



HEALTH BENEFITS GUIDE

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First Nations Health Authority
Health through wellness

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First Nations Health Authority

The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. The FNHA is the health and wellness partner to over 200 diverse First Nations communities and citizens across BC. In 2013, the FNHA began a new era in BC First Nations health governance and health care delivery by taking responsibility for the programs and services formerly delivered by Health Canada. Since then the FNHA has been working to address service gaps through new partnerships, closer collaboration, health systems innovation, reform and redesign of health programs and services for individuals, families, communities and Nations.

The FNHA is also a champion of culturally safe practices throughout the broader health care system. Taking a leadership role, the FNHA actively works with its health partners to embed cultural safety and humility into health service delivery and improve health outcomes for First Nations people.

The FNHA's community-based services are largely focused on health promotion and disease prevention and include:

- Primary health care through more than 130 medical health centres and nursing stations;
- Children, youth and maternal health;
- Mental health and wellness;
- Communicable disease control;
- Environmental health and research;
- Health benefits;
- eHealth and telehealth;
- Health and wellness planning; and
- Health infrastructure and human resources.

Our work is guided by the FNHA Vision, Values, and Directives.

Our Vision

Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities.

Our Values

- Respect
- Discipline
- Relationships
- Culture
- Excellence
- Fairness

Our Directives

- Directive #1: Community-Driven, Nation-Based
- Directive #2: Increase First Nations Decision-Making and Control
- Directive #3: Improve Services
- Directive #4: Foster Meaningful Collaboration and Partnership
- Directive #5: Develop Human and Economic Capacity
- Directive #6: Be Without Prejudice to First Nations Interests
- Directive #7: Function at a High Operational Standard

First Nations Health Benefits

First Nations Health Benefits (Health Benefits) covers specific health-related items and services to meet medical or dental needs not covered by third-party health insurance or BC Medical Services Plan (MSP).

First Nations Health Benefits provides coverage for:

- BC Medical Service Plan (MSP) premiums;
- Ambulance invoices; and
- Items and services that fall under six health benefit areas:
 - Dental;
 - Vision Care;
 - Medical Supplies and Equipment (MS&E);
 - Pharmacy;
 - Medical Transportation (MT); and
 - Mental Health.

The goal of Health Benefits is to provide First Nations in BC with coverage for items and services that:

- Are appropriate to their unique health needs;
- Reflect the cultures and perspectives of First Nations in BC;
- Promote a sustainable program;
- Contribute to the achievement of an overall health status comparable to the Canadian population;
- Shift the focus of health service delivery from a sickness model to a wellness and prevention model; and
- Are provided based on professional medical or dental judgment, the best practices of health services delivery, and evidence-based standards of care.

NOTE: THIS INFORMATION IS CURRENT AS OF SEPT. 16, 2019.

It is subject to change in order to respond to the needs of clients and to the latest information on medical practices. Contact Health Benefits:

Web: www.fnha.ca/benefits

Toll-free: 1.855.550.5454

Email: healthbenefits@fnha.ca

Eligibility

ELIGIBILITY

In order to be eligible for Health Benefits, individuals must be:

- A registered "Indian" as defined by the Indian Act, or the infant of an eligible parent; and
- A resident of British Columbia

To register for "Indian Status" visit the Indigenous Services Canada (ISC) [website](#).

Residents of British Columbia are people who:

- Are Canadian citizens or permanent residents,
- Make their home in BC, and
- Are physically present in BC at least six months in a calendar year.

Individuals are not eligible for Health Benefits if they are already covered by another third-party health insurance provided by the Federal Government or by a First Nations organization as a part of a funding agreement.

To register for Health Benefits, individuals should have their status number ready and call Health Benefits at **1.855.550.5454**.

ENROLLMENT

Individuals who are eligible for Health Benefits should enroll in the program to access their various benefits. Enrollment with Health Benefits is not automatic. Confirming enrollment is especially important for individuals who have recently moved to BC, turned 19, married or divorced, or had an employer pay MSP premiums on their behalf.

Clients who would like to confirm whether they are enrolled, or who need to register with Health Benefits for the first time, should have their status number ready and call Health Benefits at **1.855.550.5454**.

INFANT ENROLLMENT

First Nations infants up to 18 months are eligible for Health Benefits as long as at least one parent meets the Health Benefits eligibility criteria. To register an infant under an eligible parent, clients should submit the following documents to Health Benefits by mail or fax:

- A copy of the infant's birth certificate; and
- An MSP Change Request Form, available online at <http://www.fnha.ca/benefits/MSP>

After 18 months, the infant will no longer be covered under the eligible parent and will need to be registered with Health Benefits under their own status number. To register an infant for Health Benefits under their own account clients must:

- Register the infant for Indian Status at a local band office or Indigenous Services Canada (ISC); and
- Once "Temporary Confirmation of Registration" is received, call Health Benefits at **1.855.550.5454** with the child's new status number to complete the registration process.

BC Medical Services Plan

BC MEDICAL SERVICES PLAN

The BC Ministry of Health administers the Medical Services Plan (MSP) through Health Insurance BC (HIBC), which ensures that all eligible BC residents have access to medically essential care. All BC residents must have a BC Services Card to receive health services.

Health Benefits manages the MSP program for status First Nations who reside in BC; status First Nations in BC who need to register for MSP should do so through Health Benefits rather than the Ministry of Health.

MSP registration forms are available online at <http://www.fnha.ca/benefits/MSP> or by calling Health Benefits at **1.855.550.5454**.

MSP Coverage

MSP covers medically necessary services provided by doctors, nurses, and midwives. It also covers items and services delivered in hospitals. These include medications clients receive while in hospital, and surgery of various types including emergency oral surgery and cataract surgery. MSP will also cover necessary diagnostic services such as x-rays and blood tests.

In addition, MSP provides some coverage for medically required eye examinations for clients 18 years of age and under, and 65 years of age and over. MSP coverage may not be enough to cover the full cost of the eye exam, however Health Benefits vision care benefits may cover some of the remaining cost. For more information, visit the vision care benefits webpage.

MSP also covers some supplementary benefits for certain groups, including First Nations Health Authority clients. These supplementary benefits include acupuncture, chiropractic, massage therapy, naturopathy, physical therapy, and non-surgical podiatry. However, MSP coverage for these services is fairly limited. For supplementary coverage details clients should visit the MSP website at www.gov.bc.ca/MSP.

Note that MSP defines which items and services are medically necessary and not all services clients need may be covered. For details on which items and services are not covered by MSP visit www.gov.bc.ca/MSP.

From time to time, the BC Ministry of Health may change the items or services that MSP covers. Health Benefits will not automatically take over covering these items or services. Health Benefits will determine on a case-by-case basis whether the item or services will be covered as a benefit.

Clients with questions about MSP coverage can call Health Benefits at **1.855.550.5454**.

Who should register for MSP?

- Clients and dependents who are new to BC;
- Clients and dependents returning to BC (after 3 or more months away);
- Clients who have turned 19 years of age; or
- Clients who previously had their premiums paid by an employer or other source (e.g. individuals on Income Assistance).

Clients who previously had their premiums paid by an employer or other source, and would like Health Benefits to pay their MSP premiums, should call **1.855.550.5454** to be added to the Health Benefits MSP group.

The Ministry of Health is eliminating MSP premiums in January, 2020. The MSP program will continue to provide eligible B.C. residents with provincially insured health care benefits. Clients should still register for MSP through Health Benefits. Most children are dependents on their parent or guardian's MSP coverage. When an Health Benefits client turns 19 years old, they should confirm with Health Benefits that they have their own MSP account to make sure coverage remains active and they do not receive a bill.

Clients who need a PHN

Clients who do not have an active PHN should submit an MSP Registration Form with supporting documentation to Health Benefits via mail or fax. Clients will also need to visit an Insurance Corporation of BC (ICBC) driver licensing office and request a Photo BC Services Card.

The following information and supporting documentation must be submitted with the MSP Registration form, which is available online at <http://www.fnha.ca/benefits/MSP>.

- Provide the following mandatory information:
 - Band name and number;
 - Full status number;
 - Legal first and last name, as shown on government issued ID;
 - Date of birth; and
 - Residential address (cannot be a P.O. Box number).
- Provide a previous PHN if applicable.
- Ensure all boxes are marked off and all information is complete.
- Include a copy of government issued picture ID such as a Canadian birth certificate, Canadian citizenship card/certificate, or Canadian passport.
- Make sure application is clearly printed, signed, and dated by applicant (and spouse if needed).
- Provide legal documentation that grants Power of Attorney if an individual is signing on behalf of someone else, or clearly indicate that they are a witness for someone who is incapable of signing personally.

Making Changes to MSP Information

Clients who would like to update their MSP information (e.g., add, remove, or change information) should complete an MSP Change Request Form available online at <http://www.fnha.ca/benefits/MSP> and mail or fax it to Health Benefits. All Change Request Forms should be submitted with the necessary supporting documentation (e.g., a copy of the marriage certificate, birth certificate, etc.).

Backdating MSP Coverage

Clients who did not register with MSP through Health Benefits, and have been billed for MSP premiums as a result, may be eligible for backdated MSP coverage. Eligibility for backdated coverage depends on several factors such as the date the client moved to BC or the date the client obtained "Indian Status." For more information about backdating MSP coverage call Health Benefits at **1.855.550.5454**.

Obtaining a BC Services Card

The BC Services Card can be obtained from an ICBC driver licensing office, or by contacting Service BC toll free at: 1.800.663.7867. BC residents are required to update their picture ID in order to maintain an active PHN. For more information visit www.gov.bc.ca/bcservicescard.

Extra Billing

“Extra billing” is when a health care professional (e.g., doctor) bills a client more than what MSP pays for the service, meaning that the client has to pay for the difference in cost. **Health Benefits will not pay extra billing charges nor reimburse clients who have paid extra billing charges.** If clients receive bills from a doctor or hospital which they think is an “extra billing” charge, they should follow up with the Ministry of Health Medical Beneficiary Branch. For detailed information about MSP please visit www.gov.bc.ca/MSP.

MSP AND LEAVING BRITISH COLUMBIA

Health Benefits eligibility is based on residency in BC, which is defined by MSP. If clients leave BC for extended periods of time it might impact their eligibility for Health Benefits.

Travelling Outside of BC or Canada

MSP provides limited coverage to BC residents travelling outside of the province or country. Health Benefits clients are **strongly advised** to purchase additional health insurance before leaving BC, whether travelling to another province or outside of Canada. For more information visit the MSP website at www.gov.bc.ca/MSP.

Health Benefits will cover items and services purchased or received in another province as long as they would be eligible for Health Benefits coverage if bought in BC, and were delivered by an eligible health professional. Detailed information about covered items and services under the dental, vision care, MS&E, and pharmacy benefits can be found in the online PBC Member Profile or the PBC Benefit Booklet, and the PharmaCare Plan W formulary. Please note that clients will likely have to pay for the item or service out-of-pocket and request reimbursement from Health Benefits.

Clients can contact Health Benefits at **1.855.550.5454** if they have any questions.

Temporary Absence

Clients who are planning to be in another province for up to 24 months (e.g., students or individuals working on a short-term contract) should contact Health Benefits at **1.855.550.5454** to make sure their coverage continues while they are away. Interruption to MSP coverage may require the client to re-apply.

Permanent Moves

Clients who are moving to another province in Canada should contact Health Benefits at **1.855.550.5454** to cancel their MSP and enroll in the federally-run Non-Insured Health Benefits (NIHB) program. Health Benefits will provide coverage for the month the client leaves and two additional consecutive months. Clients moving outside of Canada will have coverage for the month they leave.

Health Benefits Overview

Health Benefits covers specific health-related items and services that fall under six health benefit areas:

- Dental;
- Vision Care;
- Medical Supplies and Equipment (MS&E);
- Pharmacy;
- Medical Transportation (MT); and
- Mental Health.

The mental health benefit provides coverage through three programs:

- Mental Wellness and Counselling;
- Indian Residential School Resolution Health Support; and
- Missing and Murdered Indigenous Women and Girls Health Support Services.

Plan Coverage

The Health Benefits program offers a comprehensive, principle-based, and community-driven plan. Items and services that are core benefits under the plan are fully covered.

Flexibility in Coverage

In order to offer clients more choice and flexibility, the plan also enables clients to access additional, alternative items and services that were previously unavailable. If, in consultation with a medical professional, clients choose an alternative to the core benefits, the plan may pay up to the amount covered for the equivalent core benefit. Clients will be responsible for any difference in cost. This way, clients can choose the item or service that best meets their needs.

For example, the plan fully covers white dental fillings as a core benefit. Rather than exclude gold fillings completely, the plan offers coverage for gold fillings up to the amount covered for white fillings. This gives clients greater flexibility when discussing treatment options with a dental professional.

Coordination of Benefits

When clients have access to another third-party health insurance, they should submit claims to that plan first and to Health Benefits second. One exception is the pharmacy benefit, where clients should submit claims to PharmaCare first.

Opting Out of Third-Party Insurance

Clients can choose to opt out of private, employer-sponsored, or other public health care coverage once enrolled with Health Benefits. However, it is important to note that private insurance may offer additional benefits not available through Health Benefits. For example, Health Benefits does not include coverage for physiotherapy, chiropractic treatment, massage therapy, naturopathy, or other paramedical or supplementary services. If clients opt out of their private insurance they may lose coverage for those services.

PARTNERSHIPS

Health Benefits provides some benefits through partnerships with First Nations organizations and other provincial health organizations. Health Benefits has partnered with Pacific Blue Cross (PBC), BC PharmaCare, and First Nations organizations to offer clients a convenient way to access their benefits.

Partnership with Pacific Blue Cross

Health Benefits has partnered with PBC to administer the following benefits:

- Dental;
- Vision Care;
- Medical Supplies and Equipment; and
- Some pharmacy items and services.

Clients can find detailed information about what items and services are covered under these benefits areas through the online PBC Member Profile, available at www.pac.bluecross.ca.

The PBC Member Profile is an online service that offers convenient and secure access to benefit information 24 hours a day. Once logged in, clients can:

- Make and track online claims;
- View benefit coverage details;
- Track benefit usage; and
- Download claim forms.

Clients can often receive reimbursements for online claims within two business days if they enter direct deposit information into their Member Profile account. Note that many providers can bill PBC directly for services, which mostly eliminates the need to pay out-of-pocket and then submit a claim for reimbursement.

The PBC Member Profile displays benefit areas in three categories: Health, Dental, and Drug.

- The Health category contains the vision care and the MS&E benefits;
- The Dental category contains the dental benefit; and
- The Drug category contains some pharmacy items and services not covered by PharmaCare Plan W.

Clients can explore these categories to learn about specific coverage details, including which items and services are core benefits and which are items included to provide flexibility in coverage. Items that show as “Paid As” are alternative options, where the plan will pay up to the amount covered for the equivalent core benefit. For example, gold dental fillings are shown as “paid as white dental fillings” to indicate that gold fillings are covered up to the same coverage amount as white fillings.

Some pharmacy items and services are covered by PBC. Clients can search the Drug category on the Member Profile for details about which items and services are covered. Items that show as “Not a Benefit” on the Member Profile might be covered by PharmaCare Plan W. Clients with questions about pharmacy coverage should call Health Benefits at **1.855.550.5454**.

Partnership with PharmaCare

The vast majority of pharmacy items and services are covered through PharmaCare. Clients receive coverage for their eligible prescription and over-the-counter items through PharmaCare Plan W. Clients can search the PharmaCare Plan W formulary for details about which items and services are covered. Providers can bill PharmaCare directly through PharmaNet. Clients can submit out-of-province reimbursement requests directly to PharmaCare.

Partnerships with First Nations Organizations

Health Benefits has partnered with First Nations Bands and organizations to better administer the following benefits:

- Medical Transportation; and
- Mental Health.

Health Benefits has funding agreements with many First Nations Bands and organizations to enable communities to run the medical transportation and mental health programs with support from Health Benefits. Clients who need to access these benefits can call Health Benefits at **1.855.550.5454** to check if their community runs their medical transportation or mental health programs.

Dental

Health Benefits provides coverage for dental services to maintain good oral health, prevent cavities and gum disease, and restore function. Seeing an oral health provider regularly can help catch dental problems before they get too serious and require more extensive procedures. Oral health is directly linked to general health and wellness. Dental infections can make certain health conditions - such as diabetes, heart disease, and pregnancy - more complicated.

The dental benefit is administered through a partnership between Health Benefits and PBC. Clients can access detailed information about their dental benefits through the online PBC Member Profile, available at www.pac.bluecross.ca.

Dental Benefit Coverage.

Health Benefits covers specific dental items and services under the following categories:

- Bridges;
- Crowns, Inlays, Onlays, Veneers;
- Dental Surgery;
- Dentures;
- Exams and X-rays;
- Fillings;
- Night guards;
- Orthodontic Services;
- Periodontal Services;
- Preventive Services; and
- Root Canals and Related Services.

Items and services not covered under the dental benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

Most oral health providers in BC are registered with PBC and can directly bill for items and services. Clients who see a provider not registered with PBC will need to pay out-of-pocket and submit a reimbursement request to PBC after their appointment. Note that reimbursement requests may be denied and are still subject to coverage criteria and maximums.

Clients are strongly encouraged to discuss billing with their provider before booking an appointment or purchasing items. Questions clients should ask their provider:

- Is the provider registered with PBC for billing?
- Is the item or service fully covered by my plan?

Approvals Before Service

Some items and services covered under the dental benefit require approval before oral health providers can bill for them. Providers can submit approval requests directly to PBC. Once they receive authorization, they can provide the item or service and bill PBC directly.

If PBC denies an approval request, clients have the option of appealing the decision. Clients should submit appeals to PBC. More information on appeals can be found in the Appeals section. Clients cannot appeal decisions on items and services that are considered Exclusions.

If clients decide to pay out-of-pocket for an item or service before PBC has authorized an approval request - or despite PBC denying an approval request - there is the risk they will not be reimbursed.

Oral health providers can identify which items and services require approval and which are covered under the dental benefit by checking the PBC Provider Portal, "PROVIDERnet." If the provider is unable to determine requirements or coverage, the client or oral health provider should contact Health Benefits at **1.855.550.5454**.

Dental Exclusions

Some dental items and services are considered Exclusions under the dental benefit. Clients cannot seek exception or appeal for Excluded items. Dental benefit Exclusions include, but are not limited to:

- Cosmetic treatments;
- Implants; and
- Ridge augmentation.

Authorized Providers

Dental services must be provided by a licensed oral health professional such as a dentist, denturist, dental therapist, or dental hygienist.

Accessing Dental Benefits

1

- Client makes an appointment with an oral health provider.
- Client confirms that provider can directly bill PBC.

2

- Client attends appointment.
- If required, provider establishes treatment plan and submits approval requests to PBC.
- Client learns about any out-of-pocket charges before undergoing treatment.

3

- Provider delivers services based on treatment plan and authorized approval requests.

4

- Providers registered with PBC submit invoices directly.
- Providers not registered with PBC provide client with an invoice. Client will need to pay out of pocket and request reimbursement from PBC.

Vision Care

Health Benefits provides coverage for eye exams and corrective eyewear to ensure clients maintain good eye health. Eye exams are important to check the eyes for common diseases and to evaluate the eyes as an indicator of overall health. Regardless of age or physical health, a comprehensive eye exam will help detect any eye problems early when they are most treatable.

The vision care benefit is administered through a partnership between Health Benefits and PBC. Clients can access detailed information about their vision care through the online PBC Member Profile, available at www.pac.bluecross.ca.

Vision Care Benefit Coverage

Health Benefits covers specific vision care items and services under the following categories:

- Eyewear and Repairs; and
- Tests and Exams.

Items and services not listed as a benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

Most vision care providers in BC are registered with PBC and can directly bill for items and services. Clients who see a provider not registered with PBC will need to pay out-of-pocket and submit a reimbursement request to PBC after their appointment. Note that reimbursement requests may be denied and are still subject to coverage criteria and maximums.

Clients are strongly encouraged to discuss billing with their provider before booking an appointment or purchasing items. Questions clients should ask their provider:

- Is the provider registered with PBC for billing?
- Is the item or service fully covered by my plan?

Vision Care Exclusions

Some vision care items and services are considered Exclusions under the vision care benefit. Clients cannot seek exception or appeal for Excluded items. Vision care benefit exclusions include, but are not limited to:

- Items that support the use of prescription eyewear (e.g., contact lens solution, glasses cases);
- Industrial safety frames or lenses;
- Non-prescription items;
- Surgical procedures (e.g., laser eye surgery); and
- Vision training.

Authorized Providers

Vision care services must be provided by a licensed vision care professional such as an ophthalmologist, optometrist, or optician.

Accessing Vision Care Benefits

1

- Client makes appointment for eye exam.
- Client confirms that provider can directly bill PBC.
- Client learns about any out-of-pocket charges before the exam.



2

- Client attends appointment.
- Provider may give the client a corrective eyewear prescription if needed.



3

- Client uses the prescription to buy new eyewear.



4

- Providers registered with PBC submit invoices directly.
- Providers not registered with PBC will provide client with an invoice. Client will need to pay out-of-pocket and request reimbursement from PBC.

Medical Supplies and Equipment (MS&E)

Health Benefits provides coverage for certain Medical Supplies and Equipment (MS&E) for clients who receive care at home. When it is needed, using medical equipment is important for one's safety and can provide clients with greater mobility and independence.

The MS&E benefit is administered through a partnership between Health Benefits and PBC. Clients can access detailed information about their MS&E benefits through the online PBC Member Profile, available at www.pac.bluecross.ca.

MS&E Benefit Coverage

Health Benefits covers specific MS&E items and services under the following categories:

- Bathing and Toileting Aids;
- Braces and Splints;
- Cushions and Protectors;
- Diabetic and Heart Patient Devices;
- Foot Orthotics and Orthopedic Shoes;
- General Medical Supplies and Equipment
- Hearing Aids and Repairs;
- Lifting and Transfer Aids;
- Limb and Body Orthotics;
- Low Vision Aids;
- Offloading Boots (Air Casts);
- Ostomy Supplies;
- Oxygen, Sleep, and Breathing Aids;
- Prosthetics and Supplies
- Surgical Stockings and Pressure Garments;
- Urinary Supplies and Devices;
- Walking Aids and Wheelchairs; and
- Wound Care Supplies.

Clients must have a prescription or written recommendation for an eligible MS&E item to receive coverage. Most MS&E items are fully covered under the MS&E benefit. If asked to pay for an item at the counter, clients can call Health Benefits at **1.855.550.5454** to confirm if the item is covered.

Items not listed as a benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

Some MS&E providers in BC are registered with PBC and can directly bill for items and services. Clients who see a provider not registered with PBC will need to pay out-of-pocket and submit a reimbursement request to PBC after their appointment. Note that reimbursement requests may be denied and are still subject to coverage criteria and maximums.

Clients are strongly encouraged to discuss billing with their provider before booking an appointment or purchasing items. Questions clients should ask their provider:

- Is the provider registered with PBC for billing?
- Is the item or service fully covered by my plan

Approvals Before Service

Some items and services covered under the MS&E benefit require approval before MS&E providers can bill for them. Providers can submit approval requests directly to PBC. Once they receive authorization they can provide the item or service and may be able to bill PBC directly.

If PBC denies an approval request, clients have the option of appealing the decision. Clients should submit appeals to PBC. More information on appeals can be found in the Appeals section. Clients cannot appeal decisions on items and services that are considered Exclusions.

If clients decide to pay out-of-pocket for an item or service before PBC has authorized an approval request - or despite PBC denying an approval request - there is the risk they will not be reimbursed.

MS&E providers can identify which items and services require approval and which are covered under the MS&E benefit by checking their PBC Provider Portal, "PROVIDERnet." If the provider is unable to determine requirements or coverage, the client or MS&E provider should contact Health Benefits at **1.855.550.5454**.

MS&E Exclusions

Some items are considered exclusions under the MS&E benefit. Clients cannot seek exception or appeal for excluded items. MS&E benefit exclusions include, but are not limited to:

- Household items;
- Home renovations (e.g., ramps, stair lifts);
- Items that are not medically necessary (e.g., items for cosmetic purposes);
- Items required for medical trials or studies; and
- Sports equipment (e.g., treadmills, exercise items).

Authorized Providers

MS&E items must be provided by a licensed pharmacy or medical supply and equipment provider.

Accessing MS&E Benefits

1

- Client receives prescription or written recommendation/assessment for an eligible MS&E item and brings it to an appropriate MS&E provider.

2

- Provider assesses client and submits approval request to PBC, if necessary.
- PBC reviews approval request and determines eligibility based on benefit guidelines.
- Client learns about any out-of-pocket charges before paying for item.

3

- Client receives medical item or device from provider.

4

- Providers registered with PBC submit invoices directly.
- Providers not registered with PBC will provide client with an invoice. Client will need to pay out-of-pocket and submit a reimbursement request to PBC.

Pharmacy

Health Benefits provides coverage for pharmacy items and medications. It is important for clients to have access to the medical care that is most appropriate for their health and their medical condition. Prescription and over-the-counter (OTC) items are used to treat short-term illnesses, and are one of the many ways to help patients with chronic conditions live healthier, longer, and more fulfilling lives.

The pharmacy benefit is administered through a partnership between Health Benefits, PBC, and BC PharmaCare. Clients can access detailed information about their pharmacy benefits through BC PharmaCare's formulary search. Additional information about coverage for pharmacy items is available through the online PBC Member Profile, available at www.pac.bluecross.ca.

In addition, multiple provincial agencies including the BC Cancer Agency, BC Transplant, BC Renal Agency, and the BC Centre for Excellence in HIV/AIDS provide specialty pharmacy items to all BC residents living with specific illnesses or conditions.

Pharmacy Benefit Coverage

Health Benefits covers specific pharmacy items and services under the following categories:

- Prescription drugs;
- Over-the-counter drugs; and
- Non-drug over-the-counter items (e.g., lancets for diabetic use).

BC PharmaCare is the primary provider of eligible pharmacy items and services through Plan W. PBC provides supplementary pharmacy coverage.

It is very important that clients enroll in Plan W so they can access their pharmacy benefits. Confirming enrollment is especially important for clients who live in communities on the Yukon and Alberta borders, or who have recently:

- Moved to BC;
- Turned 19; or
- Married or divorced.

Clients who would like to confirm whether they are enrolled, or who need to enroll with Plan W for the first time, should have their status number ready and call Health Benefits at **1.855.550.5454**.

Most pharmacy items are fully covered under the pharmacy benefit. If clients are asked to pay for their medication at the pharmacy counter, it's likely that the item is not covered. Clients should ask their pharmacy provider for a recommendation that is covered by the Health Benefits pharmacy benefit.

Items not listed as a benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

Clients will only be covered if they obtain pharmacy items and services from pharmacies registered with PBC and PharmaCare. Items and services purchased from other pharmacies are not eligible for reimbursement. Pharmacies registered with PBC and PharmaCare can direct bill for all eligible pharmacy items and services.

Brand Name and Generic Drugs

It is important to understand the differences and similarities between *brand name* and *generic drugs*.

Brand name drugs are the first version of a drug to be sold within a country and can only be sold by the company that researched and developed the drug (e.g., Tylenol). Brand name drugs are more expensive because of the money invested in research, development and marketing.

Generic drugs are a copy of a brand name drug that any company can sell (e.g., acetaminophen). Generic drugs have the same active ingredients as the brand name drug but cost less because the drug company does not need to invest money in creating it. Generic drugs undergo the same regulatory testing and are just as safe as brand name drugs.

Most public and private drug plans, including Health Benefits, cover a mix of brand name and generic drugs. If there is a medical reason the client cannot take a generic drug on Health Benefits formulary list, the prescriber may be able to request Special Authority to ensure the medication is covered.

Approvals Before Services

Some items and services covered under the pharmacy benefit require approval before pharmacy providers can bill for them. Approvals for pharmacy items covered under PharmaCare are called Special Authorities. Approvals for pharmacy items covered under PBC are called Prior Authorizations.

Prescribers can submit Special Authority requests directly to PharmaCare, and Prior Authorization requests directly to PBC. If they receive authorization, they can provide the item or service and bill PharmaCare or PBC directly. If PharmaCare denies a Special Authority request, prescribers can resubmit the request with additional rationale.

If clients decide to pay out-of-pocket for an item or service before PharmaCare or PBC has authorized a Special Authority or Prior Authorization request - or despite PharmaCare or PBC denying the request - reimbursements will not be issued.

Pharmacy providers can identify which items and services require approval and which are covered under the pharmacy benefit by checking the Pharmicare Plan W formulary search, or their PBC Provider Portal, "PROVIDERnet." If the provider is unable to determine requirements or coverage, the client or pharmacy provider should contact Health Benefits at **1.855.550-5454**.

Pharmacy Exclusions

Some items and services are considered Exclusions under the pharmacy benefit. Clients cannot seek exception or appeal for excluded items. Pharmacy benefit Exclusions include, but are not limited to:

- Alternative therapies (e.g., glucosamine and evening primrose oil);
- Anti-obesity drugs;
- Certain over-the-counter (OTC) items;
- Clinic and physician fees;
- Cough preparations containing codeine;
- Drugs with investigational or experimental status;
- Fees for writing prescriptions or completing a form;
- Fertility agents and impotence drugs;
- Household products (e.g., soap and shampoos);
- Megavitamins;
- Prescriptions written by a veterinarian; and
- Vaccinations for travel.

Authorized Providers

Pharmacy items must be provided by a licensed pharmacy or medical supplies and equipment provider.

Accessing Pharmacy Benefits

1

- Client visits a health care provider (doctor, nurse practitioner, or pharmacist) who prescribes or recommends a treatment.
- Some OTC items are available directly from the pharmacy without a prescription.

2

- If a prescribed item is not on the PharmaCare Plan W or PBC formulary, the prescriber requests Special Authority or Prior Authorization directly from PharmaCare or PBC.

3

- The pharmacy provider bills the prescription or OTC item and processes payment.
- Items covered under PharmaCare Plan W are billed to PharmaCare.
- Items covered under PBC are billed to PBC.

4

- Client receives medication or over-the-counter item.
- The pharmacist is available to provide information about healthy medication use and to answer any questions the client may have, such as how to take the medication, how to know the medication is working, and any possible side-effects of the medication.

Medical Transportation

Health Benefits provides medical transportation (MT) benefits to support clients accessing medically necessary health services not available in their community of residence. Eligible clients may be provided with funding for meals, accommodation, and transportation as required. For more information on who is eligible for medical transportation benefits, see the chapter on Eligibility.

MT Benefit Coverage

Medical transportation may be provided for clients to access medically necessary health services not available in their community of residence. Medically necessary health services may include:

- Medical services insured through the BC Medical Services Plan (MSP);
- Publicly-funded diagnostic tests and preventive screening programs;
- Services covered by First Nations Health Benefits (e.g., dental, vision, etc.);
- Traditional healers; and
- Treatment at the nearest appropriate facility in BC funded by or referred to by the National Native Alcohol and Drug Abuse Program (NNADAP).

The MT benefit covers the most economical and efficient means of transportation, taking into account the urgency of the situation and the medical condition being addressed.

Items and services not listed as a benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

Documentation

Clients requesting MT coverage must provide the following documentation before travel can be arranged:

- A referral from a general practitioner or family doctor; and
- Confirmation of an upcoming appointment from the health provider or facility.

For eligible, pre-approved MT trips, clients must provide confirmation of attendance (COA) from the health provider or facility after their appointment. Travel expenses will not be reimbursed without a written COA.

Client Responsibilities

Clients who receive MT benefits from Health Benefits have certain responsibilities, including:

- When possible, clients should give at least five days' notice to allow time for travel arrangements to be made. Without enough notice, clients may have to re-schedule their appointment, or pay for their travel out-of-pocket and request reimbursement later.
- Clients should get prior approval from Health Benefits or the responsible First Nations community or organization for all non-emergency trips.
- Clients should attend their medical appointment as scheduled. Clients who do not attend medical appointments may be required to pay back any benefits they have received, and pay for their travel costs on subsequent medical travel.
- Clients should get a signed or stamped COA from the health professional or facility where they had their appointment, and provide it to Health Benefits or the appropriate First Nations community or organization.

- Clients should protect all original warrants or vouchers given to them for their medical trip because they will not be replaced if they are lost or stolen.
- Clients should give as much notice as possible when cancelling an appointment, and at least 24 hours' notice when cancelling hotel or flight arrangements.
- Clients need to keep all their original receipts from their travel so they can submit them for reimbursement.
- Threatening or abusive language or behaviour used towards patient travel clerks or health providers will not be tolerated, and may result in clients being asked to pay for their travel out-of-pocket and request reimbursement later.

Escorts

Clients may be eligible to travel with an escort under certain conditions, such as when the client:

- Is a minor;
- Requires assistance with activities of daily living such as dressing, eating, or bathing; and
- Is undergoing a medical procedure (e.g., day surgery) or has a medical condition that will result in the client requiring assistance;
- Will receive instructions on specific and essential home medical or nursing procedures that cannot be given to the client only;
- Faces a language barrier; and
- Is travelling to give birth, including travel to be near medical care while awaiting childbirth (prenatal confinement).

Clients must provide documentation from their health care provider to support their need for an escort.

MT Exclusions

Some types of travel are considered Exclusions under the MT benefit. Clients cannot seek exception or appeal for excluded travel. MT benefit Exclusions include, but are not limited to:

- Accessing medical appointments when already outside of Canada;
- Compassionate travel (e.g., travelling to visit a family member receiving medical treatment);
- Payment of fees for a doctor's note that supports a client request for MT benefits;
- Travel back to a client's community of residence if the client becomes ill while away from home;
- Travel by clients in the care of a federal, provincial, or territorial institution (e.g., clients who are in prison);
- Travel by clients when necessary medical services are available in their current area of residence;
- Travel to access medical appointments located outside of Canada;
- Travel to access non-medically necessary services;
- Travel to access services requested by a third party (e.g., medical exams required for a job or for insurance purposes);
- Travel to access treatment or an assessment that is court-ordered or a condition of parole;
- Travel to adult day care or respite care;
- Travel to interval or safe houses; and
- Travel where the only purpose is to pick up prescriptions, vision care products, or medical supplies and equipment that don't need to be fitted.

Accessing Medical Transportation Benefits

1

- Client has an appointment for a medically-necessary health service not available in their home community.

2

- Client contacts Health Benefits to see if they are covered by a Funding Agreement (FA). If they are covered by an FA, then MT benefits are arranged through the band office or office of a First Nations organization.
- Clients not covered by an FA should submit an MT request to Health Benefits with all relevant documentation.

3

- Health Benefits or band office reviews the request and determines eligibility based on program guidelines.
- Health Benefits or band office makes travel arrangements and forwards the information to the client.

4

- Client attends the appointment as scheduled and obtains written confirmation of attendance (COA).
- Client submits COA to Health Benefits or to their band office, as applicable.

Mental Health

Health Benefits provides clients with access to counselling services from a qualified mental health provider. Counselling is a tool for individuals experiencing a difficult situation to resolve their emotional distress and enjoy greater wellness. Health Benefits administers coverage for mental health counselling through three programs:

1. Mental Wellness and Counselling (MW&C);
2. The Indian Residential School Resolution Health Support Program (IRS RHSP); and
3. The Missing and Murdered Indigenous Women and Girls Health Support Services (MMIWG HSS).

Each program has its own eligibility criteria. All services require prior approval from Health Benefits. Services not listed as a benefit may be covered on an exceptional basis. Clients should call Health Benefits at **1.855.550.5454** to learn more about exceptional coverage.

MENTAL WELLNESS AND COUNSELLING

Mental Wellness and Counselling is designed to support clients who are in need of professional assistance to resolve emotional distress and enjoy greater wellness.

Mental Wellness and Counselling Coverage

Health Benefits provides the following counselling services through the MW&C program:

Service	Counselling Hours	Coverage Period
Initial Assessment	2 hours	12 months
Counselling	20 hours	

Mental Wellness and Counselling Exclusions

Some services are considered exclusions under the MW&C program. Clients cannot seek exception or appeal for excluded items. MW&C Exclusions include, but are not limited to:

- Assessment services for issues such as fetal alcohol spectrum disorder, learning disabilities and child custody;
- Early intervention programs for infants with delayed development;
- Educational and vocational counselling, including psychoeducational assessments;
- Life skills training;
- Psychiatric emergencies for person(s) at risk of harm to self or others;
- Services funded by another program or agency, including psychiatric and family physician services through BC MSP;
- Services including: psychoanalysis, hypnotherapy, expressive arts therapy, and sex therapy;
- Services that are part of, or to be used for, legal actions including court-ordered assessments; and
- Substance abuse counselling/therapy.

INDIAN RESIDENTIAL SCHOOL RESOLUTION HEALTH SUPPORT PROGRAM

The Indian Residential School Resolution Health Support Program (IRS RHSP) is a national program administered in BC through Health Benefits. Through the IRS RHSP, counselling is available to address mental distress and inter-generational trauma resulting from the legacy of the residential school system in Canada. Services are available for former students who attended a residential school listed in the 2006 Indian Residential Schools Settlement Agreement. Services are also available to the family members of those students. First Nations and non-First Nations individuals are eligible for the program.

IRS RHSP Coverage

Health Benefits provides the following counselling services through the IRS RHSP:

Service	Counselling Hours	Coverage Period
Initial Assessment	2 hours	12 months
Counselling	20 hours	

MISSING AND MURDERED INDIGENOUS WOMEN AND GIRLS HEALTH SUPPORT SERVICES

The Missing and Murdered Indigenous Women and Girls Health Support Services (MMIWG HSS) is a national program administered in BC through Health Benefits. Counselling is available to address mental distress and trauma resulting from the issue of missing and murdered Indigenous women and girls in Canada. Services are available for survivors, family members, and others affected by the issue. First Nations and non-First Nations individuals are eligible for the program. The program will be in place until June 2020.

MMIWG HSS Coverage

Health Benefits provides the following counselling services through the MMIWG Health Support Services:

Service	Counselling Hours	Coverage Period
Initial Assessment	2 hours	12 months
Counselling	20 hours	

IRS RHSP and MMIWG HSS Exclusions

Some services are considered exclusions under the mental health benefit. Clients cannot seek exception or appeal for excluded items. IRS RHSP and MMIWG HSS Exclusions include, but are not limited to:

- Accommodations and treatment fees for facility-based addictions treatment
- Any service provided by a non-eligible provider
- Psychiatric and family physician services insured through the BC MSP
- Services for a purpose other than mental health counselling (e.g., psychoeducational testing/assessments, educational and vocational counselling, life skills training, life coaching/mentoring, early intervention/enrichment programs, sex therapy)
- Services for the purpose of a third party (e.g., school application, employment assessment, to support legal action, child custody, etc.)
- Services funded by another program or agency (e.g., counselling provided to incarcerated clients, who have mental health coverage through the Provincial Health Services Agency)
- Telehealth through instant messaging or emails.

Authorized Providers

Mental health counselling is provided by psychologists, social workers, and clinical counsellors who are registered with Health Benefits and have received training in cultural safety and humility. A list of registered mental health providers can be found on our website at <http://www.fnha.ca/benefits/mental-health> or by contacting Health Benefits at **1.855.550-5454**.

ADDITIONAL RESOURCES

Travel for Mental Health Programs

Clients who require travel assistance to access counselling through the IRS (Indian Residential School) program or MMIWG Health Support Services please contact IRS.travel@fnha.ca or 1.877.477.0775.

Clients who require travel assistance to access counselling through the Mental Wellness and Counselling program, please contact Health Benefits at **1.855.550-5454**, or see the Medical Transportation webpage for more information.

Accessing Mental Health Benefits



Appeals

When coverage for a benefit has been denied, the client, their parent or guardian, or their representative has the right to appeal the decision. This requires writing a letter of appeal that describes the situation in detail. Appeals must be submitted within 12 months from the date the benefit was denied.

Clients must include the following information in their letter of appeal:

- The condition for which the benefit is being registered;
- The diagnosis and prognosis, including what alternatives have been tried;
- Relevant diagnostic test results (e.g., dental x-rays); and
- Justification for the proposed treatment and any additional supporting information.

There are two levels of appeal available to Health Benefits clients. If an appeal is denied and there is new information that could support it, clients may escalate the appeal and ask for another review within 30 days of the appeal being denied. All appeal materials should be clearly marked “APPEALS – CONFIDENTIAL.”

To initiate an appeal call Health Benefits at **1.855.550-5454**.

Orthodontics Appeals

In addition to the letter of appeal and supporting documentation, orthodontic appeals should include the following information provided by the orthodontist or dentist:

- Orthodontic Summary Form, with HLD Index results;
- Diagnostic test results, including:
 - Cephalometric radiographs with associated scale for calibration;
 - Frontal and profile photographs;
 - Intra-oral photographs depicting the right, left, and anterior occlusal relationships;
 - Panoramic radiographs; and
 - Diagnostic orthodontic models.
- Treatment plan, estimated duration of active and retention phases of treatment, and an outline of billable costs; and
- Signature of parent or guardian, including their Band name and status number.

Reimbursements

When providers are not able to bill PBC or Health Benefits directly for eligible items and services, clients will need to pay out-of-pocket and then request reimbursement. If the cost of the item or service is more than what Health Benefits covers, clients will have to pay out-of-pocket for the remaining balance.

Dental, Vision, MS&E Reimbursements

Reimbursement requests for dental, vision care, and MS&E items and services can be submitted electronically using the PBC Member Profile, available at www.pac.bluecross.ca, or can be mailed to PBC. Requests must be submitted within one year from the date on which the item or service was received.

Online submission through the PBC Member Profile is recommended as reimbursement will usually occur within two business days. If clients are submitting requests to PBC by mail, they must submit the appropriate reimbursement form and all original itemized receipts. Dental, vision care, and MS&E forms can be found online at www.pac.bluecross.ca. Clients should mail reimbursement requests to:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

Medical Transportation, Mental Health, Pharmacy Reimbursements

Reimbursement requests for items and services under medical transportation and mental health should be submitted to Health Benefits.

Some pharmacy items and services are also eligible for reimbursement through Health Benefits. These include:

- Claims for infants who do not yet have a Personal Health Number (PHN);
- Claims for infants who do not yet have a status number;
- Out-of-province expenses that were denied by Pharmacare; and
- Co-payment amounts charged by pharmacies that are above the amount covered by PharmaCare for the following items:
 - Rapid-acting analogue insulins (Humalog, novo-rapid in the name);
 - Cystic fibrosis nutritional supplements/vitamins; and
 - Diabetes supplies (insulin pumps, needles and syringes, blood glucose test strips).

All requests must be received by Health Benefits within one year from the date on which the item or service was received. Clients should submit the Client Reimbursement Form with all original itemized receipts to Health Benefits either by mail or fax.

The Health Benefits client reimbursement form can be found online at:

<http://www.fnha.ca/benefits/reimbursements>.

Out-of-Province Pharmacy Reimbursements

Reimbursement requests for eligible pharmacy items filled outside of BC should be mailed to PharmaCare. Submit all original itemized receipts and prescriptions with the PharmaCare Out-of-Province Client Reimbursement Form, found online at <https://www2.gov.bc.ca/assets/gov/health/forms/5480fil.pdf>.

Mail requests to:

Health Insurance BC
PO BOX 9684 STN PROV GOVT
Victoria, BC V8W 9P7

Frequently Asked Questions

GENERAL QUESTIONS

Can I continue to use my current provider (e.g., oral health provider or optometrist) if they do not bill PBC directly?

*Yes, that is your choice. However, we encourage clients to call **1.855.550.5454** to make sure that the item or service is covered. If the provider does not bill PBC, clients will have to pay out-of-pocket for the item or service and submit a reimbursement request to PBC. Also, providers may charge more than the rate covered, but PBC only reimburses up to the maximum coverage rate, regardless of what the provider charges.*

Why should I keep my private insurance if I am eligible for Health Benefits?

Some benefits covered under private or employer-sponsored insurance are not covered under Health Benefits (e.g., physiotherapy or chiropractic treatment).

Does Health Benefits provide out-of-country coverage?

Health Benefits may cover the cost of supplemental health insurance premiums for approved students or migrant workers. Supplementary health insurance coverage for all other travel outside of Canada (e.g., vacation travel) is not a benefit under Health Benefits. When travelling outside of Canada, it is recommended that you buy travel health insurance in case of an emergency.

What is the difference between an Exception and an Exclusion?

*If a client has exceptional needs or circumstances, Health Benefits may provide additional coverage for an item or service as an Exception. Exception requests are determined on a case-by-case basis. Exclusions are items and services that are **excluded** from Health Benefits coverage under all circumstances. Excluded items and services are not available through the exceptions process and cannot be appealed.*

Can I appeal a decision and how would I go about it?

When coverage for an item or service has been denied, the client or their parent/guardian has the right to appeal the decision. Appeals must be forwarded in writing and can be initiated by either the client, their legal guardian, or the client's interpreter. More detailed information can be found in the "Appeals" section of this guide on page 31.

How do I make a complaint about a provider or health organization?

Clients can email provider@fnha.ca if they would like to make a complaint.

AMBULANCE BILLS

Why have I received a bill for ambulance services?

Health Benefits covers ambulance bills for our clients. To receive coverage, clients must provide BC Ambulance with their status number and PHN to allow BC Ambulance to invoice Health Benefits. Clients with questions about ambulance bills should call Health Benefits at **1.855.550.5454**.

I received an ambulance and hospital bill for medical care incurred in the United States and, unfortunately, I did not buy travel insurance for travel outside of Canada. Can Health Benefits assist in paying?

No, Health Benefits does not cover medical bills incurred outside of Canada. Clients may want to contact the Ministry of Health Out-of-Country Claims Department to discuss any other coverage they may have through MSP.

BC MEDICAL SERVICES PLAN (MSP)

I filed my income tax return and the Canada Revenue Agency is indicating that I owe for unpaid MSP premiums. Why?

If clients receive a bill for unpaid MSP premiums, they likely are not registered with the Health Benefits MSP group. Clients who receive a bill for unpaid MSP premiums should complete an MSP application form, available online at <http://www.fnha.ca/benefits/MSP> and submit it to Health Benefits with the attached bill and supporting documentation. Health Benefits may backdate coverage for eligible clients up to a maximum of five years.

Which services are not covered by MSP?

Some MSP exclusions include: cosmetic surgery, reversal of sterilization, in-vitro fertilization, artificial insemination, genetic screening and other genetic investigations including DNA probes, acupuncture, hypnotherapy, acupressure, and procedures still in the experimental or developmental phase. Clients should contact MSP for a complete list of what is covered and what is not.

What's the difference between a BC Care Card and a BC Services Card?

On February 15, 2013 the provincial government introduced the BC Services Card. This card replaces the BC Care Card and can be combined with a driver's license. It is secure government issued identification that British Columbians can use to prove their identity and access provincially-funded health services. In the future, the BC Services Card will provide in-person and online access to other government services. A BC Services Card can be issued at an ICBC driver licensing office or you can contact Service BC at 1.800.663.7867 for an alternate approach to get a new card. For more information about the BC Services Card, visit www.gov.bc.ca/bcservicescard.

BENEFITS

The provider (e.g., oral health provider, optometrist) is charging me for treatment. Why?

Health Benefits has a specific fee schedule for each benefit area that outlines what items and services are covered, how much coverage is available, and how often clients can access the benefit. Health care providers may charge above what Health Benefits covers, and clients are responsible for covering these additional costs.

I have been prescribed a drug and the pharmacist has told me that it is not covered through Health Benefits. Why?

*Health Benefits drug plan is comprehensive. If you have been prescribed an item that is not covered, the prescriber can request Special Authority from BC PharmaCare for exceptional coverage. Alternatively, you can ask the pharmacist for other treatment options that are covered. Clients with coverage questions can call Health Benefits at **1.855.550.5454**.*

Is my local pharmacy an approved PharmaCare site?

*Pharmacies in BC and some pharmacies along the BC border are eligible to enroll with PharmaCare. If you would like to know if your pharmacy is enrolled with PharmaCare, please ask your pharmacy directly. If you would like to discuss this further, contact the Health Benefits at **1.855.550.5454**.*

Why does my oral health provider have to send in a request before performing some services?

Predetermination, or prior approval, is common practice for most public and private dental plans. The predetermination process ensures that both the oral health provider and Health Benefits client are informed of the policies and understand what is covered. Clients must meet all of the clinical criteria and guidelines established by Health Benefits, where applicable, for the treatment to be considered for coverage.

Are chiropractic, massage therapy, naturopathy, physical therapy, or podiatry services covered through Health Benefits?

No, these services (often called “supplementary or paramedical benefits”) are not covered by Health Benefits. However, MSP does provide some coverage of supplementary benefits for clients registered with the Health Benefits MSP group. MSP will pay a set amount per visit up to a combined maximum of 10 visits each calendar year. Please note that most health practitioners may charge above what MSP covers, meaning clients will have to pay out-of-pocket for the difference in cost. For more information visit Health Insurance BC at www.health.gov.bc.ca/.

First Nations Health Authority

Health Benefits Contact Information

GENERAL

Toll-Free: 1.855.550.5454

Email: healthbenefits@fnha.ca

Fax: 1.888.299.9222

Clients should have their status card and BC Services Card ready when calling.

IN-PERSON INQUIRIES

1166 Alberni Street

Room 701

Vancouver, BC V6E 3Z3

MAILING ADDRESS

First Nations Health Authority

Health Benefits

540 - 757 West Hastings Street

Vancouver, BC V6C 1A1

ONLINE

www.fnha.ca/benefits

COMMUNITY RELATIONS REPRESENTATIVES

Health Benefits has a Community Relations Representative in each of the five health regions. For contact information, email communityrelations@fnha.ca

Pacific Blue Cross

GENERAL

Toll-Free: 1-855-550-5454

MAILING ADDRESS

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

ONLINE

www.pac.bluecross.ca



First Nations Health Authority
Health through wellness

www.fnha.ca

