POLICY STATEMENT

1. The Department of Health provides assistance to eligible persons who require health care products and services and medical travel support beyond the coverage conferred by the Nunavut Health Care Plan and one's third-party plan.

PRINCIPLES

2. This policy and its application are guided by the following principles:
    a. Health programs should be understandable and easy to access for eligible persons;
    b. The cost of health care products and services as well as medical travel should not be a barrier to care;
    c. The Extended Health Benefits Program is a payer of last resort;
    d. The Extended Health Benefits Program is divided in the following three streams:
        i. Stream 1-Medical Travel Support;
        ii. Stream 2-Specified Conditions; and
        iii. Stream 3-Seniors;
    e. The amounts covered by the Extended Health Benefits Program are in line with those conferred by Health Canada's Non-Insured Health Benefits Program; and
    f. Decisions under this policy are to be rendered in a timely manner.

APPLICATION OR SCOPE

3. This Policy applies to individuals who meet the eligibility criteria specified in the provisions of this Policy.

DEFINITIONS

4. In this Policy,
    a. "Aboriginal" means:
        i. A registered Indian according to the *Indian Act*;
        ii. An Inuk recognized by one of the Inuit Land Claim organizations; or
        iii. An infant less than one year of age whose parent is a registered Indian according to the *Indian Act* or an Inuk recognized by one of the Inuit Land Claim organizations.
    b. "Client escort" means a client escort as defined under the Government of Nunavut's Medical Travel Policy;

c. “Commercial accommodation” excludes private accommodation and includes a motel, a hotel, a lodge, an apartment, a serviced suite and a place rented through an offline or online rental agency;
d. “Director of Medical Insurance” means the Director of Medical Insurance appointed under subsection 23(1) of the *Medical Care Act*;
e. “Exception Prescription Drug” means a prescription drug that is not listed on the formulary;
f. “Formulary” means Health Canada’s Non-Insured Health Benefits Drug Benefit List, Chronic Renal Failure Formulary and Palliative Care Formulary, as amended;
g. “Medical practitioner” means a person licensed to practice medicine in a province or territory of Canada;
h. “Medical trip” means a medical travel approved under the Government of Nunavut’s Medical Travel Policy;
i. “Northern area” means a location designated and published as such by the Director of Medical Insurance pursuant to section 5(e);
j. “Nurse Practitioner” means a nurse practitioner as defined in the *Nursing Act* of Nunavut, or a person who is not licensed, registered or entitled to practice in Nunavut, but is entitled to practice the profession of nurse practitioner in another Canadian jurisdiction;
k. “Private accommodation” means any accommodation that:
    i. is owned or rented on a usual basis by a client’s relative or friend; and
    ii. is not co-rented or co-owned by the client or the client’s spouse or common-law partner;
l. “Third-party plan” includes
    i. Health Canada’s Non-Insured Health Benefits (NIHB); and
    ii. group health insurance and health benefits
        1. provided against a premium or not;
        2. accessible through the current or former employer of the person, a relative of the person or a member of the person’s household; and
        3. that covers one or more of:
            a. dental care;
            b. audiology services and products;
            c. vision care;
            d. medical supplies and appliances;
            e. prescription drugs; and
            f. medical travel support that covers flight co-payments, meals or accommodation while on a medical trip.

ROLES AND RESPONSIBILITIES

Director of Medical Insurance

5. In accordance with this Policy and its guidelines, the Director of Medical Insurance
    a. shall assess the eligibility of persons applying for registration pursuant to sections 25 and 32 and register eligible persons;

b. shall de-register persons who no longer meet the eligibility criteria specified in this Policy;
c. shall, following a consultation with a pharmacist, approve or refuse exception coverage for a version of a drug other than the least expensive one when an application under section 10 is made;
d. shall assess the eligibility of claims received under this Policy as well as authorize or refuse their payment;
e. shall designate locations to be considered northern areas under this Policy and publish them on a publicly available web page of the Department of Health;
f. shall provide justification for the decisions made under this Policy and its guidelines to persons who are subject to the decision;
g. shall assess and render decisions on applications for special coverage of a condition pursuant to section 27 and publish approvals according to section 29;
h. shall decline or confirm pre-approval as required by the guidelines; and
i. may, as appropriate, delegate the tasks in section 5.a. to 5.h. to staff in his or her division.

Deputy Minister of Health

6. In accordance with this Policy and its guidelines, the Deputy Minister of Health shall assess appeals and render decisions on them according to sections 34 to 37.

PROVISIONS

Third-Party Coverage

Categories of benefits

7. For the purposes of this Policy, the categories of benefits are dental care, audiology services and products, vision care, medical supplies and appliances, prescription drugs and medical travel support or their equivalent as they may be named by a third-party plan.

Participation in Third-Party Plan

8. A person is not eligible for a category of benefits under this Policy if the person is eligible for a third-party plan that covers that category of benefits and the person
    a. chooses not to participate in the third-party plan as a whole; or
    b. chooses not to participate in that category of benefits under the third-party plan.

Payer of Last Resort

9. The amounts to which a client is entitled under this Policy are reduced by the amounts paid by the client’s third-party plan.

Prescription drugs

Generic and brand-name drugs

10. When both generic and brand-name versions of a prescription drug that is a benefit under section 26.a or 33.a exist, this Policy only covers the cost of the least expensive drug except if
    a. a medical practitioner or nurse practitioner applies for an exception on behalf of the client and documents the adverse reaction that occurred with the least expensive drug;
    b. the Director of Medical Insurance approves the exception for a different version to be covered following a consultation with a pharmacist; and
    c. the prescribing medical practitioner or nurse practitioner writes “no substitution” on the prescription.

Client choice

11. When this Policy only covers the least expensive version of a drug pursuant to section 10, the client may choose to obtain a more expensive version of that drug and pay for the difference in price.

Stream 1-Medical Travel Support

Eligibility

12. A client is only eligible for the benefits specified in sections 14 to 21 for the day(s) of a medical trip on which he or she
    a. does not have a third-party plan that covers flight co-payments, ground transportation, meals or accommodation for the medical trip;
    b. has exhausted the flight co-payments, ground transportation, meals or accommodation benefits provided by his or her third-party plan for the medical trip; or
    c. has a third-party plan that covers flight co-payments, ground transportation, meals or accommodation for the medical trip at lesser rates than the ones established in sections 14 to 21.

All-Inclusive Option From Third-Party Plan

13. Notwithstanding section 14.c., a client is not eligible for the benefits specified in sections 14.b to 21 on the day(s) of a medical trip for which
    a. the client’s third-party plan offered the client the option to stay, at no expense to the client, in an all-inclusive housing facility that covers;
        i. accommodation;
        ii. meals; and
        iii. ground transportation in the city where the client is sent for care for journeys between the health facility, the airport and the housing facility; and
    b. the client chose not to avail that option.

Transportation expenses

14. The following client and client escort expenses incurred while on a medical trip are benefits under this Policy
    a. the flight co-payment specified under the Medical Travel Policy;
    b. taxi fare between the person's home or the local health centre and the airport in Coral Harbour, Whale Cove, Resolute Bay and Arctic Bay;
    c. ground transportation in the city of the point of referral if the journey is between two of the following locations: health facility, airport and accommodation; and
    d. ambulance charges to transfer the client from one health facility to another.

Stay in private accommodation

15. A client is entitled to a $50 nightly accommodation allowance for a stay in a private accommodation if
    a. the stay is documented in a billet form by one regular occupant of the private accommodation; and
    b. the private accommodation is used to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Meals for stay in private accommodation in northern area

16. When an accommodation that is located in a northern area and meets the criteria in section 15 is used during a client's medical trip, the client is entitled to
    a. a $50 meal allowance per day when the client is not admitted in a health facility; and
    b. a supplementary $50 meal allowance per day, per client escort assisting the client.

Short-term stay in hotel, motel or lodge in northern area

17. Subject to sections 20 and 21, a client is entitled to the reimbursement of expenses incurred to rent one hotel, motel or lodge room while on a medical trip if
    a. the hotel, motel or lodge room rented is in a northern area where the client is sent for care; and
    b. the hotel, motel or lodge room is rented to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Short-term stay in commercial accommodation outside northern area

18. Subject to section 20 and 21, a client is entitled to the reimbursement of commercial accommodation rental expenses incurred up to a nightly maximum of $125 while on a medical trip if
    a. the commercial accommodation is located outside a northern area and is where the client is sent for care; and
    b. the commercial accommodation is rented primarily to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Meals during stay in a hotel, motel or lodge in northern area or a commercial accommodation outside of a northern area

19. Subject to sections 20 and 21, when an accommodation that meets the criteria specified in sections 17 or 18 is rented during the client's medical trip, the client is entitled to
    a. a $50 meal allowance per day when the client is not admitted in a health facility; and
    b. a supplementary $50 meal allowance per day, per client escort assisting the client.

Long-term care plan - before start of medical trip

20. If prior to the commencement of a client's medical trip the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, indicates in writing that the client's medical trip is likely to last more than 90 days, the client is not entitled to the benefits specified in sections 17 to 19 but can avail the private accommodation benefits specified in sections 15 and 16 or
    a. an accommodation allowance of $60 per day that a private accommodation is not used;
    b. a meal allowance of $20 per day that a private accommodation is not used; and
    c. a supplementary meal allowance of $20 per client escort providing assistance to the client for each day that a private accommodation is not used.

Long-term care plan - after start of medical trip

21. If after the commencement of a client's medical trip the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, indicates in writing that the client's medical trip is likely to last more than 90 additional days from the date on which the notice is written, the client

a. ceases to be eligible for the benefits specified in sections 17 to 19 at the end of the 30th day after which the notice is written but remains eligible for the private accommodation benefits specified in sections 15 and 16; and
b. becomes is eligible for the following starting on the 31st day after which the notice is written:
    i. an accommodation allowance of $60 per day on which a private accommodation is not used;
    ii. a meal allowance of $20 per day on which a private accommodation is not used; and
    iii. a supplementary meal allowance of $20 per client escort providing assistance to the client for each day on which a private accommodation is not used.

Inquiry into projected length of medical trip

22. From time to time, the Director of Medical Insurance may require a client to provide documentation prepared by the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, estimating the duration of the client's medical trip.

Breastfed infants

23. The meal allowances specified in sections 16.a, 19.a, 20.b and 21.b.ii are not payable when the client is an infant who is still breastfed.

Stream 2-Specified Conditions

Eligibility

24. A person is eligible for registration under section 25 if the person
    a. is not aboriginal;
    b. is under the age of 65;
    c. is enrolled in the Nunavut Health Care Plan; and
    d. has a condition listed on schedule A or a condition accepted for special coverage under section 28 of this Policy.

Registration

25. A person who meets the eligibility criteria specified in section 24 can register for the Specified Conditions Stream of this Policy following the registration process set out in Guideline 1 (Registration).

Benefits

26. A person registered for the Specified Conditions Stream under section 25 is entitled to
    a. the full cost of prescription drugs listed on the formulary that are prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 of this Policy for which the person is diagnosed and registered;

b. the full cost of exception prescription drugs that are
    i. prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 of this Policy for which the person is diagnosed and registered; and
    ii. pre-approved for the client according to Guideline 2 (Claims and Pre-Approvals);
c. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
    i. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
    ii. are prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 for which the person is diagnosed and registered; and
d. the following if they are rendered necessary to manage the side effects of a prescription drug described in section 26.a. or 26.b or of medical supplies and appliances described in section 26.c.:
    i. dental care as described in section 33.d
    ii. the full cost of prescription drugs listed on the formulary that are prescribed to the person;
    iii. audiology services and products as described in section 33.e.;
    iv. vision care as described in section 33.g.;
    v. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
        1. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
        2. are prescribed to the person.

Request for special coverage of condition

27. A person who meets the eligibility criteria specified in sections 24.a to 24.c and is diagnosed with a condition that is not listed in schedule A of this Policy and that has not been previously approved for special coverage under section 28 may request that the Director of Medical Insurance considers approving special coverage for that condition by submitting the appropriate form signed by the person's nurse practitioner or medical practitioner and bearing the following information:
    a. patient's name;
    b. patient's date of birth;
    c. patient's Nunavut Health Care Plan card number;
    d. patient's contact information
    e. the condition that is the subject of the request;
    f. evaluation of whether the condition is life threatening or will become life threatening if untreated;
    g. an assessment of the chronicity of the condition;
    h. the medical practitioner's name; and
    i. the medical practitioner's contact information.

Decision on special coverage for a condition

28. On receiving a duly filled form submitted pursuant to section 27, the Director of Medical Insurance shall, after having considered the chronicity of the condition, its life-threatening nature and any other relevant factor
    a. decide to approve or refuse special coverage; and
    b. communicate the decision to the patient and the medical practitioner or the nurse practitioner listed in the form.

Publication of special approval

29. On deciding to approve special coverage for a condition pursuant to section 28, the Director of Medical Insurance shall publish the name of the condition on a publicly available web page of the Department of Health and specify that the condition is now eligible for coverage under the Specified Conditions Stream.

Retroactive diagnosis

30. A person registered under section 25 who is retroactively diagnosed with a condition listed on schedule A or a condition accepted for special coverage under section 28 is eligible for the benefits specified in section 26 pertaining to that condition starting on whichever is the latest of
    a. the day that the person enrolled in the Nunavut Health Care Plan; and
    b. the onset date for the condition as established for the first time by a medical practitioner or nurse practitioner.

Stream 3-Seniors

Eligibility

31. A person is eligible for registration under section 32 if the person is:
    a. not aboriginal;
    b. 65 years of age or older; and
    c. is enrolled in the Nunavut Health Care Plan.

Registration

32. A person who meets the eligibility criteria specified in section 31 can register for the Seniors Stream of this Policy following the registration process set out in Guideline 1 (Registration).

Benefits

33. A person registered for the Seniors Stream under section 32 is entitled to
    a. the full cost of prescription drugs listed on the formulary that are prescribed to the person;
    b. the full cost of exception prescription drugs that are prescribed to pre-approved for the client according to Guideline 2 (Claims and Pre-Approvals);
    c. ambulance charges for transportation within Nunavut;
    d. a combined maximum of $1,000 per calendar year for dental care provided by dental professionals, such as the following:
        i. diagnostic services such as examinations and x-rays;

ii. preventive services such as cleanings;
iii. restorative services such as fillings;
iv. endodontics such as root canal treatments;
v. periodontics or the treatment of gums;
vi. prosthodontics other than removable dentures;
vii. oral surgery including the removal of teeth;
viii. orthodontics to correct irregularities in teeth and jaws when there is a severe and functionally handicapping malocclusion;
ix. adjunctive services, which include additional services such as sedation;
x. new dentures once in any 5 years; and
xi. repairs to dentures unless they are required as a result of misuse, carelessness or negligence;

e. the following medically required audiology services and products:
i. complete hearing assessment performed bilaterally once in any 5 years;
ii. partial hearing re-assessment performed bilaterally once in any 2 years;
iii. bone conduction, conventional analog, CROS/BiCROS, programmable analog or digital processing hearing aids and associated services prescribed to the person by an audiologist or medical practitioner once in any five years, unless earlier replacement approved is by the Director of Medical Insurance and necessary due to a change in audition;
iv. hearing aid batteries and tubes/domes;
v. replacement of ear mold and impression once in any two years;
vi. client-initiated hearing aid performance check and readjustment once per year; and
vii. repairs to hearing aids unless they are required as a result of misuse, carelessness or negligence;

f. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
i. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
ii. are prescribed to the person; and

g. the following vision care services and products at the rates established for Nunavut in the NU Eye Care & Vision Benefit Fee Grid of Non-Insured Health Benefits' Vision Care Benefit Policy Framework, as amended:
i. vision examination once in any year;
ii. a maximum of $100 for a frame for prescription eyeglasses once in any 2 years;
iii. the full cost of lenses for prescription eyeglasses once in any 2 years;
iv. the cost of special tinting and coating of lenses for eyeglasses once in any 2 years when an optometrist or an ophthalmologist has certified that such feature is medically required; and

v. the cost of disposable contact lenses when an optometrist or an ophthalmologist has certified that prescription eyeglasses are not suitable for the person given his or her condition.

Appeals

Filing an appeal

34. With the exception of a decision on an appeal rendered pursuant to section 36, a client may appeal any decision made under this Policy or its guidelines that affects him or her by submitting the appropriate appeal form to the Deputy Minister of Health, thereby providing
    a. the client's name;
    b. the client's Nunavut Health Care Plan number;
    c. the client's contact information;
    d. the decision being appealed;
    e. the reason(s) for the appeal; and
    f. any evidence that the client deems helpful to support the appeal.

Acknowledgement

35. On receiving an appeal form submitted pursuant to section 34, the Deputy Minister of Health shall acknowledge having received the appeal form.

Decision

36. Within 30 calendar days of receiving an appeal form pursuant to section 34, the Deputy Minister of Health shall gather any additional information deemed necessary for appropriate consideration of the appeal from employees of the Department of Health, the client and any other appropriate person and decide to
    a. maintain the decision subject to the appeal;
    b. annul the decision subject to the appeal;
    c. vary the decision subject to the appeal; or
    d. make any other decision that the Deputy Minister of Health deems necessary given the circumstances.

Communication of decision

37. On rendering a decision pursuant to section 36, the Deputy Minister of Health shall inform the client of the decision made on the appeal.

No Further Appeal

38. Decisions rendered by the Deputy Minister of Health pursuant to section 36 are final and binding.

NUNAVUT LAND CLAIMS AGREEMENT (NLCA) PARAMOUNT

39. Nothing in this Policy shall be construed as to limit the authority of the NLCA. The Agreement shall take precedence over this Policy.

FINANCIAL RESOURCES

40. Financial resources required under this Policy are conditional on approval by the Legislative Assembly, and on the availability of funds in the appropriate budget.

PREROGATIVE OF CABINET

41. Nothing in this directive shall in any way be construed to limit the prerogative of the Executive Council to make decisions or take actions respecting non-insured benefits outside the provisions of this Policy.

SUNSET CLAUSE

42. This Policy shall sunset on 31 March 2021 unless revised by Cabinet sooner.

Premier

Alcohol Dependency
Alzheimer's Disease
Asthma
Cancer
Celiac Disease
Cerebral Palsy
Certain Disorders of Blood & Immune System
Chronic Obstructive Lung Disease
Chronic Psychosis
Cleft Lip / Palate
Congenital Anomalies & Chronic Disease of the Urinary System
Congenital Cytomegalovirus Infection
Congenital Heart Disease
Crohn's Disease
Cystic Fibrosis
Dermatomyositis
Diabetes Insipidus
Diabetes Mellitus
Drug Dependency
Epilepsy
Head Injury
HIV Infection
All other HIV Related Diseases
Hypertension (Subject to certain BP levels)
Ischemic Heart Disease
Lupus Erythematosus
Multiple Sclerosis
Muscular Dystrophy
Osteoarthritis
Pernicious Anemia
Phenylketonuria
Psoriasis
Rheumatic Fever
Rheumatoid Arthritis
Rickets
Scleroderma
Scoliosis
Spina Bifida
Spinal Cord Injury
Tuberculosis
Ulcerative Colitis
Wegeners Granulomatosis

This guideline explains how to register for benefits.

Initial Registration for the Seniors Stream

1. A person eligible for the Seniors Stream may register for benefits by providing the Director of Medical Insurance with a duly filled application form that includes, if required, an employer-signed statement of third-party plan coverage.

Initial Registration for the Specified Conditions Stream

2. A person eligible for the Specified Conditions Stream may register for benefits by providing the Director of Medical Insurance with a duly filled application form that includes
    a. a statement by a nurse practitioner or medical practitioner specifying which condition(s) listed on schedule A or accepted for special coverage under section 28 of this Policy that the person is diagnosed with, as well as the drugs currently prescribed to the person for the condition(s); and,
    b. if required, an employer-signed statement of third-party plan coverage.

Registration for Additional Conditions

3. A person registered under the Specified Conditions Stream can register for coverage of an additional condition listed on schedule A or accepted for special coverage under section 28 of this Policy by providing the Director of Medical Insurance with a duly filled form, which includes
    a. a statement by a nurse practitioner or medical practitioner specifying which additional condition the person is diagnosed with and the drugs currently prescribed to the person for the condition.

Subsequent Registration

4. From time to time, the Director of Medical Insurance may require that clients registered for the Seniors and Specified Conditions Streams renew their registration for Extended Health Benefits.

Submitting Registration Documents on Behalf of Dependent

5. A person may submit registration documents on behalf of a dependent.

Confirmation or Refusal of Coverage

6. On receiving forms pursuant to paragraph 1 to 3, the Director of Medical Insurance will assess eligibility and confirm the benefits for which the client is eligible.

EXTENDED HEALTH BENEFITS – GUIDELINE 2 (CLAIMS AND PRE-APPROVALS)

This guideline explains how clients can claim their Extended Health Benefits and sets requirements for pre-approvals.

Key concepts:

1. Three key concepts apply to the claims process:
    a. "Direct billing" means that the vendor bills the Director of Medical Insurance for a covered product or service directly and on behalf of the client;
    b. "Deferred payment" means that the client pays the vendor directly for a covered product or service and then applies to the Director of Medical Insurance for reimbursement; and
    c. "Prior approval" means a written permission from the Director of Medical Insurance to purchase an item or service and have it covered under the Extended Health Benefits Policy.

Deadline to Submit Claim For Deferred Payment

2. With the exception of retroactive diagnosis claims pursuant to section 30 of the Policy, claims for deferred payment need to be submitted 90 calendar days after the service or product was provided.

Submission of a Claim

3. To claim a benefit through deferred payment, the client must provide the Director of Medical Insurance with a duly filled claim form and all the additional documentation required for that benefit as outlined in Table 1. Claim Methods, Additional Documents Required and Pre-Approvals.

Payment of Benefits

4. Based on the category of benefit being claimed through deferred payment, the client may elect to have the payment issued to him or herself, a client escort, or a host.

Claim on Behalf of a Dependent

5. When a client is a person's dependent, that person may claim payment of a benefit on behalf of the client if that person has paid for the service or product for the dependent.

Table 1. Claim Methods, Additional Documents Required and Pre-Approvals

Policy Section	Benefit	Claim Method	Additional Documents Required for Deferred Payment Claims	Note
Transportation				
14.a.	Flight co-payment	Deferred payment	Receipt*	
14.b.	Taxi fare in community	Deferred payment	Taxi receipt(s)*	
14.c.	Ground transportation at referral point	Deferred payment	Taxi, shuttle or transit receipt(s)*	Clients are to use transit when it is reasonable in the circumstances
14.d.	Interfacility ambulance transfer	Direct billing or deferred payment	Transfer receipt(s)*	
Meals & Accommodation				
15 and 16	Stay in private accommodation and associated meals	Deferred payment	-Billeting form -No meal receipts	
17 to 19	Meals and accommodation for a short-term stay in a hotel, motel or lodge in a Northern Area or a commercial accommodation outside a northern	Deferred payment	-Accommodation receipt(s) in client or client escort's name* -No meal receipts	
20.a., 20.b., 20.c., 21.b.i to 21.b.ii	Long-term care plan – stay outside of a private accommodation	Direct billing or deferred payment	-Accommodation receipt(s)* -No meal receipt(s)	
Prescription Drugs				
26.a, 33.a	Prescription drug – other than coverage of higher cost drug, retroactive diagnosis and exception prescription drugs	Direct billing if Nunavut pharmacy arranges it, deferred payment otherwise	-Receipt*	Prior approval according to paragraph 10 and 11 of this guideline is required for drugs listed as "limited use benefits" on the formulary.

Prescription Drugs (Continued)				
10	Prescription drug – coverage of higher cost drug under EHB	Deferred payment	-Receipt* -Copy of prescription with "no substitution mention"	Prior approval under section 10 of the Policy is required.
30	Prescription drug – retroactive diagnosis	Deferred payment	-Receipt* -Signed statement by medical practitioner or nurse practitioner including date established for the retroactive diagnosis	
26.b, 33.b	Exception prescription drugs	Direct billing if Nunavut pharmacy arranges it, deferred payment otherwise	-Receipt*	Prior approval according to paragraph 12 and 13 of this guideline is required for drugs listed as "limited use benefits" on the formulary.
Medical Supplies and Appliances				
26.c, 33.f	Medical Supply or Appliance – cost is less than $500 (excluding tax, shipping and fitting charges)	Direct billing if vendor arranges it, deferred payment otherwise	-Copy of prescription -Receipt*	
	Medical Supply or Appliance – cost is $500 or more (excluding tax, shipping and fitting charges)	Direct billing if vendor arranges it, deferred payment otherwise	-Receipt*	Prior approval under paragraphs 6 and 7 of this guideline is required.
Other Benefits				
33.c	In-community ambulance for seniors	Direct billing or deferred payment	-Receipt*	
33.d	Dental care	Deferred payment	-Receipt*	
33.e	Audiology services and products	Direct billing if vendor arranges it, deferred payment otherwise	-Receipt* -Copy of the prescription	
Other Benefits (Continued)				

33.g	Vision care	Deferred payment	-Receipt* -Certification by optometrist or ophthalmologist that tinting or coating of lenses is medically required (if applicable)	
26.d	Side effects coverage	Direct billing or deferred payment based on terms of pre-approval and vendor or Nunavut pharmacy's willingness to arrange direct billing	Listed in pre-approval terms and determined by the type of benefit being claimed	Prior approval under paragraphs 8 and 9 of this guideline is required.

* If a client does not have a third-party plan, original receipts need to be submitted.
If the client has a third-party plan, the client has to
(i) demonstrate or have demonstrated to the satisfaction of the Director of Medical Insurance that this amount is not eligible for coverage under the third-party plan, or
(ii) submit the slip issued by the third-party plan detailing the item or service, the total cost for it and the amount covered by the third-party plan instead of the original receipt. The Director of Medical Insurance may still request a copy of the original slip at a later time.

Pre-Approval for Medical Supplies and Appliances Benefit

6. When submitting a request for prior approval of a medical supply or appliance that costs $500 or more excluding taxes, fitting costs and shipping costs, the client must provide the Director of Medical Insurance with
    a. a filled-in request for prior approval form;
    b. a copy of the prescription; and
    c. quotes from three different vendors for the item.
7. Upon receiving a request for prior approval under paragraph 5 of this guideline, the Director of Medical Insurance will determine whether the medical supply or appliance meets the criteria specified under this Policy and issue a letter declining or confirming prior approval for one of the three quotes.

Pre-Approval for Side Effects Coverage

8. When submitting a request for prior approval of side effects coverage pursuant to section 26.d. of the Policy, the client must provide the Director of Medical Insurance with
    a. a statement signed by a medical practitioner, a nurse practitioner, a pharmacist, a physiotherapist or an occupational therapist documenting the side effects of the prescription drug described in section 26.a. or 26.b. or of

the medical supplies and appliances described in 26.c. that the client experiences; and,

b. as applicable,
    i. a letter from a dentist detailing the dental care needed to manage these side effects; or
    ii. a prescription for anything listed in sections 21.b.ii. to 21.b.v that is needed to manage these side effects.

9. Upon receiving a request for prior approval under paragraph 7 of this guideline, the Director of Medical Insurance will issue a letter
    a. declining prior approval; or
    b. confirming prior approval and the method and additional documents required to secure payment of the benefit.

Pre-Approval for a Prescription Drug listed as a Limited Use Benefit

10. Prior approval of a drug listed as a limited use benefit on the formulary requires that the client's prescribing medical practitioner or nurse practitioner submits the appropriate form to the Director of Medical Insurance.
11. Upon receiving a request for prior approval under paragraph 10 of this guideline, the Director of Medical Insurance will evaluate the request using the same criteria that Health Canada Non-Insured Health Benefits program uses to assess eligibility for coverage and
    a. request further information from the prescribing medical practitioner or nurse practitioner or the client to complete the eligibility assessment;
    b. issue a letter declining prior approval; or
    c. issue a letter confirming prior approval including any conditions that may be appropriate.

Pre-Approval for an Exception Prescription Drug

12. Prior approval of an exception prescription drug for a client requires that the client's prescribing medical practitioner or nurse practitioner submits the appropriate form to the Director of Medical Insurance.
13. Upon receiving a request for prior approval under paragraph 12 of this guideline, the Director of Medical Insurance will evaluate the request by taking into consideration the same criteria that Health Canada's Non-Insured Health Benefits program uses to assess eligibility for coverage and, on the recommendation of an advisory committee comprising at least one pharmacist and one medical practitioner,
    a. request further information from the prescribing medical practitioner or nurse practitioner or the client to complete the eligibility assessment;
    b. issue a letter declining prior approval for the client; or
    c. issue a letter confirming prior approval for the client including any appropriate conditions.

Return of Original Receipts

14. An original receipt that is submitted as part of a claim will be returned if the amount paid under this Policy does not cover the whole cost of the purchase shown on the receipt.

Nunavut Pharmacies – Prescription Drugs

1. Prescription drugs as limited use benefits on the formulary require prior approval through the process described in paragraphs 10 and 11 of guideline 2.
2. Exception prescription drugs require prior approval through the process described in paragraphs 12 and 13 of guideline 2.
3. To assist with direct billing, the Director of Medical Insurance will regularly provide Nunavut pharmacies with a list showing
    a. the names of clients eligible for drug benefits through the Seniors Stream;
    b. the name of clients eligible for drug benefits through the Specified Conditions Stream and the condition(s) for which each client is covered; and
    c. the coverage level provided under this Policy for the clients mentioned in paragraph 3. a. and 3. b. who participate in a third-party plan that covers prescription drugs;
    d. the limited use benefits drugs for which the clients mentioned in paragraph 3. a. and 3. b. have received prior approval;
    e. the exception prescription drugs for which the clients mentioned in paragraph 3.a. and 3. b. have received prior approval.
4. Nunavut pharmacies are to contact the Director of Medical Insurance's Office if they are uncertain about whether a client is eligible for coverage or if a drug is approved for a specific client.
5. Nunavut pharmacies assume responsibility for recovering the cost of prescription drugs dispensed to a client through direct billing if the client is ineligible for coverage or if a drug is not approved for a specific client.
6. Nunavut pharmacies have 30 calendar days from the day on which a drug is dispensed to a client under this Policy using the direct billing method to submit a claim to the Director of Medical Insurance that specifies
    a. the name, DIN, quantity and total cost of the drug dispensed;
    b. the share of the cost paid for by or billed to the client's third-party plan, if any;
    c. the share of the cost billed to the client for him or her to submit a claim to his or her third-party plan, if any;
    d. the client's name and Nunavut Health Care Plan number;
    e. the prescription number; and
    f. the prescriber's name and license number.

Vendors - Medical Supplies and Appliances & Audiology Services and Products

7. Vendors need to secure the approval of the Director of Medical Insurance to use direct billing before providing a service or product to a client and invoicing the Department of Health under this Policy for it.

8. If the Director of Medical Insurance has agreed to pay through direct billing for a product or service covered for a client under this Policy, the vendor can provide the said product or service to the client and then has 30 calendar days to submit a claim to the Director of Medical Insurance that specifies
    a. the particulars and total cost of the product or service;
    b. the share of the cost paid for by or billed to the client's third-party plan, if any;
    c. the share of the cost billed to the client for him or her to submit a claim to his or her third-party plan, if any;
    d. proof that the product or service was provided to the client;
    e. a copy of the prescription for the product or service; and
    f. the client's name and Nunavut Health Care Plan number.