



Your Group *Benefits* Booklet

CDMI (Canada Dry Motts Inc.)

Canada Dry Mott's inc. Retirees (Quebec Employees)

Group Policy Number:
91382-5

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Welcome to your Group Benefits Plan

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

This program is insured by Medavie Inc. (also known as Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada, which together will be referred to as “Blue Cross” for convenience of reference.

Medavie Blue Cross insures all health benefits. All other benefits are insured by Blue Cross Life Insurance Company of Canada.

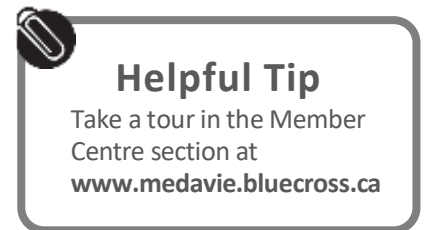
Blue Cross has been a trusted health services partner for individuals, employers and governments across Canada for over 70 years. Our core purpose is to help improve the health and well-being of people and their communities.

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

About this Booklet

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

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



Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.
- **Coverage Details:** Contains important information regarding the eligibility requirements for your group benefits coverage. In addition, these details explain when your coverage begins and ends, plus other useful information that will help you take advantage of the coverage available to you.
- **Rights and Responsibilities under the Policy:** Outlines your responsibilities under the group policy, such as notifying your employer upon change in status, and your rights, for example your right to privacy.
- **How to Submit a Claim and Obtain More Information:** Additional information on the various options available to you for submitting claims and how you can obtain more information regarding your coverage.
- **Helpful Tips:** Throughout this booklet we have provided useful tips to help you better understand and get the most out of your group benefits.

Medavie Mobile App

Submit a claim, access an electronic version of your ID card, check coverage, find a health professional in your area, and much more! Visit www.medavie.bluecross.ca/app for more information or to download the app.

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**Participation to the Group Insurance
Plan is mandatory.**

Summary of Benefits

Member Life Benefit

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

Summary of Benefits

Drug Benefit

Deductible	\$850 per Participant or per family, per calendar year
Reimbursement Level	100%*
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	No
Drug Formulary	
– Participant under Age 65	Open Formulary
– Participant Age 65 and over	Provincial Formulary Equivalent
Benefit Maximum (Participant under Age 65)	
Diabetic Supplies	See benefit details
Allergy Sera	Included
Varicose Vein Injections	Included
Vaccines	Included
Vitamins	Injectable vitamins only
Benefit Maximum (Participant Age 65 and over)	Provincial Formulary Equivalent maximums
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member dies
Survivor Coverage	24 months

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

Summary of Benefits

Health Spending Account Benefit

Deductible	None
Plan Administration	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member on the claim form)
Credit Allocation Frequency	Annually
Benefit Details	
Calendar Year	January 1 st to December 31 st
Account Type	Credit Carry Forward
Grace Period for Active Members	90 days
Grace Period for Terminated Members	90 days
Termination	
	When the Member dies
Survivor Coverage	
	Credit Allocation applicable to survivors continues on an annual basis until death of surviving spouse

Key Terms

You and Your Dependents

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

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

Retired Employee: A person who is a resident of Canada and ceases to work for the Employer in order to retire.

Member: A Retired Employee who is eligible and approved for coverage under this policy.

Dependent: Your Spouse or Child.

Spouse: The person who:

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

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

Child: A person who:

- is a resident of Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
 - a) is under age 21;
 - 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 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 policy.



Helpful Tip

You are responsible for enrolling your Dependents under the plan when they become eligible.

In addition, you are responsible for removing them when they no longer meet the definitions outlined here.

You can update your family and/or Dependent status by filling out and submitting a change form, available through our website.



Helpful Tip

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

Other Important Terms

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



Helpful Tip

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

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

- Medically Necessary;
- usual, customary and reasonable, meaning that:
 - the amount charged is consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
 - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- recommended or prescribed by a Physician or Health Practitioner who:
 - does not normally reside in the Participant's home;
 - is not the Participant's Family Member; and
 - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
 - does not normally reside in the Participant's home; and
 - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the policy is in effect, unless otherwise specified.



Helpful Tip

Family member refers to a Participant's:

- Spouse;
- father or mother, or their spouse or common-law partner;
- children, or the children of the Participant's spouse or common-law partner;
- brothers and sisters;
- grandchildren; or
- grandparents.

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

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

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

Key Terms

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.

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.

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

- the policyholder 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.

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

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

Coverage Details

Who is Eligible for Coverage?

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

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

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

Coverage is effective on the date of retirement.

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

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted if your application is received by Blue Cross more than 31 days after the date upon which you or your Dependent became eligible for coverage, with the following exceptions:

- Quebec Participants who are late in applying for drug benefits do not need to submit proof of health for drug coverage.

How do I Enrol for Coverage?

Application Form

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

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

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the policy. In addition, when you enrol for coverage you must also enrol all of your eligible Dependents, subject to the exceptions noted below:

- you are allowed to waive the Drug benefit coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. In this case, you or your Dependents will again be eligible for Drug benefit if there is a change in your family status or if you or your Dependents' other coverage terminates for reasons outside of your control.



Helpful Tip

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



Helpful Tip

If you do not enrol for coverage within 31 days of eligibility, you may be restricted when applying for benefits and your benefit levels may be reduced.

When Does My Coverage Begin?

Retired Employees

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

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

Dependents

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

- the date you become eligible for coverage;
- the date they meet all of the eligibility requirements;
- the date Blue Cross approves their proof of health, if required; or
- the date following their discharge from hospital if they were hospitalized on the date they would have become eligible for coverage, unless:
 - they were covered under a Previous Policy, in which case their coverage begins on the effective date of the policy; 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 insurance policy that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this group policy.

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the policy terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- you (or your Spouse, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you die;
- you or your Dependents commit a fraudulent act against Blue Cross; or
- the policyholder defaults in payment of premiums.

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

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

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

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

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



Helpful Tip

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

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

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

Coverage Details

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

- You must, within 31 days of the date of termination of your group coverage:
 - submit the application form provided by Blue Cross for the purpose of conversion to individual coverage; and
 - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by Blue Cross;
- the individual policy will be issued without requiring proof of health;
- the premium for the individual policy is based upon the individual policy rates in effect on the date of application and the age and sex of the Participant on that date;
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are specified in the *Right to Convert to Individual Coverage* provision of the applicable benefit.

Survivor Coverage

In the event of your death, coverage for your Dependents will continue without payment of premiums for certain benefits, if specified in the Summary of Benefits.

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

- the group policy 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, and also means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Government Health Care Coverage

Blue Cross will not pay for any health care services or supplies available under government health care coverage, or administered by government funded hospitals, agencies or providers. Blue Cross will only consider Eligible Expenses in excess of those provided under government health care coverage.

Other Health Plans

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

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



Helpful Tip

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



Helpful Tip

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

Expenses for Yourself:

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

Expenses for Your Spouse:

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

Expenses for Your Child:

- If a Child is covered as a dependent by both you and your Spouse, you should submit their claim to the plan of the parent whose birthday comes first in the year.
- In the event of divorce or separation, the plan of the parent with whom the Child resides (the plan of the parent with custody of the Child) pays first.



Helpful Tip

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

Member Life Benefit

Purpose of Coverage

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

Payment of Claims

Beneficiary

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

Time Limit to Submit a Claim

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

Right to Convert to Individual Coverage

Eligibility for Conversion

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

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages, without exceeding age 65.

Terms and Conditions of the Converted Policy

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

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

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

Drug Benefit

Purpose of Coverage

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

Additional Definitions

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

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) or a natural health product number (NPN) in Canada;
- considered by Blue Cross to be a Life-Sustaining Drug or a drug that requires a prescription by law;
- prescribed by a physician or by a Health Practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Blue Cross as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

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

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

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

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

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

What Blue Cross Will Pay

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

- payment is limited to the reimbursement level and the benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
 - dollar, quantity or frequency maximums;
 - Special Authorization; and/or
 - co-ordination with patient assistance programs;
- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses listed below, provided they also meet the definition of Eligible Expenses contained under the *Key Terms* provision of this booklet (and for Participant Age 65 and over, they also meet the Provincial Formulary Equivalent):

- diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM) sensors and insulin pump supplies;
- intrauterine contraceptive device (IUD) and diaphragms;
- ostomy supplies;
- viscosupplementation injections;
- preparations and compounds if their main ingredient is an Eligible Drug; and

- prescribed Eligible Drugs that appear on the following drug formulary:

Participant under Age 65:

- **Open Formulary:** List of all Life-Sustaining Drugs and Eligible Drugs that require a prescription by law. This list is not subject to the Medication Advisory Panel decisions;

Participant Age 65 and over:

- **Provincial Formulary Equivalent:** List of prescription and non-prescription drugs as determined by the appropriate provincial program. This list is not subject to the Medication Advisory Panel decisions.

Special Authorization

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

How does the Special Authorization process affect my claim?

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

You can request a Special Authorization Prescription Drug Form from your pharmacy, your employer, the nearest Blue Cross customer information centre or from our website. You must complete the patient section of the form, have your physician complete and sign the remaining portion and mail your completed form to the nearest Blue Cross office.

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

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

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

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug.

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

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

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



Helpful Tip

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

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



Helpful Tip

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



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 policy.

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

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 18 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 are not eligible for reimbursement:

- a) varicose vein injections;
- b) antihistamines and allergy sera;
- c) smoking cessation aids;
- d) vaccines;
- e) vitamins;
- f) weight loss treatments;
- g) natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
- h) fertility treatments;
- i) erectile dysfunction treatments;
- j) hair growth stimulants;
- k) services, treatment or supplies that:
 - i. are not Medically Necessary;
 - ii. are for cosmetic purposes only;
 - iii. are elective in nature; or
 - iv. have experimental or investigative indication;
- l) procedures related to drugs injected by a Health Care Professional in a private clinic;
- m) 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;
- n) 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;
- o) services, treatment or supplies the Participant receives free of charge;
- p) charges that would not have been incurred if no coverage existed; or
- q) drugs that are eligible under the travel benefit provided by the group policy (if applicable).



Helpful Tip

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



Helpful Tip

Shop around for the best price for your prescription drugs.

For the same prescription, the price can vary depending on where you go, even among stores in the same chain.

Right to Convert to Individual Coverage

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

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

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

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

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

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

Out-of-pocket Maximum per Calendar Year

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

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

Participants Age 65 Years and Over

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

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

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

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

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.

Health Spending Account Benefit

Purpose of Coverage

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

Additional Definitions

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

Grace Period – Credits Carry Forward: The period of time commencing at the end of a Calendar year within which claims for reimbursement must be submitted to Blue Cross. This period of time is specified in the Summary of Benefits.

What Blue Cross Will Pay

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

HSA Credits

Under an HSA, you have access to a pre-determined amount of HSA credits. Credits represent the value allocated to the HSA in any particular Calendar year (specified in the Summary of Benefits).

The HSA credits will be available to you according to the Credit Allocation Frequency specified in the Summary of Benefits.

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

These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits. For example, they can be used to cover Deductibles, co-payments, or amounts above plan maximums.

Health Spending Account Benefit

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

*Prescription required

**For Therapeutic massage services only

Exclusions and Limitations

The following are examples of expenses which are not covered:

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

Further to this list, please refer to the Summary of Benefits for Specific Benefit Exclusions or Specific Expense Exclusions (if any).

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the type of Plan Administration that applies to Participants under the policy.

Account Type

Credit Carry Forward

Credits may be used to reimburse Eligible Expenses incurred in the same Calendar year the credits were allocated.

Unused credits can also be carried forward into the following Calendar year. Credits cannot be carried forward more than one year. At the end of the second Calendar year, unused credits from the first are forfeited.

Claims must be applied to any carry forward credits before current Calendar year credits are used.

Claims must be submitted in the Calendar year they were incurred. However, there is a Grace Period specified in the Summary of Benefits, within which claims may be submitted after the Calendar year end.

Grace Period for Terminated Member

If your employment ends, or your group terminates coverage with Blue Cross, you will have the Grace Period for terminated Members (specified in the Summary of Benefits) within which to use the remaining balance. Only eligible expenses incurred prior to the termination of coverage are eligible.

Rights and Responsibilities Under the Policy

What Are My Responsibilities Under the Policy?

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 designation(s). You must complete the group benefits application form within 31 days from the date you become eligible for coverage.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Failure to do so could result in the need for proof of health before your requested change in coverage takes place. Changes that must be reported to your employer include:

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

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

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

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

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

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

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

Designations made under a previous group insurance policy

Any beneficiary designation made under your previous group policy has been carried forward to this group policy. You should review the existing designation to ensure it reflects your current intentions.

Providing Proof of Claim

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

Blue Cross must approve your proof of claim and may require you to provide additional information and/or require you to undergo a medical examination by a physician or Health Professional as often as deemed necessary. Blue Cross reserves the right to suspend or deny a claim until you have submitted the additional information requested to process the claim.

Costs associated with providing proof of claim are your responsibility.



Helpful Tip

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

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

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

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



Helpful Tip

Your proof of claim must be submitted in either English or French. If the original proof of claim is in a language other than English or French, you are responsible for any costs associated with translating your proof of claim.

Submitting Claims After Your Group Policy Terminates

If the group policy has terminated, you must submit proof of claim to Blue Cross **within 90 days** following the termination date of this group policy.

Recovering Damages From a Third Party (Subrogation)

If you have the right to file legal action against a third party (individual or corporate body) for a loss relating to any claim submitted under this group benefits plan, Blue Cross is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross.

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

Reporting Health Insurance Fraud

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

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

How You Can Help

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

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

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

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

What Are My Rights Under the Policy?

Privacy

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

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



Helpful Tip

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



Helpful Tip

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

Toll free:
1-877-412-8809

StopFraud@medavie.
bluecross.ca

www.medavie.bluecross.
confidenceline.net

What is personal information?

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

How is Your Personal Information Used?

Your personal information is necessary for Blue Cross to process your application for coverage under its life and Drug Benefit plans. Your personal information is used to provide the services outlined in your group policy of which you are an eligible Member, to understand your needs so that we can recommend suitable products and services, and to manage our business.

To Whom Could This Personal Information be Disclosed?

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

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



Helpful Tip

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

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

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

Disputing a Claim Decision

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

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

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

Copy of the Group Policy

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

The Rights of Blue Cross Under the Policy

Right to Audit

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

Recovery of Overpaid amounts

Blue Cross has the right to recover from a Participant:

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

If the excess amounts cannot be recovered, Blue Cross has 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 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.

Blue Cross also has 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 who has been charged with an offence in regards to the provider's conduct or practice.



Helpful Tip

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

How to Obtain More Information

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- one of our Quick Pay locations;
- your group benefits administrator; or
- our Customer Information Contact Center at the toll-free number listed below.

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

How to Submit a Claim

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

- **Provider eClaims**
For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).
- **Member eClaims**
You can quickly and easily submit your drug and Health Spending Account claims (as applicable) through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.
- **Mobile App**
Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.

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

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

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

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

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

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

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



Helpful Tip

Instead of a cheque by mail, get reimbursement directly to your bank account by signing up for direct deposit. It's fast, and convenient. Visit our website to register.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, seven days a week. The website provides additional information regarding your coverage and other useful options including:

- **Coverage inquiry:** Detailed information about your group benefits plan;
- **Forms:** Printable versions of Blue Cross forms;
- **Requests for new identification cards;**
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider;
- **Submit claims** electronically.

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



Helpful Tip

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



Helpful Tip

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

Additional Resources and Member Services

Blue Cross Contact Information

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

Atlantic Provinces: 1-800-667-4511

Ontario: 1-800-355-9133

Quebec: 1-888-588-1212

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

Alternatively, you can email your question(s) to inquiry@medavie.bluecross.ca or visit our website at www.medavie.bluecross.ca.



Helpful Tip

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

Connect with Blue Cross

Like us on Facebook at facebook.com/MedavieBlueCross

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

My Good Health[®]

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

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



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

Name of policyholder: KEURIG CANADA INC.