



Your Health Benefits

**A FIRST NATIONS GUIDE TO ACCESSING
NON-INSURED HEALTH BENEFITS**

AFN Health & Social Secretariat Mandate & Goal

We are responsible to protect, maintain, promote, support, and advocate for our inherent, treaty and constitutional rights, (w)holistic health, and the well-being of our nations.

This will be achieved through policy analysis, communications, and, most importantly, lobbying on behalf of First Nations' communities and individuals to ensure properly funded services and programs are delivered at the same or better level enjoyed by all Canadians.

The AFN is publishing this NIHB Handbook to assist First Nations in accessing Non-Insured Health Benefits. This Handbook is not an endorsement by AFN of current NIHB policies and criteria. In fact, AFN is continually working to remove restrictions to benefits and to obtain full recognition by the Government of Canada of its fiduciary obligation in the provision of health services to First Nations. See the AFN Action Plan on NIHB at

http://www.afn.ca/cmslib/general/NIHB%20Action%20Plan_Fe.pdf

NON-INSURED HEALTH BENEFITS (NIHB)

What types of health benefits can a registered First Nations Citizen access under the NIHB program?

■ Benefits	Page
1. Eye and Vision Care	2
2. Dental	6
3. Medical Transportation	10
4. Drugs	14
5. Medical Supplies and Equipment	17
6. Crisis Counselling	20
7. Approved Health Services Outside of Canada	22

■ More Information	
Procedures for Appeals	24
Consumer Rights in Health Care	27
Your Information Rights	28
First Nations & Inuit Health Branch (FNIHB) Regional Offices	32

■ Background

- The Assembly of First Nations' Health and Social Secretariat has a role to ensure that all First Nations citizens, regardless of residence, have access to quality health services provided by the First Nations and Inuit Health Branch (FNIHB) of Health Canada.
<http://www.afn.ca/article.asp?id=103>
- First Nations, supported by AFN, assert that health benefits are an Inherent Aboriginal and Treaty Right and are constitutionally protected. Health services are to be comprehensive, accessible, fully portable, and provided as needed on a timely basis without regard to a person's financial status, residence, or the cost of benefit.
- The NIHB Program draws its authority from federal Cabinet approval of the 1979 Indian Health Policy and the Non-Insured Health Benefits Renewed Mandate in 1997. First Nations Inuit Health Branch may make changes to benefit policies at any point in time.

1. EYE AND VISION CARE BENEFITS

■ What is covered?

Payment is made to the provider in the areas listed below. All eye and vision care benefits require prior approval.

General eye and vision exams if not covered by a private, federal or provincial/territorial health plan	<ul style="list-style-type: none"> ■ Every two years for a person 18 years old and over. ■ Every year for a person younger than 18 years. ■ When there is a change or correction in vision. <p>* A person with diabetes should schedule regular eye exams as recommended by their doctor.</p>
Specific eye exams	<ul style="list-style-type: none"> ■ May be approved by a FNIHB Vision Care consultant on a case by case basis; ■ When a severe abnormality in ocular or visual condition requires a thorough assessment using specific tests. ■ Specific eye exams for diabetics will be approved as part of this process.
Follow-up exams	<ul style="list-style-type: none"> ■ May be approved by a FNIHB Vision Care consultant on a case by case basis; ■ When required by certain ocular or visual conditions. ■ Specific eye exams for diabetics will be approved as part of this process.
First pair of eyeglasses	<ul style="list-style-type: none"> ■ With a written prescription from the doctor. ■ Lenses and frames up to a maximum amount determined by the regional FNIHB office. ■ Lenses include: unifocal (distance or near vision), aspheric, bifocal, or high index (HIL). Some restrictions apply.
Replacement eyeglasses	<ul style="list-style-type: none"> ■ Every two years for a person 18 years old and over. ■ Every year for a person younger than 18 years. ■ An accepted amount of change or correction in vision is required according to NIHB guidelines. ■ Lenses include: unifocal (distance or near vision), aspheric, bifocal, or high index (HIL). Some restrictions apply.
Eyeglass repairs	<ul style="list-style-type: none"> ■ The total cost of the repair must not be more than it would cost to replace with standard frames. ■ Within a two year period for a person 18 years old and over. ■ Within a one year period for a person younger than 18 years. ■ The repairs will make the glasses usable. <p>*Replacement frames or sets of lenses are not eyeglass repairs.</p>

Remember

1. The rules about what is covered may vary by region.
2. Prior approval is needed to access any benefit under the vision care policy in all cases.

Who may be involved in providing this care?

- Licensed Optometrists (Eye Doctor)
- Eye Specialists (Ophthalmologist)
- Opticians (Prepares the eyeglasses that have been prescribed.)

Exceptions or Special Cases

All cases as described below require prior approval *and* a written prescription with proper medical justification that will be provided by the health practitioner.

Monocular Individuals	<ul style="list-style-type: none">■ Polycarbonate lens or other safety frames and lenses.
Replacement eyeglasses	<ul style="list-style-type: none">■ Are provided if there is a new prescription indicating a change in vision within the NIHB Program guidelines. In the case of breakage, damage or loss, written justification and appropriate written proof such as an accident or police report is required.■ Requests must be made within the two year period for those over age 18, or within the one year period for those under 18.
Contact lenses	<ul style="list-style-type: none">■ When <i>medically necessary</i> as prescribed for medical eye conditions. (<i>Medically necessary</i> conditions include but are not limited to: astigmatism, anisometropia or antimetropia, corneal irregularities, and treatment of certain ocular pathologies). Individuals who meet the above criteria, and also have a neurological or arthritic condition which makes it difficult for them to physically handle contact lenses, may be eligible for extended wear contact lenses.■ Back-up eyeglasses are also included as a benefit.
Replacements of contact lenses	<ul style="list-style-type: none">■ 1 every 2 years for regular soft, and gas permeable soft and hard lenses.■ Reviewed on a case by case basis for extended wear (soft lenses).■ Written prescription and reasons for replacement with request for prior approval are required before this time frame.■ When medically necessary as prescribed for a medical eye condition.

Trial of bifocals	<ul style="list-style-type: none"> ■ Attempt fulltime use for a three month period, and if unsuccessful, the frames will be used for reading glasses and a separate pair of distance glasses can be dispensed.
Tints and coating for lenses	<ul style="list-style-type: none"> ■ Anti-Reflective Coating – in cases where the individual is eligible for High Index Lenses. ■ Scratch Resistant Coating – for polycarbonate, high index lenses and children’s glasses. ■ Tints – in some cases such as albinism, aniridia, and certain chronic conditions of the anterior segment of the eye causing photophobia. ■ Ultraviolet Protection Filter – in some cases such as aphakia, cataracts, retinal degeneration or dystrophy, or photosensitivity. ■ Replacements can occur once per lifetime of ophthalmic lenses for anti-reflective coating, scratch resistant coating, tints, and ultraviolet protection filter on glasses.
Frames	<p>Will be evaluated on a case by case basis for approval for the following frames.</p> <ul style="list-style-type: none"> ■ Flex frames (only for those who are neurologically compromised); ■ Frames and unifocal lenses (2nd set) for those who cannot wear bifocals; or ■ oversized frames.

■ What is not covered/Exclusions

- Vision care goods and services covered by provincial/territorial health insurance plans
- Additional carrying cases for glasses or contact lenses
- Cleaning kit
- Esthetic products
- Shampoo (e.g. “no more tears” type shampoo solution)
- Vision exams required for a job, drivers license, or to engage in sports activity
- Vision exams at the request of a 3rd party (e.g. completing a report or medical certificate)
- Contact lenses for esthetic purposes
- Contact lens solution
- Industrial safety frames or lenses for sports or professional use
- Sunglasses with no prescription
- Progressive, or trifocal lenses
- Photocromic/photocromatic lenses
- Replacements or repairs as a result of misuse, carelessness, or negligence

- Implants (e.g. punctual occlusion procedure)
- Refractive laser surgery
- Treatments with investigational/experimental status
- Vision training

■ For additional information

- Review the Vision Care Framework at the website address below.
http://www.hc-sc.gc.ca/fnih-spni/pubs/eye-yeux/2005_vision-vue_frame-cadre/index_e.html
- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.

2. DENTAL BENEFITS

■ What is covered?

Payment for treatment is made to the provider for the services listed below.

<p>Diagnostic services: Exams and radiographs (x-rays)</p>	<ul style="list-style-type: none"> ■ Up to four examinations per 12 month period for a person under 17 years old. ■ Up to three examinations (complete, recall, specific, emergency) per year for a person 17 years old and over and provided they are within NIHB Program guidelines. <p>Radiographs (x-ray):</p> <ul style="list-style-type: none"> ■ 6 Intraoral x-rays in a 12 month period. ■ Temporo Mandibular Joint (TMJ) requires predetermination. ■ Panoramic x-ray, 1 every 120 months without predetermination and the 2nd one after 120 months without predetermination. More than 2 in a lifetime require predetermination. ■ Cephalometric (side shot) requires predetermination.
<p>Preventative services (cleanings)</p>	<ul style="list-style-type: none"> ■ Scaling (cleaning) in combination with root planing (scraping/cleaning below the gum line) to a maximum of 4 units per year for people 12 years of age and older, and only 1 unit per year for people under 12 years of age. ■ Topical fluoride: under 17 years of age, twice per year. 2 per 12 month period. ■ Sealants or preventive resins for eligible people under 14 years of age on permanent molars and maxillary anterior incisors. ■ Polishing: 17 and older, 1 per 12 month period. Under 17, 2 per 12 month period.
<p>Restorative services (fillings)</p>	<ul style="list-style-type: none"> ■ The maximum allowable for amalgam and tooth coloured fillings is five surfaces per tooth. ■ The maximum allowable on primary/baby teeth is up to the cost of a stainless steel crown. ■ Bonded amalgam fillings are funded at a rate of a non-bonded equivalent. ■ Replacement fillings within a two year period are subject to question. ■ Retentive Pins: cores and posts, 1 every 36 months, predetermination is required.
<p>Endodontics (root canal treatment)</p>	<ul style="list-style-type: none"> ■ Root canals may be completed on the front or anterior teeth without predetermination. ■ Predetermination is required for all other teeth (bicuspid and molars) and must meet FNIHB's Endodontic policy criteria. ■ Pulpotomies and pulpectomies (open and drain) are not eligible on primary or baby incisor teeth (four front teeth, top and bottom).

<p>Prosthodontics (removable dentures)</p> <p>Maryland bridge policy (MB)</p>	<ul style="list-style-type: none"> ■ Includes three months post-insertion care including adjustments and modifications. For immediate dentures an additional reline is permitted. ■ Predetermination is required. ■ Dentures are eligible once every 8 years. ■ Replacement dentures within an 8 year period require supporting rationale. <ul style="list-style-type: none"> – When an individual has 1 or more implants and requires a complete over- denture, the program may fund the over-denture. – Maryland Bridge will be considered on an exceptional basis when the individual’s needs meet the following criteria: <ul style="list-style-type: none"> – No more than three units per bridge. – Limited to anterior (front) sextants. – Proposed permanent tooth abutments must have nil to minimum restoration. <p>Appliances for a single space in a posterior (back) situation are not covered.</p>
<p>Prosthodontics – fixed (bridges)</p>	<ul style="list-style-type: none"> ■ Fixed prostheses are not eligible benefits. ■ Removable prosthetics (dentures complete or partial) are covered as a defined benefit once in an 8-year period.
<p>Orthodontics (braces)</p>	<ul style="list-style-type: none"> ■ The NIHB Program covers a limited range of orthodontic benefits and individuals must meet the clinical criteria and guidelines established by the NIHB Program for orthodontic treatment to be funded. This means that the child must have a severe and functionally handicapping malocclusion which is characterized as: a combination of marked skeletal discrepancies – such as an over bite problem that is associated with severe functional limitations. i.e. such as an inability to properly chew your food. ■ Dento-facial anomalies such as cleft lip and palate; (no age restriction) ■ For further information, see the NIHB Orthodontic bulletin at the website address below: http://www.hc-sc.gc.ca/fnih-spni/alt_formats/fnihb-dgspni/pdf/pubs/dent/2004-08-ortho_e.pdf or contact your regional office.
<p>Adjunctive services (sedation)</p>	<ul style="list-style-type: none"> ■ General anaesthetic services are normally limited to children under 12 years of age. Predetermination is required for this service. There are regional variations in eligibility depending on provincial and territorial services and rules.
<p>Oral surgery</p>	<ul style="list-style-type: none"> ■ Implants and ridge augmentation are not funded benefits under the NIHB program. Uncomplicated extractions are part of basic treatment and do not require predetermination. ■ Complicated or “surgical” extractions require predetermination.
<p>Other services</p>	<ul style="list-style-type: none"> ■ Periodontics (treatment of inflamed or diseased gums) surgical cases require predetermination. ■ Paediatric dentistry is an available benefit to children.

■ Remember

1. Prior approval or predetermination is required on certain benefits. For example: Crowns, and dentures, root canal treatment on bicuspid and molars must meet policy criteria.
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■ Who may be involved in providing dental care?

- Dentist
- Dental Hygienists
- Dental Specialist (Endodontist, Periodontist, Prosthodontist and Orthodontists)
- Denturist
- Dental Therapist (in some provinces)

■ Exception

Orthodontics – There is no age restriction for dento-facial anomalies such as cleft lip and palate.

■ What is not covered/Exclusions

- Extensive rehabilitation
- Implants
- Prefabricated/composite veneers and bleaching (whitening of the surface of the tooth)
- Other cosmetic/aesthetic treatment
- Ridge augmentation (for denture fitting)

■ About the Process

1. There is no longer an annual \$800 threshold; previously there was only a certain amount of basic dental work that could be done in a 12-month period before prior approval or predetermination was needed. Your dentist has a complete list of eligible services. If your dentist refuses to provide you with eligible services unless you pay up-front or requests co-payment, you should contact your FNIHB-NIHB Regional Office or the AFN as this contravenes the NIHB Program policies. The FNIHB-NIHB Regional Office may also provide you with a list of alternative providers in your area.

2. All basic treatment needs must be addressed before major procedures are requested (e.g. crowns and fixed or removable prostheses).
3. Each treatment plan is reviewed on an individual basis by the regional dental consultant. In the review, consideration is given to:
 - a) the patient's oral hygiene status, periodontal condition, and dental history;
 - b) the Non-Insured Health Benefits policy; and
 - c) any other comments noted by the dentist or denturist.

A complete treatment plan (provided by your dentist to NIHB) should outline all dental needs of the patient, for example a complete treatment plan should include:

- a) exam,
- b) x-rays,
- c) restorative,
- d) preventative,
- e) orthodontic (if under the age of 18), and
- f) any adjunctive requirements.

It also may include a notation of treatment in progress made by your dental care provider.

■ About the Predetermination Process

1. More extensive procedures require predetermination or prior approval.
2. Predetermination is a review by FNIHB of the individual's proposed treatment plan submitted by the dental provider (dentist or denturist) to the Regional Dental Officer/consultant prior to the commencement of treatment. It will include a proposed dollar cost, x-rays and relevant treatment comments.
3. Emergency dental services do not require predetermination. These consist of acute dental problems including associated examinations and radiographs, procedures for the immediate relief of pain and infection, arresting haemorrhage, and preliminary care of trauma to the mouth.

■ For additional information

- Review the Dental Benefits at the address below.
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestatiion/dent/index_e.html
- Orthodontic Benefits – Questions and Answers for Patients
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestatiion/dent/2005-10-01_qa-qr_chang...
http://www.hc-sc.gc.ca/fnih-spni/pubs/dent//2004-08-ortho/index_e.html
- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.

3. MEDICAL TRANSPORTATION BENEFITS

■ What is covered?

Assistance with the payment of transportation to the nearest appropriate health professional or health facility for individuals to access medically required health services that cannot be obtained on the reserve or in the community of residence, and may include assistance with meals and accommodation when these expenses are incurred while in transit for approved transportation to access medically required health services.

Modes of transportation	<p><u>Ground travel</u>: private vehicle, commercial taxi, fee for service driver and vehicle, band vehicle, bus, train, snowmobile taxi or ground ambulance.</p> <p><u>Water travel</u>: motorized boat, boat taxi or ferry.</p> <p><u>Air travel</u>: scheduled and chartered flights, helicopter, air ambulance or medevac.</p> <ul style="list-style-type: none"> ■ The most efficient and economical mode of transportation consistent with the urgency of the situation, and the medical condition of the individual is to be utilized at all times. Individuals who choose to use another method will be responsible for the cost difference. ■ When scheduled and/or coordinated medical transportation benefits are provided, individuals who choose to use another mode of transportation will be responsible for the full cost.
Coordinated travel	<ul style="list-style-type: none"> ■ Schedule same-day appointments for individuals travelling to the same location. ■ When an individual requires more than one medical appointment, schedule all appointments for the same day. ■ When more than one individual is travelling in the same vehicle, the rate reimbursed will be for one trip only.
Emergency transportation	<ul style="list-style-type: none"> ■ Ambulance services when required (Ground or Air Ambulance/Medevac) – some conditions apply. ■ Salaries for doctors or nurses accompanying individuals on the ambulance are not covered. ■ Licensed ambulance operators will be reimbursed according to terms, conditions and rules of regionally negotiated payment schedules.
Access to Traditional Healers	<ul style="list-style-type: none"> ■ Destination within the individual's region/territory of residence or if healer is outside the individual's region/territory travel reimbursement will be to the border only. ■ The prior approval process considers: <ul style="list-style-type: none"> – whether the healer is recognized by the local Band, Tribal Council or health professional; – the location of the healer; and – a note from a health professional confirming a medical condition.

Access to Traditional Healers (cont'd.)	<ul style="list-style-type: none"> ■ Where economical, for a traditional healer to travel to the community. ■ Costs related to honoraria, ceremonial expenses or medicines remain the sole responsibility of the individual.
Meals and accommodations	<p>Amount of coverage will depend on preset regional rates.</p> <ul style="list-style-type: none"> ■ Are covered when travelling to access medically required health services. ■ The most efficient and economical means of accommodation will be chosen taking into consideration the individual's health condition, location of accommodation, and travel requirements. ■ Accommodation arrangements will be made by FNIHB or a First Nations health authority, and individuals will be responsible for the cost difference if they choose to make their own arrangements. ■ Time away from home is a consideration in determining the meals that will be covered. ■ Overnight accommodations (including a private home) may be provided on a case by case basis. ■ Other expenses related to hotel accommodations are not covered (e.g. telephone charges, room damage, movie and/or game rentals, room service, tips, etc.). ■ When an individual needs to be close to medical treatment for an extended period, the cost of meals, accommodation, and in-city transportation to access the medical care/treatment may be covered for up to a three month transition period only.
Escorts (General)	<ul style="list-style-type: none"> ■ May include transportation, accommodations and meals for medical and non-medical escorts. ■ Pre-approval is required, and the length of time is determined by the individuals medical condition or legal requirements.
Non-medical escort criteria	<p>Coverage for the following conditions are provided as a benefit.</p> <p>Note: When an escort has been authorized, the following criteria should be considered in selecting the escort:</p> <ul style="list-style-type: none"> ■ A family member who is required to sign consent forms or provide a patient history; ■ A reliable member of the community; ■ Physically capable of taking care of themselves and the patient and not requiring assistance or an escort themselves; ■ Proficient in translating from local language to English/French; ■ Able to share personal space to support the patient ■ Interested in the well being of the individual; and ■ Able to serve as driver when client is unable to transport him/herself to or from appointment
Medical	<ul style="list-style-type: none"> ■ Medical escorts are provided for individuals with acute illness when monitoring and/or stabilization is required during travel.

Non-medical	<ul style="list-style-type: none"> ■ The individual has a physical/mental disability, or has legally been declared “mentally incompetent” and is, therefore, unable to travel unassisted. <ul style="list-style-type: none"> – The individual is medically incapacitated. – There is a need for legal consent by a parent or guardian. – To accompany a minor who is accessing required health services. – When a language barrier exists and/or interpreter services are unavailable. – To receive instructions on specific and essential home medical/nursing procedures that cannot be given to the individual only.
Addictions treatment	<ul style="list-style-type: none"> ■ Travel for alcohol, drug, solvent abuse and detox treatment. ■ Travel will be funded to the closest appropriate NNADAP funded/referred facility in the home province (some exceptions for out of province). ■ Individuals are to meet all treatment centre entry requirements prior to medical transportation being authorized. ■ Travel by the most economical and practical means. ■ For family members when their participation is an integral and scheduled portion of the treatment program and approved prior to treatment. ■ Transportation will not be provided if the individual discharges themselves from treatment against advice from the treatment center counsellor, before completing the program. An exception may be considered with proper justification in some circumstances and approval by the NIHB Regional Office.
Other medically required health services	<ul style="list-style-type: none"> ■ Travel to medical services defined as insured services by provincial/territorial health plans (e.g. appointments with physician, hospital care). ■ Diagnostic tests and medical treatments covered by provincial/territorial health plans. ■ In some regions NIHB include the coverage of (vision, dental & mental health).

■ General Principles

1. Individuals must have prior approval to access medical transportation benefits.
2. In emergency situations, when prior approval has not been obtained, expenses may be reimbursed (Need: appropriate medical justification and approval after the fact).
3. Individuals must provide proof or confirmation from the health care provider or representative that they have received health care.
4. When an individual does not attend a scheduled appointment and medical transportation benefits have been provided, the individual may have to assume the cost of the return trip or of the next trip to access medically required health services unless justification is provided to explain why the individual was unable to attend or notify the appropriate public carrier of the cancellation.
5. This benefit may be provided when the individual is referred by the provincial/territorial health care authority for medically required health services to a facility outside of Canada when such services are covered by a provincial/territorial health plan. See *Approved Health Services Outside of Canada*, section 7.

■ Exceptions

(May be considered on an exceptional basis with the appropriate justification.)

- Diagnostic tests for educational purposes (e.g. hearing tests for children required by the school).
- Speech assessment and therapy.
- Medical supplies and equipment benefits where a fitting is required.
- Transportation for methadone may be provided for up to four months.
- Provincially/territorially supported preventative screening programs when coordinated with other medical travel and the cost of testing is covered under the provincial/territorial health plan.

■ What is not covered/Exclusions

- Compassionate travel. (i.e. family visits)
- Travel for individuals in the care of a federal, provincial or territorial institution.
- Court-ordered treatment/assessment, or as a condition of parole, coordinated by the justice system.
- Travel for individuals residing off-reserve in a location where the required health service is available.
- Travel for the purposes of a third-party requested medical examination.
- The return trip home in cases of an illness while away from home other than for approved travel to access medically required health services.
- Payment of professional fee(s) for preparation of doctor's note/document preparation to support provision of benefits.
- Transportation to an adult day care, respite care and/or safe house.

■ For additional information

- Review the Medical Transportation Benefits at the website address below.
http://www.hc-sc.gc.ca/fnihb/nihb/medical_transportation/index.htm
- Review the Medical Transportation Framework at the address below.
http://www.hc-sc.gc.ca/fnih-spni/pubs/medtransp/2005_med-transp-frame-cadre/index_e.html
- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list on page 32 of this handbook.

4. DRUG BENEFITS

■ What is covered?

Payment is made directly to the provider in the areas listed below.

Prescription drugs	<ul style="list-style-type: none"> ■ Drugs that require a prescription from an authorized prescriber. ■ Drugs that are listed in the Drug Benefit List at the address below. http://www.hc-sc.gc.ca/fnih-spni/pubs/drug-med/drug-med_list/list-a_e.html
Over the counter drugs (OTC)	<ul style="list-style-type: none"> ■ Drugs and selected health products listed in the Drug Benefit List, which do not require a prescription under provincial or federal legislation, but do require a prescription for coverage under the NIHB Program.
Limited use benefits	<ul style="list-style-type: none"> ■ Benefits which do not require prior approval including: <ul style="list-style-type: none"> – multivitamin for children up to age 6; and – prenatal and postnatal vitamins for women who are pregnant or breastfeeding, and are between the age of 12 and 50 years. ■ Benefits which require prior approval and for which specific criteria has been established, and must be confirmed by a doctor's completion of the NIHB <i>Limited Use Drugs Request</i> forms. ■ Benefits which have a quality and frequency limit. A maximum quantity of [a] drug is allowed within a specific period of time. ■ For example, an individual is eligible to receive a 3-month supply of smoking cessation products which is renewable 12-months from the day the initial prescription was filled.
Chronic renal failure patients	<ul style="list-style-type: none"> ■ Eligible to receive a list of supplemental benefits that are not included in the <i>NIHB Drug Benefit List</i> but are required on a long-term basis. ■ Includes: epoetin alfa products, calcium products, special multivitamins and select nutritional supplements ■ Patients will be identified for coverage through the usual prior approval process.

■ General Principles

1. The policy is to reimburse only the best price alternative product in a group of interchangeable drug products so it covers the “lowest cost alternative drug” which is commonly known as a generic drug. However, medicine with a higher cost may be covered if the patient has had an adverse reaction to the generic drug.
2. Maximum quantities have been placed on some drugs for health and safety reasons.
3. Eligible drugs are those that are available through pharmacies that require a prescription for administration in a home setting or other ambulatory setting. (Ambulatory care settings are environments that are not a “provincially/territorially funded setting (hospital/institution) or funded by any provincial/territorial programs or clinics according to provincial/territorial legislation”).

■ Prior approval

Prior approval for a drug is needed in some cases.

- When a drug requiring prior approval is needed on an emergency basis, and timely access to the Non-Insured Health Benefits Drug Exception Centre is not possible, a pharmacist may dispense an initial course of treatment for a maximum of four days.
- The pharmacist must contact the Drug Exception Centre as soon as possible for approval to be back-dated to cover the emergency supply. Any further dispensing of the drug will follow the usual prior approval process.
- Providers requesting prior approval of drug benefits on behalf of NIHB recipients may call Health Canada's **NIHB Drug Exception Centre**:
Telephone (toll-free): 1-800-580-0950
Telephone (Ottawa): (613) 941-1558
Fax: 1-800-281-5021

■ Who can prescribe drugs

- Registered Pharmacists
- Licensed Practitioners with authorization to prescribe within the scope of practice in their province or territory

■ Exceptions

1. Drugs that are not listed in the *Drug Benefit List* may be approved for coverage on a case by case basis when an exceptional need is demonstrated.
2. This need must be established by the prescriber by completing an Exception Drug Request form.
3. "*Limited use*" drugs – have a established criteria which the individual must meet in order for the cost to be covered.
4. Consideration for individuals who require more than the maximum allowable.
5. Consideration for individuals who have experienced an adverse reaction with a best price alternative drug, and a higher cost alternative is requested by the prescriber.

■ What is not covered/Exclusions

- Anti-obesity drugs
- Household products (e.g. soap & shampoos)
- Cosmetics
- Alternative therapies (e.g. glucosamine and evening primrose oil)
- Drugs with investigational/experimental status
- Megavitamins
- Vaccinations for travel indications
- Hair growth stimulants
- Fertility agents and impotence drugs
- Selected over-the-counter products
- Codeine containing cough preparations
- Darvon® and 642® (propoxyphene)

■ For additional information

- Review the Drug Benefits at the address below.
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/drug-med/index_e.html
- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.

5. MEDICAL SUPPLIES AND EQUIPMENT BENEFITS (MS&E)

■ What is covered?

Payment is made to the provider for MS&E in the categories listed below.

Categories

General Medical Supplies & Equipment

- Bathing and Toileting Aids
- Cushions and Protectors
- Environmental Aids (Dressing and Feeding)
- Miscellaneous Supplies and Equipment
- Lifting and Transfer Aids
- Mobility Aids (Walking Aids, Wheelchairs)
- Ostomy Supplies and Devices
- Urinary Supplies and Devices (Catheter Supplies and Devices, Incontinence Supplies)
- Audiology (Hearing Aids and Supplies)
- Wound Dressing Supplies
- Orthotics and Custom Footwear
- Oxygen Therapy
- Pressure Garments and Pressure Orthotics (Compression Device and Scar Management)
- Prosthetic Benefits (Breast, Eye, Limbs)
- Respiratory Therapy Benefits

For a complete list of eligible MS&E in alphabetical order by category see the address below.
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/provide-fournir/med-equip/criter/a-z_index_e.htm

■ Remember

1. The rules about what is covered may vary by region.
 2. Prescriptions are required.
 3. Prior approval is required in some circumstances.
-

■ General Principles

1. Eligible benefits are those available through registered pharmacies and MS&E providers for personal use in a home setting or other ambulatory setting. (Ambulatory care settings are environments that are not a “provincially/territorially funded setting (hospital/institution) or funded by any provincial/territorial programs or clinics according to provincial/territorial legislation”.)
2. Guidelines outlining recommended quantities or replacements are based on the average medical needs of individuals. Requests exceeding these guidelines may be considered on a case by case basis if a medical need is demonstrated.

■ Equipment

1. Medical equipment may be rented or leased on a temporary basis until it is determined that the individual will have a continuing long term need.
2. The program will request warranties at time of approval.
3. Previously provided items may be replaced if an individual's medical needs change.
4. When a MS&E item is rented, the rental agreement must include maintenance and repair costs, as the NIHB Program does not pay for maintenance or repairs of rental equipment.
5. MS&E items that have an annual quantity limitation must be provided and billed for no more than a 3-month period at a time. This applies to items claimed with or without prior approval.

■ Who may be involved in prescribing the supplies and equipment?

- Licensed Doctors
- Medical Specialists

■ Exceptions

Benefits not on the approved list may be covered when an exceptional need is demonstrated and established by the prescriber. The prescriber will need to provide NIHB with a letter of justification for consideration.

■ What is not covered? (Exclusions)

- Implants
- Items for cosmetic purposes
- Items used exclusively for sports, work or education
- Experimental equipment
- Part of a surgical procedure
- Hospital beds and mattresses
- Grab bars permanently fixed
- Therapeutic devices and/or orthopaedic footwear “off the shelf”
- Foot products manufactured only from laser or optical scanning or computerized gait and pressure analysis systems
- Cochlear implants
- Assistive listening devices
- Assistive speech devices
- Scooters
- Providing oxygen for indications which do not meet the medical criteria of the NIHB Program (e.g. angina and pain relief from migraines)
- Post-operative: surgical stripping, sclerotherapy, and edema conditions
- Temporary prosthetics required as part of a surgical procedure
- Electric/myo-electric limb prosthetics
- Respiratory equipment for in-patients of an institution
- Custom-made mask for ventilation
- Incentive spirometer

■ For additional information

- Review the Medical Supplies and Equipment Benefits at the address below.
http://www.hc-sc.gc.ca/fnihb-spni/nihb-ssna/provide-fourrir/med-equip/criter/a-z_index_e.htm
- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.

6. CRISIS COUNSELLING BENEFITS

■ What is covered?

Payment is made to the provider for the services listed below, if they are not available to the individual through any other federal, provincial, territorial or other third party health plan.

Counselling	<ul style="list-style-type: none">■ When there is a crisis, at-risk situation and there is no other source of immediate funds for services.■ Fees for professional mental health therapists for an initial assessment and the development of a treatment plan to a maximum of two hours.■ Mental health short term crisis treatment and referral services by, or recognized by, professional mental health therapists including initial assessment and development of a treatment plan.■ Treatment plans must include duration and cost.
Service in the community	<ul style="list-style-type: none">■ Fees and associated travel costs for the professional mental health therapist when it is deemed cost effective to provide such services in a community.

■ Remember

1. Prior approval is required.
2. The nature of this service is short-term. (i.e. usually a 10 hour time period)

■ Who may be involved in providing this care?

- Registered Therapists (Those within the disciplines of clinical psychology or clinical social work.)
- Mental Health Therapists
- In exceptional cases, a provider who is under the direction of a registered clinical psychologist or registered clinical social worker.

■ What is not covered/Exclusions

- Psychiatric Services
- Psychoanalysis
- Educational and Vocational Counselling
- Life skills training
- Early Intervention Programs (for infants with delayed development.)
- Any assessment service that is not considered to be a mental health crisis (e.g. fetal alcohol spectrum disorder, learning disabilities, and child custody and access).
- Court-ordered assessment/therapy services to individuals.
- When another program or agency is required to provide the service.

■ For additional information

- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.
- Review the Crisis Counselling Benefits at the address below.
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/crisis-urgence/index_e.html

7. APPROVED HEALTH SERVICES OUTSIDE OF CANADA

■ What is covered?

Payment is made to the provider in the areas listed below.

Supplemental Health Insurance	<ul style="list-style-type: none">■ Privately acquired supplemental health insurance.■ For approved students or migrant workers.
Non-Insured Health Benefits	<ul style="list-style-type: none">■ For health services received outside the country, when the individual is medically referred for treatment not available in Canada, and when such services are not covered by provincial/territorial health plans.■ Transportation, accommodation and meals will be considered for payment in the above situation.■ Only the difference between the full cost of health services received and the amount which is recoverable from provincial/territorial or third-party plans will be considered for payment where services are deemed a Non-Insured Health Benefit.

■ General Principles

1. Prior approval is required.
2. The individual must:
 - a) be eligible for the NIHB program;
 - b) be currently enrolled in a provincial or territorial health insurance plan and continue to meet residency requirements for provincial/territorial health coverage;
 - c) be a student following a course of post-secondary training or education or be a migrant worker;
 - d) be a legal dependent of an approved student or migrant worker(s); or
 - e) someone who requires treatment outside of the country because there is no treatment available here, and in terms of primary care, is approved for payment of treatment by the province.

■ What is covered

- The cost of privately acquired health insurance for approved students or migrant workers and their legal dependents.
- Transportation benefits, when eligible recipients are medically referred and approved for treatment outside of Canada by a provincial or territorial health care plan.

■ What is not covered/Exclusions

- Any benefits, including medical transportation, for which eligible individuals were neither referred outside of Canada, nor received prior approval before leaving Canada.
- Benefits that are elective in nature, and could be accessed in Canada.
- Supplementary health insurance coverage for all other outside-of-Canada travel.

■ For additional information

- Call your First Nations & Inuit Health Branch (FNIHB) regional office or a designated First Nations health authority. Please refer to the contact list included on the page 32 of this handbook.
- Review the Payment of NIHB Outside of Canada at the address below
http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna/2003_booklet_livret_info/3_inform_e.html

PROCEDURE FOR APPEALS

An eligible First Nations person, their parent or guardian may initiate an appeal process when a benefit has been denied through the NIHB Program. There are three levels of appeal available; namely Level 1, Level 2, and Level 3.

In order for a case to be reviewed as an appeal, a letter from the individual or parent/guardian, accompanied by supporting information from the provider or prescriber must be submitted to the NIHB Program. In many cases the service provider will be required to provide part of the information being requested. The usual information requested by NIHB is:

1. The condition for which the benefit is being requested;
2. The diagnosis and prognosis, including what other alternatives have been tried;
3. Relevant diagnostic test results; and
4. Justification for the proposed treatment and any additional supporting information.

The individual or parent/guardian should submit their letter of appeal and supporting documentation by mail, clearly marked "APPEALS-CONFIDENTIAL".

Upon receiving the appeals submission, the NIHB Program will arrange to have the case reviewed by the benefit management and medical, dental, orthodontic or vision care professional. The decision will be made based on the specific needs of the individual, medical justification, the availability of alternatives and NIHB policy. The individual or parent/guardian will be provided with a written explanation of the decision taken by FNIHB-NIHB. If the individual or parent/guardian has not heard within one month of submitting the appeal, they may contact the Regional Office for an update. **(See pg. • for a list of Regional Offices).**

■ Where to Submit an Appeal for Drug Benefits

To initiate an appeal, the individual should submit their documentation, addressed to the NIHB Drug Exception Centre, and mailed to Non-Insured Health Benefits, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

If the individual does not agree with the Level 1 Appeal decision, the individual may choose to have the appeal reviewed at the second level. The submission should be addressed to the Director, Benefit Management, and mailed to the NIHB Program, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

If the individual does not agree with the Level 2 Appeal decision, the individual may choose to have the appeal reviewed at the third and final level. The submission should be addressed to the NIHB Director General, and mailed to the NIHB Program, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

■ Where to Submit an Appeal for Dental, Medical Supplies and Equipment, Vision, Mental Health and Medical Transportation Benefits

To initiate an appeal, the individual should submit their documentation addressed to the NIHB Regional Manager, clearly marked "APPEALS-CONFIDENTIAL" and mail it to the Regional Office.

If the individual does not agree with the Level 1 Appeal decision, the individual may choose to have the appeal reviewed at the second level. The submission should be addressed to the NIHB Regional Director, and mailed to the Regional Office.

If the individual does not agree with the Level 2 Appeal decision, the individual may choose to have the appeal reviewed at the third and final level. The submission should be addressed to the NIHB Director General, and mailed to the NIHB Program, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

■ Where to Submit an Appeal for Orthodontic Benefits

The appeal must be submitted before the child reaches the age of 18. No appeals will be considered after the individual's 18th birthday

For an appeal to an orthodontic benefit, the following information and diagnostic test results must be provided and submitted by your Orthodontist or provider:

1. Diagnostic Orthodontic Models -- soaped and trimmed (mounted or unmounted);
2. Cephalometric – radiograph(s) and tracing;
3. Photographs – 3 intra oral and 3 extra oral;
4. Panoramic radiograph or full mouth survey;
5. Treatment plan, estimated duration of active and retention phases of treatment and costs submitted either on a NIHB Orthodontic Summary Sheet, CAO Standard Orthodontic Information Form or letter on the Orthodontist's letterhead;
6. Completed NIHB Dent-29 Form; and
7. Parent/Guardian signature (including Band name and number and/or date of birth).

To initiate an appeal, the parent/guardian should submit their documentation addressed to the NIHB Orthodontic Consultant, and mailed to the Orthodontic Review Centre, Non-Insured Health Benefits, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

If the parent/guardian does not agree with the Level 1 Appeal decision, the parent/guardian may choose to have the appeal reviewed at the second level. The submission should be addressed to the Director, Benefit Management, and mailed to the Orthodontic Review Centre Non-Insured Health Benefits, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

If the parent/guardian does not agree with the Level 2 Appeal decision, the parent/guardian may choose to have the appeal reviewed at the third and final level. The submission should be addressed to the NIHB Director General, and mailed to the Orthodontic Review Centre at the NIHB Program, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9.

Source for the section *Procedure for Appeals*: HC's FNIHB – NIHB at
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/appe/index_e.html

CONSUMER RIGHTS IN HEALTH CARE

1. You have the right to be informed:
 - about preventive health care, including education on nutrition, birth control, drug use, and appropriate exercise;
 - about the health care system, including the extent of government insurance coverage for services, supplementary insurance plans and the referral system to auxiliary health and social facilities and services in the community;
 - about your own diagnosis and specific treatment program, including prescribed surgery and medication, options, effects and side effects; and
 - about the specific costs of procedures, services and professional fees undertaken on behalf of the individual consumer.
2. You have the right to be respected as the individual with the major responsibility for your own health care. Additionally, you have the:
 - right that confidentiality of your health records be maintained;
 - right to refuse experimentation, undue painful prolongation of life or participation in teaching programs; and
 - right as an adult to refuse treatment, and the right to die with dignity.
3. You have the right to participate in the decision making affecting your own health:
 - through consumer representation at each level of government in planning and evaluating the system of health services, the types and qualities of service and the conditions under which health services are delivered; and
 - with the health professionals and personnel involved in direct health care.
4. You have the right to equal access to health care (health education, prevention, treatment and rehabilitation) regardless of the individual's economic status, sex, age, creed, ethnic origin and location. Additionally, you have the:
 - right to access adequately qualified health personnel;
 - right to a second medical opinion; and
 - right to a prompt response in emergencies.

■ Source for the section *Consumer Rights to Health Care*:

Consumers Association of Canada at
<http://www.healthwest.nf.ca/healthandwellness-rights.htm>

YOUR INFORMATION RIGHTS

■ Your Privacy Rights

In order to process NIHB benefits, Health Canada collects, uses, discloses and retains an individuals' personal information, and does so in accordance with the applicable federal laws and policies. These include:

- The Privacy Act – The Privacy Act gives Canadians the right to access information that is held about them by the federal government. The Act also protects against unauthorized disclosure of personal information. In addition, it controls how the government will collect, use, store, disclose and dispose of any personal information;
- The Access to Information Act;
- The Library and Archives of Canada Act;
- Treasury Board Secretariats' (TBS) Privacy and Data Protection Policies;
- TBS's Government Security Policy;
- The Health Canada Security Policy; and
- The NIHB Privacy Code.

For additional information regarding your privacy rights for information held by NIHB visit http://www.hc-sc.gc.ca/fnih-spni/pubs/priv/2005_code/index_e.html

The privacy of health information held by First Nation health authorities, health care professionals (such as doctors, dentists, pharmacists, etc.), hospitals and health clinics is governed by:

- Provincial privacy and health legislation;
- Rules of professional conduct and codes of ethics applicable to regulated health professionals;
- First Nations' Privacy Codes, where applicable; and
- Privacy Codes adopted by different organizations, where applicable.

Individuals are urged to question the privacy practices of anyone who collects their personal health information. All "health information custodians" should be able to answer questions such as:

- Why is my personal health information being collected, and what will be done with it?
- What are the consequences if I refuse to consent to the collection or use of my personal health information?
- What policies and safeguards exist to protect my personal health information?
- Who has access to my personal health information, and for what purposes?
- How can I access my personal health information in your files?
- Who is responsible, and how do I make a complaint if I believe that my personal health information is being collected, used or disclosed improperly?

For additional information regarding your privacy rights visit:

http://www.naho.ca/firstnations/english/pdf/Privacy_Toolkit.pdf

■ Health Canada's NIHB Privacy Code and Consent

On February, 2004 – Health Canada announced a new approach to the Non-Insured Health Benefits (NIHB) Program's Consent Initiative. Under this approach, the NIHB Program does not require a signed consent form for day-to-day processing activities and program administration. First Nations will continue to receive benefits for which they are eligible without signing a consent form.

In a few instances, where client safety or inappropriate use of the system may be a concern, the NIHB Program will seek the express consent of clients to share their personal information with health care provider. This consent may be provided verbally or in writing. In a few cases, NIHB may refuse to pay for prescriptions until a patient safety plan is in place.

■ Withdrawal of Consent

For those individuals who may have signed a consent form in the past and wish to withdraw their consent. Withdrawal of consent must be made in writing to the NIHB Program, First Nations Inuit Health Branch, Health Canada, Postal Locator 4006A, 55 Metcalfe Street, Ottawa Ontario K1A 0K9. Include in the letter, with your legal name, date of birth, identification number (treaty/status, 9 or 10 digit number, etc.), address telephone number and your signature. FNIHB-NIHB will send a written confirmation that your consent has been withdrawn.

NOTES

First Nations & Inuit Health Branch (FNIHB) Regional Offices

FNIHB Pacific Region (BC)

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
757 West Hastings Street, Suite 540
Vancouver, British Columbia V6C 3E6
Toll free: 1-800-317-7878
Telephone: (604) 666-3331

FNIHB Alberta Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Canada Place
9700 Jasper Avenue, Suite 730
Edmonton, Alberta T5J 4C3
Toll free: 1-800-232-7301
Telephone: (780) 495-2703

FNIHB Saskatchewan Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1920 Broad Street, 18th floor
Regina, Saskatchewan S4P 3V2
Toll free: 1-877-780-5458

FNIHB Manitoba Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
391 York Avenue, Suite 300
Winnipeg, Manitoba R3C 4W1
Toll free: 1-800-665-8507
Telephone: (204) 983-8886

FNIHB Ontario Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1547 Merivale Road, 3rd floor
Postal Locator 6103A
Nepean, Ontario K1A 0L3
Toll free: 1-800-640-0642
Telephone: (613) 952-0093

FNIHB Atlantic Region (PE, NS, NB, NL)

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
1505 Barrington Street, Suite 1816
Halifax, Nova Scotia B3J 3Y6
Toll free: 1-800-565-3294
Telephone: (902) 426-2656

Yukon Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
300 Main Street, Suite 100
Whitehorse, Yukon Y1A 2B5
Telephone: 1-867-667-3942

NWT and Nunavut

Non-Insured Health Benefits
Northern Secretariat
First Nations and Inuit Health Branch
Health Canada
60 Queen Street, 14th floor
Postal Locator 3914A
Ottawa, Ontario K1A 0K9
Toll free: 1-888-332-9222

FNIHB Québec Region

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Guy-Favreau Complex, East Tower, Suite 216
200 René Lévesque Boulevard West
Montréal, Québec H2Z 1X4
Toll free: 1-877-483-1575



Having Difficulty QUITTING Smoking?

Did you know
that the following
are covered under NIHB:

- **Nicotine Patch**
(Habitrol, Nocoderm, Nicotrol)
- **Nicotine Gum**
(Nicorette)
- **Bupropion HCl**
(Zyban)



Please visit your doctor or health professional for further information

This handbook was developed by the AFN Health and Social Secretariat as a tool to help First Nations navigate through the First Nations Inuit Health Branch's Non-Insured Health Benefits Program (NIHB). For further information on exceptions, limited use benefits or for filing an appeal because a benefit was denied, contact your NIHB regional office.

The AFN acknowledges with appreciation, the expert guidance and contributions of the First Nations Caucus on NIHB in the development of this handbook.

If you are experiencing difficulties in accessing general health care, dental services or accessing services which are funded by the non-insured health benefits (NIHB) program (delivered by Health Canada), please report accessibility issues at the following AFN website: <http://www.afn.ca/article.asp?id=3328>

Assembly of First Nations (AFN)

AFN Health Secretariat

810 – 473 Albert Street
Ottawa, Ontario K1R 5B4

Toll free: 1-866-869-6789

Telephone: (613) 241-6789 Extension 240

vstevens@afn.ca