



Your Group *Benefits* Booklet

Guillevin International Cie

Retirees Before February 1, 1994

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91557

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August 1, 2021



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 and dental benefits are self-insured by the plan sponsor and are administered by Medavie Inc. Travel benefit is insured by Medavie Inc. and all other benefits are insured by Blue Cross Insurance Company of Canada.

Medavie Inc. (also known as Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada, together 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 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.

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Summary of Benefits

Member Life Benefit

Benefit Formula	Flat amount
Benefit Maximum	\$5,000
Non-Evidence Limit	\$5,000
Termination	Death of the Member

Dependent Life Benefit

Benefit Amount	
Spouse	\$5,000
Child*	\$2,500/Child
Termination	Death of the Member
Survivor Coverage	6 months

*From birth or 28 weeks gestation if stillborn.

Summary of Benefits

Drug Benefit

Deductible	\$100/Participant, maximum of \$100/family per Plan Year, combined with Extended Health Care
Reimbursement Level	100%*
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Days Supply	100-days maximum supply
Drug Formulary	
Specialty High Cost Drugs	Managed Go-Forward Formulary
All Other Eligible Drugs	Open Formulary
Plan Management Features	
Substitution Provision	Generic Substitution
Opioid Management Strategy	Included
Additional Benefit Modules	Benefit Maximum
Glucose Monitoring Systems	\$4,000/Plan Year
Managing Chronic Disease	\$500/Plan Year
Varicose Vein Injections	Included
Smoking Cessation Aids	\$500/lifetime
Vaccines (including injection service when administered by a pharmacist)	Included
Injectable Vitamins	Included
Intrauterine Contraceptive Devices (IUD)	Included
Diaphragms	Included
Termination	Death of the Member
Survivor Coverage	6 months

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

Summary of Benefits

Extended Health Care

Deductible

Hospitalization	None
All Other Extended Health Care	\$100/Participant, maximum of \$100/family per Plan Year, combined with Drug Benefit

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Convalescent Care/Physical Rehabilitation (combined)	100%	\$20/day to a maximum of 180 days/Plan Year	Semi-private
Medical Services and Supplies			
Ambulance Transportation	100%	Included	
Nursing Care	100%	\$10,000/Plan Year	
Health Practitioners:		Maximum per Plan Year	
<i>Mental Health Practitioners (Psychologist/ Counselling Therapist/Psychoeducator/ Psychotherapist)</i>	100%	\$350* (combined)	
<i>Social Worker</i>	100%	\$350*	
<i>Chiropractor (including 1 X-ray)</i>	100%	\$350*	
<i>Naturopath</i>	100%	\$350*	
<i>Acupuncturist</i>	100%	\$350*	
<i>Dietitian</i>	100%	\$350*	
<i>Osteopath (including 1 X-ray)</i>	100%	\$350*	
<i>Chiropodist/Podiatrist (including 1 X-ray)</i>	100%	\$350* (combined)	
<i>Audiologist</i>	100%	\$350*	
<i>Speech Therapist</i>	100%	\$350*	
<i>Occupational Therapist</i>	100%	\$350*	
<i>Physiotherapist/Athletic Therapist/ Rehabilitation Technician</i>	100%	\$350* (combined)	
<i>Massage Therapist/Kinesitherapist/ Orthotherapist</i>	100%	\$350* (combined)	

*Reimbursement per visit is limited to Usual, Customary and Reasonable charges.

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 Plan Years for approved purchase
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	\$700/lifetime
Hearing Aids	100%	\$500/lifetime
Custom Orthopedic Shoes and Custom Made Foot Orthotics (combined)	100%	\$400/Plan Year
Diagnostic Tests**	100%	Included
Ultrasounds/Electrocardiograms/CT Scans/X-rays/MRI**	100%	\$1,000/Plan Year
Other Medical Services and Supplies	100%	See benefit details
Accidental Dental	100%	Predetermination of claim required
Vision Care		
Eye Examination/Lenses/Frames/Contact Lenses/ Laser Eye Surgery (combined)	100%	\$350/24 consecutive months
Intraocular Lenses Used in Cataract Surgery	100%	1 lens/eye/lifetime
Termination	Death of the Member	
Survivor Coverage	6 months	

*Pre-authorization required.

**Diagnostic imaging services coverage for residents of Quebec only.

Key Terms

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, was covered under the Plan Sponsor's group plan on the day preceding the date of retirement and meets the retirees eligibility requirements determined by the Plan Sponsor.

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

Dependent: Your Spouse or Child.

Spouse: The person who:

- is a resident of Canada; and
- meets one of the following criteria:
 - is married to the Member;
 - is in a civil union with the Member as defined by the Civil Code of Quebec; or
 - has been living with the Member in a conjugal relationship for at least 1 year; however, where required by provincial legislation, this 1 year period is waived if a child is born of such 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:

- is a resident of 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 22;
 - b) is under age 26 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.

Plan Year: The first Plan Year begins on August 1, 2021 and ends on June 30, 2022. Subsequent Plan Years begin on the first day of July in a given year and end on the last day of June the following year.



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.

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

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

- 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.



Helpful Tip

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

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.

Key Terms

Where more than one form or an alternative 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.

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; or
- 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 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.

Insured Benefits: Benefits underwritten and administered by Medavie Inc. or Blue Cross Life Insurance Company of Canada, one or the other of which assumes all liability for their payment.

In this plan, member life, dependent life and travel benefits are Insured Benefits.

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;
- the Spouse or a Child no longer meets the Dependent definition; or
- death of a Dependent.

Proof of health is 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.

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.



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.



Helpful Tip

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

Key Terms

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 and extended health 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.

Coverage Details

Who is Eligible for Coverage?

You are eligible for coverage if you meet the definition of Employee outlined above in the *Key Terms*.

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.

Coverage is effective on the date of retirement.

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

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted in the following circumstances:

- if the coverage for yourself or your Dependents exceeds the non-evidence limit specified in the Summary of Benefits; or
- 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 \$250 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 Form

Once you receive an email from Blue Cross confirming your access to the online enrolment system, you can enrol for coverage. To obtain coverage, you must complete and submit online the application form and submit proof of health, if required for one of the reasons listed above.

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

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, subject to the exceptions noted below:

- it is your choice whether or not to obtain coverage for optional benefits; and
- you are allowed to waive the health benefits coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. 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

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

Non-evidence limit refers to the amount of coverage for which you or your Dependents are eligible, without having to submit satisfactory proof of health.

The non-evidence limits for each benefit (if any) are specified in the Summary of Benefits.



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.



Helpful Tip

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

When Does My Coverage Begin?

Employees

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

- the effective date of the plan;
- the date of your retirement; or
- the date Blue Cross approves your proof of health, if required.

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, or for dependent life coverage, as specified in the dependent life Summary of Benefits (if applicable).



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.

When Does My Coverage End?

Please note Guillevin International reserves the right to amend, modify, or terminate any of its benefit programs covering employees and former employees, including retirees, at any time including after employees' retirements.

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;
- you (or your Spouse, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you die;
- you or your Dependents commit a fraudulent act against Blue Cross or the plan sponsor; or
- the plan sponsor defaults in payment of premiums.

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

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.

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.



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.

Coverage Details

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

- You must, within 31 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 and the age and sex of the Participant on that date;
- 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.

Survivor Coverage

In the event of your death, coverage for your Dependents will continue for certain benefits, if specified in the Summary of Benefits.

Survivor Coverage for your Dependents will terminate on the earliest of the following dates:

- the group plan termination date;
- the date the maximum Survivor Coverage period has been reached, as specified in the Summary of Benefits;
- the date your Dependents obtains similar coverage under another plan; or
- the date your Dependents are no longer considered to be eligible Dependents (for reasons other than your death).

What if I Have Coverage Elsewhere?

With the exception of the travel benefits provided under the travel benefit section of this booklet, 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

Blue Cross will not pay for any health care services or supplies available under government health care coverage, or administered by government funded hospitals, agencies or providers. 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:

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.



Helpful Tip

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



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.

Coverage Details

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.

Member Life Benefit

Purpose of Coverage

If the Member dies while covered by this benefit, Blue Cross will pay the Member's beneficiary the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Payment of Claims

Beneficiary

Member life benefits will be paid to the Member's beneficiary.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

The Member has the right to purchase an individual life policy from Blue Cross if their member life benefit coverage terminates on or before their 65th birthday due to termination of coverage for the group or class of Employees to which the Member belongs.

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages.

Terms and Conditions of the Converted Policy

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.

They are also subject to the following additional terms and conditions:

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the types of individual life policies available for conversion are:
 - a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);
 - a non-convertible term life policy that provides level term coverage to age 65; or
 - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage available under the individual life policy is the lesser of:
 - the amount of member life benefit coverage in effect on the termination date;
 - the amount of any scheduled reduction of the member life benefit coverage;
 - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination;
 - \$400,000 for residents of Quebec or \$200,000 for residents outside of Quebec; and
- the coverage provided by the individual life policy cannot be less than:
 - the minimum amount Blue Cross will normally issue for the type of policy selected; or
 - \$10,000 for residents of Quebec.

Dependent Life Benefit

Purpose of Coverage

If a Dependent dies while covered by this benefit, Blue Cross will pay the Member the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Payment of Claims

All benefits will be paid directly to the Member.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

On or before their 65th birthday, a Spouse residing in any province or a Child who is a resident of Quebec has the right to purchase an individual life policy from Blue Cross if their dependent life coverage terminates for one of the following reasons:

- death of the Member;
- termination of the Member's life coverage for a reason that entitles the Member to convert their member life benefit to an individual policy; or
- the Spouse or Child is no longer eligible for coverage as a Dependent.

Terms and Conditions of the Converted Policy

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.

They are also subject to the following additional terms and conditions:

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the types of individual life policies available for conversion are:
 - a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);
 - a non-convertible term life policy that provides level term coverage to age 65; or
 - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the coverage provided by the individual life policy cannot be:
 - more than the amount of dependent life benefit coverage in effect on the termination date; or
 - less than the minimum amount Blue Cross will normally issue for the type of policy selected or \$5,000 for residents of Quebec.

Drug Benefit

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 is determined by Blue Cross to be essential and does not require a prescription by law. 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 active ingredients; and
- are administered in the same way.

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 Plan 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;

Drug Benefit

- 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;
- managing chronic disease services, including initial assessment, counselling and follow up sessions, education relating to symptom management, medication usage, and development of action plans, for medical conditions deemed eligible by Blue Cross;
- 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 Go-Forward Formulary:** This list is established at a specific date and, after that date, only drugs approved by the Medication Advisory Panel will be added to the list.

All Other Eligible Drugs

- **Open Formulary:** List of all Essential Non-Prescription Requiring Drugs and Eligible Drugs that require a prescription by law. 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.

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.

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.



Helpful Tip

Visit our website for helpful information on managing chronic diseases
www.medaviebc.ca/livebetter.



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.



Helpful Tip

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

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.

Generic Substitution:

Exception: If the physician indicates the prescribed Interchangeable Drug cannot be substituted, Blue Cross will reimburse the prescribed Interchangeable Drug despite the fact that a lower cost Interchangeable Drug may be available.

Opioid Management Strategy

If the Summary of Benefits specifies that opioid management strategy applies, certain Eligible Drugs will not be eligible for reimbursement, and other Eligible Drugs may require Prior Authorization. Opioid management strategy ensures Participants are reimbursed for drugs with the best clinical evidence for pain management while managing the potential for overuse or misuse.

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.

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 within 12 months of 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) varicose vein injections;
- b) smoking cessation aids;
- c) vaccines;
- d) injectable and oral vitamins;
- e) treatments for weight loss, including drugs, proteins and food or dietary supplements;



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.



Helpful Tip

If you have a Pay Direct or Deferred Payment 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.



Helpful Tip

If you pay up front and submit your claim for reimbursement, you may end up with surprise out-of-pocket expenses if your pharmacist charged you more than would have been permitted by the Blue Cross system.

- f) natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;
- g) fertility treatments;
- h) sexual dysfunction drugs;
- i) hair growth stimulants;
- j) 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;
- k) procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
- l) 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;
- m) 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;
- n) services, treatment or supplies the Participant receives free of charge;
- o) charges that would not have been incurred if no coverage existed;
- p) drugs that are eligible under the travel benefit provided by the group plan (if applicable);
- q) all forms of cannabis; or
- r) 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.

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

The group plan must be administered in accordance with the Act Respecting Prescription Drug Insurance ("the Act") for Quebec Participants, including the Act's provisions about maximum coinsurance, out-of-pocket maximums, eligible drugs, exception drugs and eligible pharmacy services.

Under no circumstances will the *Exclusions and Limitations* provision of this benefit render drug benefit coverage for Quebec Participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Plan Year

If, in any Plan Year, a Member spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses for themselves or their Dependents, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that Plan Year. The contribution amount includes the Deductible, amounts in excess of the reimbursement level or co-payment, if applicable.

Participants Age 65 Years and Over

At age 65, a Quebec Participant is automatically registered as a beneficiary of the RAMQ public drug plan. Therefore, on reaching age 65, a Quebec Participant must decide whether to:

- cancel their automatic registration with the RAMQ drug plan in order to continue their coverage under this benefit; or
- accept coverage under the RAMQ public drug plan.

The decision to accept coverage under the RAMQ public drug plan is irrevocable.

Quebec Participants who decide to accept coverage under the RAMQ public drug plan are no longer eligible for coverage under this benefit.

Exception: If the Summary of Benefits specifies this benefit is supplemental to the RAMQ public drug plan coverage, the following expenses are eligible, subject to the Deductible and Reimbursement Level specified in the Summary of Benefits:

- the Deductible and coinsurance paid by the Quebec Participant under the RAMQ public drug plan; and
- reimbursement for any Eligible Drug that is not included in the RAMQ public drug plan but is covered under this benefit.

If the Member decides to join the RAMQ public drug plan, the Member's Dependents must also register with the RAMQ public drug plan.

If a Quebec Participant decides to maintain coverage under this benefit, Blue Cross reserves the right to modify the premium rates applicable to this benefit for any Quebec Participant age 65 and over.

Extended Health Care

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.

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 the provincial hospital act 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.

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.



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.

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 within 14 days of their discharge from a Hospital where they received Acute Care.

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.

Charges for the services of a personal support worker in the Participant's home may also be eligible if the Participant is under the active care of a nurse or requires home care for recuperation after a discharge from Hospital. Personal support workers offer essential services related to the Activities of Daily Living.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the Activities of Daily Living.

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

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



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.

Extended Health Care

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

- manual or electric wheelchair, including inserts;
- wheelchair cushion to a maximum of 1 per 3 Plan Years;
- manual or electric hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
- insulin pump for the Treatment of type 1 diabetes, 1 pump per 4 Plan Years to a maximum of \$7,000;
- compression pump, traction equipment;
- aerosol equipment (mist tent) to a lifetime maximum of \$1,000; and
- patient lifter.



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.

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

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 Plan Years.

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 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 and cervical collars.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A \$10,000 lifetime maximum applies to myoelectric limbs;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of \$200 per Plan Year;
- stump socks to a maximum of 5 pairs per Plan Year; and
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of \$300 per Plan Year.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of \$300 per Plan Year.

This coverage excludes:

- microprocessor knees;
- wigs when hair loss is not due to an underlying pathology or its treatment, hair replacement therapy and other procedures for physiological hair loss (for example, male pattern baldness); 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.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes or prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
 - the shoes have been prescribed by an attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;
 - the Participant provides a copy of the biomechanical or gait analysis from the prescribing Health Practitioner; and
 - the shoes are dispensed by an Approved Provider of orthopedic shoes.
- 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, physiatrist, rheumatologist or chiropodist/podiatrist; and
 - they are dispensed by an Approved Provider of custom made foot orthotics.



Helpful Tip

For more information on which expenses qualify under your orthopedic shoes and orthotics coverage, visit our website. www.medaviebc.ca/benefitupdates.

This coverage excludes the purchase and repair of pre-fabricated orthopedic shoes without permanent modifications and extra-depth shoes.

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

- laboratory analyses; and
- for residents of Quebec, 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 Plan Year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of \$300 per Plan Year;
- burn pressure garments to a maximum of \$500 per Plan Year;
- graduated compression garments (including stockings) to a maximum of 2 pairs per Plan Year;
- ostomy supplies, catheters and catheterization 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;
- sleeves for lymphedema to a maximum of 2 per Plan Year;
- surgical brassieres to a maximum of 2 per Plan Year; and
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of \$550 per 60 consecutive months (rental, maximum 1 per 3 months).

Extended Health Care

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 180 days 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 2 years 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;
- laser eye surgery; and
- intraocular lenses used in cataract 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 within 12 months of 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) charges that are eligible under the travel benefit provided by the group plan (if applicable);
- i) services or supplies normally intended for recreation or sports;
- j) extra supplies that are spares or alternates;
- k) charges for missed appointments or the completion of forms;
- l) medical examinations or routine general check-ups;
- m) Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
- n) mileage or delivery charges to or from a Hospital or Health Practitioner; or
- o) 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.

Rights and Responsibilities Under the Plan

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, as well as your beneficiary designations. You must complete the group benefits application form within 31 days from the date you become eligible for coverage.

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
- Change of beneficiary
- Application for benefits previously waived

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

Benefits payable as a result of your death will be paid to your last designated beneficiary or beneficiaries.

Subject to the provisions of the law, the beneficiary is the person you have designated on your group benefits application form. You may change your beneficiary by submitting a signed written declaration to Blue Cross.

If you designate 2 or more beneficiaries (other than alternatively) without any specification as to how the death benefit will be divided, the benefit payable will be divided equally among the designated beneficiaries.

If your beneficiary predeceases you, you must designate a new beneficiary.

If you die and a beneficiary has not been named in writing, the death benefit will be payable to your estate.

Providing Proof of Claim

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

Blue Cross must approve your proof of claim and may require you to provide additional information and undergo a medical examination by a physician or Health Practitioner as often as deemed necessary. 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.



Helpful Tip

It is very important to maintain up-to-date beneficiary designations.

When insurance money is paid to the estate, it may be subject to creditor claims and estate taxes.

However, when a beneficiary is named, this person receives the entire benefit tax free, regardless of what debts may be owed by the deceased.

You can change your beneficiary by filling out a beneficiary designation form available through your employer or on our website.



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.

Rights and Responsibilities Under the Plan

Submitting Claims After Your Group Plan Terminates

If this plan has terminated, proof of claim for Insured Benefits must be received by Blue Cross:

- for accidental damage to natural teeth, **within 6 months** following the termination date of this group plan; or
- **within 90 days** following the termination date of this group plan for all other Insured Benefits.

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.

What Are My Rights Under the Plan?

Privacy

In the course of providing customers with quality life, health and travel coverage, Blue Cross acquires and stores certain personal information about its clients and their dependents.

Protecting the confidentiality of client information is fundamental to the way we do business. Our staff takes our privacy policies and procedures very seriously.



Helpful Tip

Health care fraud in Canada is estimated to cost between \$2 billion and \$12 billion annually.



Helpful Tip

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

Toll free:

1-877-412-8809

StopFraud@medavie.

bluecross.ca

www.medavie.bluecross.

confidenceline.net

What is personal information?

Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is Your Personal Information Used?

Your personal information is necessary for Blue Cross to process your application for coverage under its life, health and travel plans. Your personal information is used to provide the services outlined in your group plan, to understand your needs so that we can recommend suitable products and services, and to manage our business.

To Whom Could This Personal Information be Disclosed?

Depending on the type of coverage you carry, release of selected personal information to the following may be necessary in order to provide the services outlined in the group plan of which you are an eligible member:

- other Canadian Blue Cross organizations to administer your benefit plan if you reside outside the Atlantic Provinces, Quebec or Ontario;
- specialized health care professionals when required to assess benefit eligibility;
- government and regulatory authorities in an emergency situation or where required by law ;
- Blue Cross Life Insurance Company of Canada and other third parties, on a confidential basis, when required to administer your benefits; or
- the plan member in any contract under which you are a participant.



Helpful Tip

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

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your Dependents is not released to a third party without permission unless necessary to fulfil the services Blue Cross is contracted to provide to you.

By becoming a Blue Cross customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above.

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.

Copy of the Group Plan

Where legislated, you have the right to request a copy of the contract for insured benefits, your application for benefits and any written statements or other record provided to Blue Cross as proof of your health.

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.

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.

If overpayment amounts or amounts paid in error cannot be recovered, Blue Cross has the right to reduce future Insured Benefit payments to the Participant until the amount is fully recovered.

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.



Helpful Tip

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

How to Obtain More Information

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);
- one of our Quick Pay® locations;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for life benefits can be obtained through your group benefits administrator.

How to Submit a Claim

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

- **Provider eClaims**
For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).
- **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.
- **Mobile App**
Filing a claim has never been quicker or easier! Submit your claims through the 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.

- **Quick Pay®**
Quick Pay is a unique service of Blue Cross. Through Quick Pay, you may submit all your dental, drug and extended health care claims and receive immediate adjudication.

Quick Pay provides you with an opportunity to discuss how the claim was adjudicated, Co-ordination of Benefits, subrogation or other details of your benefit program. You meet face-to-face with a customer service representative equipped to answer your questions.

To find the Blue Cross office or Quick Pay location nearest you, visit our website at www.medaviebc.ca/ouroffices.

- You can also mail your completed claim form to the nearest Blue Cross office.

You can submit your claims for **life benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.



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.

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.

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



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.



Helpful Tip

Please record your password in a secure site for future reference.

Additional Resources and Member Services

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:

Atlantic Provinces: 1-800-667-4511

Ontario: 1-800-355-9133

Quebec: 1-888-588-1212

From Anywhere in Canada: 1-888-873-9200

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

Connect with Blue Cross

Like us on Facebook at facebook.com/MedavieBlueCross

Follow us on Twitter at [@MedavieBC](https://twitter.com/MedavieBC)

My Good Health®

My Good Health 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 My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to medaviebc.mygoodhealth.ca and simply follow the instructions to register for your free account!



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.



Helpful Tip

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