Samuel, Son & Co., Limited

Harmony Level 2

Group Plan Number:
90146

Effective Date:
November 1, 2022

Advisor:
AGA Benefit Solutions

MEDAVIE BLUE CROSS™

Welcome to your Group Benefits Plan

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

In this plan, drug, extended health and dental benefits are self-insured by the plan sponsor and are administered by AGA Benefit Solutions, hereafter called AGA. 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 75 years. Our core purpose is to help improve the health and well-being of people and their communities.

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

About this Booklet

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

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

Helpful Tip

Take a tour in the AGA website at
https://adherents.aga.ca/en/

Your booklet is divided into the following sections:

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

Helpful Tips: Throughout this booklet we provide useful tips to help you better understand and get the most out of your group benefits.

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Summary of Benefits

Drug Benefit

Deductible	None
Reimbursement Level*	70%**
Overall Benefit Maximum	$45,000/Plan Year
Dispensing Fee Maximum	$7/prescription Not applicable to Quebec Participants
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes (Quebec Members only)
Days Supply	100-days maximum supply (1-month supply may apply to some drugs)
Drug Formulary	
Specialty High Cost Drugs	Telus Complete Formulary
All Other Eligible Drugs	Telus Complete Formulary
Plan Management Features	
Substitution Provision	Mandatory Generic Substitution
Additional Benefit Modules	**Benefit Maximum**
Smoking Cessation Aids	$500/lifetime*** Prescription and over-the-counter products (including natural health products)
Vaccines (including injection service when administered by a pharmacist)	Included***
Termination	When the Member's employment terminates or when they retire (whichever occurs earlier)
Survivor Coverage	24 months

*For Quebec Participants, reimbursement for pharmacy services and the out-of-pocket maximum meet the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Out-of-pocket maximum of $1,500 per Participant/family per Plan Year.

***Subject to the Overall Benefit Maximum.

Summary of Benefits

Extended Health Care

Deductible	
Hospitalization	None
Vision Care	None
All Other Extended Health Care	None

	Reimbursemen Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Convalescent Care/Physical Rehabilitation	100%		
Chronic Care	100%	$25/day	
Drug and Alcohol Rehabilitation	100%	$10,000/lifetime	
Medical Services and Supplies			
Ambulance Transportation	70%		
Nursing Care	70%	$5,000/12 consecutive months/condition	
Health Practitioners:		**Maximum per calendar year**	
Psychologist/Social Worker/Counselling Therapist/Psychoeducator/Psychotherapist (combined)	70%	$1,000	
Chiropractor (including X-rays)	70%	$325	
Naturopath	70%	$250	
Acupuncturist	70%	$250	
Dietitian	70%	$250	
Osteopath (including X-rays)	70%	$250	
Podiatrist/Chiropodist (combined, including X-rays)	70%	$250	
Audiologist	70%	$250	
Speech Therapist	70%	$250	
Occupational Therapist	70%	$250	
Physiotherapist	70%	$325	
Massage Therapist	70%	$325	

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*		
Wheelchair (including cushions and inserts)	70%	See benefit details
Hospital Bed (including mattress and safety side rails)	70%	See benefit details
Equipment for Administration of Oxygen	70%	See benefit details
Percussor	70%	See benefit details
Suction Pump	70%	See benefit details
Bi-level Positive Air Pressure (BiPAP)	70%	See benefit details
Continuous Positive Airway Pressure (CPAP)	70%	See benefit details
Ventilator	70%	See benefit details
Compression Pump (purchase)	70%	$1,500/lifetime
Traction Equipment	70%	See benefit details
Patient Lifter (purchase)	70%	1/5 calendar years to a maximum of $2,000/lifter
Mobility Aids and Orthopedic Appliances		
Canes/Crutches (purchase)	70%	2/lifetime
Canes/Crutches (rental)	70%	1/month
Walking Aids (purchase)	70%	1/5 calendar years
Walking Aids (rental)	70%	1/month
Casts/Splints (purchase)	70%	See benefit details
Casts/Splints (rental)	70%	1/month
Trusses (purchase)	70%	1/5 calendar years
Trusses (repairs/adjustments)	70%	$300/calendar year
Braces (purchase)	70%	1/lifetime
Braces (rental)	70%	1/month
Braces (repairs/adjustments)	70%	$300/calendar year
Cervical Collars	70%	See benefit details

*Pre-authorization required.

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Prostheses		
Standard Artificial Limbs	70%	See benefit details
Myoelectric Limbs	70%	1/limb/lifetime to a maximum of $10,000/limb
Artificial Eyes	70%	See benefit details
Artificial Nose	70%	See benefit details
Breast Prosthesis	70%	1/12 consecutive months
Wigs	70%	$750/lifetime
Diabetic Equipment		
Glucometer	70%	1/48 consecutive months
Glucose Monitoring Systems	70%	$4,000/calendar year
Other Diabetic Equipment	70%	See benefit details
Hearing Aids	100%	$400/36 consecutive months
Custom Orthopedic Shoes/Custom Made Foot Orthotics (combined)	70%	$400/calendar year
Diagnostic Tests	70%	See benefit details
Other Medical Services and Supplies		
Allergy Testing Materials	70%	$50/calendar year
Artificial Larynx (purchase)	70%	1/lifetime
Artificial Larynx (repair)	70%	$300/calendar year
Burn Pressure Garments	70%	$500/calendar year
Graduated Compression Garments (including stockings)	70%	$500/calendar year
Ostomy Supplies/Catheters/Catheterization Supplies	70%	See benefit details
Oxygen	70%	See benefit details
Speech Aid Equipment	70%	$500/lifetime
Sleeves for Lymphedema	70%	2/calendar year
Surgical Brassieres	70%	2/calendar year
Transcutaneous Electrical Nerve Stimulator (TENS) Device	70%	$700/lifetime
Visual Training and Remedial Eye Exercises	70%	$150/lifetime
Contact Lenses due to an Illness	70%	$200/24 consecutive months
Accidental Dental	100%	Predetermination of claim required

Summary of Benefits

Extended Health Care

Vision Care	Reimbursement Benefit Maximum Level	
Eye Examination	100%	$75/24 consecutive months/12 consecutive months for a Participant under age 19
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	100%	$225/24 consecutive months/12 consecutive months for a Participant under age 19
Termination	When the Member's employment terminates or when they retire (whichever occurs earlier)	
Survivor Coverage	24 months	

Summary of Benefits

Dental Benefit

Deductible	None
Fee Guide Schedule	Current year less 1 year/Province of Provider (Specialist fees paid at General Practitioner rate)

	Reimbursement Level	Benefit Maximum
Preventive Care	100%	$1,800/calendar year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		2/12 consecutive months
Preventive Treatment		
Polishing of teeth		2/12 consecutive months
Fluoride treatment		2/12 consecutive months
Scaling		8 Units/12 consecutive months (combined with Root Planing)
Basic Care	80%	$1,800/calendar year combined with Preventive Care and Major Restoration
Endodontic Services		Included
Periodontic Services		Included
Root Planing		8 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$1,800/calendar year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services		See benefit details
Restorations on implants		1/tooth every 10 calendar years
Orthodontic Services	50%	$1,500/lifetime (Participants under age 19)

Lowest Cost Alternative Benefit	Inlays and crowns Bridgework
Termination	When the Member's employment terminates or when they retire (whichever occurs earlier)
Survivor Coverage	24 months

Summary of Benefits

Travel Benefit

Deductible	None
Reimbursement Level	100%
Coverage Duration*	
Under age 75	First 180 days of Trip outside province of residence
Age 75 and over	First 60 days of Trip outside province of residence
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$5,000,000/Participant/Incident**
Worldwide Travel Assistance	Yes
Referral Outside of Canada* **	$500,000/Participant/lifetime
Termination	When the Member's employment terminates or when they retire (whichever occurs earlier)
Survivor Coverage	24 months

*Coverage duration will be determined based on the age of the Participant on their departure date.

**Incident: An individual occurrence of Emergency illness or injury.

***Pre-authorization required.

You and Your Dependents

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

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

Employee: A person who:

- resides in Canada; and
- works a minimum of 25 hours per week for the employer.

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

Dependent: Your Spouse or Child.

Spouse: A person who:

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

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

Child: A person who:

- resides in Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:

  a) is under age 22;
  b) is under age 26 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

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

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

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.

Helpful Tip

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

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

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

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

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

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

Helpful Tip

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

Activities of Daily Living: The following 6 activities:

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

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

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

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

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

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

Helpful Tip

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

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

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

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

Helpful Tip

Family member refers to a Participant's:

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

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

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

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

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

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

Insured Benefits: Benefits underwritten and administered by Medavie Inc. which assumes all liability for their payment. In this plan, travel benefit is an Insured Benefit.

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

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

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

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

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

Helpful Tip

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

Plan Year: The period of time beginning on the first day of January in a given year and ending on the last day of December.

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

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

Self-Insured Benefits: Benefits that are:

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

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

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

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

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

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

Who is Eligible for Coverage?

You are eligible for coverage on the **first day of the month following a complete month of employment** if you meet the definition of Employee and are Actively at Work. 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.

Helpful Tip

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

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

You do not need to provide proof of health to obtain group benefits coverage.

How do I Enroll for Coverage?

Application

Please complete online enrollment within your first 30 days of employment using Connect. Contact your Human Resources Business Partner with any further questions.

Can I Opt Out of Coverage for Certain Benefits?

Application for coverage is mandatory. You are not allowed to individually select the benefits you want under the plan. In addition, when you enroll for coverage you must also enroll all of your eligible Dependents. You are allowed to waive the health benefits coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. In this case, a proof of similar coverage under another group policy is mandatory and you or your Dependents will again be eligible for health benefits if you experience a Life Event.

Helpful Tip

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

When Does Coverage Begin?

Employees

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

- the effective date of the plan; or
- the date you meet all of the eligibility requirements.

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

Helpful Tip

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

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

Illness/Accident

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

Maternity Leave/Parental Leave

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

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

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

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

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

When Does Coverage End?

Coverage ends on the earliest of the date:

- the plan terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your Spouse no longer meets the definition of Spouse;
- your Child no longer meets the definition of Child;
  your employment is terminated;
- you or your Dependents reach the termination age or termination date, if any, specified in the
- Summary of Benefits;
- you retire, 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 or the plan sponsor defaults in payment of premiums.

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

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

Helpful Tip

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

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

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

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

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

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

- 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 for certain benefits, if specified in the Summary of Benefits.

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

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

What if I Have Coverage Elsewhere?

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

Government Health Care Coverage

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

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

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

Helpful Tip

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

Other Health Plans

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

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

Helpful Tip

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

Expenses for Yourself:

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

Expenses for Your Spouse:

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

Helpful Tip

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

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.

Drug Benefit

Purpose of Coverage

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

Additional Definitions

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

Eligible Drug: A drug that is:

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

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

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

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

- are considered pharmaceutical equivalents by Health Canada;
- contain the same active ingredients; and
- are administered in the same way.

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

Over-the-counter: Medicines are drugs you can buy without a prescription.

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

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

What AGA Will Pay

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

- payment is limited to the reimbursement level and the benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
  - Prior Authorization; or
  - co-ordination with Patient Support Programs;
- payment for a Specialty High Cost Drug may be reduced by the amount of financial assistance available under a Patient Support Program;

- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit;
- payment for biologic drugs may be limited to the cost of a biosimilar drug as determined by Blue
- Cross; payment for Eligible Drugs not dispensed by an approved retail pharmacy will be limited to a pricing schedule as determined by Blue Cross; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

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

- diabetic supplies, including test strips, lancets, needles and syringes but excluding insulin pump
- supplies;
- viscosupplementation injections;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formularies:

Specialty High Cost Drugs:

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

All Other Eligible Drugs:

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

Helpful Tip

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

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

Prior Authorization

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

How does the Prior Authorization process affect my claim?

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

You can request a Prior Authorization Prescription Drug Form from your pharmacy, your employer, the AGA customer information centre or from AGA 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 AGA office.

Helpful Tip

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

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

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

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

Plan Management Features

Substitution Provision

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

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

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

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

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.

Payment of Claims

How Payments are Made

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

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

Helpful Tip

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

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

Time Limit to Submit a Claim

AGA must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

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

a) varicose vein injections;
b) injectable and oral vitamins;
c) treatments for weight loss, including drugs, proteins and food or dietary supplements;
d) natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;
e) fertility drugs;
f) sexual dysfunction drugs;
g) hair growth stimulants;
h) services, treatment or supplies that:
   i. are not Medically Necessary;

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.

ii. are for cosmetic purposes only;
iii. are elective in nature; or
iv. have experimental or investigative indication;

i) procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
j) 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;
k) 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;
l) services, treatment or supplies the Participant receives free of charge;
m) charges that would not have been incurred if no coverage existed;
n) drugs that are eligible under the travel benefit provided by the group plan (if applicable);
o) all forms of cannabis; and
p) pharmacy services.

Right to Convert to Individual Coverage

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

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

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

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

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

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

Out-of-pocket Maximum per Plan Year

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

Participants Age 65 Years and Over

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

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

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

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

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

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

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

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

Purpose of Coverage

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

Additional Definitions

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

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

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

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

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

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

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

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

Drug and Alcohol Rehabilitation Facility: An establishment that provides rehabilitation for drug addiction, alcohol addiction, or both. The establishment must be licensed by the appropriate government body and be operated in accordance with the applicable laws within its jurisdiction.

Drug and Alcohol Rehabilitation Facilities do not include rest homes, maternity homes, nursing homes, retirement homes, residential and long-term care centres, or facilities intended for custodial care, physical rehabilitation or mental illness.

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

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

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

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

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

What AGA Will Pay

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

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

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

Hospitalization

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

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

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

Drug and Alcohol Rehabilitation: Room accommodation when a Participant is admitted to a Drug and Alcohol Rehabilitation Facility for drug addiction, alcohol addiction, or both.

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

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

Medical Services and Supplies

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

This coverage excludes inter-Hospital transfers.

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

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

Helpful Tip

Before receiving nursing services you should obtain pre-approval from the Insurer by contacting the toll-free number listed at the end of this booklet.

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

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

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

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

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

This coverage excludes:

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

Helpful Tip

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

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

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

Helpful Tip

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

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

If there is a long-term need for equipment due to extended illness or disability, Blue Cross may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment is limited to the Usual, Customary and Reasonable charges for the equipment, unless otherwise specified in the Summary of Benefits.

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

This coverage excludes charges for special mattresses and air conditioning or air purifying equipment.

Mobility Aids and Orthopedic Appliances: Charges for the purchase or rental of crutches, canes and walking aids, casts, splints, trusses, braces and cervical collars.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs;
- myoelectric limbs to a maximum of 1 per limb per lifetime and of $10,000 per limb;
- artificial eyes;
- artificial nose;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per 12 consecutive months; and
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of $750 per lifetime.

Repair or adjustments of eligible prosthetic appliances are covered.

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 the following diabetic equipment:

- glucometer;
- glucose monitoring systems: continuous glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes; and
- other diabetic equipment: 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.

This coverage excludes pressurized insulin injectors and insulin pumps.

Diabetic supplies are eligible under the drug benefit.

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

This coverage excludes batteries and exams.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

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

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

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

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

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

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

- allergy testing materials to a maximum of $50 per calendar year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per calendar year;
- burn pressure garments to a maximum of $500 per calendar year;
- graduated compression garments (including stockings) to a maximum of $500 per calendar year;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;

- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of 2 per calendar year;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $700 per lifetime; visual
- training and remedial eye exercises performed by an ophthalmologist or optometrist to a maximum of $150 per lifetime; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of $200 per 24 consecutive months. The contact lenses must improve sight to at least 20/40 and this level of improvement must not be possible with eyeglass lenses.

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

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

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a
- fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the employer;
- initiated within 180 days of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for
- approval within that period; and
performed within 2 years of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

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

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

Vision Care

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

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

- corrective eyeglasses (frames and lenses) and contact lenses;
- laser eye surgery; and
- intraocular lenses used in cataract surgery.

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

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. AGA 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 AGA 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. AGA 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. AGA 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. AGA 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 AGA, subject to any Benefit Maximums applicable.

Time Limit to Submit a Claim

AGA must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

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

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

Right to Convert to Individual Coverage

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

Purpose of Coverage

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

Helpful Tip

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

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

Additional Definition

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

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

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

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

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

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.

What AGA Will Pay

AGA 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 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 60% of the amount indicated in the provider fee guide for the dental service provided;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;
  - a licensed denturist when the services are within the scope of their profession; or
  - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

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

Helpful Tip

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.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

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

X-rays: Charges for:

- complete series to a maximum of 1 per 3 calendar years;
- panoramic to a maximum of 1 per 3 calendar years;
- intra-oral:
  - periapical; and
  - occlusal and bitewings to a maximum of 1 procedure 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;
- oral hygiene instruction to a maximum of 1 Unit per lifetime;
- pit and fissure sealants (limited to Participants under age 18);
- scaling; and
- space maintainers (limited to Participants under age 18).

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

Basic Care

Restorations: Charges for:

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

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

Endodontic Services: Charges for:

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

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

Periodontic Services: Charges for:

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

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

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments;

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

Oral Surgery: Charges for:

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

General adjunctive services: Charges for:

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

Major Restoration

Extensive Restorations: Charges for:

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

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

Other Restorative Services: Charges for:

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

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 calendar years;
- bridgework to a maximum of 1 per tooth per 5 calendar years;
- restorations on implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per tooth per 10 calendar years, if specified in the Summary of Benefits; and
- initial construction and insertion of an initial permanent denture or bridgework if necessary due to the extraction of at least 1 natural tooth while covered under this benefit.

Helpful Tip

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

Orthodontic Services

Charges for:

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

Helpful Tip

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

Payment of Claims

How Payments are Made

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

- pay the portion of the claim that is not covered by this benefit and AGA 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 AGA.

Time Limit to Submit a Claim

AGA must receive proof of claim within 12 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 AGA, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

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

Date of Treatment

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

Exclusions and Limitations

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

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) anti-snoring or sleep apnea devices;
g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
h) services, treatment or supplies that are:
    i. not Medically Necessary (except for Preventive Care services);
    ii. for cosmetic purposes only; or
    iii. experimental or investigative;
i) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
j) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;

k) services that are eligible under the extended health care (if applicable);
l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
m) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) veneers;
o) implants and related services;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

Purpose of Coverage

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.

Emergency: a sudden and unexpected illness or injury that requires immediate medical Treatment due to:

- an injury resulting from an accident;
- a new medical condition which begins during a Trip; or
- a medical condition that existed prior to a Trip provided that it is not part of an established treatment program.

Hospital: A facility that:

- is licensed as an accredited hospital outside of the Participant's province of residence;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by Blue Cross.

Immediate Family Member: A Participant's parents, spouse, child, brother or sister.

Incident: An individual occurrence of Emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the Participant. No more than 3 persons can qualify as a Travel Companion for any given Trip.

Trip: Travel outside of the Participant's province of residence.

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 Travel insurance confirmation and the assistance card that is available to you on the AGA member portal.

Hospitalization: Charges for Hospital room accommodation (not a suite of rooms) and for Medically Necessary inpatient and outpatient services.

Physician Fees: Fees charged for physician or surgeon services.

Medical Appliances: The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

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.

Diagnostic Services: Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

Drugs: The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of the Trip. The Participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the Participant;
- the date of purchase;
- the name of the medication;
- the Drug Identification Number, if available;
- the quantity and strength of the drug; and
- the total cost.

Paramedical Services: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for Treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;
b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or
c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

With respect to Treatment under categories (a) or (b):

- Treatment must begin while the Participant is covered by this benefit and end within 6 months of the accident, unless deferred Treatment is approved by Blue Cross due to the age of the Participant; and the maximum reimbursement per Participant per Incident is $2,000.

With respect to Treatment under category (c), the maximum reimbursement per Participant per Incident is $200.

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.

Repatriation to the Province of Residence: The cost of repatriating the Participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the plan. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- economy fare to the Participant's home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Participant is not possible for medical reasons considered acceptable by Blue Cross, Blue Cross may require repatriation of any Participant or transfer to other medical facilities. If the Participant refuses repatriation or transfer, all rights to benefits in relation to the Incident are terminated.

Transportation to Visit the Participant: The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to the Hospital where the Participant has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. Blue Cross may waive the 7 day waiting period if Blue Cross is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to identify the body of the Participant, if deceased.

Vehicle Return: The fees charged by a commercial agency to return the Participant's vehicle, whether private or rental, to the Participant's residence or to the nearest appropriate vehicle-rental agency, when the Participant is unable to drive as a result of an Emergency illness or injury. A medical certificate from the attending physician confirming the Participant's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

Return of the Deceased: The cost of preparing and transporting the remains of the deceased Participant to their province of residence to a maximum of $5,000.

Meals and Accommodation: The cost of commercial accommodation and meals when the Participant's travel is delayed due to an Emergency illness or injury 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 Incident).

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;
- 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, including 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.

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.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage, and Referral Outside of Canada: Blue Cross must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

Blue Cross will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts Blue Cross would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within 4 months of the date the expense was incurred.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

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

a) the Participant fails to communicate with Blue Cross in the event of medical consultation or hospitalization following an injury or illness;
b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
c) the purpose of the Trip is primarily or incidentally 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;
d) expenses have already been paid or are eligible for refund from a third party;
e) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning to avoid all travel or avoid non-essential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or
f) expenses are incurred as a result of:
    i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
    ii. an illness or injury that occurred while operating a vehicle under the influence of drugs (including marijuana) or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;
    iii. an injury or illness resulting from non-compliance with medical treatment or therapy that has been prescribed;
    iv. suicide, attempted suicide or voluntary injury or illness; or
    v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

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 pregnancy complications that occur within 8 weeks of the expected date of delivery; or
c) expenses incurred due to an Emergency that occurs while participating in:
    i. a sport for remuneration;
    ii. a motor vehicle or speed contest of any kind; or
    iii. any Extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

Referral Outside of Canada

No payment will be made for:

a) services available in Canada;
b) health care services or treatments unavailable in Canada due to waiting lists;
c) health care services or treatments that physicians in Canada have refused to perform;
d) services, treatment or supplies that are experimental or investigative;
e) services provided while the Participant is not under the Treatment of a physician; and
f) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition means an illness:

- that begins within 12 months of the date the Participant obtained coverage under this benefit; and

- for which, in the 12 month before the date the Participant obtained coverage under this benefit, the Participant has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

What Are My Responsibilities Under the Plan?

Keeping Your Employer Informed

It is your responsibility to provide your employer with a completed and signed application form, including accurate information on your family status, as well as your beneficiary designations. You must complete the group benefits application form within 31 days from the date you become eligible for coverage.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Changes that must be reported to your employer include:

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

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Providing Proof of Claim

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

- AGA for Drug, Extended Health Care and Dental benefits (if applicable); or
- Blue Cross for all other benefits.

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.

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

If this plan has terminated, proof of claim for the Insured Benefit must be received by Blue Cross within 90 days following the termination date of this group plan.

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 or AGA, as appropriate, is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross or AGA, as appropriate.

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

Reporting Health Insurance Fraud

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

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

How You Can Help

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

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

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

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

Helpful Tip

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

Toll free: 1-866-876-9238

www.clearviewconnects.com

What Are My Rights Under the Plan?

Privacy

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

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

What is personal information?

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

How is Your Personal Information Used?

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

To Whom Could This Personal Information be Disclosed?

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

- specialized health care professionals when required to assess benefit eligibility;
- government and regulatory authorities in an emergency situation or where required by law;
- other third parties, on a confidential basis, when required to administer your benefits; or the plan member in any contract under which you are a participant.

Helpful Tip

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

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

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

Disputing a Claim Decision

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

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

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

Copy of the Group Plan

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

The Rights of Blue Cross and AGA Under the Plan

Right to Audit

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

Helpful Tip

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

Recovery of Overpaid Amounts

Blue Cross and AGA have the right to recover from a Participant:

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

Blue Cross and AGA have the right to reduce future benefit payments to the Participant until the excess amount is fully recovered.

Termination or Suspension of Benefit Payments

Blue Cross or AGA may, without prior notice, suspend or terminate the rights and benefits of a Participant in the following circumstances:

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

Blue Cross or AGA also have the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or AGA or who has been charged with an offence in relation to the provider's conduct or practice.

How to Obtain a Claim Form

Drug, Extended Health Care and Dental benefits (if applicable) claim forms can be obtained from any one of the following sources:

- the AGA plan member website (see instructions below); or
- the AGA Customer Information Contact Centre at the toll-free number listed below.

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

How to Submit a Claim

AGA offers several convenient options to quickly and efficiently submit your Drug, Extended Health Care and Dental benefits claims:

- **Member eClaims**
  You can quickly and easily submit your health, drug and dental claims (as applicable) through AGA 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.

- You can also mail your completed claim form to AGA office.

You can submit your claims for all other benefits to Medavie Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form; or
- providing them to your group benefits administrator.

AGA 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 AGA forms;
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider;
- **Submit claims** electronically.

Helpful Tip

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

To register for the plan member website:

1. Log in to the AGA website at **https://adherents.aga.ca/en/.**
2. Click on *REGISTER*.

AGA Contact Information

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Centre at:

AGA Benefit Solutions
2200-3500, De Maisonneuve Blvd. W
Westmount (Quebec) H3Z 3C1

Montreal: 514-935-5444
Toll free: 1-800-363-6217, option #2
Fax: 514-935-1147

Helpful Tip

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

Alternatively, you can email your questions to **samuel.clientservice@aga.ca** or visit our website at **www.aga.ca**.

Blue Cross Contact Information (Travel Benefit)

For more information about your Travel Benefit coverage, 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

Helpful Tip

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

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

Your Health Spending Account

In addition to your group insurance plan, your employer is pleased to offer you a Health Spending Account (HSA) allowance. You will find below useful information on your HSA and how it works.

What is a HSA?
A HSA in an account through which you can be reimbursed for health-related expenses non-refundable or not covered under your group insurance plan.

You are entitled to $300 dollars annually based on your coverage level (Harmony Level 2)

The reference period for calculating the HSA allowance is the calendar year. If you become eligible for the HSA in the course of the period, the allowance will be prorated based on the number of days remaining in the reference period.

If you do not use your entire HSA allowance during the reference period, the balance will be carried forward to the following period. However, the remaining balance may not be carried forward more than once. Thus, unused amounts will be lost after 2 years. You have up to 2 months after the end of the period to submit your claims.

What are eligible expenses?
The employee can use this allowance to pay for any service included in the definition of "medical expense" under the federal Income Tax Act (e.g. Co-insurance and deductible paid under the group insurance plan, prescription drugs, dental care, eye care, and a number of other paramedical services). Some expenses are not eligible, such as cosmetic surgery or teeth whitening.

The expenses can be incurred for yourself or for your dependents, even if you chose individual coverage. An employee's dependent is any person meeting the definition of dependent under the Income Tax Act.

How can I make HSA claims?
Normally, you should always begin by submitting your claims to your group insurance plan (or your spouse's plan, if applicable). If you want to use your HSA to pay for medical expenses not reimbursed under the group insurance contract, you must check the appropriate box on the claim form, available on paper or through our members portal. Amounts not paid under the group insurance contract are not automatically reimbursed from the HSA. You can also view your account balance on our members portal.

What happens upon termination of your insurance coverage?
Only the expenses incurred before the coverage end date (e.g. employment, retirement or death) are eligible. Any claims must be submitted within 31 days following the coverage end date, after which the unused portion of the allowance is cancelled. There is no clawback of allocated credits when the employee leaves before the end of the year.

More questions?
For any questions, please contact our customer services from Monday to Friday between 8:30 a.m. and 8:00 p.m. at 1.800.363.6217 or visit our website at www.aga.ca .