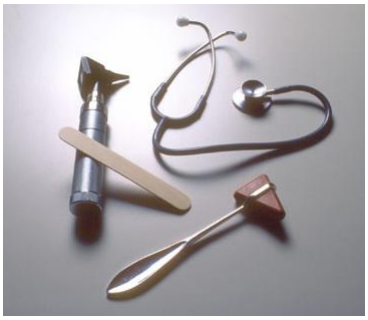
Your Health Care Plan ...
A select protection



BLUE CROSS®

Health Care Plan for CN Pensioners sponsored by the CN Pensioners' Associations Inc. effective January 1, 2018

Issued December 2017

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This Plan is supervised by a committee chosen from members of the CN Pensioners' Associations of the various regions of the country.

Foreword

The Health Care Plan for CN Pensioners (hereinafter "the Plan") offers you a **select protection** designed to provide you and your family with financial assistance for medically required health care expenses not covered by your provincial hospital and Medicare plans.

This protection **supplements** the government plans: it is designed and priced on the premise that you have enrolled in the government plan offered in your province of residence whether such enrollment is compulsory or optional.

Several options are available giving you the flexibility to choose the coverage that best suits your personal needs.

This booklet summarizes and explains the major features of the Plan as of **January 1, 2018.** We urge you to read it carefully.

In case of discrepancies between this booklet and the terms of the official insurance contract no. 93115 issued by Blue Cross, final interpretation will be governed by the insurance contract.

What are the protections offered?

The Plan provides for the reimbursement of a wide range of eligible expenses for hospital services, prescription drugs and other medical treatments that are not covered by your provincial plans.

Eligible expenses for necessary medical care, services and supplies are reimbursed based on the reasonable and customary charges in the region where they are incurred, less any amount normally payable by government plans. Maximums and deductibles applicable to certain benefits will be adjusted from time to time to take inflation into account.

Who is eligible to join the Health Care Plan no. 93115 for CN Pensioners?

You are eligible to join the Plan if you meet the following three criteria:

- You are a CN pensioner receiving a monthly pension from which the premium for the option selected can be deducted;
- You are a resident of Canada;
- You are covered by a provincial Medicare plan.

A CN pensioner is a person receiving a retiree's pension or a survivor's pension from CN.

You may also cover your dependents if they are covered by a provincial Medicare plan. The definitions of **eligible dependents** are as follows:

Your spouse: a person who has been living with you in a conjugal relationship for at least one year, or your legally married spouse, whoever of the two is designated as your spouse on the enrollment card (divorce or separation terminates the status of spouse).

Your children: unmarried children (including your designated spouse's children and your legally adopted children) who depend on you for support, including those whose support was imposed upon you by a court order, and who:

- Are under age 21 (under age 18 for Quebec residents), or
- Are between ages 21 and 25 (26 for Quebec residents) and are registered as full-time college or university students, or
- Are physically or mentally disabled, regardless of age, provided that their disability began while they were covered under this Plan or another plan and has been continuously disabled since that time.

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

If you submit a claim for a dependent child who is over age 21 but under age 25 (26 for Quebec residents), please provide Blue Cross with a college or university registration proof for **each term.**

If you do not cover your dependents when they become eligible for the first time, they will not be covered at a later date, except if they are already covered under another insurance plan and join within the 31 days following the end of such other coverage.

What are the options available?

The Plan provides **four** options that are described on the following pages. **Furthermore, Option C offers three choices of deductible and two choices of reimbursement for hospital services**.
Please read the description of each option carefully before selecting the option that best meets your needs. See next page for an overview.

Types of coverage

Deductible

OPTION A

Extended Health care 

Prescription Drugs 

$2.50 or $7.50 per drug*

OPTION B***

Extended Health care 

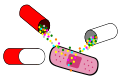
Hospital (semiprivate) 

None

OPTION C

Extended Health care 

Hospital (semiprivate) 

Prescription Drugs 

Either: **C1: $2.50 or $7.50 per drug***
C2: $3.75 or $11.25 per drug* plus $175/$265 for each other type of coverage**
C3: $6.25 or $18.75 per drug* plus $290/$400 for each other type of coverage**

OPTION D

Extended Health care 

Hospital (private or semiprivate) 

Prescription Drugs 

Vision care 

$2.50 or $7.50 per drug*

* Generic and Original / Unique.
** Annual deductible (Person / Family).
*** Option B is not available for a retiree under age 65 living in Québec if he/she is not covered for drug expenses under his/her spouse's group insurance plan or any other group plan

Which option should I choose?

The option to select is a matter of personal preference and circumstances. To choose the option best suited to your personal needs, you should first consider the following points:

- Whether you are over or under age 65;
- Whether or not you have dependents;
- Whether or not you are covered under another plan;
- Coverage provided under the Medicare plan in your province of residence;
- The premium rates for each option.

When choosing your coverage, evaluate your present as well as your future medical requirements, and familiarize yourself with the Medicare plan of your province of residence.

How do I enroll?

You must complete the enrollment card indicating your option (A, B, C1, C2, C3 or D) and your choice of individual or family coverage, and return it, within **two months** of the date you receive your first monthly pension payment, to the address below, regardless of your province of residence:

Blue Cross
Administration department
550 Sherbrooke Street West
Suite L15
Montréal, Québec H3A 6T6

No proof of good health is required for coverage under this Plan. Blue Cross will send you a drug card which serves as an identification card confirming your protection.

Upon enrollment, please provide Blue Cross with the name and date of birth of your dependents. If you elect the family coverage, Blue Cross will issue two drug cards which serve as identification cards.

If you want to enroll, please write to Blue Cross at the above address.

May I enroll at a later date?

Once the enrollment period has expired, you may no longer join the Health Care Plan for CN Pensioners.

However, you may postpone your enrollment if you are covered under your spouse's group insurance plan or a new employer group insurance plan. You may then join our Plan at the time your coverage under either of these plans terminate provided you join within 31 days following the end of your coverage, at which time you must provide Blue Cross with the following information:

- Name and address;
- CN identification number (PIN);
- Name of previous health care insurer;
- Contract number/certificate number of previous health care plan;
- Date of termination of previous health care coverage; and
- Name and age of dependents, if any.

When does the insurance take effect?

If you are a CN retiree, your coverage starts on the effective date indicated on your enrollment card. Coverage for a surviving spouse will be effective retroactively to the date of death of the retiree. Monthly premiums will be deducted from your pension payment retroactively to the effective date of coverage or on your survivor pension two months following the death of the retiree for a surviving spouse.

If you cover your eligible dependents, i.e. your spouse and/or your children, their coverage becomes effective on the same date as yours.

Hospital coverage for you or a dependent, either of which is in hospital when coverage is to commence, will **not** become effective **until** one month after discharge from hospital, unless the hospitalized person was insured under another hospital insurance contract immediately prior to joining the Plan.

May I change my current coverage?

If you have been covered by the Plan for at least a full year, you have the following choices effective January 1 of each year provided you have notified Blue Cross before December 30:

- If you are insured under Option D (which has to be maintained for at least two years), you may choose Option A, B, C1, C2 or C3;
- If you are insured under Option C1, you may choose Option A, B, C2 or C3;
- If you are insured under Option A, you may choose Option B, C2 or C3;
- If you are insured under Option C2, you may choose Option B or C3;
- If you are insured under Option C3, you may choose Option B.

With the exception that Option D must be maintained for 2 years, you may make any change of option you like on the following specific occasions, provided you notify Blue Cross within 31 days of the occasion:

- When you reach age 60, age 65, and every five years thereafter (earlier in the case of a disability retirement);
- At the 65th birthday of the designated spouse;
- Upon death of the pensioner or spouse;
- Upon your marriage;
- Upon your divorce;
- At termination of dependents' eligibility;
- When you move to another province.

May I cancel my coverage?

You may also cancel your coverage at any time but, should you do so, you will not be allowed to re-enroll in the Plan.

The only exceptions to this rule are:

- Upon your death, your surviving spouse may enroll or re-enroll in the Plan, even if you cancelled or declined the coverage.
- You will be able to re-enroll in our Plan if you cancelled your coverage to be covered under your spouse's group insurance plan or a new employer's group insurance plan. When this coverage terminates, you may re-enroll provided you do so within 31 days following the end of your coverage.

Any reimbursement of premium will be limited to three months.

What do I have to do?

Any change of option or coverage (individual or family) must be made by completing the appropriate form and by returning it to Medavie Blue Cross either by fax at 1-514-286-8444 or by mail at the following address (regardless of your province of residence):

Medavie Blue Cross
Administration department
550 Sherbrooke Street West
Suite L15
Montréal, Québec H3A 6T6

What if I move?

If you change your permanent address, you should inform Blue Cross in writing at the address shown above.

If you move to another province, you must submit all your claims to the Blue Cross office of your previous province of residence until the date your coverage under the Medicare plan of your new province of residence begins.

Your monthly premiums will be adjusted accordingly once Blue Cross has been notified of the change.

If you move temporarily for 6 months or less, Blue Cross and the Provincial Plan stay with the province of origin.

What if I am covered by the Health Care plan provided by Veterans Affairs (VA) of Canada?

If you are covered by the Health Care plan provided by Veterans Affairs (VA) of Canada you remain eligible for the coverage provided by the Plan.

Furthermore, you have the possibility to cover **only** your spouse given he/she is not eligible for the coverage provided by VA. In order to do so, you have to elect single coverage in your enrolment form and indicate that the person covered is your spouse as opposed to you.

However, if you have children and want them to be covered by the Plan you have to be covered and elect the family coverage.

What if I am institutionalized?

If you are institutionalized in a well-established extended care home, nursing home or psychiatric hospital where your medications are provided by the institution, you remain eligible for the coverage provided by the Plan.

Furthermore, you have the possibility to cover **only** your spouse. In order to do so, you have to elect single coverage on your enrolment form and indicate that the person covered is your spouse as opposed to you.

However, if you have children and want them to be covered by the Plan, you have to be covered and elect the family coverage.

What if I am covered under another group health insurance policy?

Should you or any eligible member of your family be covered under another group health insurance plan, any benefits payable under this Plan and the other plan will be coordinated so that payments from all sources do not exceed the expenses actually incurred.

This feature of the Plan is designed to avoid duplication of benefits from more than one plan under which you and your dependents might be covered. It usually works this way:

- As a pensioner, your benefits are paid first by the Plan; any balance is then submitted to the other plan under which you may be covered.
- Your eligible spouse covered under another plan has benefits paid first by that plan; any balance is then submitted to the Plan.
- A child covered as a dependent by both parents has benefits paid first by the plan of the parent whose birthday comes first in the year.

What happens in case of death?

When an insured pensioner dies, coverage for the spouse is automatically maintained at no cost for two months following the month in which the pensioner dies. Within these two months, the surviving spouse must decide whether or not to enroll with Blue Cross in order to continue coverage.

The surviving spouse may join the Plan if the following three criteria are met:

- The surviving spouse is a CN pensioner receiving a monthly pension from which the premium for the option selected can be deducted;
- The surviving spouse is a resident of Canada;
- The surviving spouse is covered by a provincial Medicare plan.

On the death of a non-insured pensioner, the spouse may, within two months following the receipt of his/her first monthly surviving spouse's benefit, join the Plan and elect individual or family coverage under any of the options offered.

Once CN Pensions and Benefits Administration has been notified of the death, an enrollment card will be sent to the surviving spouse.

When does the insurance end?

Coverage for you and your dependents will end in any of the following events:

- If you cancel your insurance;
- If the monthly pension and the monthly allocation provided by CN in your Health Care Spending Account (if applicable) do not cover the premium;
- If you move outside Canada and are no longer covered by the provincial plan;
- If the group contract is cancelled.

Insurance for your dependents will end when they no longer meet the eligibility requirements.

What is the cost of the insurance?

You pay the cost of the Plan through monthly premiums deducted from your CN pension and/or withdrawn from your Health Care Spending Account provided by CN (if applicable). The premium rate is based on the CN pensioner's age (except for British Columbia residents where the premium rate is based on the year of birth relative to 1940) and will change automatically on the first of the month following his/her 65th birthday (except for British Columbia residents).

Protection under the Plan is uniform across Canada. However, premium rates vary to take account of the different provincial plans and the cost of claims submitted under this Plan in each province. These premium rates are usually adjusted annually.

Extended health care

Extended health care coverage is offered under Options A, B, C1, C2, C3 or D.

Extended health care Deductibles

Deductible under Options A, B, C1 and D:

- None.

Deductible under Option C2:

- $175 per person, per calendar year;
- $265 per family, per calendar year.

Deductible under Option C3:

- $290 per person, per calendar year;
- $400 per family, per calendar year.

The deductible is the amount of eligible expenses that you pay before benefits are payable. It will be adjusted upward from time to time to take inflation into account. You will be notified in advance of future adjustments.

Example (under Option C2)

Amount claimed by the retiree: $400
Amount claimed by the spouse: $400

- Retiree will assume a deductible of $175 if single coverage (the amount reimbursed will then be $180 or 80% of $225)
- Retiree will assume a deductible of $175 and the spouse will assume a deductible of $90 if family coverage (the amount reimbursed for the family will then be $428 or 80% of $535)

Reimbursement

Reimbursement under Options A, B, C1, C2, C3 or D:

- 80% of eligible expenses.

The coinsurance is the percentage of eligible expenses that are not reimbursed (i.e., 20%).

Eligible expenses

The following expenses will be reimbursed **if judged by Blue Cross as being usual and reasonable, as well as medically necessary. Expenses must be prescribed by a physician, unless otherwise indicated.**

- Charges for services of the following specialists who are duly qualified and members of their professional association. Expenses incurred must result from illness or injury. **No doctor recommendation is required except for massage therapy.** When a registered nurse provides foot care services they will be reimbursed only if the nurse is trained, qualified and insured for professional liability for foot care and only when the medical condition of the patient justifies such services.

Maximum reimbursement

Specialist	Per Visit	Per Calendar Year Per Specialist
Psychologist	$40	$500
Physiotherapist/ athletic therapy	40	500
Chiropractor	40	500
Podiatrist/Chiropodist/Nurse	40	500
Dietician	40	500
Naturopath	40	500
Speech therapist	40	500
Massage therapy	40	500
Optometrist	-	50

An eligible expense for these specialists corresponds to the amount incurred, subject to the reasonable and customary (R&C) charges in the region where they are incurred.

Example

Physiotherapy expense of $80

- Eligible (R&C) amount: $60
- Reimbursement: 80% of eligible expense ($60) to a maximum of $40 per visit and of $500 per person per calendar year

So, 80% of $60 equals $48. However, the covered person is reimbursed a maximum of $40 up to a maximum reimbursement of $500 per calendar year. For purposes of satisfying the deductible under the Options C2 and C3, an amount of $60 would be deducted; such amount corresponding to the eligible R&C amount given the expense incurred exceeds this amount.

If the services of the specialist are covered by a provincial plan, the reimbursement from this Plan may be limited in accordance with applicable legislation.

- Charges of a registered nurse at the patient's home, to a maximum reimbursement of $3,000 per person per calendar year. These services must not be provided by a close relative or in a hospital. Services that are of a custodial or hygienic nature are excluded.
- Mammary prostheses (including bras), to a maximum reimbursement of $200 per person in each calendar year.

Should you need prior approval for certain expenses, please call Blue Cross, toll-free, at 1-888-873-9200

- Foot orthoses and orthopaedic adjustments to regular shoes, to a maximum reimbursement of $125 per person in each calendar year.
- Charges in excess of $60 per pair for orthopaedic shoes; limited to two pairs per person in each calendar year. For example:

  Charges incurred: $150
  Eligible expense:
  $150 - $60 = $90
  Reimbursement:
  80% x $90 = $72
  The insured person receives $72.
- Elastic support, surgical and custom made gradient support stockings, to a maximum reimbursement of $100 per person in each calendar year.
- Hearing aids (excluding batteries), to a maximum reimbursement of $600 for each person in any consecutive 48-month period. Repairs are not covered.
- Diabetic supplies: needles, syringes, alcohol swabs, reactive sticks and reflectometers such as glucometers and dextrometers.
- Rental or purchase of a manual hospital bed for a bed-confined patient, oxygen equipment or respirator. Prior approval must be obtained from Blue Cross.
- Rental or purchase of a regular wheelchair (non-regular wheelchair if medically required and if a regular wheelchair is not appropriate) or of a scooter, up to the provincial maximum for a regular wheelchair and up to an overall maximum reimbursement of $1,200 per person in any consecutive 48-month period. Prior approval must be obtained from Blue Cross. Cushions and repairs are also eligible and included in the overall maximum
- Charges for the purchase of one (1) C-pap in any consecutive 60-month period, plus any charges related to parts or repairs.
- Hospital outpatient care, oxygen and diagnostic services, including laboratory tests (including blood tests) and X-rays.

- X-ray, radium and radio-isotope treatments.
- Colostomy supplies.
- Dental treatment required for damaged natural teeth as a result of an accidental blow, a fracture or a dislocation of the jaw, provided the treatment starts within 180 days of the accident and the accident occurs while the person is covered by the Plan. Payment will be in accordance with the dental association fee guide for general practitioners of the province where the services are rendered, to a maximum reimbursement of $1,000 per accident for each person.
- Professional ambulance services **in case of emergency**, including air ambulance or transportation on a regularly scheduled flight, to and from the nearest hospital able to provide essential care, when warranted. The reimbursement is limited to $1,000 per person in each calendar year. An ambulance must include namely:
  - rescue equipment;
  - a stretcher;
  - breathing equipment;
  - a first-aid kit.
- Artificial limbs or eyes, and the following supplies: crutches, walking aids, splints, trusses, dressings, trapezes, braces and casts.
- Those expenses incurred outside your province of residence specified on page 27.

Exclusions

The Plan does not cover:

- Treatment of obesity;
- Dental expenses, unless incurred as a result of accidental injury;
- Equipment such as orthopaedic mattress, exercise equipment, air conditioner, air purifier or whirlpool;
- Therapeutic apparel;
- Magnetic Resonate Imaging (MRI) if covered by provincial Medicare plan;
- Diapers for incontinent persons;
- Service maintenance agreements;
- Out-of-country expenses.

Prescription drugs

Prescription drug coverage is offered under Options A, C1, C2, C3 or D.

This benefit covers the expenses listed hereafter, provided they meet the definition of eligible expenses under this Plan:

- Preparations and compounds if their main ingredient is an Eligible Drug; and
- Prescribed Eligible Drugs that appear on the managed formulary (i.e. list of Eligible Drugs and Life-Sustaining Drugs that are subject to the decisions of the Medication Advisory Panel).

Eligible Drug

A drug that is:

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

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

Life-Sustaining Drug

An Eligible Drug that does not require a prescription by law but which Blue Cross is satisfied is necessary for your survival. A prescription from a Physician or Health Practitioner is still needed for reimbursement.

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Medication Advisory Panel

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

Deductibles for prescription drugs

Deductible under Options A, C1 and D:

- $2.50 per drug for generic and original drugs;
- $7.50 per drug for unique drugs.

Deductible under Option C2:

- $3.75 per drug for generic and original drugs;
- $11.25 per drug for unique drugs.

Deductible under Option C3:

- $6.25 per drug for generic and original drugs;
- $18.75 per drug for unique drugs.

The deductible is the amount of eligible expenses that you pay before benefits are payable. It will be adjusted upward from time to time to take inflation into account.

Example (under Options A, C1 or D)

If the physician gives you a prescription with two generic drugs and three unique drugs appearing on it, you will pay the following deductibles when getting your prescription filled:

- Generic drugs: 2 x $2.50 = $5.00
- Unique drugs: 3 x $7.50 = $22.50
- Total: $27.50

Definition of drugs

- Unique drugs (Single source brand-name drugs): a drug that has a trade name and is protected by a patent. Only the company holding the patent can produce and sell the drug, without any competition;
- Original drugs (Multi source brand-name drugs): a unique drug for which the patent has expired and for which one or several generic drugs exist;
- Generic drugs: an exact copy of a unique drug. It is just that the patent on the unique drug has expired. **Since Health Canada imposes the same standards and tests on generic drugs as it does on unique drugs, generic drugs are as effective and as safe.**

Reimbursement

Reimbursement under Options A, C1, C2, C3 or D:
- 80% of eligible expenses.

The coinsurance is the percentage of eligible expenses that are not reimbursed (i.e., 20%).

Dispensing fee maximum

Maximum eligible dispensing fee for reimbursement under Options A, C1, C2, C3, or D:
- $9.00.

The Plan will therefore reimburse 80% of each dispensing fee submitted up to a maximum reimbursement of $7.20 (i.e. 80% x $9) and you will assume 20% of the dispensing fee submitted (up to $9) plus 100% of the portion of the dispensing fee submitted in excess of $9, if any.

A dispensing fee is the professional fee charged by pharmacists for the cost of evaluating, preparing, and packaging a prescription drug. It applies whether you purchase generic, unique or original drugs.

In Quebec, as there is no dispensing fee posted by the drug store, the dispensing fee will be estimated by Blue Cross as equal to the total drug cost minus the ingredient cost.

Mark-up maximum

Maximum mark-up under Options A, C1, C2, C3, or D:
- 10%.

The Plan will therefore reimburse 80% of each mark-up submitted (subject to a 10% maximum) and you will assume 20% of the mark-up submitted (subject to a 10% maximum) plus 100% of the mark-up that exceeds 10%, if any.

The mark-up is the profit margin requested by the pharmacist. This component is added to acquisition cost to form the ingredient cost.

Mandatory generic substitution provision

The Plan will base the reimbursement of an eligible prescription drug to the lowest cost generic equivalent product that can legally be used to fill the prescription, even if your physician specifies “no substitution” on the actual script.

- Reimbursement for unique drugs (single source brand-name drugs) will continue to be based on the actual cost of the prescribed drug since the unique drug is still protected by a patent which does not allow substitution of generic drugs.
- Reimbursement for original drugs (multi source brand-name drugs) will now be based on the lowest cost generic equivalent product that can legally be used to fill the prescription. Therefore, if you decide to purchase the original drug, you will assume 100% of the cost difference between the original and the generic drug (lowest price for the generic) and the plan provisions will apply to the price of the generic.
- Reimbursement for generic drugs will be based on the lowest cost generic equivalent product that can legally be used to fill the prescription (usually the actual cost of the prescribed drug since the generic is already used).

Out-of-pocket maximum

The out-of-pocket expenses (i.e. deductible, coinsurance, eligible dispensing fee and eligible mark-up) are limited to $2,000 per person per year (subject to applicable provincial legislation), after which the eligible drug expenses are reimbursed at 100% for the rest of the year.

Special drugs

Drugs that require Special Authorization or drugs for Patient of Exception are reimbursed provided an application for reimbursement under the Special Authorization drug process has been submitted to the provincial drug plan or to Blue Cross.

Eligible expenses

- Eligible drugs;
- Preparations and compounds if their main ingredient is an Eligible Drug;
- Vaccines, subject to an annual maximum reimbursement of $500 per person per year; or
- Liquid nitrogen treatments, subject to the reasonable and customary (R&C) charges in the region where they are incurred.

Exclusions

The Plan does not cover:

- Varicose vein injections;
- Antihistamines and allergy sera;
- Smoking cessation aids;
- Vitamins;
- Weight loss treatments;
- Natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
- Fertility treatments;
- Erectile dysfunction treatments;
- Hair growth stimulants;
- Services, treatment or supplies that:
  - Are not medically necessary;
  - Are for cosmetic purposes only;
  - Are elective in nature; or
  - Have experimental or investigative indication.
- Procedures related to drugs injected by a Health Care Professional in a private clinic;
- Expenses that are covered under any government health care coverage or charges payable under a workers' compensation board/commission, any automobile insurance bureau or any other similar law or public plan;
- Services, treatment or supplies the Participant receives free of charge;
- Charges that would not have been incurred if no coverage existed;
- Charges for Marijuana use (prescribed or not); or
- Drugs that Blue Cross determines are intended to be administered in hospital, based on the route of administration and the condition the drug is used to treat.

Hospital

Hospital coverage is offered under Options B, C1, C2, C3, or D.

Hospital Deductibles

Deductible under Options B, C1 and D:

- None.

Deductible under Option C2:

- $175 per person, per calendar year;
- $265 per family, per calendar year.

Deductible under Option C3:

- $290 per person, per calendar year;
- $400 per family, per calendar year.

The deductible is the amount of eligible expenses that you pay before benefits are payable. It will be adjusted upward from time to time to take inflation into account. You will be notified in advance of future adjustments.

Example (under Option C3)

Amount claimed by the retiree: $400
Amount claimed by the spouse: $400

- Retiree will assume a deductible of $290 if single coverage (the amount reimbursed will then be $88 or 80% of $110)
- Retiree will assume a deductible of $290 and the spouse will assume a deductible of $110 if family coverage (the amount reimbursed for the family will then be $320 or 80% of $400)

Reimbursement

Reimbursement under Options B, C1 and D:

- 100% of eligible expenses for acute care;
- 80% of eligible expenses for convalescent and physical rehabilitation services.

Reimbursement under Options C2 and C3:

- 80% of eligible expenses

The coinsurance is the percentage of eligible expenses that are not reimbursed (i.e., 20%).

Eligible expenses – Options B, C1, C2 or C3

Charges for a **semiprivate** hospital room that are in excess of the provincially paid standard ward accommodation charges, for an unlimited number of days. If you choose accommodation in a privately operated hospital, reimbursement is limited to $50 per day.

Eligible expenses – Option D

Charges for a **private or semiprivate** hospital room that are in excess of the provincially paid standard ward accommodation charges, for an unlimited number of days. If you choose accommodation in a privately operated hospital, reimbursement is limited to $90 per day.

Please note that the availability of private or semiprivate rooms is not under the control of Blue Cross. The Plan does not provide for payment when a semiprivate room is required, but not available.

Eligible Expenses – Options B, C1, C2, C3 or D

Benefits for **convalescent and physical rehabilitation** shall be limited to a maximum of thirty days for all periods of hospitalization during a calendar year, for as long as the insured is entitled to these services, and up to the amount that the hospital is allowed to charge directly to the patient for a semiprivate accommodation.

These benefits shall be payable only if the insured is admitted less than fourteen days after his discharge from a hospital where he received active care, provided he was admitted there after the effective date of his coverage.

Definition

Under the Plan, hospital is defined as a legally operated institution that:

- Is primarily engaged in providing medical, diagnostic and surgical facilities and services for the care and treatment of sick and injured persons on an inpatient basis; and
- Provides such facilities and services under the supervision of a staff of doctors with a 24-hour-a-day nursing service with registered nurses.

The following may not be considered as hospitals:

- Institutions that are principally homes for the elderly;
- Rest homes and nursing homes;
- Institutions that provide psychiatric care;
- Institutions for the care and treatment of drug addicts and/or alcoholics.

Exclusions

The Plan does not cover the charges for alternate level care and chronic care confinement in any institutions, including hospitals.

Vision care

Vision care coverage is offered under Option D.

Deductible

none

The deductible is the amount of eligible expenses that you pay before benefits are payable. It will be adjusted upward from time to time to take inflation into account. You will be notified in advance of future adjustments.

Reimbursement

80% of eligible expenses

The coinsurance is the percentage of eligible expenses that are not reimbursed (i.e., 20%).

Eligible expenses

- Charges for prescribed contact lenses or glasses (frame and lenses), including sunglasses and safety glasses, to a maximum reimbursement of $150 per person in any period of 36 consecutive months from the date of purchase;
- Charges for prescribed interocular (foldable) lens required for a cataract surgery, up to a lifetime maximum reimbursement of $600 per person.

Exclusions

The Plan does not cover:

- Glasses for cosmetic purposes;
- Laser eye surgery.

Are there any other exclusions?

The Plan **does not cover:**

- Any services and supplies that the person is eligible to receive under any government plan or law, or charges for which the law prohibits payment;
- Charges that would not have been requested if no insurance coverage had existed;
- Charges for any care, treatments, services or products other than those judged necessary by competent authorities for the treatment of an injury or illness;
- Charges for experimental services and treatments, and those attributed to the application of new processes or treatments not yet in current use;
- Intentionally self-inflicted injuries, while sane or insane;
- Fees for doctor's visit to patients home as these cannot be insured under the Canada Health Act;
- Preventive treatments;
- Charges for services rendered outside Canada;
- Charges not covered in accordance with a medical or hospital insurance act if incurred outside Canada;
- Rest cures, travels for health reasons, examinations prior to a trip, or for insurance or other similar purposes, and periodic health check-ups;
- Charges for physician's visits in the hospital, home or office in your province of residence;
- Charges covered under the provincial Medicare plan if the person is not insured by such plan;
- Treatments or prostheses for cosmetic purposes;
- Charges for medical care, supplies and services that are not included in the list of eligible expenses.

What if I travel outside my province of residence?

If you travel outside your province of residence <u>but inside</u> Canada, the following eligible expenses would be reimbursed at a level of 80% after the applicable Extended Health Care deductible, if any, by the Plan:

- Charges for standard hospital ward accommodation in excess of the hospital expenses covered by the plan of your province of residence;
- Reasonable and customary fees of a physician or a surgeon for medical treatment in excess of the expenses covered by the plan of your province of residence;
- All eligible expenses under the Extended Health Care coverage;
- Prescription drugs as described on pages 17 to 21, unless you are covered under Option B.

These expenses must be incurred on an emergency (non elective) basis; **referral cases are also excluded**.

If you travel outside your province of residence <u>and outside</u> Canada, none of your expenses incurred outside Canada will be reimbursed.

<u>It is therefore strongly recommended that you purchase private medical insurance.</u>

Blue Cross offers you an incentive as an insured member under the Plan if you purchase your travel insurance from Blue Cross when travelling outside Canada. It is important to note that the Blue Cross private travel insurance policy you purchase does not form part of the Plan. It is a separate insurance policy.

Blue Cross pays the cost of your private travel medical insurance for the first 15 days of each trip, regardless of the number of trips taken per year, provided:

- You purchase travel insurance for the <u>entire</u> duration of your trip;
- The Blue Cross travel insurance is purchased directly at your regional Blue Cross office;

- The minimum duration of the stay is 16 days; and
- Coverage under the Plan is maintained for the duration of the trip.

The cost of this protection will be based on the total length of the trip, less the 15 days paid by Blue Cross. The 15-day premium discount is only applied on the premium charged for medical and hospital travel insurance. The discount does not apply to the Baggage or Trip Cancellation benefit.

Make sure you give Blue Cross your CN PIN and the group Plan number 93115.

The terms, conditions, exclusions and costs relating to your Blue Cross travel insurance vary by province of residence. Please note that exclusions relating to pre-existing conditions may apply. For clear and precise information, please contact your regional Blue Cross office (Refer to Blue Cross claims offices on page 32).

How do I make a claim?

Should you or your insured dependents incur hospital expenses, ask the hospital to send all invoices that are not covered by your province to your regional Blue Cross claims office. Blue Cross will then pay the eligible expenses incurred.

If the hospital bills you, you should pay all expenses and then send the receipt to Blue Cross to obtain a reimbursement (refer to page 32 for addresses).

Should you or your insured dependents incur prescription drug expenses, you must take the following steps:

- Give your pay-direct drug card to the pharmacist along with your provincial drug card, if any.
- The pharmacist will enter the data indicated on your card and your prescription into his computer system.
- Within seconds, this data will be electronically processed and the computer system will indicate your portion of the cost.
- You will pay for only your portion of the cost (coinsurance, deductible, etc.). You will not pay the portion of the cost covered by the Plan.
- You do not need to submit a claim form directly to Blue Cross, unless you want to submit a claim through your CN Health Care Spending Account, if any. Your claim is submitted automatically through the computer system

If your eligible spouse is covered under another plan, he/she should have her/his benefits paid first by that plan; any balance could then be submitted to the Plan. Thus, your spouse should not use the pay-direct drug card in that specific situation since he/she must use her/his own pay-direct drug card first or he/she must send paper claim form to his/her plan first.

If ever you find yourself having to buy prescription drugs from a non-participating pharmacy, you will need to pay for the full cost of the drugs and then send the original receipts with a completed claim form to Blue Cross.

Should you or your insured dependents incur other medical expenses, it is important to keep all original receipts.

You may get a claim form from your regional Blue Cross claims office or print it from the Blue Cross Web site. This form, along with your original receipts, must be returned to the Blue Cross claims office. When making your first claim each year, total receipts should exceed the deductible applicable to your option.

Blue Cross must receive claims no later than April 30th following the calendar year in which the expenses were incurred (subject to provincial legislation). Late submittal will result in the non-payment of your expenses.

Should you or your insured dependents incur **medical expenses outside your province of residence,** be sure to obtain detailed receipts.

In most cases of hospitalization in Canada, the hospital will bill charges up to ward level directly to your provincial health care plan. However, some hospitals may bill you for the total cost of your room, physicians' fees and medical charges. When this occurs, send the detailed receipts to your provincial health care plan. Keep a copy or a photocopy of your receipts.

Once you have received payment from the provincial plan, complete a Blue Cross claim form and return it, together with all itemized receipts and details of payment made by the provincial plan, to your regional Blue Cross office.

Alternative to paper claim submission

Blue Cross also offers the technology whereby you may scan your medical expense receipts and submit your request for reimbursement through your computer or your smart phone and the money will be deposited directly into your bank account.

Should you need claim forms or information on your claim, please call Blue Cross, toll-free, at 1-888-873-9200 or visit their Web site at www.medavie.bluecross.ca.

Where can I get more information about ...

The Health Care Plan for CN pensioners

For questions about ...	Call Blue Cross at ...
▪ Enrolling in the Plan ▪ Changing options ▪ Cancellation of coverage ▪ Premium rates	1-866-660-7670
▪ Payment of claims ▪ Definition of benefits ▪ Coverage details ▪ Obtaining prior approval for certain expenses ▪ Obtain claim forms	1-888-873-9200

You may also go to the Blue Cross Group Benefit Web site at **www.medavie.bluecross.ca** to obtain general information about your Plan and your current coverage, to view your claims and reimbursement history and to print generic claim forms.

Provincial hospital and medical plans

This booklet describes the Plan. If you require any information about your provincial hospital and medical plans, please contact the appropriate government authorities.

Blue Cross claims offices

ATLANTIC PROVINCES
Atlantic Blue Cross Care
644 Main Street, P.O. Box 220
Moncton, New Brunswick E1C 8L3

QUÉBEC
Medavie Blue Cross
Administration department
550 Sherbrooke Street West
Suite L15
Montréal, Québec H3A 6T6

ONTARIO
Ontario Blue Cross
185 The West Mall, Suite 1200
P.O. Box 2000
Etobicoke, Ontario M9C 5P1

SASKATCHEWAN
Saskatchewan Blue Cross
516 Second Avenue North,
Box 4030
Saskatoon, SK S7K 3T2

MANITOBA
Manitoba Blue Cross
599 Empress Street
P.O. Box 1046
Winnipeg, Manitoba R3C 2X7

ALBERTA, YUKON AND NORTHWEST TERRITORIES
Alberta Blue Cross
10009 – 108th Street NW
Edmonton, Alberta T5J 3C5

BRITISH COLUMBIA
Pacific Blue Cross
P.O. Box 7000
Vancouver, BC V6B 4E1

Direct Deposit

Blue Cross offers “Direct Deposit” should you want your claim reimbursements to be deposited directly into your personal bank account. This service avoids any mailing delays as the moneys are deposited in your account within two days after your claim has been processed; an explanation of benefits statement will continue to be sent to you through the mail.

Should you wish to prevail yourself of this service, simply provide Blue Cross with a cheque marked “VOID” with your next claim form. Blue Cross will then take the necessary actions so that all your future claim reimbursements are automatically deposited directly into your personal bank account, or until such time as you advise them of a change.

This booklet summarizes in non-technical terms the major features of the Health Care Plan for CN Pensioners. It contains important information and should be kept in a safe place known to you and your family.

As future conditions cannot be foreseen, the Plan can be modified at any time.

In the event that services or expenses covered by a government-sponsored program are suspended, modified or discontinued, or co-payments are introduced or increased, the Plan will not automatically assume coverage of these services, expenses or co-payments.

For more information on the impact of government policy changes on your existing coverage, please call Blue Cross, toll-free, at 1-888-873-9200.

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