HEALTH

JULY 2021

HEALTH BENEFITS INFORMATION

FOR SASKATCHEWAN TEACHERS
AND THEIR FAMILIES

YOUR PLAN INFORMATION

Plan document number:

5	1	5	8	5

Member identification number:

0	1								

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INTRODUCTION

The STF Members' Health Plan provides Saskatchewan teachers and their eligible family members with comprehensive coverage for prescription drugs, vision and other health-care expenses, including out-of-country emergency medical expenses.

Members don't pay any premiums to this Plan. As negotiated through the provincial collective bargaining process, funding for the Members' Health Plan is provided by the Saskatchewan government based on a fixed percentage of annual teachers' salaries.

The Saskatchewan Teachers' Federation is responsible for the design, management and administration of the Members' Health Plan. All of the benefits provided by the Plan are self-insured by the Federation and covered by a master plan document issued by Canada Life.

This booklet contains general information only. The exact terms and conditions of your group health benefits are described in the master plan document, which is considered the final authority in the event of any discrepancy or misunderstanding in interpretation.

This booklet contains important information and should be kept in a safe place.

YOUR RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

Right to Privacy

At the Saskatchewan Teachers' Federation we are dedicated to protecting your privacy and safeguarding your personal information. The STF Members' Health Plan collects personal information relevant to your insurance coverage, including your name, address, teacher's certificate number, social insurance number, birthdate and dependant information. This information is secured and access is limited to personnel from the Members' Health Plan, Canada Life and/or its claims agents, and any person or organization that has relevant information about you or your dependants that is required in order to process your claims, maintain our databases and provide health care and other related services to you.

We use your personal information to identify you, protect both you and the Plan from error and fraud, comply with legal requirements and administer all of the health and financial services provided to you. This includes many tasks, such as:

- Determining your eligibility for coverage.
- Maintaining your claim file.
- Processing and managing your claims.
- Underwriting activities and financial reporting.
- Conducting internal and external audits.
- Preparing regulatory and statutory reports.

Right to Access Information

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be made in writing to the Members' Health Plan.

YOUR RESPONSIBILITIES

Complete an Enrolment Form

Each time you sign a new contract of employment, a new Enrolment form must be completed and submitted to the Saskatchewan Teachers' Federation. Your school board must complete their section of the form to verify your employment and you must complete the remainder of the form and submit it to the Federation. The information provided on the Enrolment form will be used to determine if you and your family members are eligible for benefits and the period of eligibility.

Enrolment Forms are available from your school board and on the Federation website, www.stf.sk.ca.

Know Your Member ID Number

Your health plan member ID number is assigned to you when you're first enrolled in the Plan. This number is unique to you and will be required every time you make an inquiry or submit a claim. You must include your number on all correspondence to ensure accurate, efficient and confidential service.

Your member ID number is on your health benefit card. If you're a teacher on a temporary contract, your ID number is on the health benefit card included with your confirmation of enrolment letter from the Members' Health Plan. Your member ID number never changes.

Please note that when your coverage terminates, you will no longer be able to use your health benefit card.

Keep Your Records Up to Date

It's critical that you maintain accurate records for you and your family, so that your claims can be processed as quickly as possible and you receive updates on benefit and Plan information.

It's your responsibility to inform us of any changes to:

- Your name, mailing address, telephone number or preferred email address.
- Your spouse or eligible dependent children.
- Your co-ordination of benefits information (e.g., if your spouse obtains a group health benefit plan or if their plan coverage terminates).
- Your contract status (e.g., if you're on a board-approved leave, resign or retire).

You may be asked to provide supporting evidence of a change in your personal information, including, but not limited to, custody agreements and verification of student status, dependant or marital status.

You can update most of your personal information online in the MySTF section of the Federation website. Alternatively, you can complete and submit an STF Change of Information form to the Federation.

Please note, if there's a change in your contract status (e.g. you resign or retire) you must submit an STF Change of Information form before your contract end date. This form is available on the Federation website or by calling the Members' Health Plan.

MEMBER SERVICES

THE FEDERATION

The Saskatchewan Teachers' Federation administers your health plan and strives to provide teachers and their families with outstanding member service.

Online Services and Information

The Federation website provides information, forms and tools to help you manage your health benefits when it's convenient for you. Visit www.stf.sk.ca/pension-benefits/health-plan for Plan details, claim forms, newsletters, Enrolment forms and Change of Information forms. Updates to this booklet can be downloaded from the website as well.

You can also manage your personal information online when you log in to the MySTF section of the website.

Go to My Profile to change your name or contact information.

Go to My Benefits > Health Plan > Manage Family Coverage to:

- Print health claim forms.
- Change spouse and dependent children information.
- Upload student verification documents for dependent children aged 21 to 25 who are full-time students.
- Change your spouse's group benefits information.

If You Have Questions

Our professional staff at the Members' Health Plan provides timely, personalized service to members. If you have any questions about eligibility, commencement and termination of coverage, health benefit cards, or other general questions about the Plan, contact us at:

STF Members' Health Plan
2317 Arlington Avenue
Saskatoon SK S7J 2H8

T: 306-373-1660 or 1-800-667-7762
F: 306-374-1122
E: health@stf.sk.ca
www.stf.sk.ca

CANADA LIFE

Canada Life processes all health, prescription drug, vision and out-of-country medical expense claims.

Online Services and Information

Register for Canada Life GroupNet to:

- Register for direct deposit.
- Submit health claims online.
- Check the status of your claims.
- View your claims history.
- Check your vision balances and next eligible service date.

To register, visit the Federation website at www.stf.sk.ca/pension-benefits/health-plan, and select Canada Life GroupNet. Alternatively, you can download the Canada Life GroupNet Mobile free app from the Apple Store or Google Play.

Claim Inquires

If you have a question about a claim that you have submitted, contact Canada Life at 1-800-957-9777.

You'll need to provide the plan document number 51585 and your member ID number (01_ _ _ _ _ _ _ _) when calling either the Members' Health Plan or Canada Life, or when registering for Canada Life GroupNet.

ELIGIBILITY DETAILS

ELIGIBILITY CRITERIA

You're eligible to participate in the Members' Health Plan if you have completed 20 full or partial days of teaching service (known as the qualification period), and you meet one of the following requirements:

- You're a teacher employed under a continuous, replacement or temporary contract with a board of education or a conseil scolaire pursuant to Section 200 of *The Education Act, 1995*.
- You're a member of the Saskatchewan Teachers' Federation and employed as a teacher in an independent school that receives operating funding from the provincial Ministry responsible for PreK-12 education, provided that the teachers in the school are not members of any trade union and are not covered by any other collective bargaining agreement.

This Plan only provides coverage if you and your dependants are covered under a provincial health plan and have residence status in your home province.

If you retire, you're not eligible for health plan benefits starting on the date that retirement benefits first become payable under the Saskatchewan Teachers' Retirement Plan or the Saskatchewan Teachers Superannuation Plan (your "retirement date"). If after retirement date you continue to teach or return to teach under contract, health plan benefits will not recommence until the first school day following your retirement date.

If you're on a school board-approved leave of absence, coverage will be extended during your period of leave. If you're receiving disability benefits from the Teachers' Long-Term Disability Plan, coverage under the Members' Health Plan will be extended until the end of the month of your 65th birthday.

Substitute teachers are not eligible for coverage under the Plan.

EFFECTIVE DATE

After you've completed the 20-day qualification period, coverage will be applied retroactively to the first school day of your contract. Please note that a qualification period (completion of 20 full or partial days of teaching service) will be required for each new contract if there has been a break in service of more than 120 days.

TERMINATION AND REINSTATEMENT OF COVERAGE

Termination of Coverage

Your coverage under the Members' Health Plan terminates when your employment ends, you're no longer eligible, you're no longer a teacher as defined by *The Education Act, 1995*, or the Plan terminates, whichever is earlier.

Teachers employed on a temporary contract cease to be eligible for benefits on the last school day of the contract.

Retiring teachers are not eligible for benefits starting on the date that retirement benefits first become payable under the Saskatchewan Teachers' Retirement Pan or the Saskatchewan Teachers Superannuation Plan (your "retirement date").

If you're receiving disability benefits from the Teachers Long-Term Disability Plan, health plan benefits terminate at the end of the month of your 65th birthday.

Reinstatement of Coverage

If you're employed under a continuous or replacement contract that terminates on June 30 (or the last school day of the year), and you enter into a like contract of employment on the next school day, you're entitled to retroactive benefits.

If you're on a temporary contract, benefits will cease on the last school day of the contract. If you enter into another contract, benefits will commence on the **first school day** of the new contract. Please note: If you're on a temporary contract ending June 30 and you sign a new contract of employment effective July 1, your benefits will be reinstated on the first school day of the new contract. Therefore, you would not have coverage under the Members' Health Plan over the summer months.

If after your retirement date you continue to teach or return to teach under contract, health plan coverage will not be reinstated until the first school day following your retirement date.

A qualification period (completion of 20 full or partial days of teaching service) will be required for each new contract if there has been a break in service of more than 120 days.

Obtaining Health Insurance After Termination

If your coverage under this Plan is terminating for any of the reasons stated in this booklet, including retirement, you can apply for health insurance from another insurance provider.

If you retire, you're eligible to apply for group health benefits through the Superannuated Teachers of Saskatchewan within 60 days after retirement without having to provide evidence of insurability. Contact the STS at 306-373-3879 for complete information.

Canada Life offers Plan Direct, an individual health-care plan designed for people retiring or leaving their job. Medical evidence of insurability is not required for former members of the Members' Health Plan if you apply within 60 days after your coverage under this plan ends. Contact Canada Life at 1-800-565-4066 for information about their individual health insurance products.

You can apply for private coverage offered by other insurers; however, you may need to provide evidence of insurability.

FAMILY COVERAGE

The Members' Health Plan provides coverage for your eligible spouse (legal or common law) and eligible dependent children as defined below. In order to be eligible, your spouse and/or dependant children must have valid provincial health plan coverage and have residence status in their home province.

Eligible Spouse means:

- Your legal spouse or the person who has been living with you in a spousal relationship for at least 12 consecutive months.

Eligible Dependent Children means unmarried children (natural, adopted or stepchildren) who are:

- Under age 21 and dependent upon you for support. (Children under age 21 are not covered if they're working more than 30 hours per week, unless they're full-time students).
- Age 21 or older but under age 26, dependent upon you for support and in full-time attendance at an accredited post-secondary educational institution. (Verification of student status is required for your child to be

eligible for coverage).

- Incapable of supporting themselves because of a physical or mental disability, provided the disabling condition began before they turned age 21 or while they were a full-time student under age 26, and the disabling condition has been continuous since that time. (Supporting medical information is required for your child to be eligible for coverage).

If you're the legal guardian of a child who does not meet the definition as stated, please contact the Members' Health Plan. We will request additional information from you to determine if the child may be eligible for benefits.

Your spouse's and/or dependant's coverage terminates when your coverage terminates or when your spouse or dependant no longer qualifies, whichever is earlier.

Verification of Dependant Eligibility

Student Status

If your dependent child is age 21 or older but under age 26 and a full-time student at an accredited post-secondary institution, verification of student status is required. Confirmation of continued enrolment must be submitted to the Members' Health Plan each year or semester.

The document or letter verifying your child's student status must include:

- The student's full name.
- The start and end date of classes.
- Confirmation that the student is in full-time attendance.
- The signature of the registrar of the educational institution.

You can upload the student verification document online in the MySTF section of the Federation website, or send it to the Members' Health Plan by email, fax or mail.

Coverage under the Plan begins on the first day of classes unless your dependent child has been a full-time student during the past academic term and is continuing full-time studies in the fall. Coverage is then extended throughout the summer and into the fall academic term.

Benefits will cease on the last day of the month in which your child receives a degree or completes their education program. It's your responsibility to remove your child as an eligible dependant at that time. You can update the information online through MySTF or submit a Change of Information form.

Physical or Mental Disability

For dependent children who are incapable of supporting themselves because of a physical or mental disability, you're required to provide detailed medical information when the child turns 21 to support eligibility for continued coverage under the Plan.

Survivor Benefits

If a member of the Members' Health Plan dies while his or her spouse and dependent children are insured under this Plan, coverage for the spouse and dependent children will continue to the earlier of:

1. The date they cease to be eligible dependants.
2. Twenty-four months after the member's death.

If a member's child is born after his or her death, the child is considered to be an insurable dependant.

Survivor benefits are paid to the surviving spouse. If there is no surviving spouse, benefits are paid as follows:

1. For a child who meets the definition of eligibility and who has reached the age of majority, to him or her.
2. For a minor child who meets the definition of eligibility, to his or her legal guardian.

BENEFIT SUMMARY

The Members' Health Plan covers a wide range of medical expenses beyond what your provincial health plan provides. The benefits provided by your plan are summarized below. Please see the Benefit Details section of the booklet for more information related to specific benefits.

Benefit reimbursement levels and benefit maximums apply individually to each eligible family member. There is no overall lifetime health-care maximum.

Reimbursements will not exceed reasonable and customary charges. A reasonable and customary charge is the maximum amount that an insurance company determines is a fair reimbursement level, based on:

- Their pool of claims for that benefit in a particular geographic location,
- Practitioner fee schedules,
- Interaction with plan sponsors and other insurance companies,
- Maximum prices established by law.

IN-CANADA PRESCRIPTION DRUGS & DIABETIC DRUG SUPPLIES	REIMBURSEMENT LEVEL (NO DEDUCTIBLE)	BENEFIT MAXIMUM
Prescription Drugs Tier 1: National Formulary Tier 2: Special Authorization Tier 3: Saskatchewan Formulary	 100% 75% 100%	Unlimited
Diabetic Drug Supplies	100%	$2,000 each calendar year (Includes diabetic supplies under the Medical Supplies & Equipment category)
Erectile Dysfunction Drugs	100%	Unlimited
Fertility Drugs	100%	$15,000 lifetime
Smoking Cessation Drugs	100%	$500 lifetime
Vaccines	100%	$300 every 2 calendar years

VISION	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Eye Examination • You and your eligible spouse, and dependent children at least age 21 but under age 26 • Disabled dependants age 21 or older	100%	$125 every 24 months
Eye Examination • Dependent children under age 21	100%	$125 every 12 months
Vision Services and Supplies • You and your eligible spouse and dependent children	100%	$400 every 24 months

HEALTH PRACTITIONERS	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Acupuncturist Audiologist Chiropractor Dietitian Massage Therapist Naturopath Occupational Therapist Osteopath Physiotherapist/Athletic Therapist Podiatrist/Chiropodist Speech Therapist	80%	$500 per calendar year for each practitioner listed.
Psychologist/Social Worker	90%	$2,500 per calendar year

MEDICAL SUPPLIES & EQUIPMENT	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Hearing Aids	80%	$1,200 every 4 years
Custom-Made Compression Hose	80%	$500 each calendar year
Custom-Made Foot Orthotics & Orthopedic Shoes	80%	$500 each calendar year
Mechanical or Hydraulic Patient Lifters (excluding stair lifts)	80%	$2,000 per lifter (electric) once every five years
Outdoor Wheelchair Ramps	80%	$2,000 lifetime
Hairpieces	80%	$1,000 every 2 calendar years
External Breast Prosthesis	80%	1 (per side) every 12 months
Surgical Brassieres	80%	2 every 12 months
Blood-Glucose Monitoring Machines	80%	1 every 4 years
Flash Glucose Monitoring Machines	80%	No frequency maximum
Continuous Glucose Monitoring Machines, Sensors and Transmitters	80%	$4,000 each calendar year
Insulin Infusion Pump	80%	$6,300 every 4 years
Diabetic Supplies	80%	$2,000 each calendar year (Includes diabetic supplies under prescription drugs)
Transcutaneous Nerve Stimulators (TENS)	80%	$700 lifetime
Extremity Pumps for Lymphedema	80%	$1,500 lifetime
Certain Medical Supplies, Appliances and Equipment	80%	Reasonable and customary charges

AMBULANCE, HOSPITAL & PRIVATE NURSING	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Ambulance	100%	No maximum
Hospital Room	100%	Semi-private room
Chronic Care	100%	$20 per day to a maximum of 90 days
Respite Care	100%	$20 per day to a maximum of 90 days
Private Duty Nursing	100%	$25,000 every 3 years

TRAVEL COVERAGE	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Out-of-Country Emergency	100%	Unlimited
Out-of-Country Non-Emergency	100%	$50,000 lifetime
Travel Assistance	100%	See Benefit Details

OTHER COVERAGE	REIMBURSEMENT LEVEL	BENEFIT MAXIMUM
Medical Travel in Canada	100%	$2,000 lifetime

BENEFIT DETAILS

The Members' Health Plan covers the following services and supplies, provided they are not covered under your provincial government plan and provincial law permits coverage. All expenses will be reimbursed at the level and up to the maximums shown in the Benefit Summary section of the booklet.

Covered expenses and limitations apply to each eligible family member. Covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

PRESCRIPTION DRUGS AND DIABETIC DRUG SUPPLIES

The Members' Health Plan provides coverage for eligible prescription drugs and diabetic drug supplies provided in Canada.

Covered Expenses

The Plan will only cover the cost of the lowest-priced equivalent generic drug, unless Canada Life has approved coverage of the brand name drug.

If a prescribed drug cannot be substituted, you can submit a Request for Brand Name Drug Coverage form to Canada Life for review. To obtain this form, contact Canada Life at 1-800-957-9777. You'll be required to provide acceptable medical evidence that the prescribed drug cannot be substituted.

The Plan provides coverage for the list of medications and diabetic drug supplies indicated under the following formularies, as well as certain other eligible drugs:

Tier 1: National Formulary Drugs

The National Formulary is a managed drug formulary that includes a comprehensive list of commonly prescribed drugs that are both medically and cost effective. Covered drugs and diabetic drug supplies covered under this category include:

- The drugs listed in the Telus Health National Formulary in effect on the date of purchase.

- The following diabetic drug supplies: syringes, test strips, lancets, disposable needles for use with non-disposable insulin injection devices, and sensors for flash glucose monitoring machines*. *(See Medical Supplies and Equipment on page 22 for other diabetic supplies and equipment covered under the Plan).*

* To be eligible for coverage for flash glucose sensors, you must be at least 18 years of age, use insulin to manage blood sugar/glucose levels and have at least two years of experience self-managing your diabetes.

Tier 2: Special Authorization Drugs

Special Authorization drugs are medications that are prescribed only after other drug therapies prescribed during the course of treatment have not been effective. Covered drugs in this category include:

- The drugs on the Telus Health Special Authorization list in effect on the date of purchase.

Tier 3: Saskatchewan Formulary Drugs

The Saskatchewan Formulary is a listing of the high-quality, therapeutically effective drugs that have been approved for coverage under the Saskatchewan Drug Plan. Covered drugs in this category include:

- The drugs listed in the Saskatchewan Formulary in effect on the date of purchase.

Other Eligible Drugs

- Eligible vaccines.
- Fertility drugs.
- Drugs used to treat erectile dysfunction.
- Smoking cessation drugs requiring a prescription.

Limitations

Coverage is not available for:

- Drugs eligible under a provincial drug plan (coverage is limited to the deductible amount and co-insurance you are required to pay under that plan).
- Any single purchase of drugs which would not reasonably be used within 90 days.
- Drugs covered under exception drug status under a provincial formulary unless they are included in the National Formulary or Special Authorization drug list.

- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy.
- Drugs dispensed during treatment as an inpatient or an outpatient in a hospital.
- Allergy extracts.
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.

Health Assure Check

Before your prescription is filled, a Health Assure check will be done on your drug claim history to assist the pharmacist in identifying any drug interaction warnings, limits on quantity of medication, therapeutic duplication and duration of therapy. Depending on the outcome of this check, the pharmacist may refuse to dispense the prescribed drug and further consultation with your physician may be necessary to have the proper medication prescribed.

Saskatchewan Special Support Program

If you're a Saskatchewan resident, you may be eligible to have a portion of your prescription drug expenses paid for by the provincial government through the Saskatchewan Special Support Program.

Your pharmacist will advise you to apply for the SSP and provide you with an application form. Send your completed application to the Saskatchewan Drug Plan Special Support Program. You will receive a notification letter from the Ministry of Health with detailed information regarding your application. Send a copy of the notification letter to Canada Life by email to sdppharmacare@gwl.ca or fax 204-946-7664. Make sure to include your Plan and ID number found on your health benefit card. Failure to apply could result in a suspension of your prescription drug benefits until you make application.

Seniors' Drug Plan

If you're a Saskatchewan resident, 65 years of age or older, you may be eligible to have a portion of your prescription drug expenses paid for by the provincial government through the Saskatchewan Seniors' Drug Plan.

Prior to you or your eligible spouse turning age 65, you'll receive a letter from Canada Life Drug Services requesting that you apply for the Saskatchewan Seniors' Drug Plan by a specified date. Once your application is processed, you'll receive a letter from the Seniors' Drug Plan confirming eligibility. You must fax a copy of this letter to Canada Life at 204-946-7664 by the specified date to avoid suspension of your prescription drug benefits.

VISION

Covered vision expenses and limitations apply to each individual eligible family member. Benefit periods (i.e., 12- or 24-month periods) apply from the date of purchase of the service or supply, not your effective date of coverage. **The date of purchase is the date the service or supply was paid for in full.**

To confirm the date you'll be eligible for an eye exam or vision supplies, or to confirm the amount of coverage still available in the current benefit period, contact Canada Life at 1-800-957-9777 or access Canada Life GroupNet to check your vision balances and next eligible service date.

Eye Exams

Eye exams must be performed by a licensed optometrist or ophthalmologist.

Vision Services and Supplies

Vision services and supplies must be prescribed and/or provided by a licensed optometrist or ophthalmologist and provided by a qualified optician.

Covered Expenses

- Prescription glasses (frames and/or lenses).
- Contact lenses and contact lens service.
- Sunglasses with prescription lenses.
- Safety glasses with prescription lenses.
- Laser eye surgery.
- Visual training and therapy preformed in the office of a licensed optometrist or ophthalmologist.

HEALTH PRACTITIONERS

The Members' Health Plan covers out-of-hospital services by the health practitioners listed below, provided they are licensed, certified or registered.

Licensed, certified or registered means licensed, certified or registered to practice the profession by the appropriate licensing, certification or registration authority of the jurisdiction in which the care and/or services

are provided or, where no such authority exists, possessing a certificate of competency from the professional body that established professional standards of competency and conduct.

Covered Expenses

Services of the following health practitioners are eligible for coverage:

- Acupuncturist
- Audiologist
- Chiropractor
- Dietitian
- Massage therapist
- Naturopath
- Occupational therapist
- Osteopath
- Physiotherapist/athletic therapist
- Podiatrist/chiropodist
- Psychologist/social worker
- Speech therapist

MEDICAL SUPPLIES AND EQUIPMENT

All expenses in this category must be prescribed by a physician, unless otherwise specified, and must indicate the medical diagnosis for which the equipment or supply is required. For claiming purposes, expenses are considered to be incurred the date the supply is received and paid for in full.

Certain medical supplies and equipment not listed may be eligible for coverage. Please contact the Members' Health Plan for further details.

Covered Expenses

- Rental or, at the Members' Health Plan's discretion, purchase of a manual wheelchair or a standard hospital bed. When deemed necessary, an electric wheelchair may be substituted.
- Rental or, at the Plan's discretion, purchase of certain medical supplies, appliances and equipment, including but not limited to, breathing equipment, prosthetic equipment, orthopedic equipment, mobility aids, etc.

- Charges for the initial placement of a non-myoelectric limb and artificial eyes.
- Custom-made foot orthotics and custom-made orthopedic shoes prescribed by an approved health-care provider (physician or podiatrist) and specifically designed and molded for the patient's foot. Custom-fit and modifications to existing or new orthopedic shoes are not eligible. Birkenstocks, Finn Comfort, Rockport, Nike, etc., are not eligible. This benefit includes the biomechanical assessment and casting fee. Invoice must include a detailed description of the type of orthotics, the casting technique used and the date dispensed. A copy of the biomechanical exam or gait analysis is also required with the claim.
- Hearing aids, tubing and ear moulds provided at the time of purchase. Excludes replacement batteries and routine maintenance.
- Hairpieces required as a result of a medical condition.
- Custom-made compression hose required as a result of a medical condition.
- Transcutaneous Nerve Stimulators (TENS) required as a result of a severe, chronic condition.
- Ostomy supplies including irrigation sets, bags, deodorants, pads, adhesives or skin creams when not covered under your provincial government health plan.
- The following diabetic supplies: novolin-pens or similar insulin injection devices using a needle, insulin infusion sets, bloodletting devices including platforms. (More diabetic drug supplies are covered under Prescription Drugs and Diabetic Drug Supplies, page 18).
- Blood-glucose monitoring machines.
- Insulin infusion pumps.
- Continuous glucose monitoring machines, sensors and transmitters. To be eligible for coverage, you must use insulin to manage blood sugar/glucose levels. To establish coverage, a Pre-treatment/Estimate form must be submitted to Canada Life prior to submitting a claim.
- Flash glucose monitoring machines. A physician's referral is not required. However, to be eligible for coverage you must be at least 18 years of age, use insulin to manage blood sugar/glucose levels, and have at least two years of experience self-managing your diabetes.

AMBULANCE & HOSPITAL

Covered Expenses

- Ambulance transportation, including air ambulance services, to the nearest centre where adequate treatment is available, and where a licensed ambulance company provides services.
- Semi-private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care.
- A hospital is defined as an institution that is legally termed a hospital, is open at all times, offers inpatient accommodation, has a staff of one or more physicians available at all times, and continuously provides 24-hour nursing by graduate registered nurses.
- Out-of-province outpatient charges not covered by the government health plan in your home province.
- Diagnostic x-rays and tests when not covered under your provincial government health plan.

CHRONIC CARE, RESPITE CARE AND PRIVATE NURSING

To establish the amount of coverage available for chronic care, respite care and services provided by a private duty nurse, you must apply for a pre-care assessment.

Covered Expenses

- Chronic care provided in a hospital, nursing home or for home nursing care, for a condition where improvement or deterioration is unlikely within the next 12 months.
- Respite care provided at home or at a day program or as an inpatient admission to a facility where the patient would reside for a specific period of time.
- The government authorized co-payment for accommodation in a nursing home. Residences established primarily for senior citizens, or which provide personal rather than medical care, are not covered.
- Services of a registered nurse, licensed practical nurse, or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse as prescribed by a

physician. Care provided does not include homemaking or companionship duties. Charges will not be considered for services provided in a hospital, or when the nurse normally resides in the patient's home.

TRAVEL COVERAGE

OUT-OF-COUNTRY EMERGENCY

The health plan covers medical expenses incurred as a result of a medical emergency arising while you or your eligible family members are temporarily outside Canada for vacation, business or education purposes. To qualify for coverage, you must be covered by the government health plan in your home province.

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

A medical emergency is either:

- Any sudden, unexpected injury; or
- The onset of a condition not previously known or identified prior to departure from Canada; or
- An unexpected episode of a condition known or identified prior to departure from Canada. An unexpected episode means it would not have been reasonable to expect the episode to occur while travelling outside of Canada. If a person was suffering from symptoms before departure from Canada, Canada Life may request medical documentation to determine if, in the circumstances, it could have reasonably been anticipated that the person may require medical treatment while outside of Canada.

Covered Expenses

The Plan covers the following services and supplies when related to out-of-country emergency 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 when you or your dependant is covered.
- Medical supplies provided during a covered hospital confinement.
- Paramedical services provided during a covered hospital confinement.

- Hospital outpatient services and supplies.
- Medical supplies provided out of hospital if they would have been covered in Canada.
- Prescription drugs.
- Out-of-hospital services of a professional nurse, if prescribed by a physician.
- For emergency care only, ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available.

Limitations

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.
- The amount payable under this Plan for comparable treatment in Canada plus the cost of return transportation.

No benefits will be paid for:

- Any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management, or follow-up care 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.

OUT-OF-COUNTRY NON-EMERGENCY

Non-emergency care outside of Canada is covered for you and you eligible family members if:

- It is required as a result of a referral from your usual Canadian physician.
- It is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties.
- You're covered by the government health plan in your home province for a portion of the cost.
- A pre-authorization of benefits is approved by Canada Life before you leave Canada for treatment.
- The maximum amount payable for non-emergency care is $50,000 in a person's lifetime.

Covered Expenses

The same services and supplies listed under out-of-country emergency care.

Limitations

No benefits will be paid for:

- Investigational or experimental treatment.
- Transportation or accommodation charges.

TRAVEL ASSISTANCE

Travel Assistance coverage provides benefits and support to travellers in emergency situations worldwide, 24 hours a day, seven days a week. The network locates medical services and obtains Canada Life's approval of covered services when required as a result of a medical emergency arising while you or your dependants are travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You and your dependants must be covered by the government health plan in your home province to be eligible for Travel Assistance benefits.

The following services are covered, subject to Canada Life'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 on an inpatient basis for more than seven 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 your dependant 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 dependant's medical condition, to a maximum of $1,500.
- The cost of comparable return transportation home for you or your dependant and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependant is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.
- In the case of death, preparation and transportation home of the deceased.
- Return transportation home for minor children travelling with you or a dependant that is left unaccompanied because of your or your dependant's hospitalization or death. Return of round-trip transportation for an escort for minor children is also covered when considered necessary.

- Costs of returning your or your dependant's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependant 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 includes telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

Please refer to Canada Life's brochure, Travel Assistance, for additional details.

MEDICAL TRAVEL IN CANADA

If your doctor refers you or your eligible family members for treatment by another physician within your own province, or elsewhere in Canada and the round-trip distance is 1,000 kilometres or more, the Members' Health Plan will pay for the following expenses:

- Travelling expenses for the person requiring the treatment and one companion, if recommended by the attending doctor. Benefits are limited to either round-trip economy class travel or automobile fuel expenses. Taxi, car rental charges and automobile repair charges are not covered.
- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred. Telephone and meal expenses are not covered.

Transportation and lodging expenses associated with in-Canada medical travel are limited to a maximum of $2,000 in a person's lifetime. All claims must be supported by documentation and receipts.

In order to assess a claim for medical travel in Canada you must submit, in addition to receipts for travel and lodging, confirmation from your physician of:

- The nature of the patient's medical condition.
- Written referral to another physician for treatment.
- The nature of the treatment provided.
- If charges are claimed for a companion, a physician's written recommendation that the patient is to be accompanied.

PRIOR AUTHORIZATION

Canada Life maintains a limited list of services, supplies and drugs that require prior authorization in order to determine if coverage will be provided. Prior authorization is intended to help ensure that a service or supply represents reasonable treatment. If required, you can obtain the Prior Authorization form by contacting Canada Life.

If the use of a lower-cost service or supply represents reasonable treatment, you or your family member may be required to provide medical evidence why the lower-cost alternative cannot be used before coverage for a more expensive service or supply will be provided.

Designated Provider Limitation

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

- Limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Canada Life.
- Decline a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

OTHER HEALTH PROGRAMS

Health Case Management

Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that 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.

In determining whether to implement health case management, Canada Life 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.

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented health case management and the person does not participate or co-operate.
- The person has not adhered to the treatment plan recommended by their attending physician with respect to the use of the service or supply.

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Patient Assistance

A patient assistance program provides assistance to people with the purchase of services or supplies. Canada Life can require a person to apply to and participate in any patient assistance program to which the person may be entitled. Further, Canada Life can reduce the amount of coverage for a service or supply by the amount of financial assistance the person is entitled to receive for that service or supply under a patient assistance program.

SUBMITTING A CLAIM

You have 15 months from the date an eligible expense is incurred to submit a claim to Canada Life, unless the expense was incurred outside of Canada. Claim periods for out-of-country claims depend on the province in which you live (See Out-of-Country Claims).

All expenses must be paid for in full in order for your claim to be processed.

To submit a health claim, you'll need the plan document number (51585) and your personal member ID number, which can be found on your health benefit card. If you're on a temporary contract, your plan and member ID number is on the card included with your confirmation of enrolment letter.

After your claim has been processed, an explanation of benefit statement (itemization of expenses) will be provided to you by Canada Life for income tax purposes and to co-ordinate benefits with other insurers.

Please note that the Members' Health Plan allows assignment of benefits (AOB) to health-care providers. This means a health-care provider, such as your optometrist, may be paid directly by Canada Life for the services or supplies you or an eligible family member receive. By authorizing the provider to receive payment from Canada Life, you don't have to pay the whole bill, submit your claim and wait to be reimbursed. Ask your health-care provider if they offer assignment of benefits. Please note that you'll still be required to pay any portion of your claim that's not eligible for coverage.

PRESCRIPTION DRUG, VISION AND HEALTH CLAIMS

Using Your Health Benefit Card At the Pharmacy

You can present your health benefit card to the pharmacist at most pharmacies in Canada and they will submit your claim electronically so it can be processed immediately.

If you're on a temporary contract, present the pharmacist with the health benefit card included with the confirmation of enrolment letter you received from the Members' Health Plan.

You must keep all original receipts for at least 12 months to support your claims in the event you're audited by Canada Life.

Provider eClaims

Approved health-care providers can also submit your claim electronically to Canada Life right from their office. Your claim will be processed immediately so you'll know whether your claim has been approved and if you need to pay anything. Also, if your provider allows assignment of benefits (AOB), you're out-of-pocket expenses may be reduced or eliminated. Ask your health-care provider if this option is available.

The following types of health-care providers are able to use Provider eClaims:

- Acupuncturist
- Chiropractor
- Dietitian
- Massage therapist
- Naturopath
- Optometrist/optician
- Physiotherapist
- Podiatrist
- Psychologist
- Speech therapist

For a list of approved providers in your area, see *Find a Provider* on Canada Life GroupNet for Plan members.

Submitting Your Claim Online

All health claims can be submitted online through Canada Life GroupNet for Plan members.

Online claim submission is available 24 hours a day, seven days a week. In order to submit a claim online, you must register for Canada Life GroupNet. To register, visit the Federation website at www.stf.sk.ca/pension-benefits/health-plan and click on Canada Life GroupNet. You'll require the Plan document number (51585) and your member ID number. During the registration process you must also sign up for direct deposit and eDetails under Your Profile. By doing so, your claim payment will be deposited directly into your bank account and you'll be emailed notification of the claim details when your claim has been processed.

Please note that **you have twelve months from the date the expense is paid to submit a claim online**. If your claim is over twelve months old, complete and submit a Healthcare Expenses Statement form. Online claim submission is not available after your contract termination date, so after your termination date you'll need to submit a Healthcare Expenses Statement form for any expenses incurred while on contract.

Canada Life Online Claim Audits

Canada Life may audit your online claim, so you must retain all original claim receipts and supporting documentation for at least 12 months. In the event Canada Life audits your claim, you must provide the requested documentation to them within the time frame specified. If you don't submit your receipts within the required time frame, online claim privileges will be suspended until the audit process is complete.

Submitting a Healthcare Expenses Statement Form

All health expense claims can be submitted by mailing a Healthcare Expenses Statement form directly to Canada Life. When submitting a Healthcare Expenses Statement form, complete one claim form for all family members for whom you're claiming expenses. Send the completed form, along with all original receipts or invoices attached to the address on the form.

Healthcare Expenses Statement forms are available on the Federation website, www.stf.sk.ca/pension-benefits/health-plan, or by calling the Members' Health Plan.

All claims must be accompanied by the appropriate original receipts and documentation required to process your claim. Photocopies, credit card and/or cash register receipts are not acceptable. Enclose all medical information, including letters of referral and pertinent medical information (e.g., the medical diagnosis for the prescribed item). Your claim may be denied if information is missing. If you have questions about what documentation is needed to complete your claim submission, please contact the Members' Health Plan or Canada Life prior to submitting your claim.

All receipts and documentation become part of Canada Life's records and will not be returned to you. Please be sure to keep a copy of your claim form and receipts for your own records.

Processing and Payment

You can arrange for your claim payment to be deposited directly into your bank account by registering for Canada Life GroupNet. (See Submitting Your Claim Online). Your payments will be directly deposited whether you submit a claim online or use a Health Claim form.

If you don't register for direct deposit, a claim cheque will be mailed to you directly from Canada Life.

If you submit your claim online, you will be notified when your claim has been processed and the claim details will automatically appear in your claims history.

OUT-OF-COUNTRY CLAIMS

Submitting Your Claim

Out-of-country expenses must be submitted within a certain time period, which varies by province of residence and is subject to change. Please be aware of these time limits and submit your claim as soon as possible after the date of service.

In Saskatchewan, out-of-country claims, other than those for Travel Assistance expenses (see page page 28), should be submitted for consideration within six months of the date of service. You must complete and submit the following forms:

1. Statement of Claim Out-of-Country Expenses
2. Schedule "A" and Schedule "B"

If you reside outside of Saskatchewan, you must complete and submit the Statement of Claim Out-of-Country Expense form and, if applicable, the government assignment and authorization to provide medical information forms from your home province.

The out-of-country claim form and schedules are available on the Federation website under www.stf.sk.ca/pension-benefits/health-plan or by calling the Members' Health Plan.

You can submit the claim online through Canada Life GroupNet by uploading the completed claim form and receipts, or send the completed forms along with all original receipts and bills to the address on the claim form. Please keep a copy of your claim for your own records.

Processing and Payment

All eligible charges for your claim will be paid, including the portion that is covered by your provincial medical plan. Your provincial medical plan will then reimburse Canada Life for their share of the expenses, except for those provinces requiring you to mail your claim directly to their plan first.

Inquiries

To verify the claims submission period applicable in your home province, or if you require assistance in completing or obtaining any of the applicable forms, please contact Canada Life Out-of-Country Claims Department at 1-800-957-9777.

CO-ORDINATION OF BENEFITS

Your health plan benefits may be co-ordinated with the benefits provided by any other plan to increase your coverage for eligible expenses. The total amount received from all sources cannot exceed the amount of the actual expenses incurred.

Benefits will automatically be co-ordinated or reduced by any amount payable under a government plan. The reduced amount is then considered to be the covered expense under all other co-ordination provisions. It is subject to any applicable deductibles, reimbursement levels and maximums under this Plan.

Co-ordinating Your Claim

You and your spouse must first submit your own claims to your own group plans, regardless of whether or not you have reached the benefit maximum. If you and your spouse are both members of the Members’ Health Plan, you can co-ordinate benefits so that eligible expenses are calculated first as a member and secondly as a dependent spouse at the same time. You can use your health benefit cards at the pharmacy or other health-care providers so they can electronically co-ordinate benefits for you.

If you’re submitting the balance of a claim to another plan, you must include the explanation of benefit (itemization of expenses) that you receive from Canada Life. This allows the other insurer to reimburse you properly for the claims incurred.

Remember to include copies of receipts and bills when submitting claims for co-ordination of benefits, as well as retaining the same for your own files.

Claims for dependent children must be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). This applies whether the parents are spouses, or in the event of a separation or divorce, when there is joint custody.

If you're separated or divorced and one parent has full custody of a dependent child, claims should be submitted in the following order:

- To the plan of the parent with custody of the child.
- To the plan of the spouse of the parent with custody of the child.
- To the plan of the parent without custody of the child.
- To the plan of the spouse of the parent without custody of the child.

Any amount that is not paid by the first plan, may be submitted to the plan of the other spouse. Each person will receive payment for the portion of the eligible claim submitted to their plan, regardless of who incurred the total cost. The Members' Health Plan cannot pay benefits to any individual or organization other than the covered member under whose plan the claim is being submitted.

Please ensure you advise the Members' Health Plan if you separate or divorce so that the correct order for payment of benefits can be determined. If the Plan is not advised, it is assumed that the first payor is the plan of the parent who has the earlier birthday in the calendar year.

GENERAL PLAN LIMITATIONS

No benefits will be paid for:

- Expenses private insurers are not permitted to cover by law.
- Services or supplies not listed as covered expenses.
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage.
- Medical examinations for the use of a third party.
- Obtaining further medical information regarding claims for covered expenses, or any expenses incurred for the completion of claim forms.
- Charges for which the insurer is not permitted by law/legislation to cover. Any changes to provincial legislation or government health insurance plans will not automatically result in a change of coverage provided under the Members' Health Plan.
- Services or supplies the insured person obtains or is entitled to obtain under any government plan.
- The failure of an insured person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to a government plan to which they are entitled. If the insured person is not a member of a government plan by reason of having "opted-out," or for any other reason is not a member of a government plan, the insured person will be deemed, for the purposes of this Plan, to be a member of the government plan.
- Extra charges that may result due to the physician opting out of the government health insurance plan.
- Services or supplies that do not represent reasonable treatment or the least expensive, appropriate treatment.
- Services or supplies not medically necessary.
- Charges in excess of the specific limitations and maximum amounts described in the Benefit Summary, including combinations of various Plan maximums, deductibles, co-insurance, reasonable and customary charges and frequency limitations.
- Experimental or investigational treatment not generally accepted by the medical community or involving therapies not prescribed or paid for under provincial or federal medical reimbursement plans.

- Treatment not recognized under Canada Revenue Agency bulletins that define the parameters of a private health services plan.
- Any sickness or bodily injury occurring in the course of employment if you, your spouse or dependant is eligible for coverage through the workers' compensation legislation in your province of residence.
- Charges in connection with general health exams.
- Services or supplies associated with:
  - Treatment performed only for cosmetic purposes.
  - Recreation or sports only, rather than with other daily living activities.
- Any care, service or supply in connection with a change in gender.
- Charges for any method of contraception other than covered drugs.
- The renovation or alteration in any physical way to an insured person's residences, vehicles or place of business, including the filtration or purification, whether mechanical or electronic, of air, water or other environmental factors.
- The repair or alteration of any prosthetic device incurred after the initial placement and fitting, or charges incurred due to the replacement of any prosthetic device unless the replacement is due to a change in the insured person's physical condition.
- Private or semi-private room charges in an acute care hospital where the type of care is primarily custodial care or while awaiting admission to a custodial care facility.
- Private duty nursing care provided in hospital, or when a nurse normally resides in the patient's home.
- The purchase of a myoelectric controlled prosthetic. However, an amount equal to the reasonable and customary charges for the initial placement of a non-myoelectric prosthetic device will be considered.
- Sickness or bodily injury resulting from insurrection or war (declared or not), any related act, or participation in any riot.
- Extra medical supplies that are spares or alternates.
- Services or supplies received outside Canada except as listed under Out-of-Country Care and Travel Assistance.
- Services or supplies received out of province in Canada unless you are covered by the government health plan in your home province and Canada Life would have paid benefits for the same services or supplies if they had been received in your home province. This limitation does not apply to Travel Assistance.

NOTES

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