STANDARD PLAN – SUPPORT DOCUMENT

Benefit improvement summary

All school district/local Support Staff dental plans will be updated to provide a minimum level of coverage, which is outlined below:

Plan	Minimum Coverage Provisions
Basic Services	Plan pays: 85%
Major Services	Plan pays: 60%
Orthodontic Services	Plan pays: 60% Lifetime Maximum: $1,000

- If your current dental plan provides a lower coverage level, the increase will be effective July 1, 2023
- If your current dental plan provides a higher coverage level, **there will be no change to coverage**.

The Standard Plan will also be updated effective July 1, 2023 to include the following improvements:

Benefit Provision	Current Provincial Standardized Extended Health Plan	Coverage Improvements
Vision Care	$550 per 24 months	$625 per 24 months
Eye Exams	$75 per 24 months	$125 per 24 months
Hearing Aids	$1,000 per 5 years for Adults and per 2 years for Children	$4,000 per 5 years for Adults and per 2 years for Children
Acupuncturist	$500 per year	$600 per year
Naturopath	$500 per year	$600 per year
Physiotherapist	$900 per year	$1,000 per year
Podiatrist/Chiropodist	$500 per year	$600 per year
Psychologist	$850 per year	• Addition of Clinical Counsellors & Social Workers • $1,500 per year (combined maximum for Psychologist, Clinical Counsellors & Social Workers)
Speech therapist	$500 per year	$600 per year

Pacific Blue Cross (PBC) Information Microsite

PBC has developed a website specifically for those groups that are participating in the Standard Plan to provide information regarding the plan design and answers to frequently asked questions. A link to the microsite will be shared once updates are completed, which will include information on benefit improvements to the Standard Plan.

Introduction to Blue RX

Your group has been identified as not having the Blue RX drug formulary as part of your current extended health care plan. As the Standard Plan includes a managed drug formulary (Blue RX), it is important that all members understand the impact this change may have on their drug coverage.

The managed drug plan includes the following:

- Generic substitution (widely used in hospitals and in current plans)
- Lowest-cost treatment alternatives
- PBC Prior Authorization Drugs and PharmaCare Special Authority Approval
- Limits on dispensing fees and drug mark-up

Attached to this email is a PBC bulletin outlining the Blue RX formulary for your reference. This bulletin and much more information about Blue RX will be provided on the microsite.

For those groups that do not already have the Blue RX drug formulary, there is a one year grace period for drugs that require approval for continued coverage and for those drugs that are excluded from the Blue RX plan because there is another drug therapy available. These drugs will continue to be reimbursed based on the cost of that drug but it is important to note that the managed drug plan dispensing fee and mark-up maximum will still apply.

Members taking drugs that are either excluded or require approval under the Blue RX Formulary will receive a letter from PBC. This letter will outline the steps needed for coverage approval or notification that the drug will no longer be covered. After one year, the grace period for covering these drugs will expire so it is important that members submit the required documentation to PBC to have the drug approved for continued payment or to discuss alternative drug therapies with a physician if the drug is excluded from the plan because there are other therapies available.

If a member is taking a brand name drug that does not require special approval but does have a lower cost generic drug available, the member or dependent has the option at point of sale to continue with the brand name drug and pay the higher cost or transition to the generic and have more of the cost reimbursed.

Frequently Asked Questions

Before voting, members may have questions about the Standard Plan or how it will be implemented. Here are responses to some frequently asked questions. If you have any other questions, please contact your HUB consultant for more information.

Q: ***Can a member who was previously terminated from the plan due to reaching the extended health care plan's current maximum age be reinstated since the Provincial Standardized Extended Health Care Plan has a termination age of retirement?***

A: Those members that were terminated from the extended health care plan due to reaching the maximum age of their current extended health plan and who still meet the eligibility requirements of

the plan can be reinstated as of the effective date of the Provincial Standardized Extended Health Care Plan for your group. They will need to complete an enrolment form within the open enrolment period. Please note that this is only applicable to the extended health plan. If the member's dental plan has a set termination age, this provision still applies.

Q: ***Can a member who was previously terminated from the extended health care plan due to reaching the lifetime maximum be reinstated since the Provincial Standardized Extended Health Care Plan has an unlimited lifetime maximum?***

A: Those members who were terminated from the extended health care plan due to reaching the lifetime maximum of their current plan can be reinstated as of the effective date of the Provincial Standardized Extended Health Care Plan for your group if they continue to meet the eligibility requirements of the plan. They will need to complete an enrolment form within the open enrolment period.

Q: ***How will the deductible of the plan be applied with a mid-year effective date of the Standard Plan?***

A: For most union locals, participating in the Standard Plan means an increase in the annual deductible. As of the effective date of the Provincial Standardized Extended Health Care Plan, the $100 annual deductible will need to be satisfied before any further claims are reimbursed. For example, if your current plan has a $25 annual deductible and a member has already satisfied this prior to the Standard Plan effective date, the remaining $75 deductible will need to be satisfied before any further claims are reimbursed.

Q: ***How will the maximum for eligible expenses such as paramedical practitioners and vision care be applied with a mid-year effective date of the Standard Plan?***

A: For union locals that opt into the Standard Plan, any eligible expenses incurred prior to the effective date of the Standard Plan will be adjudicated by PBC based on the current plan provisions. Any eligible expenses incurred on or after the effective date will be adjudicated based on the Standard Plan.

For example, if your current Physiotherapist maximum is $500 per person per calendar year and a member has already been reimbursed $500 for this service, if any further Physiotherapist services are received on or after the effective date of the Standard Plan, they would be eligible up to an additional $500 for the remainder of the year (as the calendar maximum for this service under the Standard Plan is $1,000 per person per calendar year).

Conversely, if the current Physiotherapist maximum per calendar year is $1,200 and the member has already been reimbursed this maximum amount prior to the effective date of the Standard Plan, no further reimbursement will be provided for these services for the remainder of the year. The $1,000 per person per calendar year will be reinstated at the beginning of the following calendar year.

Q: ***If a union local did not have coverage for eye exams prior to joining the Standard Plan and incurred an expense for an exam prior to joining the Standard Plan, can this be claimed under the Standard Plan?***

A: No. Eye exam expenses incurred prior to the effective date of joining the Standard Plan will be adjudicated by PBC based on the current plan provisions. Only eligible expenses incurred on or after the effective date of joining will be adjudicated based on the Standard Plan.