My **Health** Benefit

HEALTH ASSOCIATION NOVA SCOTIA

Health Association Nova Scotia is a not-for-profit, non-government, membership-based association with over 60 years' experience in delivering shared services. Serving over 130 health and health-related organizations from across Nova Scotia, we are dedicated to achieving service excellence through innovation, outstanding performance, and an exceptional customer experience. One of our core service offerings is Group Benefits Solutions. We provide a range of comprehensive and cost-effective employee benefits plans, designed to help protect plan members and their families. We offer both mandatory and optional (voluntary) coverage. Your employer may offer all or some of the Health Association's benefits.

The Health Plan is a 'Self-Insured' plan of Health Association Nova Scotia. A Provincial Group Benefits Advisory Committee, comprised of equal Union and Employer representation from both health authority and continuing care sectors collaborate with Group Benefits Solutions.
Medavie Blue Cross provide Administration Services Only (ASO)

This is a summary of the Health Association Nova Scotia **Health Plan.** For more detailed information, visit our website at www.healthassociation.ns.ca or contact your Benefits Administrator. In the event of a discrepancy between this publication and the contracts, the contracts will prevail.

ELIGIBILITY – Who is eligible?

To be eligible, all plan members must have provincial health coverage.

If you have been hired as a **permanent employee** to work at least 40% of a regular work week, you are entitled to coverage for you, your spouse and dependents.

If you have been hired for a **term (temporary) position** for a period of no less than 12 months, to work at least 40% of a regular work week, you are entitled to coverage for you, your spouse and dependents.

Your spouse is defined as someone to whom you are married legally or common law (defined as having lived with your partner for 12 months or more; the 12 month cohabitation period is waived in the event a child is born of such relationship). This includes a spouse of the same sex.

Your dependent child is defined as an employee's or spouse's child who:

- is either under age 21 or under age 26 and a full-time student at an accredited school, college, or university; and
- is unmarried (legally or common law); and
- is not employed on a full-time basis; and
- is not eligible for benefits as an employee under this or any other group plan.

A child who is incapable of employment due to a mental or physical condition that occurred before reaching the maximum age will continue to be covered if approved by the insurance company.
Note: Dependents between ages 21 and 26 have the same coverage and restrictions as adults and not the same as dependents under age 21.

If you meet the eligibility requirements you MUST participate in this benefit unless you have other group or association plan coverage.

When will coverage begin?

NSH and IWK employees: Health Coverage starts the first of the pay period following the date of eligibility. If you are eligible on the first of the pay period, your coverage will start immediately.

All other employees: Health Coverage starts on first of the month following the date you are eligible. If you are eligible on the first of the month, your coverage will start immediately.

If your employer offers this benefit you must enrol unless you have other group or association plan coverage. You must provide proof of coverage elsewhere or you will be enrolled with single coverage.

When will coverage end?

NSH and IWK employees: Coverage ceases when you are no longer eligible, or the end of the pay period that your employment ends, or retirement, whichever comes first. Note: Prescription Drug Coverage for you and your spouse ceases at age 70.

All other employees: Coverage ceases when you are no longer eligible, or the end of the month that your employment ends, or retirement, whichever comes first. Note: Prescription Drug Cover for you and your spouse ceases at age 70.

Refer to "Continuation of Coverage" for Retiree Coverage

COVERAGE
What is Covered?

Prescription Drugs

The plan covers drugs that require a written prescription, have a drug identification number and are on the Medavie Blue Cross Managed Formulary (this list is subject to change without notice). *Prescription Drug Coverage for you and your spouse ceases at age 70.* An electronic drug look-up tool is available on the Medavie Blue Cross site or mobile app www.medaviebc.ca/app

For each prescription fill, you pay the dispensing fee up to $492 per family per calendar year, for the lowest priced alternative (typically a generic) drug covered under the managed drug formulary. Please show your Benefits Card to your pharmacist. If you do not have a card, please contact your employer or Group Benefits Solutions at 1-866-886-7246.

Prescription drugs are the biggest cost for your group plan. We manage the drug costs using the following strategies to support the plan members prescription drug needs and the sustainability of the plan.

Defined drug list: The formulary is made up of a list of clinically-effective and affordable prescription drugs that are used to treat most medical conditions. For drugs that are not covered by your plan, a suitable alternative can usually be found within the formulary that offer similar, equally-effective medical results and is available at a lower cost.

Prior Authorization: Certain Eligible Drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Prior Authorization id established by Medavie Blue Cross and may include requiring the Participant to participate in a Patient Support Program. The first time you present a prescription for an Eligible Drug on the Prior Authorization list your pharmacist will indicate the need for Prior Authorization. You and your physician must complete a Prior Authorization Prescription Drug Form and submit to Medavie Blue Cross You will receive confirmation in writing regarding the decision and if approved, this confirmation will include the effective date and duration of your approval.

Mandatory Drug Substitution (Lowest Cost Alternative): Your plan will pay up to the cost of the lowest-cost alternative, typically the generic drug, even if a brand name medication is dispensed. This means the Medavie Blue Cross Substitution Provision applies and an Interchangeable Drug has been prescribed, Medavie Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug. In the case of biologic drugs, Medavie Blue Cross reserves the right to reimburse to a less expensive biosimilar drug. Participants may request a higher cost Interchangeable Drug; however, they will be responsible for paying the difference in cost between the Interchangeable Drugs. For Participants with an adverse reaction to the Interchangeable Drug dispensed, Medavie Blue Cross will consider reimbursement to another Interchangeable Drug on a case by case basis only through the Prior Authorization process.

Step Therapy: For many conditions, such as high blood pressure, diabetes, gout, high cholesterol and depression, there are a number of equally safe and effective treatment options to choose from. Under Step Therapy, the plan will reimburse the cost of a therapeutic substitution by your pharmacist, making it easier for you to get proven safe and effective treatments in a way that can save money for you and your drug plan. For more information call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511. Alternatively, you can email your questions to inquiry@medavie.bluecross.ca or visit the website at www.medaviebc.ca

Exclusions and Limitations

Expenses associated with the following categories of drugs or services are not eligible for reimbursement, even when prescribed:

- injectable and oral vitamins;
- treatments for weight management, including proteins and food or dietary supplements;
- natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;
- hair growth stimulants;
- services, treatment or supplies that:
  - are not Medically Necessary;
  - are for cosmetic purposes only;
  - are elective in nature; or
  - have experimental or investigative indication;
- procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
- drugs that Medavie 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;
- 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;
- services, treatment or supplies the Participant receives free of charge;
- charges that would not have been incurred if no coverage existed;
- all forms of cannabis; or
- pharmacy services.

Vision Care

Eye Exams: Eye exams are reimbursed at the Medavie Blue Cross usual, customary and reasonable level. The total maximum eye exam (including retinal imaging) is once every two consecutive calendar years for you and your spouse, and once every consecutive calendar year for participants under age 21.

Lenses, Frames, Contact Lenses and Laser Eye Surgery: The Plan covers a total $345 every two calendar years for prescribed eyeglasses (frames and lenses), contact lenses, laser eye surgery, and intraocular lenses used in cataract surgery (once every calendar year for participants under age 21).

Visual Training: Visual training services are covered as required for the treatment of ocular muscle imbalance, or other medical condition(s) as approved by Medavie Blue Cross, to a lifetime maximum of $200 per person. These services are reimbursed at 100% of the eligible expense, as established and approved in advance by Medavie Blue Cross.

Certain approved providers may offer a pay direct arrangement. In such circumstances, the approved provider will submit the claim to Medavie Blue Cross electronically and you will only pay the provider the portion of the claim that is not covered by this benefit. If pay direct is not available, please refer to the How to Submit a Claim section of this document.

For more information call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511. Alternatively, you can email your questions to inquiry@medavie.bluecross.ca or visit the website at www.medaviebc.ca

Also, download the Medavie Blue Cross Mobile App by visiting www.medaviebc.ca/app

Paramedical Practitioners

Services are reimbursed at the insurers Usual, Customary and Reasonable level. Any amount over this is not covered.

Paramedical practitioners must be licensed and certified within their respective fields of expertise and validated/registered with Medavie Blue Cross. If your provider is not registered please contact us, Health Association Nova Scotia, and we can give direction to the paramedical practitioner.

The Plan covers up to the maximum $1,500 in each calendar year for the combined services of a:

- Acupuncturist
- Chiropractor
- Chiropodist or Podiatrist
- Homeopath
- Massage Therapist
- Naturopath
- Occupational Therapist
- Osteopath
- Physiotherapist
- Dietician
- Speech Therapist

The Plan covers up to the maximum $1,800 in each calendar year for the combined services of a:

- Counselling Therapist
- Psychologist
- Psychotherapist
- Social Worker

The Plan does not cover charges for any treatment performed in a hospital or covered under your provincial health plan.

There is a calendar year maximum of $35 per practitioner for x-rays.

Note:

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

- consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
- in the opinion of Medavie 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.

Other Eligible Supplies and Services

- Semi-private or private hospital room coverage.
- Professional ambulance, to nearest hospital , to a maximum of $1,000 in a calendar year.
- Private duty nursing, to a maximum of $10,000 in a calendar year (treatment plan must be submitted).
- Diagnostic X-ray services.
- Oxygen.
- Accidental dental treatment (treatment plan must be submitted within 180 days of the accident).
- Diabetic supplies (can use benefits drug card)
- Diabetic equipment, to a maximum of $700 in five calendar years (see medical supplies and equipment for insulin pumps).
- For insulin dependent plan members:continuous glucose monitoring (CGM) receivers, transmitters or sensors
- Ostomy supplies (can use benefits drug card)
- Speech aids, to a lifetime maximum of $500.
- Prosthetic/Remedial appliances or supplies. This coverage is limited to one each per limb per lifetime. Some maximums and limits may apply. Repairs and adjustments are subject to a maximum of $300 in a calendar year. Replacement requires a pathological or physiological change in order to be eligible.
- Hearing aids (one for each ear) to a maximum of $1,000 per hearing aid over three calendar years (includes batteries and repairs). Excludes hearing tests.
- Durable Medical equipment: rental or, when approved by Medavie Blue Cross, the purchase of:
  - manual or electric wheelchair, including cushions and inserts;
  - manual or electric hospital bed, including mattress & safety side rails;
  - equipment for the administration of oxygen, nebulizer, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
  - BiPAP and CPAP supplies to a maximum of $150 per calendar year;
  - insulin pump for theTreatment of type 1 diabetes;
  - compression pump, traction equipment;
  - patient lifter.

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

- Medical Supplies: includes but not limited to:
  - compression pumps, continuous passive motion machines up to a maximum of $4,500 every 5 consecutive calendar years or rental cost up to a maximum of $450 per 5 consecutive calendar months,
  - TENS machines to a maximum of $300 in 5 consecutive calendar years, and
  - medicated dressings & burn garments up to a maximum of $500 per calendar year.
- Stock item orthopaedic shoes which have been modified (recommendation of a physician or podiatrist required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of $200 per calendar year for adults, and $300 per calendar year for employees and dependents under age 21.
- Casted, custom-made orthotics, up to a maximum of $300 per three calendar years for adults, and $400 per one calendar year for employees and dependents under age 21 (recommendation by a physician or podiatrist required).
- Allergy serums: Covered 100%. Please note, antihistamines available over the counter are not covered.
- Vaccines are covered at 50% up to a lifetime maximum of $500. Some exclusions apply.
- Surgical stockings and support stockings: to a maximum of $200 in a calendar year. Prescription required.
- Foot care services provided by registered nurse in a foot care clinic to a maximum of $25 per visit up to $300 per person in a calendar year.
- Clinical measurement services related to biometrics to measure blood pressure, sugar levels, cholesterol, weight etc. Available only to the plan member. The maximum benefit is $100 per person in a year.
- Smoking cessation products: nicotine patches, nicotine gum, prescription medications, inhalers, and nicotine-free prescription medicine up to a combined maximum of $500 per person every 24 months. Prescription required.
- Weight management drugs: $5,000 in a calendar year, subject to prior authorization and annual re-qualification.
- Fertility medication: $15,000 lifetime max.
- Sexual dysfunction: $1,200 in a calendar year
- Gender Affirmation Benefits: $10,000 per calendar year with a $20,000 lifetime maximum. This benefit provides supplemental coverage to government funded programs. The program provides coverage for masculinization or feminization treatments and procedures following gender transitioning surgery. For more information call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511.

<u>Exclusions and Limitations</u>

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

- services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
- 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;
- 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;
- services, treatment or supplies that the Participant receives free of charge;
- charges that would not have been incurred if no coverage existed;
- services, treatment or supplies that are:
- not Medically Necessary;
- for cosmetic purposes only;
- elective in nature; or
- experimental or investigative.
- all services relating to family planning (unless specifically listed as covered), 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;
- services or supplies normally intended for recreation or sports;
- extra supplies that are spares or alternates;
- charges for missed appointments or the completion of forms;

Exclusions and Limitations/Continued...

- medical examinations or routine general check-ups;
- Treatment related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
- mileage or delivery charges to or from a Hospital or Health Practitioner; or
- services or expenses incurred as a result of:
- insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
- participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained.

Plan Member Resources

Plan Member Secure 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 MBC 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

Register at www.medaviebc.ca and log in.

Medavie Blue Cross Mobile App

Plan members can download the Mobile App for iOS and Android devices.

- Coverage inquiry: Detailed information about your group benefits plan;
- Submit a claim just by taking a photo
- Use and share a mobile ID card
- Search benefit/coverage details
- View past claims
- Find a health professional near you
- Get reminders on when to take and refill your medications

Download the app at www.medaviebc.ca/app

My Good Health®

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

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

Savings are available to Medavie Blue Cross Members across Canada. To take advantage of these savings, simply present your Medavie 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

CLAIMING

How do I make a claim?

Pharmacy Submit:

You typically do not have to submit claims for prescription drugs. You need to present your pharmacist with your benefit card to pay your "co-pay" amount at the pharmacy. The pharmacy submits for the remainder of the claim. For prescription drug claims not processed by the pharmacy, you submit directly to Medavie Blue Cross. If you choose not to use your benefit card at the pharmacy and you submit to Medavie Blue Cross a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Medavie Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

At age 70, your Medavie Blue Cross card cannot be used to pay for Ostomy supplies, Diabetic supplies, or vaccines; you must submit a claim for reimbursement.

Provider eClaims

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

Member eClaims

You can quickly and easily submit your health, drug and dental claims (as applicable) through the Medavie Blue Cross 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 the plan member website.

Mobile App

Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account. Visit www.medaviebc.ca/app for more information or to download the app.

Medavie Benefits (kiosk)

Located in Scotia Square at 1894 Barrington Street
Check with Medavie Blue Cross for service hours.

- Chat with a Medavie Benefits Speciality
- Benefit/coverage inquiries
- Onsite assistance/support self service tools (mobile app, submit a claims)

By Mail

You can also mail your completed claim form to the nearest Medavie Blue Cross office
Medavie Blue Cross, Barrington Tower, Scotia Square, 1894 Barrington St, Halifax, Nova Scotia B3J 2A8

Note:

Time Limit to Submit a Claim: Medavie Blue Cross must receive proof of claim within 18 months of the date the Eligible Expense was incurred.

All purchases and acquisition of services must be made in Canada. The only exception is the online purchase of glasses or contact lenses.

For assistance call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511.
Alternatively, you can email your questions to inquiry@medavie.bluecross.ca or visit the website at www.medaviebc.ca

Also, download the Medavie Blue Cross Mobile App by visiting www.medaviebc.ca/app

COORDINATION OF BENEFITS

What if my spouse also has coverage?

Canadian insurance companies follow a process called Coordination of Benefits (CoB) when a plan member is covered under more than one health and/or dental plan. CoB ensures you receive the maximum benefit available from your policies. In fact, two policies can be combined to give you up to 100% reimbursement of eligible claims.

When you are covered under your plan and under a spouse's plan, here's how Coordination of Benefits works:

1. Submit **your** expenses first to your benefits plan. You can then submit any unpaid portion of your claim to your spouse's plan.

2. Submit **your spouse's** expenses first to your spouse's benefits plan. You can then submit any unpaid portion of your spouse's claim to your plan.

3. If **your dependent children** are covered under your and your spouse's benefit plans, you must submit all their claims first to the benefit plan of the parent whose birth date falls earliest in the calendar year (the month, then day). Any remaining balance can then be reimbursed from the other plan. When parents are separated or divorced, the custodial parent claims under his or her plan first, then their spouse's plan (where applicable), then the plan of the parent without custody, and then their spouse's plan.

4. When you submit a claim for an unpaid balance from another insurance company, you plan will need a copy of the receipt and a copy of the statement (Explanation of Benefits E0B) showing the portion of the claim paid by the other company. Although you have 18 months to claim any remaining balances, your receipts should be submitted as soon as possible.

If you need help determining the order claims should be submitted, call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511. Alternatively, you can email your questions to inquiry@medavie.bluecross.ca or visit our website at www.medaviebc.ca

If you are covered by more than one plan, please call Health Association Nova Scotia toll-free at 1-866-886-7246 regarding any changes or updates to your Coordination of Benefits information.

If your family has more than one plan, you can coordinate benefits.
Find more information by visiting www.healthassociation.ns.ca and check out Benefits Communication to view our benefits information sheets.

CONTINUATION OF COVERAGE

What happens during a leave of absence?

If you take an approved paid leave of absence, you must continue coverage for up to 12 months.

If you take an approved unpaid leave of absence, you may continue for up to 12 months. If you take an approved maternity or parental leave, you may continue for the duration of the leave. If you choose not to continue the benefit during your leave, coverage is reinstated on your return to work.

If you are approved for benefit for your employer sponsored Long Term Disability plan you may continue benefits.

For cost sharing arrangements, please check your collective agreement or contact your employer for more details.

What happens If I lose coverage under another plan?

If you had opted-out of the health plan because you were covered under another plan, you may join the HANS Health and/or Dental plan within 60 days of losing the coverage. To be approved for family coverage after 60 days you will be required to provide medical evidence of insurability.

What happens to coverage when I turn age 65?

Your coverage does not change. We do recommend you contact Nova Scotia Seniors' Pharmacare Program when you turn 65 and notify them you have drug coverage under your employers group plan. If eligible, this will assist with a smooth transition to the Seniors' Pharmacare program when you are no longer covered for prescription drugs under this plan.

What happens to my coverage when I turn age 70.

Your prescription drug coverage ceases. Your premiums may be lower. In advance of losing drug coverage under our plan, you should contact the Nova Scotia Senior's Pharmacare Program at 902-429-6565 or toll free at 1-800-544-6191 for more information.

What happens to coverage if I die before retirement?

In the event of your death before retirement, your eligible spouse and eligible dependent children may continue their coverage for up to 24 months after your death. No premiums are required for this coverage.

What happens to my coverage when I retire?

You may be eligible for retiree benefits. Please check out the Retiree Benefits page of our website. Please contact your Benefits Administrator for more clarification.

Can I convert my coverage?

You may choose to convert your coverage to an individual policy within 31 days of your coverage ending. To convert to a health insurance plan, members can call Medavie Blue Cross toll-free at 1-800-873-2583. You can also visit their corporate website at https://www.medaviebc.ca/en/plans/moving-off-an-employers-plan

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Emergency Travel Coverage

Employees of the Health Association Nova Scotia Health Plan (and families of those with family coverage) are covered in case of a medical emergency on a trip outside your province of residence or outside Canada. Travel Coverage ceases at retirement. A medical emergency means it is unexpected and not preplanned.

For further details on the Emergency Travel Benefits, please visit www.healthassociation.ns.ca,

Questions?

If you have any questions about your benefits, talk to your Benefits Administrator (Employer) or contact Health Association Nova Scotia.

Group Benefits Solutions
Health Association Nova Scotia
2 Dartmouth Road, Bedford, Nova Scotia B4A 2K7
Toll-free: 1-866-886-7246

For more information, visit www.healthassociation.ns.ca and select the Benefits Plan Member Information button

Note: This plan may be referred to as Health or Extended Health. The reference to "extended" refers to the fact that it is health benefits over what a Canadian would be covered for under their provincial health plan.
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