



Your Group Benefits Booklet

Dalhousie University

Active Employees

Dental Plan Description:
Faculty and Senior Administration

Plan Number:
2146A

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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.

Medavie Inc. (also known as Medavie Blue Cross), which 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 70 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 from those 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.medavie.bluecross.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. In addition, these details explain when your coverage begins and ends, plus other useful information that will 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 notifying your employer upon change in status, and your rights, for example your right to privacy.
- **How to Submit a Claim and Obtain More Information:** Additional information on the various options available to you for submitting claims and how you can obtain more information regarding your coverage.
- **Helpful Tips:** Throughout this booklet we have provided 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.medavie.bluecross.ca/app for more information or to download the app.

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Summary of Benefits

Coverage During Periods of Absence from Work

Illness/Accident	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: The entire period of absence or until employment termination</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Maternity or Parental Leave/ Compassionate Care Leave	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: As required by applicable legislation</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Temporary Layoff	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: 6 months</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Sabbatical	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: 12 months</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Educational Leave	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: 12 months</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Authorized Leave of Absence (Including Disciplinary Suspension)	<p>Coverage continued: Member decision to retain or discontinue health or dental benefits*</p> <p>Maximum period: 6 months</p> <p>Payment of premiums: If benefits are retained, premiums are payable</p>
Strike/Lockout**	<p>Coverage continued: None</p> <p>Maximum period: Not applicable</p> <p>Payment of premiums: Not applicable</p>

*Exception: Quebec Participants must at least retain drug coverage unless they benefit from drug coverage under another group plan.

**Exception: Drug coverage for Quebec Participants is retained for 30 days after any strike or lockout begins, subject to the payment of premiums.

Summary of Benefits

Drug Benefit

Deductible	None
Reimbursement Level*	Tier 1: 100% of any amount in excess of the dispensing fee Tier 2: 60%
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Not Applicable
Drug Formulary	Tiered Formulary
Conditional Co-payment	Included
	Benefit Maximum
Diabetic Supplies	Tier 1
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires Coverage may also end on an earlier date as specified elsewhere in the booklet provisions
Survivor Coverage	5 years

*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
Vision Care	None
All Other Extended Health Care	None

	Reimbursement Level	Benefit Maximum
Hospitalization		
Hospital		100% for semi-private accommodation; 80% for private accommodation to a maximum of \$28/day
Ambulance Services	100%	\$25/12 consecutive months
Ancillary Services	100%	\$150/Hospital stay
Outpatient Services	100%	
Medical Services and Supplies		
Ambulance Transportation	80%	
Special Ambulance Attendant	80%	\$120/12 consecutive months
Physician Services	80%	
Nursing Care		80% for the first \$10,000/calendar year; 50% thereafter to a maximum of \$13,000/calendar year
Health Practitioners:		Maximum per calendar year
<i>Mental Health Practitioners (Psychologist/Social Worker/Clinical Counsellor/Psychoeducator/Psychotherapist (combined))</i>	80%	\$1,500*
<i>Chiropractor</i>	80%	\$500*
<i>Osteopath</i>	80%	\$500*
<i>Chiropodist/Podiatrist (combined)</i>	80%	\$500*
<i>Physiotherapist</i>	80%	\$500*
<i>X-rays (Chiropractor, Osteopath, Chiropodist/Podiatrist)</i>	80%	\$20

*Total combined maximum of \$500 for all Health Practitioners per calendar year, with the exception of Mental Health Practitioners.

*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*	80%	See benefit details
Mobility Aids and Orthopedic Appliances	80%	See benefit details
Prostheses	80%	See benefit details
Diabetic Equipment	80%	\$560/5 calendar years
Glucose Monitoring Systems	100%	\$4,000/calendar year
Hearing Aids	80%	\$200/84 consecutive months
Custom Orthopedic Shoes/Custom Made Foot Orthotics (combined)	80%	\$160/calendar year
Diagnostic Tests	80%	See benefit details
Smoking Cessation Aids	50%	\$200/lifetime
Antigen Therapy	80%	\$1,200/calendar year, to a lifetime maximum of \$2,400
Other Medical Services and Supplies	80%	See benefit details
Accidental Dental	80%	Predetermination of claim required
Vision Care		
Eye Examination/Lenses/Frames/Contact Lenses (combined)	80%	\$100/24 consecutive months/12 consecutive months for a Participant under age 19
Termination		
	When the Member retires Coverage may also end on an earlier date as specified elsewhere in the booklet provisions	
Survivor Coverage		
	5 years	

*Pre-authorization required.

Summary of Benefits

Dental Benefit (Voluntary)

Deductible	None	
Fee Guide Schedule	Current year/Province of Provider (Specialist fees paid at GP rate)	
	Reimbursement Level	Benefit Maximum
Preventive Care	100%	
Oral Exam and Diagnosis		
<i>Recall oral exams</i>		1/calendar year
Preventive Treatment		
<i>Polishing of teeth</i>		1/calendar year
<i>Fluoride treatment</i>		1/calendar year
<i>Scaling</i>		1 unit/calendar year; 90% thereafter
Basic Care	90%	
Endodontic Services		Included
Periodontic Services		Included
<i>Root Planing</i>		Included
Major Restoration	70%	\$1,000/calendar year*
Restorative and Prosthodontic Services		See benefit details
<i>Implants</i>		\$1,000/2 calendar years combined with restorations on implants*
<i>Restorations on implants</i>		\$1,000/2 calendar years combined with implants*
Orthodontic Services	50%	\$3,000/lifetime
Termination	When the Member retires Coverage may also end on an earlier date as specified elsewhere in the booklet provisions	
Survivor Coverage	5 years	

*Implants and restorations on implants are subject to both the Major Restoration and Implant Services Maximum.

Summary of Benefits

Travel Benefit

Travel Benefit is not available to Members who have chosen only Health Spending Account coverage in this plan

Deductible	None
Reimbursement Level	100%
Coverage Duration	First 180 days of Trip outside province of Residence
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	\$2,000,000/Participant/Incident*
Worldwide Travel Assistance	Yes
Referral Outside of Canada**	\$500,000/Participant/lifetime
Termination	When the Member retires Coverage may also end on an earlier date as specified elsewhere in the booklet provisions
Survivor Coverage	5 years

*Incident: An individual occurrence of Emergency Accident, Injury, Sickness or Disease.

**Pre-authorization required.

Summary of Benefits

Health Spending Account (HSA) Benefit

Method of Payment	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member on the claim form)
Credit Allocation Frequency	Annually
Benefit Details	
Policy Year	July 1 st to June 30 th
Carry Forward Type	Credit Carry Forward
Option to Exclude Participants	Yes, Participant eligibility is determined by the Plan Sponsor
Grace Period for Active Members	90 days
Grace Period for Terminated Members	90 days
Termination	
	When the Member retires Coverage may also end on an earlier date as specified elsewhere in the booklet provisions

Key Terms

You and Your Dependents

Throughout this booklet we use several key terms when we refer to you and your Dependents:

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

Employee: A person who:

- resides in Canada; and
- works a minimum of 50% of the normal hours per week for the employer.

Employees on a temporary, contractual (of less than eight months) or seasonal basis, as well as Employees who work outside of Canada on a regular basis, are not eligible for coverage unless otherwise specified in the Summary of Benefits.

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.

In the event of divorce, legal separation or discontinuance of a conjugal relationship, the Member may continue coverage or provide notice to Blue Cross to terminate coverage for the former spouse.

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

A child is considered to be mentally or physically disabled for the purposes of this definition if they are incapable of engaging in any substantially gainful activity and are financially reliant on the Member 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.



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 and/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.

Key Terms

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

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

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

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

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

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



Helpful Tip

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

Activities of Daily Living: The following 5 activities:

- Eating: the ability to manipulate prepared food or liquid into the mouth;
- Dressing: the ability to put on and remove necessary articles of clothing that are normally worn, including leg braces;
- Bathing: the ability to cleanse the entire body using soap and water, including turning on faucets and shower mechanisms, getting into and out of the bath or shower and drying oneself;
- Ambulation: the ability to move independently from place to place with or without the use of mobility aids; and
- Toileting (including continence, which is the ability to control bowel and bladder function): the ability to use a toilet, bedside commode or urinal.

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

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

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



Helpful Tip

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

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

- Medically Necessary;
- usual, customary and reasonable, meaning that:
 - the amount charged is 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

Key Terms

- the frequency and quantity in which services or supplies are purchased by the Participant are, 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;
- recommended or prescribed by a Physician or Health Practitioner who:
 - does not normally reside in the Participant's home;
 - is not the Participant's Family Member; and
 - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
 - does not normally reside in the Participant's home; and
 - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the plan is in effect, unless otherwise specified.

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

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

Where more than one form or an alternative form of Treatment exists, Blue Cross has the right to base their 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.

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.

Insured Benefits: Benefits underwritten and administered by Medavie Inc. which assumes all liability for their payment. In this plan, travel benefits are Insured Benefits.

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;
- father or mother, or their spouse or common-law partner;
- children, or the children of the Participant's spouse or common-law partner;
- 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, extended health, dental and health spending account 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.

Coverage Details

Who is Eligible for Coverage?

You are eligible for coverage if you meet the definition of Employee and are Actively at Work.

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

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

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

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

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted if your application is received by Blue Cross more than 60 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 as follows:
 - the maximum amount reimbursed under Preventive and Basic Care is limited to \$150 for the first 12 consecutive months of coverage;
 - Major Restoration will become effective following 12 consecutive months from the effective date of coverage; and
 - Orthodontic Services will become effective following 24 consecutive months from the effective date of coverage.
- Quebec Participants who are late in applying for drug benefits do not need to submit proof of health for drug coverage.



Helpful Tip

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

How do I Enrol for Coverage?

Application Form

To obtain coverage, you must complete and submit the application form provided to you by your employer and submit proof of health, if required for the reason listed above.

The completed application form must be received by Blue Cross within 60 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, subject to the exceptions noted below:

- it is your choice whether or not to obtain coverage for dental benefits; and
- you are allowed to waive the health benefits coverage for yourself 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 there is a change in your family status or if you or your Dependents' other coverage terminates for reasons outside of your control.



Helpful Tip

If you do not enrol for coverage within 60 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 you meet all of the eligibility requirements; or
- the date Blue Cross approves your proof of health, if required.

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

Dependents

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

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



Helpful Tip

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

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

Illness/Accident

If you are absent from work due to any disability recognized by Blue Cross or any disability covered by a workers' compensation board/commission or automobile insurance bureau, you may choose to retain coverage for benefits (if any) specified in the Summary of Benefits. The maximum period during which benefits will be retained is specified in the Summary of Benefits and premiums must continue to be paid for the benefits retained.

Maternity or Parental Leave/Compassionate Care Leave

During a maternity, parental or compassionate care leave of absence, you must decide whether to retain coverage for all benefits or discontinue coverage for all benefits for the maximum period provided under the applicable federal or provincial legislation. This decision is irrevocable and must be made before the leave begins. If coverage is retained, premiums must continue to be paid for all chosen benefits (if applicable) for the duration of the leave.

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

Temporary Layoff/Sabbatical/Educational Leave/Other Authorized Leave of Absence (including Disciplinary Suspension)

In such circumstances, you may choose to retain coverage for benefits (if any) specified in the Summary of Benefits. The maximum period during which benefits will be retained is specified in the Summary of Benefits and premiums must continue to be paid for the benefits retained.

Strike/Lockout

Coverage for all benefits is discontinued for the duration of any strike or lockout.

Exception: Drug coverage for Quebec Participants is retained for 30 days after any strike or lockout begins. Premiums must continue to be paid during this 30-day period.

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the plan terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your employment is terminated;
- you reach the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire from the employer, unless otherwise 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 the 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.

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;
- 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 with payment of premiums 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;
- the date your Spouse reaches age 65; or
- the date your Dependents are no longer considered to be eligible Dependents (for reasons other than your death).



Helpful Tip

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

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

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

What 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, and also 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 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.

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 has 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

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.



Helpful Tip

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

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) or a natural health product number (NPN) in Canada;
- considered by Blue Cross to be a Life-Sustaining Drug or a drug that requires a prescription by law;
- 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.

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.

Life-Sustaining Drug: An Eligible Drug that does not require a prescription by law but which Blue Cross is satisfied is necessary for the survival of the Participant. A prescription from a physician or Health Practitioner is still needed for reimbursement.

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 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.

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 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;
 - Special Authorization; and/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; 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;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formulary:
 - **Tiered Formulary:** List of Life-Sustaining Drugs and Eligible Drugs that require a prescription by law that are reimbursed at varying tiered levels determined by the Employer. Drugs selected for the first tier are 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 may be used to treat non-life threatening conditions, and are not always considered first line therapy for the treatment of specific diseases. This formulary is subject to the decisions of the Medication Advisory Panel.

Conditional Co-payment

If the Summary of Benefits specifies Conditional Co-payment applies, certain Eligible Drugs that would normally be reimbursed at the lower reimbursement level may be reimbursed at the higher reimbursement level when established criteria are met. The criteria to be met for Conditional Co-payment are established by Blue Cross.

Special Authorization

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

How does the Special Authorization process affect my claim?

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

You can request a Special 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 Special Authorization decisions is 7 to 10 working days.

You will receive confirmation in writing regarding the decision on your Special 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

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

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



Helpful Tip

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

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.

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

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

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

Payment of Claims

How Payments are Made

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

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

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, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Deferred Payment: At the time of purchase, the Approved Provider submits the Participant's claim to Blue Cross electronically to verify eligibility. The Participant pays the full amount charged by the Approved Provider and Blue Cross will reimburse the portion of the Participant's claim covered by this benefit when a specified dollar amount or a time-period threshold has been reached.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, Blue Cross will reimburse only the amount that would have been reimbursed if the claim had been submitted electronically.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 24 months of the date the Eligible Expense was incurred.



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.

Exclusions and Limitations

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

- a) varicose vein injections;
- b) antihistamines and allergy sera;
- c) vaccines;
- d) vitamins;
- e) weight loss treatments;
- f) natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
- g) fertility treatments;
- h) erectile dysfunction treatments;
- 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 Care Professional 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; or
- p) drugs that are eligible under the travel benefit provided by the group plan (if applicable).



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 Calendar Year

If, in any calendar 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 calendar 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:

- 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, subject to the Deductible and reimbursement level specified in the Summary of Benefits.

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.

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.

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/or 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.

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.

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

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

Ambulance Services: 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. The maximum is specified in the Summary of Benefits.

This coverage excludes inter-Hospital transfers.



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.

Extended Health Care

Ancillary Services: Hospital services that is Medically Necessary when a Participant is admitted to a Hospital as an inpatient outside a Participant's province of residence, if the Participant's government health care coverage prohibits payment of these expenses. The maximum is specified in the Summary of Benefits.

Outpatient Services: Diagnostic services when a Participant does not require admission to a Hospital as an inpatient outside a Participant's province of residence, if the Participant's government health care coverage prohibits payment of these expenses. This includes charges for diagnostic services if the Participant's government health care coverage prohibits payment of these expenses.

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.

Special Ambulance Attendant: Charges for travel expenses of an accompanying registered nurse or qualified medical attendant (other than a relative), when Medically Necessary and approved by Blue Cross.

Physician Services: Charges for Physician services if rendered in Canada but outside the Participant's province of residence.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant, licensed practical nurse or a member of the Victorian Order of Nurses 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 5 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



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.



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.

- group treatment sessions.

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

- manual or electric wheelchair, including cushions and inserts;
- manual or electric hospital bed, including mattress and safety side rails;
- scooter;
- 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; and
- compression pump and traction equipment.

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 calendar 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 or canes to a maximum of 2 per lifetime;
- walking aids or trusses to a maximum 1 per 5 calendar years;
- casts, splints;
- braces to a maximum of 1 per lifetime; and
- cervical collar to a maximum of 1 per calendar year.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs to a maximum of 1 per limb per lifetime;
- artificial eyes to a maximum of 1 per eye per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 2 calendar years; and
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of \$500 per 3 calendar years.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of \$40 per 12 consecutive months.

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, continuous blood glucose monitoring transmitters, 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.



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.

Extended Health Care

Insulin pumps are eligible under the durable medical equipment benefit.

Diabetic supplies are eligible under the drug benefit.

Glucose Monitoring Systems: Charges for continuing glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes.

Hearing Aids: Charges for the purchase and repair of hearing aids when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist.

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 a 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.medavie.bluecross.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 laboratory analyses and X-rays when provided by a laboratory approved by Blue Cross.

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.

Smoking Cessation Aids: Charges for smoking cessation aids when prescribed by a Physician.

Antigen Therapy: Charges for antigens, antihistamines and serums used for the purpose of desensitization, treatment of allergic conditions or environmental illnesses.

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

- allergy testing materials to a maximum of \$40 per calendar year;
- ostomy supplies, catheters and catheterization supplies;
- oxygen; and
- sleeves for lymphedema to a maximum of 2 per calendar year.

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 surrounding 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 180 days 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 ophthalmologist or optometrist.

Lenses, Frames and Contact Lenses: Charges for the following products and services are eligible when prescribed by an ophthalmologist or optometrist:

- corrective eyeglasses (frames and lenses) and contact lenses; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea. The contact lenses must improve sight to at least 20/40 and this level of improvement must not be possible with eyeglass lenses.

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

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 24 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;

Extended Health Care

- 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 (except for intrauterine contraceptive devices (IUDs)), 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 this 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 checkups;
- m) mileage or delivery charges to or from a Hospital or Health Practitioner; or
- n) services or expenses incurred as a result of:
 - i. voluntary participation in a riot, insurrection or in any war (declared or not). This includes any condition caused directly or indirectly by the hostile action of the armed forces of any country; or
 - ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or 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.

Dental Benefit (Voluntary)

Purpose of Coverage

The dental benefit is a voluntary benefit (only applicable if you have enrolled in the benefit). If you chose dental coverage, Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definition

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

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

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

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

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

What Blue Cross Will Pay

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

- payment of all Eligible Expenses is limited to the reimbursement level and benefit maximums specified below and/or in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the reimbursement level applies is the lesser of:
 - the expense actually incurred by the Member; or
 - the fee amounts specified in the dental fee guide approved by Blue Cross (the applicable guide and annual edition are specified in the Summary of Benefits);
- the Eligible Expenses for laboratory fees are limited to 100% of the provider fee suggested in the fee guide;
- Eligible Expense must have been performed by:
 - a licensed dentist;
 - a licensed denturist when the services are within the scope of their profession; or
 - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

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

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 3 calendar years;
- recall oral examination;
- emergency oral examination;
- limited or specific oral examination;

Helpful Tip

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

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

Helpful Tip

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

Helpful Tip

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

Dental Benefit (Voluntary)

- orthodontic examinations, 1 procedure per provider every 3 calendar years; and
- unmounted orthodontic diagnostic casts.

X-rays: Charges for:

- complete series to a maximum of 1 per 12 consecutive months;
- panoramic to a maximum of 1 per 12 consecutive months;
- intra-oral:
 - periapical; and
 - occlusal and bitewings to a maximum of 4 per calendar year;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

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

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- pit and fissure sealants;
- scaling;
- space maintainers;
- periodontal appliances to a maximum of 1 per 2 calendar years; and
- appliances to control harmful oral

Restorations: Charges for:

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

Removable Denture Adjustments: Charges for:

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

Oral Surgery: Charges for:

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

General adjunctive services: Charges for:

- anesthesia (related to surgery); and
- temporary dressing for the emergency relief of pain.



Helpful Tip

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



Helpful Tip

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

habits.

restorations on anterior and

Dental Benefit (Voluntary)

TMJ (Temporomandibular joint)/Myofascial pain dysfunction services: Charges for:

- X-rays to a maximum of 4 per calendar year; and
- appliances to a maximum of 1 per 2 calendar years.

Basic Care

Endodontic Services: Charges for:

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



Helpful Tip

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

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- desensitization;
- periodontal curettage;
- root planing;
- occlusal adjustments;
- adjustments to appliances; and
- other adjunctive periodontal services.



Helpful Tip

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

TMJ (Temporomandibular joint)/Myofascial pain dysfunction services: Charges for adjustments and relines.

Major Restoration

Extensive Restorations: Charges for:

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

Other Restorative Services: Charges for:

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

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 calendar years;
- bridgework;
- implants, if specified in the Summary of Benefits;
- restorations on implants (i.e. crowns, bridgework and dentures), if specified in the Summary of Benefits;
- implant related services, if implants are covered;
- construction and insertion of an initial permanent denture or bridgework; and
- replacement of an existing denture or bridge with a permanent denture or bridge so long as the existing appliance is at least 5 years old.



Helpful Tip

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

Orthodontic Services

Charges for:

- removable appliances for tooth guidance;
- fixed or cemented appliances (braces);
- retention appliances; and
- comprehensive treatment.



Helpful Tip

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

Payment of Claims

How Payments are Made

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

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 24 months of the date the Eligible Expense was incurred.

Predetermination for Claims over \$500

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

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

Date of Treatment

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

Exclusions and Limitations

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

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

Dental Benefit (Voluntary)

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

Travel 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.

Accident: An unexpected, unforeseen event or mishap that occurs without intent or design.

Accommodation: Lodging located near the Hospital where the Participant is confined.

Airfare: The regular economy-class fare on a scheduled regular flight operated by an air carrier certified by Transport Canada or an equivalent governmental authority in its country.

Disease: Any unhealthy condition of the body, or of any part of the body, that occurs while coverage is in force for Participant and in respect of which expenses are incurred during a Trip outside their province of Residence.

Emergency: Unexpected and not preplanned.

Fare: The standard fare charged for:

- an economy-class seat on a scheduled domestic or international flight;
- a coach seat on a passenger train;
- a regular seat on a passenger bus; or
- an economy-class seat on a boat;

provided that each carrier holds an operating certificate issued by Transport Canada or an equivalent governmental authority in its country of certification.

Hospital: A licensed institution that provides continuous medical and nursing care, with at least 1 physician on duty at all times and 24-hour nursing services by registered Nurses. Immediate Family Members may serve as Physicians or Nurses for this definition. The institution must offer diagnostic and surgical facilities and operate as an active treatment hospital.

Coverage excludes any facility used primarily as a clinic, rest home, nursing home, or convalescent facility or similar institution unless specifically authorized by Blue Cross.

Immediate Family Member: Anyone age 18 and older who is the Participant's child, parent, child, brother, sister, in-law (including son, daughter, father, mother, brother or sister-in-law) including natural, adopted or step relationships, as well as the Participant's spouse, grandson, granddaughter, grandfather or grandmother.

Injury: A bodily injury resulting from an Accident that occurs while the Participant is covered under this plan. The injury must be the direct and sole cause of a loss eligible under the plan, and must be sustained during a Trip outside the Participant's province of Residence, with related expenses incurred during that Trip. Injury does not include any form of Sickness or Disease unless directly caused by an Accident.

Motorized Vehicle: A passenger car, station wagon, van, jeep-type vehicle, truck, ambulance, or any motorized vehicle used by police forces at the municipal, provincial or federal police level.

Nurse: A registered nurse (R.N.) or licensed practical nurse who is authorized to practice by the appropriate government licensing body. A Nurse cannot be the Participant or an Immediate Family Member.

Travel Benefit

Physician: A licensed medical doctor, other than the Participant or an Immediate Family Member who is authorized to practice by the appropriate medical licensing body or government authority in the location where treatment is rendered.

Province: Interpreted to mean “territory” when the Participant’s Residence is located in a Canadian territory or receives treatment within a Canadian territory.

Regular Care and Attendance: The observation and treatment provided in accordance with established standards of medical practice for the condition requiring such treatment or causing Hospital confinement.

Residence: The primary dwelling occupied by the Participant, including the premises on which it is located.

Sickness: Any impairment of normal physiological function, including illness or infection, that occurs while the plan is in force for the Participant and forms the basis of a claim, with related expenses incurred during a Trip outside the province of Residence.

Travelling Companion: A person who is sharing same booked accommodation with the Participant.

Trip: Travel that begins on the date of departure from the Participant’s province of Residence and ends on the date of return to that province, up to a maximum duration 180 consecutive days.

What Blue Cross Will Pay

Blue Cross will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and in the Summary of Benefits;
- prior approval of Blue Cross must be obtained before the Eligible Expense is incurred;
- the charges must be usual, customary and reasonable, meaning that:
 - the amount charged is consistent with the amount typically charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
 - the frequency and quantity in which services or supplies are purchased by the Participant are, 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;
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit;
- payment is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this plan and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan, as specified under the Coverage Details section of this booklet); and
- payment is subject to post-payment audit.

Emergency Hospital and Medical Travel Coverage

Blue Cross will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency;
- the Participant is covered by government health care coverage when the Emergency occurs; and
- Blue Cross is satisfied the expense is necessary to stabilize the Participant’s medical condition.



Helpful Tip

Make sure to bring your Blue Cross identification card with you when you travel.

Hospitalization: Charges for Hospital room accommodation (not a suite of rooms), as well as medically required inpatient outpatient Hospital services.

Travel Benefit

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending Physician. The nurse providing the service must not be a Family Member of the Participant or an employee of the Hospital.

This coverage excludes nursing fees for custodial care.

Drugs: The cost of drugs, sera, and vaccines prescribed by a physician, or legally qualified dentist and dispensed by a registered pharmacist or physician, to a dispensing maximum of a 30-day supply.

Coverage excludes charges for the administration of injectable drugs.

Ambulance Service: The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-Hospital transfer if the attending Physician and Blue Cross determine that existing facilities are inadequate for Treatment or stabilization.

Diagnostic Services: Charges for:

- blood plasma, whole blood, or oxygen, including administration; and
- diagnostic X-rays and laboratory tests.

Medical Appliances: Charges for:

- artificial limbs, eyes, and other prosthetic appliances, to a maximum of \$2,000 per calendar year;
- purchase or rental of casts, cervical collars, crutches, trusses, splints, and braces (excluding dental braces and splints); and
- rental of a wheelchair, iron lung, or other durable medical equipment required for temporary therapeutic purposes.

Physician Fees: Fees charged for Physician or surgeon services.

Anaesthetist: Expenses for a licensed anaesthetist when recommended by a Physician.

Practitioners: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists (including 1 X-ray per practitioner) and physiotherapists.

In addition, the cost of services rendered by massage therapists (Physician referral required), speech therapists, and licensed psychologists to a maximum of \$500 per specialty per Accident, Sickness or Disease.

This excludes practitioners who ordinarily reside in the Participant's Residence or who are Immediate Family Members.

Emergency Dental Treatment Benefit: Charges for dental treatment, replacement, or X-rays provided by a legally qualified dentist or oral surgeon, when required due to an Injury to whole and sound teeth (capped or crowned teeth are considered whole and sound), resulting from a force or blow external to the mouth. Blue Cross will pay the expenses up to an aggregate maximum amount of \$2,000 per accident.

Coverage amounts are determined in accordance with the fee guide for dental general practitioners applicable to the Participant's province of Residence.

Evacuation Benefit: If, due to Injury, Sickness or Disease, a Participant requires any of the following evacuations below, Blue Cross will pay the reasonable and necessary expenses incurred:

- transportation by any conveyance licensed to carry passengers for hire (excluding ground ambulance), including air ambulance, from the location of the Accident, Sickness or Disease to the nearest Hospital capable of providing the necessary treatment (or to a medical facility or physician's clinic when appropriate), when such evacuation is recommended by the attending Physician and approved by Blue Cross;

Travel Benefit

- transportation to the Participant's province of Residence by any conveyance licensed to carry passengers for hire (excluding ground ambulance), including air ambulance, when recommended by the attending Physician and approved by Blue Cross and when the attending Physician provides written certification that Participant's medical condition after treatment warrants return for continued care or recovery; and
- transportation to the Participant's province of Residence when the Participant is confined as an inpatient under the Regular Care and attendance of a Physician, preventing return on the original scheduled return flight when that ticket is non-changeable and non-refundable.

Blue Cross will also reimburse reasonable and necessary round-trip Airfare, Accommodation, and board expenses incurred by a medical attendant or 1 Immediate Family Member accompanying the Participant, up to a maximum of \$5,000.

This benefit is payable under only 1 plan issued to the Plan Sponsor by Blue Cross.

Repatriation Benefit: The reasonable and necessary expenses incurred to transport the body of a deceased Participant whose death resulted from Injury, Sickness or Disease when located not less than 50 kilometres from their normal Residence. This includes transportation to the nearest appropriate resting place (such as a funeral home or place of interment) within the vicinity of the Participant's Residence, as well as charges for preparing the body for transportation. The maximum amount payable under this benefit is \$15,000.

Benefits are payable to the individual who incurred the covered expenses.

Family Transportation and Accommodation Benefit: If, due to Injury, Sickness or Disease, a Participant dies or is hospitalized as an inpatient for at least 4 consecutive days under the Regular Care and Attendance of a Physician, Blue Cross will pay the reasonable and necessary expenses incurred by:

- any other Participants or Travelling Companion who stay with the hospitalized Participant and are unable to return to their province of Residence on their original, non-changeable and non-refundable return date. Eligible expenses include board, Accommodation, and transportation home by the most direct route, up to the cost of a 1-way Fare; or
- an Immediate Family Member or designated representative for board, Accommodation, and 1 return Fare to travel by the most direct route between their Residence and the hospitalized Participant, when the Participant was travelling without a family member at the time of hospitalization.

Transportation reimbursement is limited to 75% of the applicable Fare. For travel by a Motorized Vehicle other than one operated under a license for the conveyance of passengers for hire, reimbursement is limited to \$0.35 per kilometre.

The total amount payable under this benefit is \$5,000 per Participant, per Accident, Sickness or Disease.

Vehicle Return Benefit: The reasonable and necessary expenses charged by a commercial agency to return the Participant's Motorized Vehicle, whether private or rental used as transportation during a trip, when the attending Physician certifies in writing that the Participant has become disabled as a result of Injury, Sickness or Disease and is unable to continue the trip by means of driving that vehicle. The vehicle will be returned by a commercial agency to the Participant's normal place of Residence or to the rental agency, as applicable.

This benefit is subject to a maximum of \$1,000 per 1 Accident, Sickness or Disease.

Rental Expense Benefit: The reasonable expenses incurred for the rental of a telephone and or television set when, as a result of Injury, Sickness or Disease, the Participant is confined as an inpatient in a hospital and is under the regular care and attendance of a Physician.

This benefit is subject to a maximum of \$200 per 1 Accident, Sickness or Disease.

Travel Benefit

Hotel Convalescence Benefit: The cost of commercial accommodation and meals when the Participant's travel is delayed due to Injury, Sickness or Disease of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending Physician. The maximum reimbursement is \$150 per Participant per day for a maximum of 20 days (up to a total maximum of \$3,000 per Injury, Sickness or Disease).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

Blue Cross, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Participants who need medical assistance or general assistance while travelling.

Medical Assistance

If the Participant requires hospitalization or a consultation with a physician as a result of an Emergency, the travel assistance provider appointed by Blue Cross will provide the following support services:

- direct the Participant to an appropriate clinic or Hospital;
- confirm with the service provider that the Participant is covered;
- ensure a follow-up of the medical file and communicate with the Participant's family physician;
- co-ordinate the return home of a Child if the Participant is hospitalized;
- repatriation of the Participant to the province of residence if the Participant meets the eligibility requirements of this expense;
- arrange for the transportation of an Immediate Family Member to the Participant's bedside if the Participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the Participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance

In Emergency situations, the travel assistance provider appointed by Blue Cross will also provide the Participant with the following services:

- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for Emergency calls;
- referral to legal counsel in the event of a serious accident;
- settlement of formalities in the event of death;
- assistance with the loss or theft of identity papers; and
- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

Blue Cross and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the Participant or for the availability of such care.

Referral Outside of Canada

When an attending physician refers a Participant outside of Canada for medical services not available in Canada, Blue Cross will cover the portion of expenses listed below which exceed those covered by the Participant's government health care coverage.

Hospital Services: Charges for:

- hospital room accommodation;
- intensive care room accommodation;
- nursing services;
- operating and recovery room services;
- diagnostic and laboratory services, including X-rays;

Travel Benefit

- oxygen and blood;
- prescription drugs including intravenous solutions; and
- physiotherapy.

Physicians and Surgeons: Charges for services rendered by a physician or surgeon.

Ambulance Transportation and Attendant: Charges for licensed ambulance services needed to transport a stretcher patient to and from the nearest hospital able to provide acute care. Charges for air transportation are included to a maximum of up to 3 economy fare seats on a regularly scheduled flight. This also includes any charges for travel expenses of an accompanying registered nurse or qualified medical attendant, other than a relative.

To be eligible for coverage under this category, all expenses must be pre-approved by Blue Cross and the Participant's government health care coverage must agree to cover a portion of the expenses.

Specific Exclusions and Limitations Applicable to Referral Outside of Canada

The following limitations apply:

- a) any referral outside of Canada must be medically necessary and not be for services that are available in Canada, as determined by Blue Cross;
- b) the claim must have pre-authorization from Government Health Care Coverage and Blue Cross;
- c) payment will be made based on the Provider's Usual, Customary and Reasonable charges for the services or supplies provided in the area in which they are rendered;
- d) payment will only be made for services or supplies provided while the Participant is under the treatment of a Physician;
- e) no payment will be made for treatment related to an illness beginning within 12 months following the Participant's effective date of coverage or for which medical treatment was received, or medication was prescribed 12 months prior to the effective date of this coverage; and
- f) services for experimental medical procedures or treatment methods not approved by the Canadian Medical Association.

Payment of Claims

How Payments are Made

Blue Cross may approve payment directly to the service provider. In certain circumstances, the Participant will pay the full cost of any Eligible Expense at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

The following benefits are excluded from the overall benefit maximum of Emergency Hospital and Medical Travel Coverage:

- Evacuation Benefit;
- Repatriation Benefit;
- Family transportation and Accommodation Benefit;
- Vehicle Return Benefit;
- Rental Expense Benefit; and
- Hotel Convalescence Benefit.

Unless otherwise specified, all benefits, including those for a Dependent Spouse or Child, are paid to the Participant or as they request. Any unpaid benefits at the time of the Member's death will go to the estate.

Continuation of Coverage

In the event the Participant is delayed beyond the termination date of coverage, coverage under this plan may be continued without payment of premium, subject to the following:

- If the Participant is in the process of returning to their province of Residence and the delay results from a mechanical failure of the mode of transportation, a traffic accident, or adverse weather conditions, coverage will remain in force for a period not exceeding 72 hours from the original termination date of coverage;
- If the Participant is hospitalized as an inpatient due to Injury, Sickness or Disease at the time coverage would otherwise terminate, coverage will continue for up to 72 hours following discharge from the Hospital; and
- If, as a result of Injury, Sickness or Disease, the Participant is not confined to a Hospital but the attending Physician determines that the Participant is medically unable to return to their province of Residence, coverage will be extended for a maximum period of 10 days from the date coverage would otherwise have ended.

Any coverage extended under this section shall be governed by the terms, conditions, and benefit limits of the Plan in effect on the date coverage would otherwise have terminated, including any applicable reductions in coverage.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage, and Referral Outside of Canada: Written notice of a claim must be provided to Blue Cross within 30 days from the date the expense was incurred, or as soon as reasonably possible.

Written proof of claim must be submitted to Blue Cross within 90 days from the date the expense was incurred.

Failure to provide notice of claim or proof of claim within the time periods specified above will not invalidate a claim where it is demonstrated that compliance was not reasonably possible and the required information was provided as soon as reasonably possible, provided that in no event shall notice or proof be accepted more than 1 year from the date the expense was incurred.

Exclusions and Limitations

Limitations Applicable to all Travel Benefit Claims

The following limitations apply:

- coverage for a Trip begins once the Participant departs the border of their province of Residence, or, when travelling by air, at the moment the aircraft takes off from within their province of Residence, provided the Participant's insurance is in effect.
Coverage ends when the Participant crosses back into their province of Residence upon returning from the Trip, or, if travelling by air, when the aircraft lands in their province of Residence, or as specified in the definition of Trip following the date of departure from the province of Residence, whichever occurs first;
- all expenses must be Emergency, non-elective in nature, incurred outside the Participant's province of Residence, and exceed the amounts payable under any individual, group or Government Health Care Plan; and
- in consultation with the attending Physician, Blue Cross may require that the Participant be transferred to another Hospital or returned to their province of Residence for ongoing treatment. If the Participant refuses the recommended transfer, Blue Cross will not be responsible for any further expenses related to the condition after the proposed transfer date.

Exclusions Applicable to all Travel Benefit Claims

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

- a) expenses that are covered under any Government Health Care Coverage, whether benefits are payable or not, or expenses for which insurance coverage is prohibited by law;
- b) expenses for which reimbursement has been made through the Plan Sponsor's other group health or hospitalization insurance plan;
- c) medical examinations requested by a third party, cosmetic procedures, and dental treatment unless required due to an Accident;
- d) charges for experimental drugs not approved by Pharmaceutical Drugs Directorate, Health Canada, any type of contraceptive and patent medicines;
- e) charges for experimental medical treatments;
- f) services for which no charge would normally be made if insurance coverage were not in place;
- g) medical expenses for treatment or surgery the Participant chooses to receive outside their province of Residence after Emergency care or diagnosis, when medical evidence shows the Participant could have returned home before undergoing such treatment or surgery;
- h) the Participant fails to communicate with Blue Cross in the event of medical consultation or hospitalization following an injury or Sickness;
- i) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
- j) the purpose of the Trip is primarily to seek medical advice or treatment, even if this Trip is on the recommendation of a physician, with the exception of Referral Outside of Canada;
- k) expenses have already been paid or are eligible for refund from a third party;
- l) expenses are incurred by a Participant who is not covered by Government Health Care Coverage; or
- m) expenses are incurred as a result of:
 - i. participation in acts of terrorism, or in a riot, insurrection or civil commotion;
 - ii. suicide or intentionally self-inflicted injury; or
 - iii. any war, whether declared or not, within Canada or the United States of America.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

- a) expenses for any care, treatment, surgery, products or services that:
 - i. are not incurred as a result of an Emergency;
 - ii. are not medically necessary;
 - iii. are performed for cosmetic purposes only;
 - iv. are not required for the immediate relief of acute pain and suffering; or
 - v. could be delayed until the Participant's return to Canada;
- b) expenses incurred due to pregnancy or childbirth, except for pregnancy complications, which are covered as any other Sickness; or
- c) expenses incurred due to an Emergency that occurs while participating in a sport for remuneration.

Health Spending Account (HSA) Benefit

Purpose of Coverage

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

Additional Definition

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

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

What Blue Cross Will Pay

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

HSA Credits

The plan sponsor pre-determines the amount of credits allocated to the HSA at the beginning of each policy year specified in the Summary of Benefits in accordance with HSA plan terms outlined in the collective bargaining agreements and for non-unionized employees, in the employee handbooks. Credits represent the monetary value allocated to the HSA by the plan sponsor and the amount that may be reimbursed by Blue Cross on the plan sponsor's behalf.

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

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

HSA credit allocation may only change if there is a change in the employment status.

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

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

Payment of Claims

How Payments are Made

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

Carry Forward Type

Credit Carry Forward

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



Helpful Tip

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



Helpful Tip

View your HSA balance through the Medavie Mobile App or the Member Centre at www.medavie.bluecross.ca

Health Spending Account (HSA) Benefits

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

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

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

Exclusions and Limitations

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

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

Health Spending Account (HSA) Benefits

Common Eligible Expenses			
Attendant Care (requires certification of need from physician)	<ul style="list-style-type: none"> Services provided in Home, Retirement Home, Nursing Home or Group Home 	<ul style="list-style-type: none"> Includes Fees from: <ul style="list-style-type: none"> - Personal Care Worker - Registered Nurse - Respite Care 	<ul style="list-style-type: none"> Includes Fees for: <ul style="list-style-type: none"> - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	<ul style="list-style-type: none"> Diagnostic Services (x-rays) Dentures Orthodontic 	<ul style="list-style-type: none"> Preventive Services, such as: <ul style="list-style-type: none"> - Recall Examinations - Polishing - Application of Fluoride 	
Diagnostic Services*	<ul style="list-style-type: none"> Diagnostic laboratory, radiological tests and scans 		
Drugs	<ul style="list-style-type: none"> Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner* 	<ul style="list-style-type: none"> Fertility Treatments Flu Shots Insulin* Liver Extract Injections* 	<ul style="list-style-type: none"> Smoking Cessation Drugs* Vaccines Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	<ul style="list-style-type: none"> Convalescent care home Hospital Nursing home 	<ul style="list-style-type: none"> Psychiatric facility Substance abuse facility 	
Medical Devices and Services*	<ul style="list-style-type: none"> Air Conditioners (required for severe chronic ailment, disease or disorder) Artificial Eyes and Limbs Blood Transfusion Fees Breast Prosthesis Cochlear Implants Crutches Diabetic Supplies 	<ul style="list-style-type: none"> Electronic Bone Healing Devices Electronic Speech Synthesizers Hearing Aids Heart Monitoring Devices Needles and Syringes Ostomy Supplies Oxygen Equipment 	<ul style="list-style-type: none"> Physician Fees Prosthetics Repairs to Eligible HSA Devices Respirators Scoters Trusses Walkers Wheelchairs (excluding accessories)
Medical Practitioner Services	<ul style="list-style-type: none"> Acupuncturist Athletic Therapist Audiologist Chiropractist/Podiatrist Chiropractor Dental Hygienist Dentist 	<ul style="list-style-type: none"> Dietician Homeopath Massage Therapist** Naturopath Occupational Therapist Osteopath Personal Care Worker* 	<ul style="list-style-type: none"> Physiotherapist Psychiatrist Psychologist Registered Nurse Social Worker Speech Therapist
Medical Transportation Services	<ul style="list-style-type: none"> Ambulance Services Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses 	<ul style="list-style-type: none"> Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required) 	<ul style="list-style-type: none"> Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	<ul style="list-style-type: none"> Health and Dental Plan Premiums (private insurance) 	<ul style="list-style-type: none"> Home or Vehicle Modifications, when required for disabled persons 	<ul style="list-style-type: none"> Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	<ul style="list-style-type: none"> Lip Reading 	<ul style="list-style-type: none"> Sign Language 	
Vision Care	<ul style="list-style-type: none"> Contact Lenses Eye Examinations 	<ul style="list-style-type: none"> Laser Eye Surgery 	<ul style="list-style-type: none"> Prescription Lenses and Frames

*Prescription required

**For Therapeutic massage services only

Health Spending Account (HSA) Benefits

Common Ineligible Expenses			
Adoption Fees	<ul style="list-style-type: none"> Adoption Fees 		
Cosmetic Procedures (aimed at purely enhancing appearance)	<ul style="list-style-type: none"> Augmentations Botox Injections Liposuction 	<ul style="list-style-type: none"> Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions) 	<ul style="list-style-type: none"> Laser Hair Removal Tattoo Removal Teeth Whitening
Cosmetics and Hygiene Products	<ul style="list-style-type: none"> Contact Lens Solution Lotions and Creams 	<ul style="list-style-type: none"> Make-up Sunscreen 	<ul style="list-style-type: none"> Toothpaste
Dietary Supplements	<ul style="list-style-type: none"> Food (except when required for enteral feeding) 	<ul style="list-style-type: none"> Minerals and Supplements 	<ul style="list-style-type: none"> Meal Replacements
Esthetic Massage Therapy	<ul style="list-style-type: none"> Aromatherapy Massage 	<ul style="list-style-type: none"> Body Wraps 	
Fees for missed appointments	<ul style="list-style-type: none"> Fees for missed appointments 		
Health Programs	<ul style="list-style-type: none"> Weight loss program fees 		
Home Appliances	<ul style="list-style-type: none"> Air Conditioners Air Purifiers 	<ul style="list-style-type: none"> Dehumidifiers Fans 	<ul style="list-style-type: none"> Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	<ul style="list-style-type: none"> Hot Tubs 	<ul style="list-style-type: none"> Saunas 	
Life and Disability Plan Premiums	<ul style="list-style-type: none"> Life and Disability Plan Premiums 		
Over the counter medications	<ul style="list-style-type: none"> Acid Controllers Allergy Medications Cough and Cold Items 	<ul style="list-style-type: none"> Creams and Lotions Digestive Aids Herbal Remedies 	<ul style="list-style-type: none"> Pain Relievers Smoking Cessation Products Vitamins
Personal Response Systems	<ul style="list-style-type: none"> Lifeline Services 	<ul style="list-style-type: none"> Health Line Services 	
Shoes	<ul style="list-style-type: none"> Off the shelf 	<ul style="list-style-type: none"> Athletic 	
Sports Equipment	<ul style="list-style-type: none"> Treadmills 		

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. You must complete the group benefits application form within 60 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 60 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/removing a Dependent
- Status updates of a Dependent student
- Change in marital status
- Application for benefits previously waived

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Providing Proof of Claim

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

Blue Cross must approve your proof of claim and may require you to provide additional information and/or require you to undergo a medical examination by a physician or Health Professional 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.

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 (if applicable).

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 fraud schemes are 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.



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.



Helpful Tip

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

How You Can Help

As a group plan member, you can help us 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 make an essential contribution to our fraud deterrence efforts.

What Are My Rights Under the Plan?

Privacy

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

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

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 (if applicable), your application for benefits and any written statements or other record provided to Blue Cross as proof of your health. You may also request, with reasonable notice, a copy of the contract for Insured Benefits (if applicable).



Helpful Tip

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

Toll free: 1-866-876-9238

www.clearviewconnects.com



Helpful Tip

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

medaviebc.ca

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 pretenses 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 (if applicable) 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 in the following circumstances, subject to approval from the Plan Sponsor:

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

How to Submit a Claim

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

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

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

- **Member eClaims**
You can quickly and easily submit your health, drug, dental and health spending account claims (as applicable) through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.
- **Provider eClaims**
For Approved Providers who have registered to submit claims to Medavie Blue Cross through our electronic claims submission service, our e-claim service allows Approved Providers to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Medavie Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).
- **Medavie Benefits+**
Medavie Benefits+ is an all-inclusive health benefits and wellness centre that provides you with an opportunity to meet face-to-face with one of our Benefits+ Specialists. Our team is happy to answer your questions and demonstrate our digital, self-service tools at one of our smart kiosks.

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

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



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.

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

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



Helpful Tip

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

Connect with Blue Cross

Like us on Facebook at facebook.com/MedavieBlueCross

BLUE ADVANTAGE[®]

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

Connected Care

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

Health Connected[®]

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

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