Yukon

Benefit Guide

Retirees

January 2019

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Benefit Guide

January 1, 2019

This Guide provides information on the Government of Yukon Public Service Group Insurance Benefits for Retirees.

The contents are designed to inform retirees of Plan details. Every effort has been made to ensure that the information presented is accurate. However, if there is a question of interpretation about the information presented in this Guide, the official benefit plan documents, insurance contracts and any legislated requirements will prevail.

The Government of Yukon expects and intends to keep the benefit program in force indefinitely, but reserves the right to modify, revoke, suspend, terminate or change the Plans, in whole or in part, at any time.

About Your Benefit Guide

This *Benefit Guide* is your reference tool, designed to help you understand your retiree benefit coverage. We encourage you to keep it handy for future reference.

To make it easy for you to navigate this *Guide*, the following handy features will help you find the information you need quickly.

These features include:

- **What's Inside** - a comprehensive table of contents to help you navigate the *Guide*
- **Overview** - highlights of your complete Benefit Plan
- **Benefits at-a-Glance** - a quick overview of your benefits and reimbursement percentages
- **Reference Points and Questions & Answers** - important information and answers to commonly asked questions placed throughout the text for easy reference
- **Glossary of Terms** - important terms and their meanings
- **Who to Call** - who you should call if you have questions

We encourage you to refer to this *Guide* whenever you have a question about your benefits. If you have questions that aren't answered here, or need clarification on a particular coverage, please contact the Public Service Commission.

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Overview

The Benefit Plan provides you and/or your dependent(s) with coverage under the Extended Health Care Plan.

Benefits at-a-Glance

Extended Health Care

	Coverage
Deductible	
• Prescription Drugs	$10.00 per prescription*
• All Other Expenses	None
Coinsurance	
• Prescription Drug Benefit	80%
• Vision Care	80%
• Miscellaneous Health Care	80%
• Hospital Benefit	100%
• Global Medical Assistance	100%
• Out-of-Country Emergency	100%
• Out-of-Province Referral	80%
Vision Care Benefit	
• Eye glasses / contact lenses/ laser eye surgery	$300 per two benefit years
Hospital Benefit	Semi-private accommodation
Global Medical Assistance Coverage	See description
Out-of-Country Emergency	Unlimited
Out-of-Province Referral	$50,000 per lifetime
Paramedical Practitioners	
• Acupuncturist, Chiropodist, Chiropractor, Registered Massage Therapist, Naturopath, Osteopath, Physiotherapist, Podiatrist, Speech Language Pathologist	Combined maximum of $1,000 per benefit year for all practitioners (except psychologist)
• Psychological Services	$1,000/benefit year
Nursing Services	$25,000/three benefit years
Orthopedic Shoes	$150/benefit year
Orthotics	$150/benefit year
Hearing Aids	$600/five benefit years
Speech Aids	$1,000 per lifetime
Orthopedic Brassieres	Two per benefit year
Wigs	$300/benefit year
Overall Maximum	Unlimited

* The per prescription deductible also applies to certain non-prescription items covered under the Drug Benefit.

Eligibility

As a retiree, you are eligible to participate in the Government of Yukon Benefit Plan if you are:

- In receipt of an immediate annuity or annual allowance payable on your retirement date, or when your deferred annuity or annual allowance becomes payable
- Covered by a provincial or territorial government health plan.

Waiting Periods

There is no waiting period for Extended Health Care Plan benefits if you are in receipt of an immediate annuity or annual allowance payable on your retirement date, or when your deferred annuity or annual allowance becomes payable.

In addition to providing coverage for you, the Extended Health Care Plan will also protect your dependents. By definition, your dependents include:

- Your spouse, either legally married or living common-law for at least one year immediately before application for coverage under the plan
- Your unmarried, dependent children (natural, adopted or stepchild of you or your spouse or a child whom you or your spouse is the legal guardian and the guardianship is court ordered) under age 21, or under age 25 if attending an accredited post-secondary institute, college or university on a full-time basis. Your dependent child will automatically have their coverage terminated at age 21, unless you advise the Public Service Commission that your child is attending a post-secondary institution on a full-time basis.
- Your physically or mentally disabled children are covered with no age restriction provided they are entirely dependent on you for support and their disability occurred while covered under the Plan as a dependent child

What happens if I have comparable coverage under my spouse's benefit plan?

If you or your dependents have coverage under another plan (e.g., your spouse's), you may decline coverage for your dependents under the Extended Health Care Plan; however, once dependent coverage is waived you may only enroll your dependents if their comparable coverage terminates.

Enrollment

Enrolling in the Benefit Plan is simple. Complete the enrollment form(s) supplied to you and forward them to the Public Service Commission for processing.

Step 1: Read

Read all of the information provided in this *Benefit Guide*. If you have questions as you go through the material, please contact the Public Service Commission.

Step 2: Complete

Complete the enrollment form.

Step 3: Submit

Submit your completed enrollment form(s) to the Public Service Commission. Please ensure your forms are complete, signed in ink and dated.

How Much Does it Cost?

The Extended Health Care is cost-shared between the Government of Yukon and yourself. The value of an employer-sponsored group plan like this one is that, typically, the premiums are lower than if you shopped individually for these benefits.

The premium cost sharing arrangement is directly related to your number of years of service with the Government of Yukon prior to your retirement and your retirement date and when you enrolled in the plan. If you retired or enrolled in the plan on or after January 1, 2019 your cost sharing arrangement will be as follows:

Years of Service	Government's Contribution	Your Contribution
Less than 15 years	0%	100%
15 years, but less than 20 years	20%	80%
20 years, but less than 25 years	25%	75%
25 or more years	50%	50%

If you retired prior to January 1, 2019, or submitted your retirement letter prior to January 1, 2019 (with a retirement date and enrollment between January 1, 2019 and December 31, 2019), your cost sharing will be based on the May 1, 2008 cost sharing arrangement. Information on your cost sharing arrangement and current premium rates is available from the Public Service Commission.

Making Changes

In order to have your coverage updated, please notify the Public Service Commission about any of the following life events:

- Marriage/Common-law relationships
- Birth/adoption of a child
- Divorce
- Loss or gain of spouse's employer coverage
- Death of a dependent

Effective Date of Coverage and Rules for Updating Your Coverage

Extended Health Care Plan

You have 60 days from the date you begin to receive an annuity or annual allowance from the Public Service Pension Plan to apply for coverage; effective January 1, 2019 late applications are not permitted. If you are in receipt of an immediate pension, your benefit coverage as a retiree will be effective the day following when your coverage as an active employee terminates. If you are in receipt of a deferred annuity, your benefit coverage will be effective the first day of the month following the date your application is received by the Public Service Commission.

If you retired, or submitted your letter of intent to retire, prior to January 1, 2019 you will be grandfathered with the option to make a late application to participate, however a waiting period will apply and coverage will be effective on the first day of the 4th month following the month in which the application is received by the Public Service Commission.

If your dependents had coverage under your benefit plan as an active employee, then their effective date of coverage will be the same as yours. If you apply for dependent coverage after 60 days of their eligibility, then a waiting period will apply and the effective date of coverage for your dependents will be the first day of the fourth month following the month in which the application is received by the Public Service Commission. If the application to add your

dependents is received within 60 days of your enrollment in the plan, then their benefit coverage will be effective the first day of the 4th month following the effective date of your coverage.

If you waive coverage for your dependents upon commencing participation in the Extended Health Care Plan because they have coverage elsewhere (e.g., through a spousal plan), and that coverage subsequently terminates, you have 60 days to apply for coverage under this Benefit Plan. This 60 day limit also applies in the case of acquiring a new dependent. If your application for coverage is received within 60 days, coverage begins on the day following the date that your dependents' comparable coverage terminated, or the date you acquire a new dependent. If your application for coverage is received after 60 days, coverage is effective on the first day of the fourth month following the month in which the application is received.

If you request a change in coverage from Family to Single, the change is effective on the first day of the month following the date the notice of change is received.

If you allow your benefit coverage to terminate after January 1, 2019 you will not be permitted to re-enrol in the plan.

Yukon Health Care Insurance Plan

Your Extended Health Care Plan covers health services and supplies over and above what is provided by the Yukon Health Care Insurance Plan. The Territory pays for many basic medical expenses for residents of the Yukon, such as:

- Doctors' and surgeons' fees
- Specialists' fees when referred by a general practitioner
- Diagnostic procedures, including x-ray and lab tests
- Maternity care
- Standard ward hospital accommodation
- Outpatient treatment

For more information about eligible expenses, contact your local Yukon Health Care Insurance Plan office.

What is the difference between the Extended Health Care Plan and the Yukon Health Care Insurance Plan?

Yukon Health Care Insurance is the mandatory health insurance plan sponsored by the Territory for residents of the Yukon. It pays for basic medical services, such as doctors' fees and standard ward hospital accommodation. The Extended Health Care Plan is a private health service plan sponsored by the Government of Yukon for Government employees. The Extended Health Care Plan provides reimbursement for many expenses, such as prescription drugs, paramedical services, and other services, not covered by the Yukon Health Care Insurance Plan.

Claims Procedures

Extended Health Care Plan

For prescription drugs, show the pharmacist your Prescription Drug Card and your claim will be processed electronically. If your prescription drug claim is not adjudicated electronically, you may submit it on-line using the benefits carrier's plan member website or you may complete a paper claim form and mail it to the benefits carrier's claims centre for processing.

For all other Extended Health Care claims:

- Your paramedical services and vision care providers may submit your claim for the service rendered directly to the benefits carrier, as long as the provider is approved and registered for *Provider eclaims**
- You may submit claims for paramedical expenses and vision care on-line using the benefits carrier's plan member website
- All other expenses require a paper claim form.

Claims for custom-fitted or pre-fabricated (off-the-shelf) orthopedic shoes will also be required to include:

- The brand name and model of the shoes
- A description of each modification made to the shoes (if applicable)
- A breakdown of the cost of the shoes and each modification (if applicable)
- A prescription which includes a diagnosis

Claims for a custom-made foot orthotic will also be required to include:

- A copy of a detailed biomechanical examination or gait analysis
- Details of the casting technique used
- A detailed description of the type of orthotic provided
- A breakdown of the charges for the orthotic
- A prescription which includes a diagnosis

Claim forms are available from the Public Service Commission, or you may print a claim form off of the Public Service Commission website. Personalized claim forms are available from the benefits carrier's plan member website. You have 18 months from the date you incurred the expense to claim for reimbursement (90 days if your coverage is terminated). If you use a paper claim form, simply fill out the form, attach the original receipts, attach the prescription (if required), and send it to the benefits carrier for reimbursement. It's always a good idea to keep a copy of your claim form and receipts for your records. You have 6 months from the date you incurred the expense to submit an on-line claim (as per above, manual claims may be submitted 18 months after the expense was incurred). If you submit your claim on-line, keep your original receipts and your prescription (if applicable) for 12 months.

*Provider eclaims is available at approved Acupuncture, Chiropractor, Registered Massage Therapy, Naturopath, Physiotherapy and Vision care providers nationwide. New providers are being added daily. You may check the *Provider eclaims* listing under Client Services - Group Benefits Plan Members – Health, Dental and Out-of-Country Coverage and Claims on www.greatwestlife.com.

What is a Prescription Drug Card?

For convenience, the benefits carrier supplies you with a Prescription Drug Card to speed up expense claims processing for prescription drugs. When you have a prescription filled, your pharmacist will use your card to electronically process your prescription expense claim on the

spot. You must pay whatever balance is owing once your eligible expense amount has been deducted. (*See Extended Health Care Plan - Prescription Drugs* for more information.)

Coordination of Benefits

If you and your spouse are separately covered for dependent Extended Health Care and/or Dental coverage, you may be eligible for reimbursement up to 100% for some of these expenses, by submitting your claims each in turn to your respective benefits carriers, as follows:

If you have incurred the expenses, you first submit your claim to your benefits carrier. Once they've processed your claim, your spouse submits the remaining expense noted on the statement of payment to their benefits carrier, including the following documents:

- A copy of the claim submitted to the first benefits carrier, and
- A copy of all receipts, and
- A copy of reimbursement details, or refusal, from the first benefits carrier.

If your spouse incurred the expenses, your spouse will submit the claim first to their benefits carrier and then to your Benefit Plan.

For expenses incurred for a dependent child, the claim must first be submitted by the parent whose birth date is first in the calendar year. If an expense is not completely paid, the remaining amount can be submitted to the spouse's plan. The documents listed above must always accompany the second claim.

For prescription drugs, the process is a little different because your Plan includes a *Prescription Drug Card*. You use your drug card to process a prescription for yourself or your dependents (if your birth date is first in the year). If there is a balance remaining once the pharmacist has processed your prescription, you pay it, and then submit the receipts to your spouse's benefits carrier for reimbursement. (*See Extended Health Care Plan- Prescription Drugs* for more information.) If your spouse's plan also has a drug card, you may be able to process both claims at once. Simply tell your pharmacist which drug card to use first to process the claim. This capability may not be available in all pharmacies or with all benefits carriers.

Does co-ordination of benefits apply if my spouse and I are both covered under the Government of Yukon's Benefit Plan?

Yes, coordination of benefits still applies, and the process for reimbursement is the same too, as if you were covered by two different benefits carriers.

Keep in Mind:

Remember by coordinating benefits with your spouse's benefit plan, you may be reimbursed for up to 100% of your Extended Health Care costs.

Q Are there time restrictions on filing claims?

A Yes, for Extended Health Care: 18 months from the date the expense is incurred. However, if your coverage has terminated, you have 90 days from the date of termination to submit outstanding expenses. Out of Country claims (other than those for Global Medical Assistance) should be submitted as soon as possible. It is very important that you send your Out of Country claims to the benefits carrier immediately as your Provincial/Territorial Medical Plan may have very strict time limitations.

Termination of Coverage

If you fail to pay your portion of the premiums, your coverage will be terminated. If your coverage terminates for any reason, you will not be permitted to re-enrol in the plan.

Extended Health Care Plan

The Extended Health Care Plan provides you and your dependents with coverage for medically-necessary expenses over and above those covered by your home territorial/provincial health insurance plan.

What does *medically necessary* mean?

Medically necessary is defined as services and supplies generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness in accordance with Canadian medical standards.

Expenses are reimbursed at the levels indicated in the following chart; however, there are certain limitations and exclusions (see *Limitations and Exclusions* at the end of this section). For prescription drugs, there is a deductible of $10.00 per prescription. There is no deductible for other Extended Health Care expenses. If applicable, after you have paid the deductible, you are reimbursed by the benefits carrier for the balance of your costs, up to the limit that the Plan covers for *reasonable and customary* charges.

Extended Health Care (single/dependent(s))	Reimbursement Level
Prescription Drugs (drug card)	80%
Vision Care	80%
Miscellaneous Supplies/Services (e.g., registered massage therapist, hearing aids)	80%
Hospitalization	100%
Global Medical Assistance (i.e., within Canada and out-of-country)	100%
Out-of-Country Emergency	100%
Out-of-Province Referral	80%

Why is there a deductible?

Deductibles are one way of sharing the total cost of benefits between employees and the Government of Yukon. For each prescription drug you purchase, you must pay a $10.00 deductible. The remaining eligible amount is then reimbursed according to the provisions of the Plan.

What are *reasonable and customary* charges?

Reasonable and customary charges are those that are normally made to people in the area where the expense is incurred. The benefits carrier will determine if the charge is *reasonable and customary*.

Keep in Mind:

Remember, by coordinating benefits with your spouse's benefit plan, you may be reimbursed for 100% of your Extended Health Care costs.

Q What happens if I leave the country for an extended period of time (e.g., for 12 months or longer)?

A You will need to contact both your home territorial/provincial health insurance plan and the Public Service Commission to discuss your ability to continue coverage under this Plan. If coverage under your home territorial/provincial health insurance plan terminates, then you will no longer be eligible for coverage under the Extended Health Care Plan.

Prescription Drugs

The plan offers extensive prescription drug coverage for you and your eligible dependents. The plan includes a $10.00 per prescription deductible and reimburses you for 80% of the cost of drugs.

What is Covered

Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada (this means only drugs that require a prescription by law are covered). Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country care provision.

- Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug
- Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered
- Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, and sensors for flash glucose monitoring machines
- Extemporaneous preparations or compounds if one of the ingredients is a covered drug

Enhanced Generic Substitution required

Many drugs are available in both generic and brand name forms. Generic forms are typically less expensive but are just as effective as brand name forms. Both drugs have the same active ingredient, same dosage strength, and same dosage form. For a brand name drug where a generic form is available, unless medical evidence is provided to the benefits carrier that indicates why the brand drug is not to be substituted, the covered expense can be limited to the cost of the lowest priced interchangeable drug. By asking your doctor to prescribe the generic form of a brand name drug, you can help minimize your out-of-pocket costs. If your doctor prescribes a brand name drug, you can:

1. Ask your pharmacist for the more cost-effective generic version of the drug, or
2. Request the brand name drug your doctor has prescribed, and pay the difference in cost between the lowest-priced generic drug and the brand name drug, or

3. If your doctor can provide medical evidence supporting the need for the brand name medication, an exception can be requested by having your doctor complete the Request for Brand Name Drug Coverage form found on www.greatwestlife.com – Client Services – Group Benefits Plan Members – Forms. Submit the completed form to the benefits carrier. If you request is approved, you will be reimbursed the cost of the brand name drug, subject to the deductible and reimbursement level. If your form is not submitted or if your request is not approved, your covered expense will be limited to the lowest priced interchangeable drug available.

Keep in Mind:
For a brand name drug where a generic form is available, unless medical evidence is provided to the benefits carrier that indicates why the brand drug is not to be substituted, the covered expense can be limited to the cost of the lowest priced interchangeable drug.

For drugs eligible under a provincial/territorial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

Which drugs qualify as prescription drugs under the Plan?

Drugs and drug supplies, as described, bearing a Drug Identification Number (DIN), when prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them. Only drugs and drug supplies that require a prescription by law are covered. There are some exceptions such as vaccines and fertility drugs as described further in this section under What Is Not Covered.

If you have any questions regarding the eligibility of prescription drugs, you can contact your physician, pharmacist or benefits carrier.

For drug claims, you will receive a prescription drug card from the benefit carrier. Present your card to the pharmacist with your prescription, which will allows the pharmacist to electronically process your claim for you.

Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

You are only required to pay the pharmacist the balance of what the benefits carrier did not cover. If you are coordinating benefits with a spouse's plan, you would submit the receipt for any remaining expense to your spouse's benefits carrier for reimbursement.

What is Not Covered

Services or supplies that the plan administrator has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, the plan administrator may take any factor into consideration including, but not limited to, the following:

- clinical practice guidelines;
- assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;

- information provided by a manufacturer or provider of the service or supply; and
- assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Drugs or drug supplies that appear on an exclusion list maintained by the plan administrator. The plan administrator may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. The plan administrator may add or remove a drug or drug supply from an exclusion list at any time.

For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

- the plan administrator determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or
- the plan administrator determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Fertility drugs
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, and over the counter drugs whether or not prescribed for a medical reason
- Drugs used for the treatment of erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the benefits carrier maintains a limited list of services and supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the benefits carrier's website as follows:

https://www.greatwestlife.com/you-and-your-family/forms/group-claim-forms/prior-authorization-forms.html

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment. If the use of a lower cost alternative service or supply represents reasonable treatment, the benefits carrier may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

If you try to purchase a prescription drug that requires authorization, you will receive a message at the pharmacy indicating that Prior Authorization is required and that the claim is declined in the meantime. A completed Prior Authorization form, which can also be found at the website noted above, must be submitted and approved by the benefits carrier before any benefits are payable.

Health Case Management

If you or one of your dependents apply for prior authorization of certain services or supplies, the benefits carrier may contact you to participate in health case management. Health case management is the benefits carrier's program for plan members requiring certain services and supplies such as high cost drugs. It may include but is not limited to:

- Consultation with the person and their attending physician to gain understanding of the treatment plan recommended by the attending physician;
- Comparison with the person's attending physician of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- Identification to the person's attending physician of opportunities for education and support;
- Monitoring the person's adherence to the treatment plan recommended by the person's attending physician;
- Designated Provider: Designating preferred provider(s) for purchase and administration of prescription drugs (as described below); and
- Patient Assistance Program: Coordinating participation in assistance programs that may help with the purchase of services or supplies (as described below).

In determining whether to implement health case management, the benefits carrier may assess such factors as the service or supply, the person's medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as the benefits carrier determines, where:

- The benefits carrier has implemented health case management and the person does not participate or cooperate; or
- The person has not adhered to the treatment plan recommended by their attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where the benefits carrier has recommended or approved health case management, the benefits carrier can require that a service or supply be purchased from or administered by a provider designated by the benefits carrier, and:

- The covered expense for a service or supply that was not purchased from or administered by a provider designated by the benefits carrier may be limited to the cost of the service or supply had it been purchased from or administered by the provider designated by the benefits carrier; or
- A claim for a service or supply that was not purchased from or administered by a provider designated by

the benefits carrier may be declined.

Patient Assistance Program

A patient assistance program means a program that provides assistance to persons with respect to the purchase of services or supplies.

A person may be required to apply to and participate in any patient assistance program to which the person may be entitled. Further, the covered expense for a service or supply may be reduced by an amount up to the amount of financial assistance the person is entitled to receive for that service or supply under a patient assistance program.

Vision Care

Vision Care covers you and your dependents for the cost of one eye examination every two benefit years. In addition to that, the Benefit Plan reimburses you for the cost of prescription eyeglasses, sunglasses, safety glasses (including repairs), contact lenses or laser eye surgery to a maximum limit of $300 every two benefit years. Intraocular contact lenses following cataract surgery are also covered one per eye per lifetime. The reimbursement level for the Vision Care Plan is 80%.

If the eyeglasses or contact lenses are required as a direct result of surgery for the treatment of keratoconus, the maximum does not apply as long as they are purchased within six months of the surgical procedure.

What is Not Covered

- Vision Care services and supplies required by an employer as a condition of employment

Will the Plan pay for multiple vision care claims such as disposable contact lenses?

Yes it will, but keep in mind that the Plan operates under a two-year benefit period. For instance, if you purchase $50 in disposable contact lenses in June, you would have $250 left for the current benefit year and following benefit year. This amount can be used with one purchase or multiple purchases.

Miscellaneous Supplies/Services

There are a number of other expenses that the Plan covers, such as registered massage therapy and hearing aids. As long as the expenses are medically necessary, reasonable and customary, and prescribed by a licensed physician (where noted), you may be able to recover some of the costs - up to 80%.

Keep in Mind:

There are a number of other expenses that the Plan covers, such as registered massage therapy and hearing aids. As long as the expenses are medically necessary, reasonable and customary, and prescribed by a licensed physician (where noted), you may be able to recover some of the costs - up to 80%.

Outlined below are eligible expenses, as well as any limitations or maximums that may apply. This list is not all inclusive; questions regarding the eligibility of a specific service or supply should be directed to the benefits carrier.

Services

- Dental services, including braces and splints, to repair damage to natural teeth caused by accidental blow to the mouth. Services must be rendered within twelve months of the accident
- Ambulance transportation to the nearest centre where adequate treatment is available.
- Paramedical practitioners (out of hospital treatment) - $1,000 per benefit year maximum for the following practitioners' services combined:
    - Acupuncture treatments
    - Chiropractor
    - Chiropodist
    - Registered Massage Therapist. Requires a physician's written prescription.
    - Naturopath
    - Osteopath
    - Physiotherapist
    - Podiatrist
    - Speech Language Pathologist. Requires a physician's written prescription.
- Psychological services ($1,000 per benefit year maximum). Applies to a Registered Psychologist or anyone who holds a graduate degree (Masters or Doctorate) in the following disciplines: psychology, social work, counseling, educational psychology, or a mental health Nurse.
- Home nursing services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, when services are provided in Canada, but only if the patient requires the specific skills of a trained nurse ($25,000 per three benefit years maximum). You should apply for a pre-care assessment before home nursing begins.
- Diagnostic x-rays and lab tests, when coverage is not available under your government plan

Supplies

- Blood glucose monitoring machines prescribed by a physician ($700 per lifetime maximum)
- Flash glucose monitoring machines prescribed by a physician
- Braces, not including anything primarily used for athletic purposes
- Colostomy, ileostomy and tracheostomy supplies, catheters and drainage bags for incontinent patients
- Devices for delivery of asthma medication
- Elastic support stockings, including pressure gradient hose, up to two pairs per benefit year
- External breast prosthesis if required as a result of surgery ($200 per benefit year maximum)
- Hearing aids, including repairs, batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician. Replacement batteries included ($600 per five benefit years maximum)
- Insulin pumps (one pump per five benefit years). Requires a physician's written prescription.
- Orthopedic shoes ($150 per benefit year maximum) and Orthotics ($150 per benefit year maximum). The orthopedic shoes and custom-made foot orthotics are generally covered when they are considered to be reasonable treatment of disease or injury, and when prescribed by a physician, chiropodist, podiatrist, chiropractor or orthopedic surgeon. The prescription must set out the medical diagnosis necessitating the supply prescribed. Prescriptions outlining symptoms rather than a medical diagnosis will not be sufficient.
- Oxygen and equipment used for its administration
- Rental, or purchase of durable equipment for use in the patient's private residence (e.g., walkers, wheelchair, hospital beds, apnea monitors)
- Surgical or mastectomy brassieres (two per benefit year)
- Temporary/permanent artificial limbs and artificial eyes, including myoelectric appliances where medically necessary. Myoelectric arms (up to $10,000 per prosthesis)

- Trusses, crutches, splints, casts and cervical collars
- Wheelchair repairs ($250 lifetime maximum)
- Mechanical or hydraulic patient lifters($2,000 per lifter once every five benefit years)
- Outdoor wheelchair ramps($2,000 lifetime)
- Extremity pumps for Lymphedema ($1,500 lifetime)
- Transcutaneous Nerve Stimulators ($700 lifetime)
- Wigs, due to hair loss from an illness ($300 per benefit year maximum)

What is Not Covered

No benefits will be payable for:

- Services or supplies purchased primarily for athletic or recreational use rather than daily living activities
- Expenses for repair or replacement of purchased durable equipment, other than wheelchair repairs
- Extra medical supplies that are spares or alternates

Hospitalization

The Yukon Health Care Insurance Plan provides some coverage while you are in hospital. Additional coverage is provided by the Extended Health Care Plan:

- Reasonable and customary charges for semi-private hospital room and board charges are covered up to 100%.
- Convalescent care for a condition that will significantly improve as a result of care and follows a 3-day confinement for acute care.

Any charges referred to as *co-insurance* or *utilization fees* are not covered.

Global Medical Assistance

The Extended Health Care Plan also offers 100% coverage for you and your dependents for travel while outside your province or territory on vacation, business or education.

Keep in Mind:

Traveling Outside Your Home Territory/Province?

- Review your Global Medical Assistance (GMA) benefit.
- Carry the benefits carrier's combined Prescription Drug Card/GMA wallet card with toll-free numbers to call in case of a medical emergency or if you need to purchase prescription drugs. The Prescription Drug Card will be accepted at pharmacies within Canada, but not outside Canada.

What is Covered

The Global Medical Assistance benefit provides:

Medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains the benefits carrier's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province/territory to be eligible for Global Medical Assistance benefits. The

following services are covered, subject to benefits carrier's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000
- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment. When services are covered under this provision, they are not covered under other provisions described in this booklet
- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of $1,500
- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation
- In case of death, preparation and transportation of the deceased home
- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

What is Not Covered

Global Medical Assistance will not be provided for the following:

- Expenses incurred where you or your dependents are temporarily or permanently residing outside of Canada
- Expenses for regular treatment of an injury or disease that existed prior to your departure

Do I have to re-enroll in the Global Medical Assistance benefit each time I travel?

No, as long as you are enrolled in the Extended Health Care Plan you are covered for Global Medical Assistance benefits. Be sure to carry your Global Medical Assistance Card (issued by the benefits carrier) with you when you travel, for immediate access to the services and coverage. The toll-free telephone numbers are listed on the reverse side of your Global Medical Assistance Card. Additional Global Medical Assistance cards can be printed from the benefits carrier's plan member website.

Out-Of-Country Care

The Extended Health Care Plan also provides coverage for out-of-country care in the event of an emergency or non-emergency.

The following services and supplies are covered when related to out-of-country care:

- Treatment by a physician
- Diagnostic x-ray and laboratory services
- Hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
- Medical supplies provided during a covered hospital confinement
- Paramedical services provided during a covered hospital confinement
- Hospital out-patient services and supplies
- Medical supplies provided out-of-hospital if they would have been covered in Canada
- Drugs
- Out-of-hospital services of a professional nurse
- For emergency care only:
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada

Emergency Care

Emergency care outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent are temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province/territory.

A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

- The amount payable under this plan for continued treatment outside Canada, or
- The amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

What is Not Covered under Emergency Care

- Any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency
- Any subsequent and related episodes during the same absence from Canada
- Expenses related to pregnancy and delivery, including infant care:
    - after the 34th week of pregnancy, or
    - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

Non-emergency Care

Non-emergency care outside Canada is covered for you and your dependents if:

- It is required as a result of a referral from your usual Canadian physician
- It is not available in any Canadian province/territory and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties
- You are covered by the government health plan in your home province/territory for a portion of the cost, and
- A pre-authorization of benefits is approved by the benefits carrier before you leave Canada for treatment.

Reimbursement is set at 80%, and is limited to $50,000 per lifetime.

What is Not Covered under Non-Emergency Care

- Investigational or experimental treatment
- Transportation or accommodation charges.

Limitations and Exclusions

There are certain limitations and exclusions under the Extended Health Care Plan. Except to the extent otherwise required by law, no benefit will be payable for any of the following:

- Expenses private benefits carriers are not permitted to cover by law
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded or administered in whole or in part by a government ("government plan"), whether coverage would have been available under this plan. In this limitation, government plan does not include the Yukon Government group plan for their employees.
- The portion of the expense for services or supplies that is payable by the government health plan in your home province/territory, whether or not you are actually covered under the government health plan
- Services or supplies that do not represent reasonable treatment
- Services or supplies not listed as covered expenses
- Services and supplies, rendered or prescribed, by a person who is ordinarily a resident in the patient's home, or who is related to the patient by blood or marriage
- Services or supplies for which a charge is made only because you have benefits coverage
- Services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport, or similar purposes
- Services or charges by a physician, or any other charges, that are covered by a provincial or territorial plan
- Products or treatments considered experimental by the benefits carrier
- Portion of charges which is the legal liability of any other party
- Services or supplies that were purchased from a provider not approved by the benefits carrier
- Services or supplies for a covered expense that are in excess of a lower cost alternative service or supply that represents reasonable treatment
- Services or supplies received out-of-province/territory in Canada unless you are covered by the government health plan in your home province/territory and the benefits carrier would have paid benefits for the same services or supplies if they had been received in your home province/territory. This limitation does not apply to Global Medical Assistance.
- Services or supplies associated with:

- treatment performed only for cosmetic purposes
- recreation or sports rather than with other daily living activities
- the diagnosis or treatment of infertility

Making Changes

If you waive coverage for your dependents when enrolling in retiree coverage with the Government of Yukon because they have coverage elsewhere (e.g., through a spousal plan), and that coverage subsequently terminates, you have 60 days to apply for coverage under this Benefit Plan. This 60 day limit also applies in the case of acquiring a new dependent. If your application for coverage is received within 60 days, coverage begins on the day following the date that your dependents' comparable coverage terminated, or the date you acquire a new dependent. If your application for coverage is received after 60 days, coverage is effective on the first day of the fourth month following the month in which the application is received.

If you request a change in coverage from Family to Single, the change is effective on the first day of the month following the date the notice of change is received.

Survivor Benefit Coverage

If a participant in the Extended Health Care Plan dies, the surviving spouse and/or eligible dependent children may continue their existing Health coverage under the Retiree Extended Health Care Plan.

Glossary of Terms

Benefits Carrier: Great-West Life

Benefit Plan: Refers to the benefits as provided for under the Government of Yukon's *Public Service Group Insurance Benefit Plan* Act

Benefit Year: April 1 to March 31

Coordination of Benefits: A provision that provides reimbursement for expenses when a person is covered by two separate benefit plans, or covered as both an employee and a dependent under the Government of Yukon's Benefit Plan

Deductible: The dollar amount you must pay prior to reimbursement being made under the Benefit Plan

Dependents: Your spouse, either legally married or living common-law for at least one year immediately before application for coverage under the plan; your unmarried dependent children (natural, adopted or stepchild of you or your spouse or a child whom you or your spouse is the legal guardian and guardianship has been court ordered) under age 21, or under age 25 if attending school on a full-time basis; your physically or mentally disabled children who are entirely dependent on you for support and their disability occurred while covered under the Plan as a dependent child

Extended Health Care Plan: Provides coverage for medically-necessary expenses over and above those covered by the Yukon Health Care Insurance Plan

Global Medical Assistance Benefit: Provides you and your dependents with assistance in locating and coordinating medical services in the event of an emergency when you are travelling outside of your home territory/province on vacation, business or education

Life Event: Situations that have an impact on the benefit coverage you need, such as: marriage, common-law relationships, birth/adoption of a child, divorce, loss or gain of spouse's employer coverage, or death of a dependent

Medically Necessary: Services and supplies generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness in accordance with Canadian medical standards.

Member: Refers to a retired employee of the Government of Yukon who has enrolled in the Benefit Plan

Prescription Drug Card: A card you use when you want to fill a drug prescription with your pharmacist that allows him/her to process your claim with the benefits carrier electronically and immediately. This card is only eligible under the Extended Health Care Plan

Reasonable and Customary Charges: Charges that the benefits carrier determines are reasonable and customary and are normally made to people in that area

Retiree: Refers to a retired employee of the Government of Yukon who has enrolled in the Benefit Plan

Yukon Health Care Insurance Plan: The mandatory, Government-sponsored health insurance plan that pays for basic medical services for residents of the Yukon

Who to Call

Extended Health Care: Questions about eligibility for benefits for you or your dependents should be directed to the Public Service Commission. Questions about your coverage or claims should be directed to the benefits carrier at 1-800-957-9777. Your policy number and ID number will be required.

Yukon Health Care Insurance Plan: General inquiries at 867-667-5209.

Great-West Life Online

Visit www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and their products and services
- news releases
- contact information
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at **www.greatwestlife.com**. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for medical and dental
- extensive health and wellness content

Using the GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Important Information

Access to Documents: You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to the insurance carrier such as evidence of insurability, subject to certain limitations.

Legal Actions: For insured benefits, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

For non-insured benefits, no legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals: For insured benefits, you have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

For non-insured benefits, you have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment: For insured benefits, if benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life's right to use other legal means to recover the overpayment.

For non-insured benefits, if benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Liability for Benefits: Your employer has entered into an agreement with the benefits carrier whereby your employer will have full liability for Extended Health Care (except Global Medical Assistance) and Dental benefits as outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by the benefits carrier.