
coreHEALTH+ FAQ

A listing of FAQs for understanding, enrolling and using the plan.

Rev 2

About the Plan / Enrollment

Is this a national plan available to incorporated companies in all provinces? The coreHEALTH+ Plan is available to **Incorporated or Limited** companies throughout Canada. However, due to various legislative changes surrounding the taxation of benefits, the coreHEALTH+ plan is not available to businesses located in the province of Quebec.

Do employees need to be in good health to participate / enroll? Current or past health condition does not affect your ability to enroll in the coreHEALTH+ program. There are some portions of the insurance coverage that will be affected if you have had a pre-existing illness. Consult the Policy document for details. The Health Spending Account (HSA) side of the coreHEALTH+ Plan has no health restrictions, past or present.

What age for the employee/spouse does the coverage go up to? Employees that are up to and including 64 years of age can be covered under the coreHEALTH+ plan. If an employee is 65 and older, they can continue to use just the Health Spending Account portion.

Is coreHEALTH+ only available to Canadian citizens? To be eligible for participation in the coreHEALTH+ plan, an employee must be either a Canadian citizen or a landed immigrant *and* be a resident of Canada.

Explain the optional "Credit Carry Forward" feature. This company wide optional feature provides for employees to carry forward any un-used portion of their HSA into the next benefit year. This can only be done for one year. For example, if an employee has a \$1,000 annual limit and submits \$600 for the entire benefit year, there will be \$400 carried into the next year's limit for a new total of \$1,400.

Does the employee pay for their health expenses first? Yes. The employee pays for their health and dental expenses personally. To get reimbursed, the employee submits a claim using the coreHealthPlus.com web site. A cheque is issued to the employee for the eligible amount of the claim, providing there is sufficient un-used balance in their account.

What is the minimum amount of the HSA per employee that can be set? There is no minimum annual amount. However, NHC does require a minimum "funding submission" of \$50 for the processing of employee claims. Any "left over" funding money can be used for other claims.

Does the employer put the money into an “account” up front? There are two ways that the “Health Spending Account” can be operated. 1) The money for each claim is paid at the time of the claim or, 2) The company can send in a block of money (called “pre-funding”) to be held in an account that will be drawn from as claims come in (the claims are then processed immediately). All coreHEALTH+ accounts can operate in either mode.

Does the system support limiting new employees from immediately claiming their full HSA limit? Yes. There are two optional features that can be applied separately or together. They are called: Waiting Period and Pro-rating. The Waiting Period is a time (1 to 6 months) that a new employee must wait after their hire date before any claims can be submitted. The Pro-rating feature will limit the annual HSA amount proportional to the number of months left in the benefit year. The pro-rating feature begins after the Waiting Period (if applicable) has been satisfied.

How does the company Plan Administrator know that the pre-fund level requires more money? An email is sent to the PA when the balance is below a pre-determined level. The level can be set to any amount.

What happens if there is an overpayment for a funding cheque? Any amount that is not needed to process the claim (due to ineligible receipts or errors, etc.) will be held in an account for the company. NHC does not pay interest on moneys held. This money will be applied to the next claim that is submitted by an employee.

Can the plan provide one employee with a greater HSA limit over another employee? Yes. This can be accommodated only if the employees are in different job classifications. According to the CRA, all employees in the same job classification must be given the same benefit level. Different job classifications can be set for:

- Different functional job levels (manager, vs. field worker, vs. part time etc.)
- Different years of service
- Different salary band
- Different geographic regions

CRA requires that a common approach of defining job classification be used consistently.

Is there a maximum or minimum number of employees that can be added to the plan? There is no maximum number of employees and the minimum number is one employee.

Who is the beneficiary of the insurance policy? The beneficiary is always set to be to the “estate of the employee”. It is always good planning to have a legal ‘Will’ in place for all members of a family.

Does every person in a company need to be on the plan? Can some opt out? Every person within a company must be on the coreHEALTH+ plan. Assigning different job classifications provides flexibility and can customize the amount of the HSA coverage.

Can an employee be enrolled as a “Single” for the insurance portion and a “Family” for the Health Spending Account (or vice versa) ? No. When entering an employee on the system, the moment a dependent is added, the coreHEALTH+ plan becomes a full “Family Plan”.

Is there a minimum number of hours per week an employee must work to qualify for being on the CoreHEALTH+ plan? Yes. The minimum number of hours is 15 per week.

Can the Plan Administrator print out Wallet Cards for all of the employees? Yes. When a Plan Administrator enters the web site and selects an employee, there will be a “Wallet Card” download option along the right side of the page. The employee can also access his or her own Wallet Card from the web site.

After enrolling, what is the turn-around time for the coverage to become active? Plan coverage is effective the first day of the month following the receipt of the signed enrollment form and void cheque. The premiums will come out on the 15th of the month.

Employee – Using the Plan

What is a Health Spending Account? The Health Spending Account is a tax-free benefit that your employer provides and pays for routine expenses up to an annual maximum. The employee first pays for the expense, then submits a claim using the online website: coreHealthPlus.com.

When filling out a claim form, what date is used for the “Receipt date”? The receipt date is to be the actual date that the service was performed or the item purchased. Carefully look at your documents, as there are other “Dates” often shown.

What type of back up documents is required with a claim submission? Original receipts with a breakdown of treatment cost and practitioner name are required. A “credit card slip” or “till tape” is not an acceptable receipt. Additionally, an “Explanation of Benefits” from a spousal plan is needed if coordinating benefits.

Does the system support employees without access to a computer / email when making claims? Yes. A manual claim submission can be done using a blank claim form made available by your Plan Administrator.

How do I make a claim for an Insurance item (unplanned event)? The insurance portion of the coreHEALTH+ plan is provided by Western Life Assurance Corporation (WL). To make a claim or to ask a question about the insurance coverage, please have your policy number ready then call the WL toll free number:

1-866-337-0408

How do I reset my password? Web site access passwords can be reset or changed for any reason by clicking on the link “Don’t know your password?”. An email will be sent to the address on file and contains instructions to complete the password reset process. Remember, your User Name is your email address that is registered in the system, all in lower case letters.

How do I get a Wallet Card? An employee can print their own wallet card by logging into the coreHealthPlus.com web site and selecting the “Wallet Card” download option along the right side of the page.

What does the Wallet Card provide? The wallet card is part of a page called “Summary of Benefits”. This page provides current information about the type of insurance coverage you have and your Health Spending Account balance. The cutout Wallet Card provides the phone numbers for emergency medical travel assistance. It also lists the type of insurance coverage you have plus the annual Health Spending Account limit. The wallet card is not a “drug card” or an “expense credit card”.

What is the list of eligible and ineligible items to claim on the Health Spending Account? In general, health and dental expenses are eligible for reimbursement if they qualify as a medical expense tax credit under the Income Tax Act of Canada. As a brief summary, the types of eligible medical expenses include:

- Prescription Drugs (with DIN #)
- Prescription Glasses & Contacts
- Dental and Orthodontics
- Laser Eye Surgery

- Physiotherapy
- Out-of-country medical
- Acupuncture
- Unpaid spousal benefit coordination

Here are some examples of ineligible expenses. Please do not include these on your Health Claim submission:

- Over the counter medications or generic sunglasses
- Herbal remedies and supplements
- Vitamins
- Provincial Health Care plan premiums
- Life Insurance premiums
- Gym memberships

DETAILED LIST: HEALTH SPENDING ACCOUNT - ELIGIBLE MEDICAL & DENTAL EXPENDITURES

GENERAL SERVICES

Any service performed by a qualified medical/dental practitioner, including but not limited to the following:

Acupuncturist	Chiropodist
Chiropractor	Christian Science Practitioner
Cosmetic Surgeon (some conditions apply *)	Dentist
Dermatologist	Gynecologist
Naturopath	Neurologist
Obstetrician	Oculist
Ophthalmologist	Optical (all services)
Optician	Optometrist
Orthodontist	Orthopedist
Osteopath	Pediatrician
Physician	Physiotherapist
Plastic Surgeon (some conditions apply *)	Podiatrist
Practical Nurse (for medical services)	Psychiatrist
Psychoanalyst	Psychologist
Registered Nurse	Speech Therapist
Surgeon	Therapist

Note: A qualified medical practitioner means a person who is authorized to practice in accordance to the laws of the province and certified according to the practitioner's governing body.

* As of March 4, 2010, expenses for purely cosmetic procedures and/or surgery are no longer eligible. If the procedure / surgery is medically necessary due to injury, deformity, accident or trauma (including psychological) a letter from a medical practitioner stating the medical reason for the procedure is required.

DENTAL SERVICES

Dental X-Rays	Denture repairs and replacement
Examinations	Extracting teeth
Filling teeth	Gum treatment
Oral surgery	Braces / Orthodontics (Treatment Plan required)
Replacement filling	

HOSPITAL SERVICES

Anesthetist	Hospital bills
Oxygen Masks/Tents	Use of operating room
Vaccines	X-Ray Technician

PRESCRIBED MEDICAL TREATMENTS

Audiology	Blood transfusion
Bone Marrow Transplant	Diathermy Nursing
Electric shock treatments	Healing services
Hydrotherapy	Injections
Insulin treatments	Organ Transplant
Physiotherapy	Pre-natal/post-natal treatments
Radium Therapy	Registered Nurse
Speech Pathology	Ultra-violet ray treatments
Whirlpool baths	X-Ray treatments

MATERIALS AND APPARATUS, WHICH ARE PRESCRIBED BY A RECOGNIZED MEDICAL PRACTITIONER

- Contact Lenses
- External Breast prosthesis
- Eyeglasses / Prescription Sunglasses
- Heart monitors or pace makers
- Hospital beds if required in home
- Inductive coupling
- Infusion pumps for diabetics, including peripherals
- Monitors attached to babies identified as being prone to Sudden Infant Death Syndrome
- Optical scanners or similar devices to enable a blind individual to read print
- Orthopedic shoes or boots
- Osteogenesis stimulator
- Oxygen tent
- Prescription medications
- Syringes
- Television closed captioning decoders
- Wigs, if required as a result of disease, accident or medical treatment

DEVICES DESIGNED AND/OR USED FOR THE FOLLOWING:

- Assist walking where the individual has mobility impairment
- Enable individuals with a mobility impairment to operate a vehicle
- Assist a person to use bathtubs/showers/toilets
- Extremity pumps or elastic support hose to reduce lymph edema swelling
- Enable deaf or mute persons to make and receive telephone calls including visual ringing indicators, acoustic coupler or teletypes
- Used by individuals suffering from a chronic respiratory ailment or chronic immune system deregulation
- Synthetic speech systems
- Braille printers and large print-onscreen devices that enable the blind to utilize computers
- Electronic or computerized environmental control systems for individuals with severe and prolonged mobility restrictions

- Electronic speech synthesizers for mute individuals
- Power operated guided chair installation for stairways
- Power operated guided lifts and transportation equipment allowing access to buildings, vehicles or to allow wheelchair access to a vehicle

OTHER MATERIALS AND APPARATUS, WHICH DON'T REQUIRE A PRESCRIPTION

- Artificial eyes
- Artificial kidney machine, including installation, operating costs
- Artificial limbs
- Blood sugar level measuring devices for diabetics
- Brace for a limb
- Catheters, catheter trays, tubing , diapers, disposable briefs required by incontinent persons
- Crutches
- Colostomy pads
- Hernia truss
- Ileostomy pads
- Iron lung
- Laryngeal speaking aid
- Spinal brace
- Wheelchair
- Any apparatus or material, paid to a doctor, nurse or hospital
- Any device to aid the hearing of a deaf person including bone conduction, telephone receivers, extra loud audible signals and devices to permit volume adjustment of telephone equipment above normal levels

OTHER EXPENDITURES

- Laser Eye Surgery
- Specially trained animals to assist blind, deaf or severely impaired persons, including the cost of its care and maintenance
- Transportation costs to hospital, clinic or doctor's office to obtain services not otherwise available
- Homemaker service
- Home care (attendant must be a non-relative)
- Reasonable costs for adapting a residence to accommodate a disabled person (ex. Wheelchair ramp, lifts, bath facilities)
- Prescription Birth Control pills
- Ambulance charges
- Rehabilitative therapy
- Lip reading
- Sign language training
- Transportation, meals and accommodations (reasonable expenses for meals, accommodation and travel costs for a patient and an accompanying attendant may be deductible if: equivalent medical services are not available locally, the route traveled is reasonably direct and medical treatment is reasonable and distance traveled is at least 80 kilometers)