no occupational guild applies to a particular practitioner, the practitioner must:

- be a registered member of their association;
- provide care and treatment within the limits of their professional scope of practice; and
- be an Approved Provider.

Illness: A deterioration of health or a bodily disorder that has been diagnosed by a physician and requires regular and continuous care.

Life Event: A situation resulting from one of the following that permits a Member to change their coverage:

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- the Member's or Dependent's other coverage terminates for reasons outside of their control; or
- death of a Dependent.

Proof of health may be required if the request is received more than 31 days after the Life Event date.

Medically Necessary: A health care service or supply provided or prescribed by a physician or Health Practitioner to treat an injury or Illness that, in the opinion of Blue Cross after consultation with its health care consultants:

- has not been provided or prescribed primarily for convenience or cosmetic reasons;
- is the most appropriate, safe and cost effective Treatment for the diagnosed injury or Illness; and
- is generally medically recognized as acceptable Treatment for the diagnosed injury or Illness.

Helpful Tip

Blue Cross will only pay for Eligible Expenses that are Medically Necessary.

Quebec Participant: A Member or Dependent is considered to be a Quebec Participant if:

- the plan sponsor has a business office in Quebec;
- the Member resides and works in Quebec; and
- the Participant is subject to the Act Respecting Prescription Drug Insurance.

Self-Insured Benefits: Benefits that are:

- fully funded by the plan sponsor who assumes sole liability for their payment; and
- administered by Medavie Inc. under an administrative services only contract with the plan sponsor.

In this plan, drug, extended health care and dental benefits are Self-Insured Benefits.

Treatment: The management and care of a Participant to improve or cure an Illness, disorder or injury. This management and care must be:

- considered appropriate and approved by Blue Cross; and
- prescribed, provided or performed by a Health Practitioner or physician practicing in the field of medicine applicable to the Participant's disease, disorder or injury.

Usual, Customary and Reasonable: Charges incurred by the Participant that are:

- consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
- in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition.

Who is Eligible for Coverage?

You are eligible for coverage if you:

- meet the definition of Employee and are Actively at Work;
- with the exception of Dental coverage, have completed the 1-month waiting period. Your coverage will be effective on the first day of the month following or coinciding with 1 month of continuous service; and
- for Dental coverage, have completed the 3-month waiting period. Your coverage will be effective on the first day of the month following or coinciding with 3 months of continuous service.



Helpful Tip

Waiting Period refers to the continuous period of time during which you must be Actively at Work before being eligible for coverage.

Your Dependents are also eligible for coverage if they meet the definition of Spouse or Child outlined above in the *Key Terms*.

To be eligible for coverage, you and your Dependents must be entitled to government health care coverage or similar coverage deemed satisfactory by Blue Cross.

You must continue to work the minimum number of hours per week to maintain eligibility under the plan.

Do I Need to Supply Proof of Health to Obtain Coverage?



Helpful Tip

Proof of health refers to statements or medical evidence about your health or the health of your Dependents.

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted if your application is received by Blue Cross more than 31 days after the date upon which you or your Dependent became eligible for coverage, with the following exceptions:

- late applicants for dental benefits (if applicable) do not need to submit proof of health (instead their maximum benefit is limited to $150 for the first consecutive 12 months of coverage); and
- Quebec Participants who are late in applying for drug benefits do not need to submit proof of health for drug coverage.

How do I Enrol for Coverage?

Application

To obtain coverage, you must submit a completed and signed application, and submit proof of health, if required for the reason listed above.

The application must be received by Blue Cross within 31 days of the date you or your Dependent become eligible for coverage.



Helpful Tip

If you do not enrol for coverage within 31 days of eligibility, you may be restricted when applying for benefits and your benefit levels may be reduced.

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the plan. In addition, when you enrol for coverage you must also enrol all of your eligible Dependents. You are allowed to waive the health benefits coverage for yourself or your Dependents. In this case, you or your Dependents will again be eligible for health benefits if you experience a Life Event, subject to proof of health if required.



Helpful Tip

Health benefits may include: drug benefits, extended health care and dental benefits.

When Does Coverage Begin?

Employees

Your coverage takes effect on the latest of the following dates:

- the effective date of the plan;
- the date you meet all of the eligibility requirements; or
- the date Blue Cross approves your proof of health, if required.

If you are not Actively at Work on the date you would have become eligible for coverage, your coverage begins on the date you resume being Actively at Work.

Dependents

Your Dependent's coverage takes effect on the latest of the following dates:

- the date you become eligible for coverage;
- the date they meet all of the eligibility requirements;
- the date Blue Cross approves their proof of health, if required; or
- the date following their discharge from hospital if they were hospitalized on the date they would have become eligible for coverage, unless:
  - they were covered under a Previous Policy, in which case their coverage begins on the effective date of the plan; or
  - they were born while this coverage is in force, in which case their coverage will be effective from their live birth.

Helpful Tip

Previous Policy refers to a group plan that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this group plan.

What Happens to my Coverage During Periods of Absence from Work?

Illness/Accident

If you are absent from work due to illness or accident, your group benefits coverage is retained. In such circumstances, please contact your group benefits administrator to discuss the maximum period for which your coverage will be retained.

Maternity Leave/Parental Leave

During a maternity or parental leave of absence, you have the choice to either retain or discontinue all coverage for the maximum period provided under the applicable legislation.

Your decision to retain or discontinue coverage must be made before the beginning of your leave of absence and this decision cannot be changed at a later date. If you decide to retain coverage, you must continue to pay your premium contributions (if any) for the whole duration of the absence.

If you are a Quebec Participant, you must at least retain drug coverage unless you benefit from drug coverage under another group plan.

Temporary Layoff/Authorized Leave of Absence/Disciplinary Suspension/Strike or Lockout

In such circumstances, please contact your group benefits administrator to discuss the benefits you must retain during such an absence and the maximum period these benefits will be retained.

When Does Coverage End?

Coverage ends on the earliest of the date:

- the plan terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your Spouse no longer meets the definition of Spouse;
- your Child no longer meets the definition of Child;
- your employment is terminated;
- you or your Dependents reach the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire and did not provide notice of continuation of coverage under the retiree class prior to retirement;
- you die; or
- the plan sponsor defaults in payment of premiums.

Coverage for your Dependents will also terminate on the date your coverage terminates.

Additionally, if you or your Dependents commit a fraudulent act against Blue Cross or the plan sponsor, Blue Cross will have the right to terminate coverage, subject to the prior approval of the plan sponsor.

No coverage will be provided to you or your Dependents while performing duties as an active member in the armed forces of any country, unless coverage must be retained under applicable provincial legislation.



Helpful Tip

The benefit of converting your group coverage is that you do so without having to provide proof of health.

Conversion premium rates will typically be higher than group premium rates currently paid.

Instead of converting your group coverage, you may prefer to apply for an individual plan, which will require Proof of Health.

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

Upon termination of coverage for certain benefits, you and your Dependents have the right to convert your group benefits coverage to an individual insurance policy, provided certain criteria are met.

The benefit details will specify if this conversion right applies to a particular benefit.

When conversion is available, the following terms and conditions apply:

- You must, within 60 days of the date of termination of your group coverage:
  - submit the application form provided by Blue Cross for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by Blue Cross;
- the individual policy will be issued without requiring proof of health;
- the premium for the individual policy is based upon the individual policy rates in effect on the date of application;
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are specified in the *Right to Convert to Individual Coverage* provision of the applicable benefit.

What if I Have Coverage Elsewhere?

Blue Cross will co-ordinate your group benefits coverage with other health plans when similar coverage is available. The co-ordination of benefits process helps ensure you get the most out of your coverage. It means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Government Health Care Coverage

Unless otherwise agreed by Blue Cross, no payment will be made for any health care services or supplies payable or available under government health care coverage or administered by government funded hospitals, agencies or providers, regardless of:

- any waiting lists; or
- whether or not you or your Dependents have applied for, or exercised your right to claim, any allowances available through any government health care coverage.



Helpful Tip

Blue Cross will help direct you to existing **government programs** whenever possible.

Blue Cross will only consider Eligible Expenses in excess of those provided under government health care coverage.

Other Health Plans

Do you take advantage of coverage under the other benefit plans available to you, such as your Spouse's? If not, you may be missing out on possible reimbursement of up to 100% of Eligible Expenses.

Blue Cross applies co-ordination of benefits according to the guidelines of the Canadian Life and Health Insurance Association Inc. (CLHIA). Here are the general rules:



Helpful Tip

The types of other plans that are potentially subject to co-ordination of benefits include any form of group, individual, family, creditor or saving insurance coverage that provides reimbursement for medical treatment, services or supplies.

Expenses for Yourself:

- You must first submit expenses incurred to this plan (where you are covered as a Member). The balance that has not been paid by this plan (if any) can then be submitted to the other plan where you are covered as a dependent (for example your Spouse's plan).
- If you are covered as a member under more than one group benefit plan, the plan that has covered you the longest pays first.

Expenses for Your Spouse:

- Your Spouse must submit any expenses incurred for themselves to their own group benefit plan (if any) first. The balance that is not paid by their plan (if any) can then be submitted to this plan.

Expenses for Your Child:

- If a Child is covered as a dependent by both you and your Spouse, you should submit their claim to the plan of the parent whose birthday comes first in the year.
- In the event of divorce or separation, the plan of the parent with whom the Child resides (the plan of the parent with custody of the Child) pays first.



Helpful Tip

For more information on co-ordination of benefits (including examples), visit our website.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) in Canada;
- considered by Blue Cross to be an Essential Non-Prescription Requiring Drug or a drug that requires a prescription by law, unless specifically listed as covered under this benefit;
- prescribed by a physician or by a Health Practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Blue Cross as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may, on an ongoing basis, add, delete or amend its list of Eligible Drugs.

Essential Non-Prescription Requiring Drug: An Eligible Drug that does not require a prescription by law but is determined by Blue Cross to be essential for the healthcare needs of the Participant. A prescription from a Physician or Health Practitioner is still needed for reimbursement.

Interchangeable Drug: An Eligible Drug that can be substituted for another Eligible Drug as both drugs:

- are considered pharmaceutical equivalents by Health Canada;
- contain the same amount of the same or similar active ingredients; and
- have the same or similar dosage form.

Medication Advisory Panel: The group of health care and other industry professionals appointed by Blue Cross to review new drugs and decide which drugs Blue Cross includes on its formularies.

Patient Support Program: A program that provides assistance and services to Participants when prescribed Specialty High Cost Drugs.

Specialty High Cost Drug: An Eligible Drug that requires Prior Authorization and:

- is considered a Specialty High Cost Drug by the Medication Advisory Panel; or
- meets the following criteria:
  - costs $10,000 or more per treatment or per calendar year;
  - is used to treat complex chronic or life threatening conditions such as cardiac, rheumatoid arthritis, cancer, multiple sclerosis or hepatitis C.; and
  - is prescribed by a specialist.

What Blue Cross Will Pay

Blue Cross will pay Eligible Drugs subject to the following terms and conditions:

- payment is limited to the reimbursement level and the benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
  - Prior Authorization; or
  - co-ordination with Patient Support Programs;

- payment for a Specialty High Cost Drug may be reduced by the amount of financial assistance available under a Patient Support Program;
- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit;
- payment for biologic drugs may be limited to the cost of a biosimilar drug as determined by Blue Cross;
- payment for Eligible Drugs not dispensed by an approved retail pharmacy will be limited to a pricing schedule as determined by Blue Cross; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses listed below, provided they also meet the definition of Eligible Expenses contained under the *Key Terms* provision of this booklet:

- diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies;
- glucose monitoring systems, including continuous glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes;
- contraceptives, including diaphragm and intrauterine contraceptive device (IUD);
- viscosupplementation injections;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formularies:

  Specialty High Cost Drugs:

  - **Managed Formulary:** List of Eligible Drugs that are subject to the decisions of the Medication Advisory Panel.

  All Other Eligible Drugs:

  - **Open Formulary:** List of all Eligible Drugs. This list is not subject to the Medication Advisory Panel decisions.

Prior Authorization

Certain Eligible Drugs require prior or ongoing authorization by Blue Cross to qualify for reimbursement. The criteria to be met for Prior Authorization are established by Blue Cross and may include requiring the Participant to participate in a Patient Support Program.

Helpful Tip

Your group benefits plan provides you with immediate access to most Eligible Drugs.

Certain Eligible Drugs require Prior Authorization before your prescription is covered.

How does the Prior Authorization process affect my claim?

The first time you present a prescription for an Eligible Drug on the Prior Authorization list your pharmacist will indicate the need for Prior Authorization.

You can request a Prior Authorization Prescription Drug Form from your pharmacy, your employer, the nearest Blue Cross customer information centre or from our website. You must complete the patient section of the form, have your physician complete and sign the remaining portion and mail your completed form to the nearest Blue Cross office.

Helpful Tip

To print a copy of our Prior Authorization Prescription Drug Form, visit our website.

Your request will be confidentially reviewed by a health care professional according to the payment criteria established. When all the required information is received by Blue Cross, the standard turn-around time for Prior Authorization decisions is 7 to 10 working days.

You will receive confirmation in writing regarding the decision on your Prior Authorization request. If your request is approved, this confirmation will include the effective date and duration of your approval.

Any fees associated with completing this form or obtaining additional medical information are your responsibility.

Plan Management Features

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug. In the case of biologic drugs, Blue Cross reserves the right to reimburse to a less expensive biosimilar drug.

Participants may request a higher cost Interchangeable Drug; however, they will be responsible for paying the difference in cost between the Interchangeable Drugs.

Mandatory Generic Substitution:
Regardless of whether the Participant's physician indicates the prescribed Interchangeable Drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug.

Helpful Tip

A generic drug and its brand name equivalent are considered to be Interchangeable Drugs. Health Canada imposes the same standards and tests on generic drugs as it does on brand name drugs. Generic drugs are effective and safe, while often being less expensive.

For Participants with an adverse reaction to the Interchangeable Drug dispensed, Blue Cross will consider reimbursement to another Interchangeable Drug on a case by case basis only through the Prior Authorization process.

Quebec Pharmacy Pricing Controls

If the Summary of Benefits specifies that Quebec pharmacy pricing controls apply, Participants will be responsible for paying the difference between the amount charged by the pharmacy for professional fees and the amount Blue Cross considers acceptable Usual, Customary and Reasonable charges.

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under the group plan.

Pay Direct: At the time of purchase, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility. The Participant will pay the Approved Provider only the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

Helpful Tip

If you have a Pay Direct plan, always have your drugs submitted electronically via the Approved Provider. This will ensure you don't end up paying more out-of-pocket than you should.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim by the end of the next calendar year following the date the Eligible Expense was incurred.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, expenses associated with the following categories of drugs or services are not eligible for reimbursement, even when prescribed:

a) smoking cessation aids;
b) oral vitamins;
c) treatments for weight management, including drugs, proteins and food or dietary supplements;
d) natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;
e) sexual dysfunction drugs;
f) hair growth stimulants;
g) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only;
    iii. are elective in nature; or
    iv. have experimental or investigative indication;
h) procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
i) drugs that Blue Cross determines are intended to be administered in hospital, based on the way they are administered and the condition the drug is used to treat;
j) expenses that are covered under any government health care coverage or charges payable under a workers' compensation board/commission, any automobile insurance bureau or any other similar law or public plan;
k) services, treatment or supplies the Participant receives free of charge;
l) charges that would not have been incurred if no coverage existed;
m) all forms of cannabis; and
n) pharmacy services.

Helpful Tip

Shop around for the best price for your prescription drugs.

For the same prescription, the price can vary depending on where you go, even among stores in the same chain.

Right to Convert to Individual Coverage

A Participant who is not a Quebec Participant and who is no longer eligible under this benefit may convert their group coverage to a similar individual drug plan provided by Blue Cross.

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

Quebec Participants who are no longer eligible for drug benefit coverage cannot convert their group drug coverage to an individual plan. If they are not eligible under another group plan, they must contact the Régie de l'assurance maladie du Québec (RAMQ) to obtain coverage from the RAMQ's public drug plan.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Acute Care: Short-term Treatment that is necessary to:

- prevent deterioration of a severe injury, episode of illness or urgent medical condition;
- promote recovery from surgery; or
- provide palliative care for an individual diagnosed with a terminal illness whose life expectancy is less than 3 months.

Chronic Care: Care for patients with long term conditions for which medical care is required.

Helpful Tip

Blue Advantage® offers savings to Blue Cross members on medical, vision care and many other products and services from participating providers across Canada.

A list of participating providers and discounts is available at **www.blueadvantage.ca**.

Such care must be provided in a public establishment that provides Chronic Care to patients who are under the direct care of a Physician at all times. The establishment must be licensed by the appropriate government body and must provide 24 hour nursing care services.

Chronic Care facilities do not include rest homes, nursing homes, retirement homes, drug addiction or alcohol treatment centres.

Convalescent Care Facility: A public establishment that provides convalescent care to patients who are under the direct care of a physician at all times. The establishment must be licensed by the appropriate government body and must provide 24-hour nursing care services.

Convalescent Care Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, drug addiction or alcohol treatment centres or facilities intended for custodial care.

Hospital: An Acute Care facility that is licensed to provide inpatient treatment. This does not include any part of such facility that is intended for long term care. The facility must:

- have facilities for diagnostic treatment and major surgery;
- qualify to participate in and be eligible to receive payments under the provisions of provincial legislation governing hospitals in the jurisdiction in which it is located;
- operate in accordance with the applicable laws of the jurisdiction in which it is located;
- provide 24-hour nursing care services; and
- require that every patient be under the direct care of a physician.

Hospitals do not include convalescent care facilities, physical or psychiatric rehabilitation facilities, maternity homes, nursing homes, rest homes, retirement residences, homes for the aged, blind, deaf, chronically or mentally ill, long-term care or assisted living facilities or drug addiction and alcohol treatment centres. It also does not include any part of a Hospital consisting of nursing care or beds that have been set aside for any of the purposes outlined in this paragraph.

Physical Rehabilitation Facility: A public establishment that provides physical rehabilitation care to patients with physical impairments or disabilities who do not require Acute Care, but who need continued medical supervision directed toward the restoration of functional ability and quality of life. The establishment must be licensed by the appropriate government body.

Physical Rehabilitation Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, facilities intended for custodial care or drug addiction and alcohol treatment centres.

Private Hospital: A privately owned institution that provides Medically Necessary services that can only be rendered in a hospital setting, to people paying privately for care. Private hospitals do not include government-funded hospitals or facilities that specialize in rehabilitation or addiction.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Hospitalization

Hospital: Room accommodation when a Participant is admitted to a Hospital as an inpatient for Acute Care. The type of room eligible for coverage is specified in the Summary of Benefits.

Convalescent Care/Physical Rehabilitation: Room accommodation when a Participant is admitted to a Convalescent Care Facility or a Physical Rehabilitation Facility.

Chronic Care: Room accommodation when a Participant is admitted to a Chronic Care facility on the recommendation and written approval of a Physician.

Private Hospital: Room accommodation when a Participant is admitted to a Private Hospital as an inpatient for Acute Care. This coverage excludes hospitalization for the treatment of drug and alcohol addiction.

Homewood Health Centre: Room accommodation when a Participant is admitted to Homewood Health Centre. The type of room eligible for coverage is specified in the Summary of Benefits.

The Centre for Addiction and Mental Health (CAMH): Room accommodation when a Participant is admitted to The Centre for Addiction and Mental Health (CAMH). The type of room eligible for coverage is specified in the Summary of Benefits.

Coverage under this category is limited to room and board only.

Hospitalization coverage excludes administrative and incidental fees (for example, television, telephone and parking).

Medical Services and Supplies

Ambulance Transportation: Charges for emergency transportation of a stretcher patient by a licensed ambulance to and from the nearest Hospital equipped to provide the emergency care needed by the Participant. This includes air or rail transportation.

This coverage excludes inter-Hospital transfers.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse where such services are provided at the Participant's home and are not primarily for custodial care or midwifery.

Nursing care services may require pre-approval from Blue Cross to be eligible for payment in whole or in part. Benefit payment amounts for approved nursing care services are based on the provincial payment schedule established by Blue Cross.



Helpful Tip

Before receiving nursing services you should obtain pre-approval from Blue Cross by contacting the toll-free number on your Blue Cross identification card.

Health Practitioners: Eligible Expenses for Treatment provided by any Health Practitioner specified in the Summary of Benefits. Coverage is limited to:

- Treatment within the scope of the Health Practitioner's practice; and
- 1 Treatment by the same Health Practitioner per day.

Unless otherwise specified in the Summary of Benefits, a physician referral is not necessary for Treatment to be eligible for coverage.

This coverage excludes:

- products provided by a Health Practitioner (unless specified as a benefit under this group benefits plan);
- comprehensive health assessments;
- charges for services obtained in Hospital; and
- group treatment sessions.



Helpful Tip

Ask your Health Practitioner if they are a Blue Cross Approved Provider before you obtain service or supplies to avoid unexpected out-of-pocket expenses.

Durable Medical Equipment: Charges for rental of the following medical equipment:

- manual or electric wheelchair, including cushions and inserts;
- manual or electric hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, feeding pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
- insulin pump for the Treatment of type 1 diabetes;
- compression pump, traction equipment; and
- patient lifter.

The purchase of durable medical equipment requires pre-approval from Blue Cross, otherwise it may be ineligible for payment in whole or in part.



Helpful Tip

You must obtain pre-approval from Blue Cross before purchasing durable medical equipment or prostheses. This will ensure you don't end up with significant and unexpected out-of-pocket expenses.

If there is a long-term need for equipment due to extended illness or disability, Blue Cross may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment is limited to once every 5 consecutive calendar years, unless otherwise specified in the Summary of Benefits.

Two pieces of equipment are similar if they serve the same purpose (for example, facilitate breathing, provide mobility, deliver insulin).

This coverage excludes charges for food substitutes for feeding pumps, special mattresses and air conditioning or air purifying equipment.

Mobility Aids and Orthopedic Appliances: Charges for the purchase or rental of crutches, canes and walking aids, casts, splints, trusses, braces, cervical collars, standard commodes, raised toilet seats and shower chairs.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs to a maximum of 1 per limb per 5 calendar years;
- myoelectric limbs to a maximum of 1 per limb per lifetime, limited to a maximum of $10,000 per limb;
- residual limb socks to a maximum of 10 per calendar year;
- artificial eyes to a maximum of 1 per eye per 5 calendar years;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of $200 per calendar year; and
- wigs to a maximum of $300 per calendar year.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of $300 per calendar year.

This coverage excludes:

- microprocessor knees; and
- replacement of prostheses unless required due to pathological or physiological change.

Diabetic Equipment: Charges for glucometer, pressurized insulin injector, insulin dosing systems or other equipment approved by Blue Cross that performs similar functions. The equipment must be used for the Treatment and control of diabetes.

Insulin pumps are eligible under the durable medical equipment benefit.

Diabetic supplies are eligible under the drug benefit.

Hearing Aids: Charges for the purchase and repair of hearing aids when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum for both ears.

This coverage excludes batteries and exams.

Orthopedic Shoes (and Supplies) and Foot Orthotics: Charges for:

- the purchase and repair of prefabricated orthopedic shoes (including extra-depth shoes), regular footwear or custom made orthopedic shoes to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
  - the shoes have been prescribed by an attending physician, orthopedic surgeon, rheumatologist or chiropodist/podiatrist.
- custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:
  - they have been prescribed by an attending physician, an orthopedic surgeon, rheumatologist or chiropodist/podiatrist; and
  - they are dispensed by an Approved Provider of custom made foot orthotics.

Diagnostic Tests: Charges for the following diagnostic tests when provided by a laboratory approved by Blue Cross:

- laboratory analyses; and
- diagnostic imaging services (ultrasounds, electrocardiograms, computerized tomography (CT Scans), X-rays and magnetic resonance imagery (MRI)). Expenses must be incurred in Canada.

This coverage excludes charges for diagnostic services if they are incurred for the purpose of health screening or if the Participant's government health care coverage prohibits payment of these expenses.

Other Medical Services and Supplies: Charges for the following medical services and supplies:

- allergy testing materials to a maximum of $50 per calendar year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per calendar year;
- burn pressure garments to a maximum of $500 per calendar year;
- graduated compression garments (including stockings), to a combined maximum of 4 pairs per 12 consecutive months, subject to the following maximums:
  - $55 per pair for elastic stockings with compression value up to 20 mmHg;
  - $160 per pair for surgical stockings with compression value 20 mmHg or higher; or
  - $160 per pair for custom-made supports with compression value 20 mmHG or higher;
- ostomy supplies, catheters and catheterization supplies;
- medical dressing;
- personal incontinence supplies;
- oxygen;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;

- inflatable compression garments to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of $150 per brassiere, limited to a maximum of 4 per calendar year;
- breast pump to a maximum of $300 per 60 consecutive months;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $300 per 5 calendar years;
- visual training and remedial eye exercises performed by an ophthalmologist or optometrist to a maximum of $150 per lifetime; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of $200 per 24 consecutive months. The contact lenses must improve sight to at least 20/40 and this level of improvement must not be possible with eyeglass lenses.

Accidental Dental: Charges for dental Treatment when required to repair or replace a sound natural tooth. A tooth is considered sound if, before the accident:

- it was free from injury, disease or defect;
- it did not need further restorations to remain intact or hold secure; and
- it had no breakdown or loss of root structure or loss of bone.

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the employer;
- initiated within 12 months of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval within that period; and
- performed within 12 months of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

Coverage amounts are determined by the fee guide for dental general practitioners applicable to the dentist's province of practice in the year expenses are incurred.

This coverage excludes accidental damage to teeth that occurs while eating.

Vision Care

Eye Examination: Charges for an eye examination performed by an Approved Provider.

Lenses, Frames, Contact Lenses and Laser Eye Surgery: Charges for the following products and services are eligible when prescribed by an Approved Provider:

- corrective eyeglasses (frames and lenses) and contact lenses; and
- laser eye surgery.

This coverage excludes expenses incurred for non-corrective sunglasses and safety glasses.

Contact Lenses or Intraocular Lenses for Cataract Surgery: Charges for contact lenses following cataract surgery or intraocular lenses used in cataract surgery.

Payment of Claims

How Payments are Made

The Participant will pay the full cost of any expense to the Approved Provider at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Certain Approved Providers may offer a pay direct arrangement. In such circumstances, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility at the time of purchase and the Participant will only pay the Approved Provider the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

Step 1. Blue Cross will apply any applicable Usual, Customary and Reasonable limits. The Eligible Expense will be equal to the lesser of the actual expense and the Usual, Customary and Reasonable charges for the service or supply;
Step 2. Blue Cross will subtract the Deductible (if any);
Step 3. the Reimbursement Level percentage will be applied to the remainder of the Eligible Expense;
Step 4. the result is the amount payable by Blue Cross, subject to any Benefit Maximums applicable.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim by the end of the next calendar year following the date the Eligible Expense was incurred.

Exclusions and Limitations

No payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) health care covered under any government health care coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;
c) health care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies that the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) services, treatment or supplies that are:
    i. not Medically Necessary;
    ii. for cosmetic purposes only;
    iii. elective in nature; or
    iv. Experimental or Investigative.
g) all services relating to family planning (unless specifically listed as a covered benefit in this booklet), including artificial insemination, laboratory fees or other charges incurred in relation to infertility treatment, regardless of whether or not infertility is considered to be an illness;
h) services or supplies normally intended for recreation or sports;
i) extra supplies that are spares or alternates;
j) charges for missed appointments or the completion of forms;
k) medical examinations or routine general check-ups;
l) Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
m) mileage or delivery charges to or from a Hospital or Health Practitioner; or
n) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained.

Right to Convert to Individual Coverage

A Participant who is no longer eligible for coverage under this benefit may convert their group coverage to a similar individual extended health care plan provided by Blue Cross. Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Helpful Tip

Blue Cross limits its payments to the amount listed in the fee guide specified in the Summary of Benefits.

Before starting your Treatment, ask your dentist if they follow the provincial fee guide.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Unit: A 15 minute interval of time or any portion of a 15 minute interval of time.

Exception: When coverage is limited by Units but fees are not described in terms of Units by either:

- the fee guide in effect where Treatment is rendered; or
- the fee guide specified by this plan;

each incident of service is considered 1 Unit, regardless of its duration.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

Helpful Tip

You are responsible for paying any expenses in excess of the fee guide listed in the Summary of Benefits. This is important to consider, since it can directly impact your out-of-pocket expenses.

- payment of all Eligible Expenses is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the reimbursement level applies is the lesser of:
  - the expense actually incurred by the Member; or
  - the fee amounts specified in the dental fee guide approved by Blue Cross (the applicable guide and annual edition are specified in the Summary of Benefits);
- laboratory fees associated with an Eligible Expense are limited to 60% of the amount indicated in the provider fee guide for the dental service provided;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;
  - a licensed denturist when the services are within the scope of their profession; or
  - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

Helpful Tip

If a dental procedure is required as a result of an accident, it is considered as an extended health care expense rather than a dental benefit expense.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a combined maximum of 1 per 36 consecutive months;
- recall oral examination;
- emergency oral examination; and
- limited or specific oral examination to a combined maximum of 1 per calendar year.

X-rays: Charges for:

- complete series or panoramic to a combined maximum of 1 per 36 consecutive months;
- intra-oral:
  - periapical;
  - occlusal to a maximum of 1 procedure per calendar year; and
  - bitewings to a maximum of 1 procedure per 9 consecutive months;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

- bacterial culture;
- biopsy of soft oral tissue;
- biopsy of hard oral tissue; and
- cytological examination.

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- oral hygiene instruction to a maximum of 1 Unit per 9 consecutive months;
- pit and fissure sealants;
- scaling; and
- space maintainers (limited to Participants under age 18).

Helpful Tip
Scaling refers to removal of plaque, calculus, and stains from teeth.

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth;
- retentive pins;
- pre-fabricated steel or plastic restorations; and
- pulp capping.

Helpful Tip
Restorations (fillings) refer to dental material used to restore the function and integrity of a tooth.

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy;
- endodontic surgery;
- bleaching (endodontically treated teeth); and
- apexification.

Helpful Tip
Endodontic Services refer to treatment of infected root canals and tissues surrounding the root of the tooth.

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- desensitization to a maximum of 3 Units per calendar year;
- periodontal curettage;
- root planing;
- occlusal adjustments to a maximum of 8 Units per calendar year;
- periodontal appliances to a maximum of 1 per 2 calendar years;
- adjustments to appliances to a maximum of 3 Units per calendar year; and
- other adjunctive periodontal services.

Helpful Tip
Periodontic Services refers to prevention, diagnosis and treatment of gum diseases.

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments;
- rebasing or relining to a combined maximum of 1 per 2 calendar years; and
- prophylaxis and polishing.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth;
- surgical incision, excision and drainage of tumours or cysts;
- frenectomy (surgical alteration of the frenum);
- removal, reduction or remodelling of bone or gum tissue; and
- post-surgical care.

General adjunctive services: Charges for:

- anesthesia;
- temporary dressing for the emergency relief of pain; and
- finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- inlays;
- onlays; and
- crowns: for teeth damaged due to caries or traumatic injury (does not include pre-fabricated steel restorations).

Inlays, onlays and crowns are eligible to a combined maximum of 1 per tooth per 5 calendar years.

Other Restorative Services: Charges for:

- cast post;
- prefabricated metal post;
- recementation of inlays, onlays or crowns; and
- removal of inlays, onlays or crowns.

Prosthodontic Services

Dentures: Charges for:

- complete and partial dentures to a maximum of 1 per 5 calendar years.

Other Prosthodontic Services: Charges for:

- bridgework to a maximum of 1 per tooth per 5 calendar years.



Helpful Tip

Prosthodontic Services refers to diagnosis, treatment, rehabilitation and maintenance of oral function, comfort, appearance and health, for patients with clinical conditions associated with missing or deficient teeth.

Orthodontic Services

Charges for:

- orthodontic examinations;
- unmounted orthodontic diagnostic casts;
- removable appliances for tooth guidance;
- fixed or cemented appliances (braces);
- appliances to control harmful oral habits;
- retention appliances; and
- comprehensive treatment.



Helpful Tip

Orthodontic Services refers to treatment to correct abnormal arrangement of teeth or jaws.

Payment of Claims

How Payments are Made

At the time of purchase, the Approved Provider will either submit the Participant's claim to Blue Cross or provide a completed claim form and proof of payment to the Participant to submit to Blue Cross. The Participant will then be required to either:

- pay the portion of the claim that is not covered by this benefit and Blue Cross will reimburse the balance to the Approved Provider directly; or
- pay the total amount requested by the Approved Provider and the Participant will receive the portion of the expenses refundable by Blue Cross.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim by the end of the next calendar year following the date the Eligible Expense was incurred.

Predetermination for Claims over $500

If the total cost of any Treatment is expected to exceed $500, the Member must submit to Blue Cross, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

Blue Cross will then notify the Member of the amount eligible for reimbursement. The Treatment must be performed by the dentist who prepared the Treatment plan; otherwise a new Treatment plan must be submitted to Blue Cross for re-assessment.

Date of Treatment

Eligible Expenses are considered to have been incurred on the date the service or supply was provided. For procedures requiring more than 1 appointment, the Eligible Expense is considered to have been incurred on the date that the entire procedure was completed or the appliance was placed.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, no payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) anti-snoring or sleep apnea devices;

g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
h) services, treatment or supplies that are:
    i. not Medically Necessary (except for Preventive Care services);
    ii. for cosmetic purposes only; or
    iii. experimental or investigative;
i) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
j) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;
k) services that are eligible under the extended health care (if applicable);
l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
m) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) veneers;
o) implants and related services;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

Purpose of Coverage

HSA is administered by Blue Cross on behalf of the plan sponsor, who assumes the sole legal and financial liability for this benefit, subject to the conditions outlined below.

> **Helpful Tip**
> You should first submit any eligible medical expenses to any other health plan. Any remaining balance can be processed through your HSA.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

(CRA) Dependent: Defined by the Canada Revenue Agency. This could include family members who are financially reliant on you such as parents, grandparents or grandchildren.

What Blue Cross Will Pay

Blue Cross will pay eligible medical expenses based upon Canada Revenue Agency guidelines. Eligible medical expenses include deductible amounts, co-payment amounts, and amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care coverage, or any other private program.

HSA Credits

The plan sponsor pre-determines the amount of credits allocated to the HSA at the beginning of each policy year specified in the Summary of Benefits. Credits represent the monetary value allocated to the HSA by the plan sponsor and the amount that may be reimbursed by Blue Cross on the plan sponsor's behalf.

The credits will be allocated to the HSA at the credit allocation frequency specified in the Summary of Benefits.

Under no circumstances will unused HSA credits be paid out as cash.

HSA credit allocation may only change in the case of a Life Event or a change in the employment status.

If a Member’s coverage is terminated, the plan sponsor may adjust the credits allocated to the HSA for that policy year. The plan sponsor must promptly notify Blue Cross of the adjusted amount of credits.

If the terminated Member has outstanding claims which were incurred prior to their termination date, these claims may be submitted within the grace period for terminated Members specified in the Summary of Benefits. These claims will be applied against any remaining credits.

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under this plan.

> **Helpful Tip**
> View your HSA balance through the Medavie Blue Cross Mobile App or the Member Centre at www.medaviebc.ca

Carry Forward Type

Credit Carry Forward

This plan allows unused credits to be transferred into the next policy year.

Credits may be used to reimburse eligible medical expenses incurred in the same policy year in which the credits were allocated. Unused credits will be carried forward into the next policy year. Unused credits cannot be carried forward into further policy years. At the end of a policy year, unused credits that have been carried forward from a previous policy year are forfeited.

Claims will be applied to credits that have been carried forward from a previous policy year before being applied against credits allocated during the current policy year.

Claims must be submitted in the policy year they were incurred or within the grace period specified in the Summary of Benefits.

Exclusions and Limitations

No payment will be made (or payment may be reduced) for:

a) expenses incurred by Members and (CRA) Dependents prior to the effective date of this benefit or following termination, in accordance with this plan;
b) over the counter medications that can be acquired without the intervention of a Health Practitioner, such as vitamins, minerals, and herbal remedies; or
c) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only; or
    iii. are elective in nature.

Common Eligible Expenses			
Attendant Care (requires certification of need from physician)	• Services provided in Home, Retirement Home, Nursing Home or Group Home	• Includes Fees from: - Personal Care Worker - Registered Nurse - Respite Care	• Includes Fees for: - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	• Diagnostic Services (X-rays) • Dentures • Orthodontic	• Preventive Services, such as: - Recall Examinations - Polishing - Application of Fluoride	
Diagnostic Services*	• Diagnostic laboratory, radiological tests and scans		
Drugs	• Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner*	• Fertility Treatments • Flu Shots • Insulin* • Liver Extract Injections*	• Smoking Cessation Drugs* • Vaccines • Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	• Convalescent care home • Hospital • Nursing home	• Psychiatric facility • Substance abuse facility	
Medical Devices and Services*	• Air Conditioners (required for severe chronic ailment, disease or disorder) • Artificial Eyes and Limbs • Blood Transfusion Fees • Breast Prosthesis • Cochlear Implants • Crutches • Diabetic Supplies	• Electronic Bone Healing Devices • Electronic Speech Synthesisers • Hearing Aids • Heart Monitoring Devices • Needles and Syringes • Ostomy Supplies • Oxygen Equipment	• Physician Fees • Prosthetics • Repairs to Eligible HSA Devices • Respirators • Scooters • Trusses • Walkers • Wheelchairs (excluding accessories)
Medical Practitioner Services	• Acupuncturist • Athletic Therapist • Audiologist • Chiropodist/Podiatrist • Chiropractor • Dental Hygienist • Dentist	• Dietician • Homeopath • Massage Therapist** • Naturopath • Occupational Therapist • Osteopath • Personal Care Worker*	• Physiotherapist • Psychiatrist • Psychologist • Registered Nurse • Social Worker • Speech Therapist
Medical Transportation Services	• Ambulance Services • Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses	• Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required)	• Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	• Health and Dental Plan Premiums (private insurance)	• Home or Vehicle Modifications, when required for disabled persons	• Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	• Lip Reading	• Sign Language	
Vision Care	• Contact Lenses • Eye Examinations	• Laser Eye Surgery	• Prescription Lenses and Frames

*Prescription or Physician referral required
**For Therapeutic massage services only

Common Ineligible Expenses			
Adoption Fees	• Adoption Fees		
Cosmetic Procedures (aimed at purely enhancing appearance)	• Augmentations • Botox Injections • Liposuction	• Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions)	• Laser Hair Removal • Tattoo Removal • Teeth Whitening
Cosmetics and Hygiene Products	• Contact Lens Solution • Lotions and Creams	• Make-up • Sunscreen	• Toothpaste
Dietary Supplements	• Food (except when required for enteral feeding)	• Minerals and Supplements	• Meal Replacements
Esthetic Massage Therapy	• Aromatherapy Massage	• Body Wraps	
Fees for missed appointments	• Fees for missed appointments		
Health Programs	• Weight loss program fees		
Home Appliances	• Air Conditioners • Air Purifiers	• Dehumidifiers • Fans	• Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	• Hot Tubs	• Saunas	
Life and Disability Plan Premiums	• Life and Disability Plan Premiums		
Over the counter medications	• Acid Controllers • Allergy Medications • Cough and Cold Items	• Creams and Lotions • Digestive Aids • Herbal Remedies	• Pain Relievers • Smoking Cessation Products • Vitamins
Personal Response Systems	• Lifeline Services	• Health Line Services	
Shoes	• Off the shelf	• Athletic	
Sports Equipment	• Treadmills		

What Are My Responsibilities Under the Plan?

Keeping Your Employer Informed

It is your responsibility to provide your employer with a completed and signed application form, including accurate information on your family status.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Failure to do so could result in the need for proof of health before your requested change in coverage takes place. Changes that must be reported to your employer include:

- Adding or removing a Dependent
- Status updates of a Dependent student
- Change in marital status
- Application for benefits previously waived



Helpful Tip

Your proof of claim must be submitted in either English or French. If the original proof of claim is in a language other than English or French, you are responsible for any costs associated with translating your proof of claim.

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Providing Proof of Claim

You must submit your claims for Eligible Expenses and benefits within applicable time limitations. Proof of claim must be provided in a form acceptable to Blue Cross.

Blue Cross reserves the right to suspend or deny a claim until you have submitted the additional information requested to process the claim.

Costs associated with providing proof of claim are your responsibility.

Recovering Damages From a Third Party (Subrogation)

If you have the right to file legal action against a third party (individual or corporate body) for a loss relating to any claim submitted under this group benefits plan, Blue Cross is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross.

You must sign and return the necessary documents to facilitate this process and you must do everything that is required of you to protect your rights to recover damages from the third party.

Reporting Health Insurance Fraud

Health insurance fraud is the intentional act of submitting false, deceiving or misleading information for the purpose of financial gain.

Whether committed on a small or large scale, fraud can lead to significant financial losses to the benefit plan and result in higher premiums and decreased coverage. Blue Cross is committed to protecting the integrity of our benefit programs for our plan sponsors and members by monitoring and resolving any abusive or fraudulent activity.

How You Can Help

As a group plan member, you can help eliminate fraudulent abuse of your plan:

- keep your identification card, plan number, member identification number and related information confidential and secure;
- carefully review your receipts for products and services claimed to ensure:
  - you understand the charges billed; and
  - the charges reflect the services received.

If you are unclear about any of the charges on your receipt, ask your provider to explain the charges to you:

- carefully review your Explanation of Benefits claim statements (EOB) for any discrepancies in services received compared to services claimed;
- never sign a blank claim form;
- from time to time, we send member verification questionnaires to confirm treatments and other related information. If you receive one of these questionnaires, please complete it and return it promptly. These questionnaires are essential to our fraud deterrence efforts.

Helpful Tip

If you suspect health care fraud, please refer it to Blue Cross through one of the following confidential methods:

Toll free: 1-866-876-9238

www.clearviewconnects.com

What Are My Rights Under the Plan?

Privacy

In the course of providing customers with quality health coverage, Blue Cross collects, uses and stores certain personal information about its members and their dependents. Protecting personal information is not new to us. Ensuring the privacy of client information has always been fundamental to the way we do business.

The purpose of our **privacy statement** is to keep you informed about privacy protection practices at Blue Cross. In addition to this privacy statement, we have an **online privacy statement** that describes our practices for protecting your personal information when you use our websites and mobile applications and a **Medavie Blue Cross mobile app privacy policy** that applies to your use of our mobile app.

Helpful Tip

For more information on our privacy protection practices, please visit our website.
medaviebc.ca

Disputing a Claim Decision

In the event Blue Cross determines that benefits are not payable, you have the right to appeal the decision by providing written notice to Blue Cross within 30 days from the date of the written denial.

The time limitation to bring an action against Blue Cross under the group plan begins on the date of the initial written denial from Blue Cross and runs until the expiry of the minimum limitation period as prescribed by the applicable provincial legislation.

Every action or proceeding against Blue Cross for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

The Rights of Blue Cross Under the Plan

Right to Audit

Blue Cross has the right, at any time, to inspect or audit the health and claim records of a Participant in relation to a claim for benefits.



Helpful Tip

The right to inspect or audit applies to records held by Blue Cross or Approved Providers.

Recovery of Overpaid Amounts

Blue Cross has the right to recover from a Participant:

- any amount paid in error;
- any amount paid as a result of claims made by the Participant on the basis of fraudulent pretences or misrepresentations; or
- any amount paid that has resulted in overpayment to the Participant.

If the amount of overpayment or claim paid in error relates to Self-Insured Benefits, the plan sponsor agrees to take reasonable steps to recover this amount.

Termination or Suspension of Benefit Payments

The rights and benefits of a Participant may be suspended or terminated without prior notice in the following circumstances:

- the discovery of a claims discrepancy or the initiation of a claim abuse investigation; or
- the filing of criminal charges or initiation of disciplinary action against the Participant by Blue Cross or the plan sponsor.

Payment of a claim may also be suspended or denied if it relates to services or supplies prescribed, provided or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or has been charged with an offence in relation to their conduct or practice.

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.



Helpful Tip

Instead of a cheque by mail, get reimbursement directly to your bank account by signing up for direct deposit. It's fast, and convenient. Visit our website to register.

How to Submit a Claim

Medavie Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

- **Mobile App**
  Filing a claim has never been quicker or easier! Submit your claims through the Blue Cross Medavie Mobile app and have your reimbursement deposited directly to your bank account.

  Visit **www.medaviebc.ca/app** for more information or to download the app.

- **Member eClaims**
  You can quickly and easily submit your health, drug, dental and health spending account claims (as applicable) through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- **Provider eClaims**
  For Approved Providers who have registered to submit claims to Medavie Blue Cross through our electronic claims submission service, our e-claim service allows Approved Providers to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Medavie Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

- **Medavie Benefits+**
  Medavie Benefits+ is an all-inclusive health benefits and wellness centre that provides you with an opportunity to meet face-to-face with one of our Benefits+ Specialists. Our team is happy to answer your questions and demonstrate our digital, self-service tools at one of our smart kiosks.

  To find the Medavie Blue Cross office or Medavie Benefits+ location nearest you, visit our website at **www.medaviebc.ca.**

- You can also mail your completed claim form to the address indicated on the applicable claim form.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- **Coverage inquiry:** Detailed information about your group benefits plan;
- **Forms:** Printable versions of Blue Cross forms;
- **Requests for new identification cards;**
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider;
- **Submit claims** electronically.

Helpful Tip

For security reasons, the plan member website is for your use only. Dependents and other family members will not have access to the site.

To register for the plan member website, visit **www.medaviebc.ca** and log in.

Blue Cross Contact Information

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Centre toll free at: **1-855-811-0020**

Alternatively, you can email your questions to **inquiry@medavie.bluecross.ca** or visit our website at **www.medaviebc.ca**.

Helpful Tip

Have your group plan number and identification number ready when you call for questions regarding your coverage.

Connect with Blue Cross

Like us on Facebook at **facebook.com/MedavieBlueCross**

BLUE ADVANTAGE®

Savings are available to Blue Cross Members across Canada. To take advantage of these savings, simply present your Blue Cross identification card to any participating provider and mention the **Blue Advantage®** program. A complete list of providers and discounts is available at **www.blueadvantage.ca**.

Connected Care

Connected Care provides convenient access to innovative products and services such as virtual care, mental wellness and other health solutions from industry leading partners. These offerings are available at preferred pricing, and you may also be covered for certain products and services under your group benefits plan. Availability is subject to change without notice. For more information, log in to the Medavie Blue Cross Mobile app or website at **www.medaviebc.ca/connected-care**.

Health Connected®

Health Connected is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using Health Connected resources.

Blue Cross is proud to help point your way to healthier living. To register for your free account go to **Connected Care** and simply follow the instructions for Health Connected or visit **medaviebc.ihealthconnected.com**.