| Benefit* | Current Plan Design Details | Proposed Plan Design Details |
|---|---|---|
| **Prescription drugs** | No pay-direct drug card | Introduce pay-direct drug card |
| | $25 annual deductible | No change |
| | No generic substitution | Introduce generic substitution[1] |
| | No dispensing fee maximum | Introduce dispensing fee maximum of $10 per prescription |
| **Paramedical (chiropractor, podiatrist, osteopath, chiropodist, naturopath)** | 50% reimbursement up to $300 per year per practitioner | No change |
| **Paramedical (physiotherapist)** | 100% reimbursement up to $55/initial visit and $35/subsequent visits; no annual maximum | 80% reimbursement up to $500 per year; no per-visit maximum |
| **Registered psychologist** | No coverage | Introduce 100% reimbursement up to $1,000 per year |
| **Speech therapy** | 100% reimbursement up to $1,000 per calendar year. | No change |
| **Vision (eye examinations)** | Up to $75 every 24 months for QUFA/$65 every 24 months for all other employee groups | Increase reimbursement to $100 every 24 months |
| **Vision (glasses, contact lenses, laser eye surgery)** | $250 every 24 months | Increase reimbursement to $300 every 24 months |
| **Long-Term Disability** | COLA provision up to a maximum of 5% per year (based on CPI) | COLA provision up to a maximum of 3% per year (based on CPI) |

* All benefit coverage amounts not listed here (e.g. semi-private hospitalization, dental, basic life insurance) remain unchanged.

[1] See attached Generic Substitution Details, from Mercer

# QUEEN'S UNIVERSITY

# GENERIC SUBSITUTION DETAILS

August 7, 2018

## Overview

The purpose of this document is to provide details regarding the proposed addition of generic substitution to the Queen's University benefits plan.

Generic drugs contain the same medicinal ingredients as the brand name drug, and are considered bioequivalent to the reference product. Non-medicinal ingredients, like fillers and ingredients that colour the drug, may be different from those of the brand name product.

In Ontario, pharmacists have a legal obligation to offer their patient the least cost alternative drug (i.e. generic) as an option unless the physician writes "no substitution" on the prescription. In the latter case, the pharmacist is obligated to fill the prescription with the brand name drug.

There is no change in reimbursement level for generic drugs or brand name drugs where no generic equivalent exists. Based on the Queen's plan experience in a recent 12-month period, these drugs represent roughly 95% of drug claims. In other words, roughly 5% of drug claims would be impacted by the proposed change of adding generic substitution. The process for how these claims would be administered is as outlined below:

**What type of documentation needs to be completed to be eligible for the full reimbursement of the brand name drug cost where a generic equivalent exists?**

Where there is a medical reason for the brand name drug to be dispensed where a generic substitution is available, the employee will need to ask their physician to complete a form (e.g., 'Request for Brand Name Drug Coverage'). The physician will then forward the form to the insurer for approval via fax or mail. Many physician offices/clinics are already familiar with this type of form as this type of process is in place with all insurers. This can be done at the time of the appointment when the prescription is issued.

**How long does it take for the insurer to review the request form?**

The insurer would have a service standard in place regarding time to review the form and make a decision. The current insurer (Great-West Life) makes a decision regarding coverage within five business days of receipt of the form.

**An employee needs to fill the prescription immediately; what happens at the pharmacy when they have to pay for the prescription but they have not heard back from the insurer about their request for reimbursement of the cost of the brand name drug?**

If the employee needs to fill the prescription immediately, they would be eligible for reimbursement of the cost of the generic drug. The employee would pay the difference in cost between the brand name drug and the generic equivalent. If the brand name drug coverage request is approved, the patient can submit the remaining portion of the claim for reimbursement.

**What happens if the request for coverage of a brand name drug is declined?**

All insurers have an appeal process for the decline to the exception request. Appeals are submitted in writing and should include the employee's reasons for believing the claim decision was incorrect along with any supporting medical information.