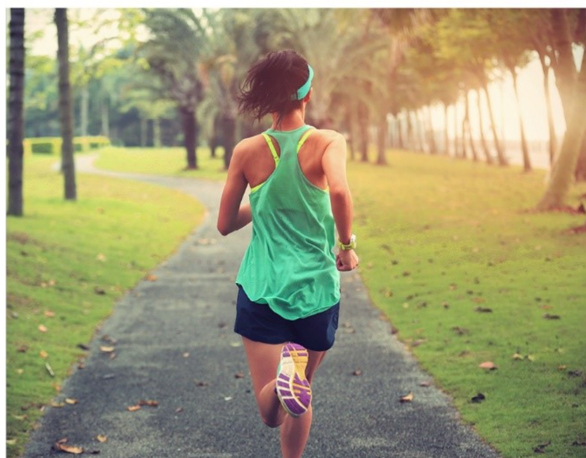

Your Group Benefits Booklet

Dalhousie University Retirees

Retiree Benefits

Plan Number: 9146

Updated Effective Date: November 1, 2022

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PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and travel coverage, Medavie Blue Cross acquires and stores certain personal information about its clients and their dependents. The purpose of this document is to keep you informed about privacy protection practices at Medavie Blue Cross.

Protecting personal information is not new to Medavie Blue Cross. Ensuring the confidentiality of client information has always been fundamental to the way we do business and our staff understand that the privacy policies and procedures we have in place to ensure confidentiality are to be taken very seriously.

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 to allow Medavie Blue Cross to process your application for coverage under its health, life and travel plans. Your personal information is used:

- to provide the services outlined in your contract or the group contract of which you are an eligible member
- 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 with us, release of selected personal information to the following may be necessary in order to provide the services outlined in your contract:

- specialized health care professionals when necessary to assess benefit or product 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 the benefits outlined in your contract or your group's contract, and
- the plan member of any contract under which you are a participant

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 fulfill the services Medavie Blue Cross is contracted to provide to you.

To whom could this personal information be disclosed? (Cont'd)

To ensure Medavie Blue Cross is able to provide you with the best possible service, it is important that the personal information we use is accurate and up to date. You can help by keeping us informed of changes of address, marital status and the addition or deletion of dependents. Should you become aware of errors in our information about you, please contact our customer service personnel and we will ensure the data is corrected.

By becoming a Medavie 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. If you prefer that we not use or disclose your personal information in those situations where it is not necessary to administer your benefit plan, please visit our Web site or write to us at the address provided.

Please note that not allowing Medavie Blue Cross to use information about you may mean we may not be able to provide you with certain products or services that may be of use to you.

For more information on Medavie Blue Cross's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

1-800-667-4511 or 1-800-355-9133 (in Ontario)

Chief Privacy Officer
Medavie Blue Cross
Risk Management Group
644 Main Street
PO Box 220
Moncton, NB E1C 8L3

or

privacyofficer@medavie.bluecross.ca

If the issue is not resolved to your satisfaction, you may file a complaint in writing to:

Office of the Privacy
Commissioner of Canada
112 Kent Street
Ottawa, Ontario K1A 1H3

ABOUT THIS BOOKLET

Medavie Blue Cross administers the following benefits on behalf of Dalhousie University Retirees:
- Hospital Benefit
- Extended Health Benefit
- Vision Benefit
- Drug Benefit
- Dental Benefit

The information contained in this booklet summarizes the important features of your group program; is prepared as information only; and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefit program are described in the group policy held by your employer.

The term “employee”, used in this booklet, shall mean a retired employee.

Where legislated, you have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to Medavie Blue Cross as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross.

Every action or proceeding against an insurer (i.e. Medavie Blue Cross) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

This booklet replaces any previously issued booklet.

HOSPITAL BENEFIT

If you (or your dependents, if applicable) incur charges in Canada for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below, less the amount allowed under any government health program. Benefit maximums are applied on a per person basis.

Co-insurance: 100%

AMBULANCE SERVICES
Maximum: $25 per person in any 12 consecutive month period

Unlimited ambulance benefits are provided under Extended Health Benefits.

ANCILLARY SERVICES
Maximum: $150 per hospital admission

Charges for ancillary services where such services are not fully covered under a Government Health Program.

HOSPITAL ROOM
The difference between standard ward accommodation and semi-private room accommodation.

OUTPATIENT SERVICES
Charges for outpatient and diagnostic services of a hospital approved by Medavie Blue Cross.

TERMINATION
Hospital benefit continues for the lifetime of the subscriber.

WHEN AND HOW TO MAKE A CLAIM
Hospital benefit is paid directly to the hospital. Your identification card should be shown at the hospital who will arrange to bill Medavie Blue Cross directly.

Claims must be submitted within 24 months of receiving services or supplies. No claims will be paid by Medavie Blue Cross after the termination date of this plan.

EXTENDED HEALTH BENEFIT

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below, less the amount allowed under any government health program. Benefit maximums are applied on a per person basis.

Co-insurance: 80%

ACCIDENTAL DENTAL
Dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered or approved for payment by Medavie Blue Cross within 180 days of the accident. Benefits will be paid up to the usual and customary fee of the current Dental Association Fee Guide for general practitioners where services are rendered.

ANTIGEN THERAPY
Maximum reimbursement: $1,200 per calendar year, to a lifetime maximum of $2,400

Charges for antigens, antihistamines and serums used solely for the purpose of desensitization and/or treatment of allergic conditions and/or environmental illness.

DIABETIC EQUIPMENT
Maximum reimbursement: $560 every five consecutive calendar years

Charges for the following equipment on the written authorization of the attending physician for treatment and control of diabetes: preci-jet, glucometer or equipment that performs similar functions and approved by Medavie Blue Cross.

DIAGNOSTIC AND X-RAY SERVICES
Charges for laboratory service and X-ray examinations.

HEARING AIDS
Maximum reimbursement: $200 every 84 consecutive months.

Charges for hearing aids (excluding batteries and exams) when prescribed by an otolaryngologist, otologist and/or registered audiologist.

HOSPITAL ACCOMMODATION

Maximum reimbursement: $28 per day

Charges of a licensed general hospital for room accommodation.

MEDICAL SUPPLIES AND EQUIPMENT

Charges for the following medical supplies and equipment, when prescribed by an authorized physician:

- rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair or hospital-type bed;
- equipment for the administration of oxygen;
- lymphoedema sleeves (limited to 2 in a calendar year);

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every 5 consecutive calendar years.

MENTAL HEALTH PRACTITIONERS

Overall maximum reimbursement: $1,500 in a calendar year

Charges for treatment, except when performed in a hospital, by a licensed psychologist, social worker, clinical counsellor, psychoeducator and psychotherapist.

SMOKING CESSATION AIDS

Maximum reimbursement: 50% of the eligible expense to a maximum reimbursement lifetime payment amount of $200.

Charges for smoking cessation aids when prescribed by a physician.

ORTHOPEDIC FOOTWEAR & SUPPLIES

Maximum reimbursement: $160 in a calendar year

Charges for orthopedic footwear when the footwear has been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending Physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for footwear modifications, adjustments, supplies and/or molded arch supports when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

OSTOMY SUPPLIES

Charges for essential ostomy supplies on the written authorization of the attending physician.

OXYGEN

Charges for oxygen on the written authorization of the attending physician.

PARAMEDICAL PRACTITIONERS

Maximum reimbursement: $20 for X-rays in a calendar year per practitioner

Overall maximum reimbursement: $500 in a calendar year

Charges for treatment, except when performed in a hospital, by a licensed chiropractor, osteopath, physiotherapist or chiropodist/podiatrist.

PHYSICIAN SERVICES

Charges outside the covered person's province of residence in excess of the allowance under a government health plan.

PRIVATE DUTY NURSING

Maximum reimbursement: 80% of the first $10,000, 50% of the next $10,000 and nil thereafter. The maximum reimbursed is $13,000 in a calendar year.

Provided you do not reside in a convalescent nursing home and the nurse is not a relative, charges for medically necessary home nursing care performed by a registered nurse, registered nursing assistant or licensed practical nurse are eligible. Written authorization of the attending physician is required.

In addition, services provided by an approved personal care worker are eligible under this benefit for up to 4 hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. The covered person may be eligible for services in his/her home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the hospital and requires temporary home care.

All nursing services must be pre-approved by Medavie Blue Cross in order to be considered for reimbursement.

PROFESSIONAL AMBULANCE

Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

PROSTHETIC APPLIANCES

Charges for the following remedial appliances or supplies, when authorized by the attending physician:

- artificial limbs (limited to one prosthetic appliance to each limb in a lifetime);
- breasts (limited to a left and a right prosthesis every two consecutive calendar years);
- eyes (limited to one left and one right prosthesis in a lifetime);
- canes or crutches (limited to two in a lifetime);
- splints;
- casts;
- trusses (limited to one truss every five consecutive calendar years); and
- braces (limited to one cervical collar in a calendar year and all other braces are limited to one in a lifetime).

Replacement must be due to pathological or physiological change. Repairs and/or adjustments are provided to a maximum reimbursement of $40 every 12 consecutive months.

Hair prosthetics (wigs), when hair loss is due to an underlying pathology or its treatment, to a maximum reimbursement of $500 every three calendar years.

Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

SPECIAL AMBULANCE ATTENDANT

Maximum reimbursement: $120 every 12 consecutive months

Travel expenses of a Registered Nurse (not a relative) when medically necessary and approved by Medavie Blue Cross.

TERMINATION

Extended Health benefit continues for the lifetime of the subscriber.

WHEN AND HOW TO MAKE A CLAIM

Extended Health benefit is reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt. You may obtain claim forms from your employer or provider of service as appropriate.

To make a claim, complete the claim form that is available.

Claims must be submitted within 24 months of receiving services or supplies. No claims will be paid by Medavie Blue Cross after the termination date of this plan.

VISION BENEFIT

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Co-insurance: 80%

CONTACT LENSES DUE TO DISEASE

Maximum reimbursement: $100 every 24 consecutive months

Charges for contact lenses when medically necessary on the written authorization of the attending physician for; ulcerated keratitis, severe corneal scarring, keratoconus or aphakia, provided sight can be improved to at least the 20/40 level.

EYE EXAMINATIONS, LENSES, FRAMES AND CONTACT LENSES

Maximum reimbursement: $100 every 24 consecutive months for adults and every 12 consecutive months for dependent children less than 18 years of age

Charges of a licensed optometrist or ophthalmologist for eye examinations. Charges for corrective eyeglasses, including lenses, frames and contact lenses, but excluding safety glasses or glasses/contacts for cosmetic purposes.

TERMINATION

Vision benefit continues for the lifetime of the subscriber.

WHEN AND HOW TO MAKE A CLAIM

Vision benefit is reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt.

Claims must be submitted within 24 months of receiving services or supplies. No claims will be paid by Medavie Blue Cross after the termination date of this plan.

DRUG BENEFIT

If you (or your dependents, if applicable) incur charges for certain prescription-requiring drugs, the eligible drug may be subject to quantity maximums, dollar maximums, deductibles, co-payments or other maximums as approved by Medavie Blue Cross. Benefit maximums are applied on a per person basis.

Co-payment: Tier 1: the participant pays the dispensing fee
Co-payment: Tier 2: the participant pays 40% for each eligible prescription item
Co-insurance: 100% of the remaining eligible expense

Payment for a Specialty High Cost Drug may be reduced by the amount of financial assistance available under a Patient Support Program.

Includes prescription drug items approved by Medavie Blue Cross and certain over-the-counter items that are considered life-sustaining in nature and that are approved by Medavie Blue Cross.

Charges also for the following supplies in a quantity prescribed by a physician and deemed reasonable by Medavie Blue Cross under Tier 1:

- diabetic supplies, including needles, syringes, swabs, test tapes, lancets and insulin pump supplies; and
- glucose monitoring systems, including continuous glucose monitoring (CGM) receivers, transmitters or sensors for participants prescribed insulin for the treatment of diabetes to a maximum of $4,000 in a calendar year.

Drug Benefits are paid directly to the pharmacy.

Tiered Formulary
Eligible drug benefits include only medically necessary drugs which by law can only be obtained with a prescription and considered by Medavie Blue Cross to be life-sustaining. Drugs are separated into two tiers with the co-pay varying among the tiers. Drugs selected for the first tier are less expensive drugs, recognized as first line therapy for the treatment of disease, and are used to treat serious medical conditions. Drugs in the second tier are drugs that are usually more expensive, may be used to treat non-life threatening conditions, and are not always considered first line therapy for the treatment of specific diseases. Any eligible medication must be authorized by Medavie Blue Cross and prescribed and dispensed by Medavie Blue Cross approved providers.

Mandatory Generic Substitution
If an interchangeable drug has been prescribed, Medavie Blue Cross will reimburse to the lowest ingredient cost interchangeable drug when prescribed by a physician and dispensed by an approved provider. Regardless of whether your physician indicates the prescribed interchangeable drug cannot be substituted, Medavie Blue Cross will only reimburse to the lowest ingredient cost interchangeable drug.

You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs. For participants with an adverse reaction to the interchangeable drug dispensed, Medavie Blue Cross will consider reimbursement to another interchangeable drug on a case by case basis only, through the defined exception process.

DEFINTIONS

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

<u>Patient Support Program</u>: A program that provides assistance and services to participants when prescribed Specialty High Cost Drugs.

<u>Special Authorization</u>: Eligible drugs that are identified by Medavie Blue Cross as requiring prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the participant to participate in a Patient Support Program.

<u>Specialty High Cost Drug</u>: An eligible drug that requires Special 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.

TERMINATION

Drug benefit ceases at age 65. Coverage continues for an under age spouse until age 65 even if the subscriber is over age 65.

WHEN AND HOW TO MAKE A CLAIM

The Medavie Blue Cross Identification Card should be shown and the provider will arrange to bill Medavie Blue Cross directly.

DENTAL BENEFIT (VOLUNTARY)

The Dental benefit is a voluntary benefit (only applicable if the retiree has enrolled in the benefit). If you chose dental coverage, the program will cover you and your dependents for a wide range of dental services including the following benefits. Dental benefits are based on the usual and customary charges up to the current Nova Scotia Dental Fee Guide for general practitioners.

BASIC BENEFITS
Co-insurance: 100%

Diagnostics
- complete examinations once every three (3) consecutive calendar years
- recall examinations one (1) in a calendar year
- bitewing two films in a calendar year
- full series or panoramic x-rays once every 12 consecutive months
- tests/analysis/laboratory procedures

Preventive Services
- polishing once, up to one (1) unit of time* in a calendar year
- fluoride treatment one (1) in a calendar year
- scaling one unit in a calendar year
- pit and fissure sealants and space maintainers
- appliances (periodontal, TMJ or Myofascial) once every (2) two calendar years

Restorative Services
- amalgam (silver) and tooth coloured (white) fillings
- full coverage prefabricated restorations
- retentive pins

Prosthodontic Services
- denture adjustments and repairs (after 3 months of initial insertion)
- denture reline or rebase once every two (2) consecutive calendar years
- tissue conditioning

Surgical Services
- extraction of teeth and roots
- surgical movement of teeth
- removal of benign tumors, cysts

General Services
- general anaesthesia and intravenous sedation in conjunction with oral surgery

*one unit of time is equal to 15 minutes

ENDODONTIC AND PERIODONTIC SERVICES
Co-insurance: 90%

Endodontic Services
- root canal therapy

Periodontic Services
- periodontal scaling and root planing
- periodontal surgery (grafts)
- periodontal, TMJ or Myofascial appliance adjustments, maintenance and repair
- occlusal equilibration

MAJOR RESTORATIVE BENEFITS
Co-insurance: 70%
Maximum: $1,000 in a calendar year

Extensive Restoratives
- inlays/onlays/crowns

Prosthodontic Services
- complete and partial dentures, limited to one upper and one lower, once every five (5) consecutive calendar years
- bridgework

This program excludes replacement of the denture unless it is at least five years old and cannot be made serviceable, and the replacement of dentures that may have been lost, mislaid or stolen.

ORTHODONTIC BENEFITS (Applicable to employees with this benefit prior to retirement)
Co-insurance: 50%
Maximum: $3,000 in a lifetime

Orthodontic Services
- removable and fixed appliances (braces)
- observations and adjustments.

Treatment rendered by an Orthodontist, including the provision of orthodontic appliances for the correction of Class I, Class II, or Class III malocclusions in relation to a primary, mixed, or permanent dentition. Treatment shall be deemed to commence on the date the initial orthodontic appliance is installed.

DENTAL EXCLUSIONS AND LIMITATIONS

The dental plan does not cover the following expenses:

1. Services and supplies, or portion thereof, which is covered by, or which the Participant is entitled to receive from, a government health plan, any other government plan, or Workers' Compensation.
2. Services and supplies for which a government or government agency prohibits the payment of benefits.
3. Services and supplies provided by a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group.
4. Services and supplies required as the result of any intentionally self-inflicted injury, or as the direct result of war (declared or undeclared) or of engaging in a riot or insurrection.
5. Services and supplies rendered for dietary planning for the control of dental caries, for plaque control or for oral hygiene instruction.
6. Services and supplies rendered principally for cosmetic purposes, unless the services are required as the result of an Accident which occurred after the Participant's effective date of coverage.
7. Services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for correction of a temporomandibular joint dysfunction.
8. Dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature.
9. Dentures which have been lost, mislaid or stolen.
10. Services and supplies rendered for the correction of any congenital or developmental malformation which is not a Class I, Class II or Class III malocclusion.
11. Implants include placement of implants, post surgical care, uncovering and placement of attachment but not prosthesis.
12. That portion of Orthodontic treatment, normally considered an Eligible Expense under this Policy, which is rendered after the Participant's effective date of coverage and which is part of a course of treatment that commenced prior to such effective date, unless the expense is not covered by any group benefit.
13. Replacement dentures required less than five years after initial or replacement dentures were provided under this Policy.
14. Broken appointments or the completion of claim forms.
15. Services for which charges would not normally be made if the Participant were not covered by this Policy.

BENEFITS FOR LATE APPLICANTS

If application for dental benefits is made more than 60 days after the date on which the employee and/or dependent first becomes eligible, the maximum benefit will be limited to $150 per covered person during the first 12 months of coverage. Major Restorative benefits for late applicants are payable after 12 months from the effective date of coverage; Orthodontic benefits are payable after 24 months from the effective date of coverage. This provision does not apply to dental services required as a result of natural teeth being damaged by a direct accidental blow to the mouth after the effective date of the late applicant's coverage.

PREDETERMINATION OF BENEFITS

When the total cost of any proposed dental treatment is expected to exceed $500, ask your dentist to complete and submit the predetermination section of the claim form to Medavie Blue Cross before the start of the treatment. You will know, beforehand, the exact amount of reimbursement. If you change dentists in the course of treatment, you will be required to submit a new treatment plan.

TERMINATION

Dental Benefit ceases when the subscriber reaches age 65. Orthodontic benefits will continue, provided the treatment is rendered within the three-month period immediately following the termination date and treatment commenced prior to the termination date.

WHEN AND HOW TO MAKE A CLAIM

Dental benefits are reimbursed to the retired employee. The retired employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt.

To make a claim, complete the claim form that is available.

Claims must be submitted within 24 months of receiving services or supplies. No claims will be paid by Medavie Blue Cross after the termination date of this plan.

GENERAL EXCLUSIONS AND LIMITATIONS

Medavie Blue Cross does not cover the following expenses:

1. Medical examinations or routine general checkups required for use by a third party.
2. Elective services obtained outside the covered person's province of residence.
3. Charges which normally would not be made if the covered person was not covered under the plan.
4. Any item or service not listed as a benefit in this plan.
5. Medications restricted under federal or provincial legislation.
6. Registration charges or non-resident surcharges in any hospital.
7. Services performed by an unqualified practitioner.
8. Charges for missed appointments or the completion of forms.
9. Charges for health care planning assessments.
10. Any health care services and supplies that are not provided by a Medavie Blue Cross approved provider.
11. Convalescent, custodial or rehabilitation services, unless otherwise specified.
12. Conditions not detrimental to health.
13. Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice.
14. Benefits the covered person receives or is entitled to receive from Workers' Compensation.
15. Mileage or delivery charges.
16. Any injury or illness resulting from the covered person's active participation in or related to civil unrest, riot, insurrection or war.
17. Participation in the commission of a criminal offense.
18. A service or supply that is experimental or investigative in nature.
19. A service or supply that is not medically necessary or proven effective.
20. Services for which the government prohibits the payment of benefit.
21. Services provided without charge or normally paid for directly or indirectly by the employer.
22. Services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement.
23. Services as a result of self-inflicted injuries or any suicide attempt, whether the covered person is sane or not.

TERMINATION OF INSURANCE

Coverage for you and your dependents will cease on the earliest of:

- the contract termination date,
- the date you cease to be eligible due to, death, age limitation, change in classification, etc.

ALTERNATIVE BENEFIT

Where more than one form or alternative form of treatment exists, Medavie Blue Cross, in consultation with its Health Care Consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure or supply with a lower cost, when deemed appropriate and consistent with good health management.

CO-ORDINATION OF BENEFITS

In the event that benefits may be claimed under more than one section of the health care plan, the claim will be assessed in a manner that provides the greatest benefit to the employee.

If you are eligible for similar benefits under another group benefit plan the amount payable through this plan shall be co-ordinated with all benefit plans and will not exceed 100% of the eligible expense. Where both spouses of a family have coverage through their own employer benefit plans, the first payer of each spouse's claim is their own employer's plan. Any amount not paid by the first payer can then be submitted for consideration to the other spouse's benefit plan (the second-payer).

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earlier birth month in the calendar year, and then to the other spouse's benefit plan. When submitting a claim to a second payer, be sure to include payment details provided by the first payer.

Benefit payments will be co-ordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines.

CONVERSION PRIVILEGE

If you should terminate your coverage, you may convert to an Individual Health and Dental plan currently issued by Blue Cross provided that application is made within 31 days following your date of termination. This conversion privilege is also available to the surviving spouse and/or dependents after the termination of the Survivor Benefit.

SURVIVOR BENEFIT

In the event of the employee's death, eligible dependents will continue to be covered for Health and Dental Benefits provided:

- the surviving spouse makes arrangements to pay the full cost of the coverage as amended from time to time and as prescribed by the University;
- any eligibility conditions continue to be met by the surviving spouse and any dependent children.

ELIGIBLE RETIRED EMPLOYEES

To be eligible for group benefits, you must be a retired employee:

- who is a resident of Canada;
- covered under your provincial government plan;
- have been a participant in the active policy:
  - at retirement; and
  - enrolled in the coverage you are continuing for at least five years directly preceding retirement;
- within 10 years of normal retirement; and
- have at least ten years of service with the policyholder.

Coverage commences following the date of retirement.

Retired employees may elect coverage, within 31 days of becoming eligible following the waiting period, by completing an application. Coverage is effective on the date of eligibility, except when the application is made after the 31 day period.

ELIGIBLE DEPENDENTS

Dependents are defined as your legal spouse (as described below), and unmarried, unemployed dependent children including natural, legally adopted or step-children. Children of a common-law spouse may be covered if they are living with the employee. All dependents must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

The term “spouse” is defined as a person of the opposite or same sex who is legally married to the employee, or has continuously resided with the employee for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation ("common law" spouse), you may elect to continue membership of the former spouse or to provide notice to Medavie Blue Cross to terminate coverage for the spouse. Medavie Blue Cross will at no time provide coverage for more than one spouse under the same plan.

Dependent children are eligible for benefits if they are less than 21 years of age or, if 21 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

Unmarried, unemployed children 21 years of age or older qualify if they are dependent upon the employee by reason of a mental or physical disability and have been continuously so disabled since the age of 21. Unmarried, unemployed children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to the age of 25 and have been continuously disabled since that time also qualify as a dependent.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, evidence of health on the dependents may have to be submitted and approved before coverage begins.

EVIDENCE OF HEALTH

Proof of good health is not required if application is made within 31 days of first becoming eligible. If coverage is not applied for within this 31 day period, evidence may be requested for the employee and his dependents, if any, before benefits commence.

Certain other situations may require the submission of evidence of health before coverage will be approved. The cost of obtaining evidence of health is to be provided at your own expense if you or your dependents do not apply for coverage within 31 days of becoming eligible.

INSTRUCTION FOR MEMBERS

Medavie Blue Cross is continually developing its Web technology to respond to the needs of our customers. One such innovation, the Plan Member Website, will help you better understand, manage and co-ordinate your benefit plan.

The Plan Member Website is simple to use and is delivered in a secure environment. Now, when you want to access general information about your plan, view your claims and payment history, or print generic claim forms, you just have to click your mouse. The Plan Member Website is available 24 hours a day; seven days a week from home or work, all you need is an Internet connection. The Plan Member Website makes life easier for you.

ON THE PLAN MEMBER WEBSITE

There are a variety of options available to you on the Plan Member Website.

Coverage Inquiry: Detailed information about the Medavie Blue Cross benefit plan
Forms: Printable versions of generic Medavie Blue Cross claim forms

Member Information
- Members can view and/or update address information (where access is available)
- Request new identification cards
- Add/update banking information for direct deposit of claim payments (where applicable)

Member Statements
- Members can view claims history for member and dependents
- View record of payments issued to member and/or the service provider
- View Health Spending Account balances (where applicable)

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

To register for the Plan Member Website, visit **www.medaviebc.ca** and log in.

Please ensure you make note of your password for future reference.

PLEASE NOTE

For security reasons, the Plan Member Website is for use of the plan member only.

We look forward to helping you take advantage of our online technology. For further information on the Plan Member Website, or for any questions about your Medavie Blue Cross benefit plan, please contact our Customer Information Center toll free at the number on the back of your identification card or e-mail *inquiry@medavie.bluecross.ca.*

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:

Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
All Other Provinces: 1-800-667-4511

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

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**

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**.

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;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed above.

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 eClaim 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 benefit plan (if any);
- eClaims through our secure plan member website;
- Mobile App (visit www.medaviebc.ca/app for more information or to download the app); or
- Mail your completed claim form to the nearest Medavie Blue Cross office. To find the Medavie Blue Cross office nearest you, visit our website at www.medaviebc.ca.