BENEFITS BY DESIGN

Catastrophic Health

ADVISOR GUIDE

Catastrophic Health: essential insured health protection plus individual choice through a health care spending account.

For advisor use only

Allow us to introduce ourselves

BENEFITS *BY* DESIGN

As a third-party administrator (TPA), Benefits by Design (BBD) manages the administration of plan member benefit plans for companies across Canada. We work with insurers and other service providers that outsource administrative services to us to improve efficiency and quality of service.

Some of those administrative services include tracking plan member eligibility, maintaining plan member data, consolidated billing, reporting, and handling plan member inquiries.

We support the independent group-focused advisor

BBD works with independent advisors who specialize in group benefits. Our goal is to help build your business and equip you with the skills and knowledge you need to be successful.

We're a benefits expert – and it's a complicated subject

Each Advisor is assigned a BBD team that works tirelessly to support you and your clients' needs. You'll gain a:

Director, Partner Solutions TPA+
Your Director supports you in conversations with clients, onboarding new groups, and answering questions regarding quotes, generating new business, and more!

Client Manager
Your Client Manager monitors your in-force clients' performance. Through regular check-ins, your Client Manager ensures the smooth operation of your clients' group benefits plans.

Client Specialist
Your Client Specialist handles the day-to-day administration of your clients' plans. They are the direct contact for your Plan Administrators.

All Directors, Partner Solutions TPA+ and Client Managers complete a Group Benefits Associate (GBA) designation to become specialists in group benefits.

We partner with best-in-class suppliers and make benefits administration easy

We choose supplier partners that share our philosophy around creating sustainable plan member benefits plans designed to protect Canadian employers and their plan members' health, wealth, and happiness. We own and support our technology platform, which gives us the flexibility to integrate with many different supplier partners.

Catastrophic Health
At-a-glance

Catastrophic Health offers a unique hybrid health plan: essential insured health protection plus individual choice through a health care spending account.

Essential health protection

The essential health protection covers plan members for essential unpredictable, and often pricey, medical expenses. Employees must satisfy their deductible before the essentials are covered at 100%.

Deductible

Coverage	Deductible cost
Single coverage deductible	$1,000 deductible for plan member
Couple/family coverage deductible	$1,000 deductible for plan member, and additional $1,000 combined deductible for eligible dependents

Satisfying the deductible

For a plan member to have 100% coverage for essential health expenses, **their deductible must be satisfied**. Any out-of-pocket costs for eligible expenses submitted through their plan are applied to their deductible. If a plan member has family coverage, an additional $1,000 combined deductible for all dependents will need to be satisfied before they have access to direct reimbursement from their plan.

Eligible expenses could include, but are not limited to:

- Prescription drugs
- Accidental Dental
- Private Duty Nursing
- Eligible medical equipment and supplies
- Semi-Private Hospital
- Ambulance

The plan member's Health Care Spending Account (HCSA) can also work towards covering the costs of the deductible. Plan members that submit eligible Catastrophic Health expenses, and have not yet used up the funds allocated in their HCSA will receive automatic reimbursement for their out-of-pocket expenses unless they have turned off auto-coordination.

Health care spending account

A health care spending account (HCSA) provides plan members with a dollar amount to use towards eligible health expenses. The Canada Revenue Agency (CRA) regulates HCSAs and determines what expenses are eligible. Here are some of the things plan members that have Catastrophic Health may use their HCSA account:

This list is not complete. A full list of eligible expenses under an HCSA is available on the Canada Revenue Agency website.

Employers design the HCSA by allocating funds to each plan member. Employers also specify whether the HCSA will allow rolling claims, whether allocations rollover, and the frequency of allocation (monthly, quarterly, semi-annually, or annually).

Stop loss threshold

Catastrophic Health consists of stop-loss protection at a $10,000/per individual threshold.

Emergency medical travel coverage

Catastrophic Health includes 100% emergency medical travel to a maximum of 60 days per trip and $5 million per incident for certain emergency services when travelling within or outside of Canada, not including the Insured's home province. Emergency services are for sudden, unexpected occurrences (disease or injury) that require immediate medical attention.

Please note: The annual deductible does not apply to the travel benefit. Travel coverage is paid from 1st dollar and is available immediately to plan members who have Catastrophic Health coverage.

Catastrophic Health
In action

Meet James

Single Deductible: **$1,000**

Health Care Spending Account: **$1,000**

First visit to the pharmacy

James has his first prescription refill for the year. He pays the pharmacy $650 out-of-pocket because he has not yet satisfied the deductible.

The claim is auto-submitted to James' HCSA by the pharmacy. Since he has available HCSA funds, James receives reimbursement for the $650 through direct deposit.

Since prescription drugs go towards satisfying the deductible, James now has a deductible balance of $350. He also has a balance of $350 remaining in his HCSA.

Next visit

James needs his second refill of the year of $650. Since there is a deductible still owing, James pays $350 out of pocket at the pharmacy. With this prescription and payment, he has satisfied the $1,000 deductible. The remaining $300 will be covered for him automatically at the pharmacy.

The remainder of the claim that James paid for is auto-submitted to James' HCSA by the pharmacy. As he has $350 left in his HCSA, he receives reimbursement for the full $350 he paid at the pharmacy.

There is no deductible left owing and the HCSA balance is now $0.

Ongoing visits

Now when James goes to fill his prescription or has any new eligible prescriptions, he has 100% coverage for the remainder of the calendar year.

When he fills his third prescription for the year, James has no deductible, and receives coverage for the claim directly at the pharmacy.

Meet Peter and Family

$1,000 deductible for plan member

$1,000 additional deductible for eligible dependents (including spouse).

HCSA balance: **$1,000**

First visit to the pharmacy

Peter's wife received a new ongoing prescription that costs $450. Their child also has a one-time antibiotic medication that costs $110.

Peter's wife and child pay $560 out-of-pocket at the pharmacy for the prescriptions. The claims are auto-submitted to Peter's HCSA by the pharmacy. Since he has available HCSA funds, Peter receives reimbursement for the $560 by direct deposit.

$440 remains to satisfy the family deductible, and $440 remains in Peter's HCSA.

Next visit

Peter's wife needs a refill of her prescription for $450. Since there is a deductible still owing, she pays $440 out-of-pocket at the pharmacy. With this prescription and payment, the combined dependent deductible of $1000 has been satisfied. The remaining $10 owed will be covered for him directly at the pharmacy.

The remainder of the claim that Peter's wife paid is auto-submitted to Peters HCSA by the pharmacy. As he has $440 available HCSA funds, they receive reimbursement for the full $440 through direct deposit.

There is no deductible left owing, and the HCSA balance is now $0.

Ongoing visits

Now when Peter's family goes to fill any eligible prescriptions, they have 100% coverage for the remainder of the calendar year.

There are no more deductibles for the employee or dependents to satisfy, and they will receive coverage of their claims directly at the pharmacy.

Reminder: Peter (the employee) has his own individual deductible of $1,000, which must be met before his eligible expenses are covered. His wife and children have an additional combined $1,000 deductible. Once met through any combination of claims, the catastrophic health plan will begin to cover their eligible expenses. Peter must still satisfy his own $1,000 deductible.

Catastrophic Health
Benefits to your client

Plan design

The plan design of a Catastrophic Health plan allows your clients to select the HCSA amount and frequency of allocations, further customizing the plan to best suit their needs.

Sustainable

Your clients can rest easy when it comes to cost. A Catastrophic Health plan offers lower-cost premiums and a measure of cost-predictability through the HCSA.

Peace of mind

Your clients and their employees will enjoy the comfort of knowing that they have the coverage they need.

Online portal

Your clients have the ability to access information about their benefits plan, complete employee change requests, download invoices, and more through Nomad, our online benefits administration portal.

Exceptional client service

Your clients are given dedicated points of contact at BBD to help them navigate their benefits plan, answer questions, and assist with claims inquires and/or issues.

Catastrophic Health
Sales support

A true back office

Whether you require assistance understanding products, quoting a group, handling a claims issue, or getting up to speed on a renewal, your BBD team is here to help.

Nomad

Our secure Nomad Advisor portal provides a dashboard of your active business with BBD. Nomad is easy to use and includes resources that support your client conversations.

Marketing materials:

Our marketing materials are available electronically through Nomad.

Nomad advisor portal

Catastrophic Health
Request to quote

You can request a quote by emailing our quoting department: quotes@bbd.ca.
Our proposals include a breakdown of the costs incurred by the organization and each individual employee.

To ensure a timely turnaround, BBD requires the following information:

- Name of client/employer
- Province the business is located in
- Nature of the business
- Length of time in business
- Requested plan design
- Employee Census data

Are they presently insured? If yes, please provide the following:

- Current plan design
- Current and/or renewal rates
- Claims experience
- Requested plan design

Please also specify the following information:

- Are there eligible employees not participating?
- Do all employees work at least 20 hours/week?
- Are the employees covered by the Worker's Compensation Board (WCB)?
- What is the percentage of family content?
- Do they have any full time contract employees? If yes, what coverage is required?
- Do they have any seasonal employees?
- Are any eligible employees currently absent from work? If yes, please provide the details.
- Are any eligible employees currently disabled? If so, please provide the following:
    - Date of disability
    - Nature of disability
    - Prognosis
    - If the life waiver was approved

Catastrophic Health
Sales process

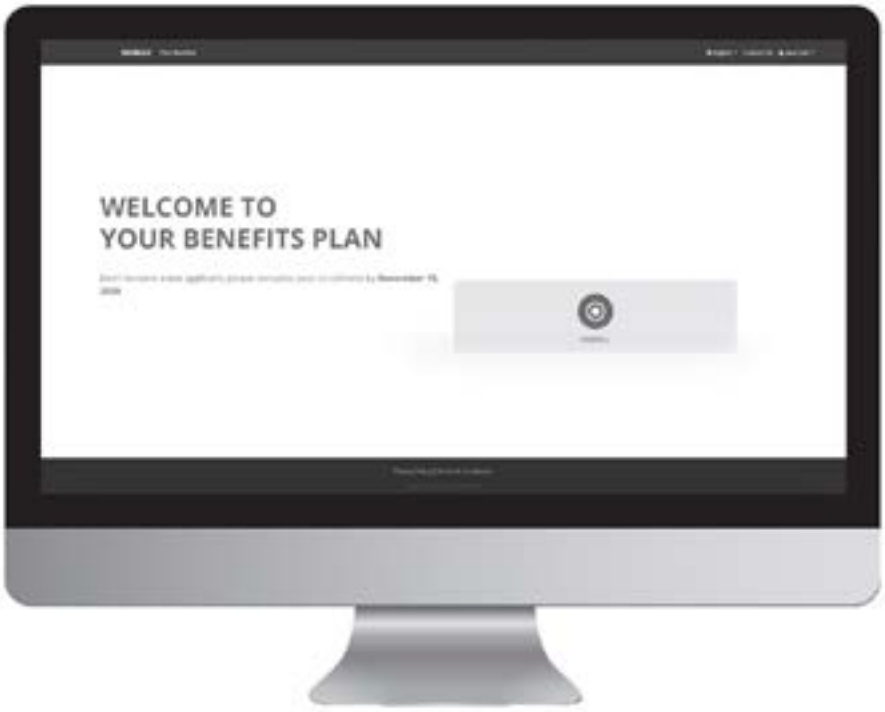
To enroll, clients complete the Master Application and the GreenShield Addendum form before forwarding them to sales@bbd.ca. Each employee will need to complete an enrollment form.

Online enrollment

Clients can streamline the benefits enrollment process (and save a few trees) by using BBD's online enrollment tool. The online enrollment tool allows plan members to easily enroll themselves in their new group benefits plan, and the Plan Administrator can monitor their progress. This reduces the administrative burden on your clients and the amount of physical paperwork required.

Paper enrollment

If your clients prefer, they can complete their benefits plan enrollment using BBD's paper forms. Once all of the forms are collected, our Implementation team sends the information to our carriers. Upon successful receipt and implementation of the plan, our Implementation team transfers the sale over to our Client Services team who will reach out to the plan administrator to introduce themselves and get them started with their benefits plan.



Catastrophic Health
After the sale

Things you need to know

- Your BBD Client Manager will reach out to you by email with information, including:
    - Group policy numbers
    - Renewal dates
    - Commissions
    - Details of timing and processing of the sale
- Your BBD Client Manager will also loop you in on the Welcome email to the plan administrator once their plan is effective.
- For Catastrophic Health plans, we strongly encourage that you run an employee roll out presentation to explain satisfying the deductible to the employees. Your Director, Partner Solutions, TPA+ and Client Manager are available to assist with this.
- BBD is here to help you navigate your client's benefits plan through our Focus 3/6/9 program.
    - At three months after your client's plan starts with us, you'll receive a personalized check-in from your BBD Client Services team. We make sure every question is answered.
    - At six months, we review the claims experience of the group and bring any high claiming patterns to your attention. We ensure the plan design is still a good fit for the group and offer suggestions if plan changes are recommended.
    - At nine months, we guide you through our renewal process. We make sure your clients can look forward to another successful year.
- Nomad, BBD's online benefits administration tool, contains all of the information about your clients' group benefits plans. View their booklet, plan summary, benefits coverage, invoices, and claims experience from your desktop, tablet, or phone.

Materials to support this stage

Employee roll out presentation

One-pager for employers

Things your client needs to know

- Your clients will receive a welcome email which includes:
    - Policy ID numbers
    - Invoicing details
    - General details of their plan
    - Nomad information
- Your clients will also receive their Nomad plan administrator portal access via email. Should they request it, our Client Services team is happy to provide a walk through of Nomad.
- To ensure the best possible onboarding experience for your clients, your Client Services team:
    - Reaches out at one week to check in on the plan administrator and answer any questions.
    - Reaches out at two weeks to let the plan administrator know that their employee packages will be arriving.
    - Reaches out at three weeks to see if the group has any questions about their employee packages.
    - Reaches out at three months as a general touch base on their plan.

Materials to support this stage

One-pager for employees

Catastrophic Health
Invoicing

HCSA deposit required

As the billing for the HCSA is done in arrears, a deposit is required on the account that is held for the duration of the benefit plan. This is two months of anticipated claims, administrative fees, commissions, and taxes when pre-authorized debit (PAD) is set up on the account, and three months of the above if not PAD is set up. The deposit is reviewed at renewal and may require adjustment if demographics have changed significantly.

First invoice

Your client's first payment will occur during the processing of the sale. Their first month's payment will be for all benefits, excluding the HCSA. The HCSA claims through GreenShield are billed two months in arrears. Your client will not see the claim charges on their first two invoices. On their third invoice, they will see the claims from the first month of their coverage and will be required to pay them.

Ongoing invoices

Every month clients will receive notification that their invoice is ready. This will reflect charges for all employees eligible for benefits that billing month and applicable HCSA claims.

If changes need to be made, they can notify their BBD Client Manager. If an invoice has already run, it cannot be adjusted. However, the next invoice will reflect the necessary changes, and charge adjustments will show as a separate line.

Catastrophic Health
Renewal process

Renewal process

Our goal for Catastrophic Health plans is to keep affordable, lower-cost insured health benefits available to all working Canadians. We have been able to achieve this goal by using a unique method of renewing for our Catastrophic Health plans.

How does the renewal work?

We use a combination of block pooling and your client's experience to help provide reasonable rates for all those participating. The loss ratio for each client determines their rating tier.

The first three tiers are based solely on the block's performance. Your client can move from tier to tier based on their own performance. If your client's loss ratio goes over 150%, they will be rated based on their individual experience.

For example

Canada Company Inc. started in tier 1 and is now in its fourth renewal year. Last year, they had a plan member incur a substantial prescription cost. Canada Company Inc. claims were over the premiums collected and now had a loss ratio of 135%. Based on this, they received an increase and moved into tier 3, and this tier still provided them reasonable rates due to the pooling of the overall healthy block.

This year, the plan member did not require the same prescriptions. Canada Company Inc.'s loss ratio was 59.6%. They will now go back into tier 1 pricing, the most favourable of the pricing tiers.

Stop-loss protection is also in place to help all groups keep a manageable benefit plan in place, regardless of their experience.

Tier system

At renewal

You can expect an annual renewal. There is a four-month lag time from when a group's renewal period ends, to when the renewal rates are implemented. This time allows:

- BBD to analyze and prepare the renewal;
- BBD to supply the renewal to you;
- You to present the renewal to your client; and
- You to review the plan design and send back requests (if any) for negotiations.

Renewals are provided a minimum of 60 days before the client's renewal date directly to advisors.

When renewing, you can expect to receive information on your client's overall claims performance and the tier level they will fall under for the next renewal year.

Please note: Clients do not get individualized reporting unless they are in tier 4. The individualized information will only be available depending on the size of the group.

Catastrophic Health
Common FAQ's

Q. HELP! A claim was denied at the pharmacy.

A. If a plan member has not satisfied their deductible before making a claim, **the claim will not be paid directly at the pharmacy.** The pharmacist will ask the plan member to pay out-of-pocket for the cost of the expense. Not to worry, the pharmacist will submit the claim to GreenShield on the plan member's behalf. The claim will be put through their HCSA automatically as long as they have auto-coordination turned on. If they have the available funds in their HCSA, the account will reimburse them for the amount paid through direct deposit.

Q. What is a deductible?

A. The deductible is the amount of money that must be paid by the plan member out-of-pocket before the essential health insurance begins to cover eligible expenses. The plan member's HCSA will automatically reimburse them for their eligible out-of-pocket expenses, provided there are sufficient funds in the account. There are two kinds of deductibles:

Single coverage deductible:

The deductible for single coverage is $1,000 and must be paid before the plan begins to cover eligible expenses.

Family coverage deductibles:

Family coverage has two separate $1,000 deductibles. The employee on the plan has an individual deductible of $1,000, while their dependents ("the family") have an additional combined deductible of $1,000. Once the family reaches their $1,000 deductible, through any combination of eligible claims, the plan will begin to cover eligible expenses for the family, excluding the employee. The employee must pay their own individual $1,000 deductible (for a maximum family total of $2,000) before coverage comes into effect for them.

Q. How is the deductible satisfied?

A. The deductible can be satisfied by submitting eligible essential health expense claims to the plan, including **prescription drug claims, eligible medical supplies/equipment supplies, ambulance claims, hospital claims, accidental dental claims, and private duty nursing claims.** Each eligible claim submitted goes towards satisfying the deductible. Once met, the plan member will have full access to the Catastrophic Health coverage and will be covered 100% for the essential eligible expenses.

Q. What submitted claims do NOT satisfy the deductible?

A. Expenses that do not satisfy the deductible include, but are not limited to:

- Massage
- Physiotherapy
- Speech therapy
- Vision Care
- Nutritionist
- Dental claims (non-accidental)
- Chiropractor

Note: The above benefits are not covered under essential health care benefits of Catastrophic Health, however, they can still be covered under the HCSA if there are available funds.

Q. How do plan members submit claims?

A. Claiming a prescription drug:

Plan members show their GreenShield ID number to their pharmacist, who will determine if the claim is approved, denied as ineligible, or if the deductible has not yet been satisfied.

If the claim is denied at the pharmacy, it may be because the plan member has not yet satisfied their deductible. In this case, the HCSA will automatically reimburse plan members for the amount of the eligible expense based on available funds, and the cost of the eligible expense will be applied towards satisfying the individual deductible.

Claiming other medical expenses:

To file a claim for expenses other than prescription drugs (i.e, physiotherapy, vision, dental) plan members need to submit their claims electronically through GreenShield+. Visit www.greenshield.ca and select “Login” to submit through their HCSA.

Q. Why did my client have to pay out-of-pocket?

A. If the plan member has not satisfied the plan’s deductible, they will need to pay out-of-pocket for the expense.

Q. What happens if the plan member has coverage through their spouse or partner's plan?

A. In cases where plan members may be covered by a spouse or partner's plan, claims must first be submitted to the spouse or partner's plan. The request to reimburse any remaining balance should be sent to GreenShield using a HCSA claim form, or by submitting online through the HCSA section on GreenShield+.

Q. Can a plan member be reimbursed directly by mail?

A. No. GreenShield no longer offers reimbursement by cheque. Plan members can register for direct deposit online in their GreenShield+ profile.

Q. Can the Health Care Spending Account dollars roll over into the next year or allocation period?

A. Yes, your client can set allocations or claims to rollover into the next year. Ask today if any adjustment needs to be made to the plan or if you have a client who would like this setup for their Catastrophic Health plan.