HEALTHCARE BENEFIT TRUST

HBT

BENEFIT FROM EXPERIENCE

Non-Union Staff (#870) at Alouette Addictions Services Society

Provided by your
Employer through the
Healthcare Benefit Trust
Effective: September 1, 2017

We make every effort to ensure the information that we distribute to organizations in electronic format is factual and up to date. To that effect, we have attempted to secure the integrity of the information that we distribute by releasing such information in a "read-only" format. However, in the event that such information is manipulated by anyone other than the Healthcare Benefit Trust or if organizations fail to update any new versions of the information distributed by the Healthcare Benefit Trust, the most recent version of the information distributed by the Healthcare Benefit Trust will govern any disputes. Moreover, the information provided by the Healthcare Benefit Trust regarding benefits may become out of date if changes are made to the Healthcare Benefit Trust's Plan Document, the Healthcare Benefit Trust's Trust Agreement, the applicable Collective Agreements in force, or the Pacific Blue Cross and Great-West Life contracts. Such changes could include, but are not limited to, increasing, decreasing or eliminating:

a) coverage for people and benefits, or
b) amounts for premiums and deductibles.

The governing documents are the Healthcare Benefit Trust's Plan Document, the Healthcare Benefit Trust's Trust Agreement, the applicable Collective Agreements in force, and the Pacific Blue Cross and Great-West Life contracts as each may be amended from time to time. In the case of any inconsistency between the terms of the information provided to organizations and placed, for example, on an organization's Intranet and the governing documents, the governing documents prevail. If your organization has any questions regarding the benefits, we urge you to contact our office for complete and accurate information.

Healthcare Benefit Trust
Suite 350, 2889 East 12th Avenue
Vancouver, BC V5M 4T5
Phone: (604) 736-2087 or 1-888-736-2087

Benefits-at-a-Glance

NON-UNION STAFF (CLASS CODE #870) AT ALOUETTE ADDICTIONS SERVICES SOCIETY

HEALTHCARE BENEFIT TRUST
HBT
BENEFIT FROM EXPERIENCE

GROUP LIFE

» Benefit Amount: $50,000

» Includes Advance Payment program for terminally ill employees

ACCIDENTAL DEATH & DISMEMBERMENT

» Benefit Amount: $50,000

» Scheduled amount paid for dismemberment or loss of use

LONG TERM DISABILITY

» Benefit Amount: 66-2/3% of monthly earnings. Benefit is taxable.

Qualification Period: 6 months

» Own Occupation: 12 months (excluding qualification period

» Any Occupation: after 12 months (excluding qualification period)

DENTAL

» **Basic Services**
(exams, fillings, etc.) 100%

» **Major Services**
(crowns, bridges, etc.) 50%

Parts A & B combined maximum is $1,500 per year

» **Orthodontic Services**
(braces) 50%
lifetime maximum $1,500; employee must be enrolled in this dental plan for 12 months prior to becoming eligible for orthodontic coverage

EXTENDED HEALTH

» **Annual Deductible** $100

» **Reimbursement of Eligible Expenses**

- under $1,000/calendar year 80%
- over $1,000/calendar year 100%

» **Lifetime Maximum** .....unlimited

» **Annual Maximum:**

- Acupuncturist $100
- Chiropractor $200
- Massage Therapist.....$400
- Naturopathic Physician $200
- Physiotherapist.....$400
- Psychologist $500

  Includes Clinical counselor and Registered Social Worker
- Podiatrist.....$200
- Speech Therapist $100

» **Orthopedic Shoes and Orthotics**

» **Out-of-Province/ Out-of-Country Emergencies** 100%

» **Prescription Drugs**

- Pay Direct Claims
- Includes oral contraceptives
- PharmaCare tie-in
- Reimbursement is subject to PharmaCare's Low Cost Alternative and Reference Based Pricing payment policies

» **Hearing Aids** .....$600 per 48 months

» **Vision Care**.....$225 per 24 months

» **Wigs or Hairpieces** .....$500 per lifetime

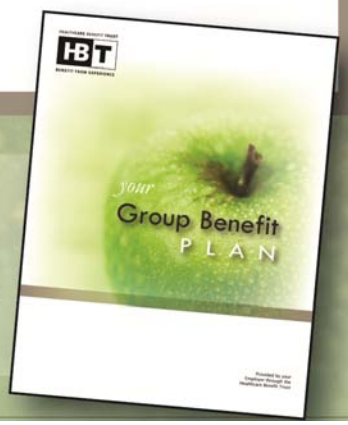
CARESnet

You can obtain online information on your Dental and Extended Health coverage and claims through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

All benefits are subject to the applicable Collective Agreement currently in force, the Pacific Blue Cross and Great-West Life contracts, and the Healthcare Benefit Trust's Plan document.

Benefits-at-a-Glance is intended as a summary only.

For more information, please refer to your benefits booklet.



Effective: September 1, 2017

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Group Life

The Group Life benefit is paid to your beneficiary or estate in the event of your death from any cause.

eligibility

Full-time and part-time employees are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the day specified in your employer's human resources policies.

amount of benefit

Refer to the *Benefits-at-a-Glance*.

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. This person will receive your Group Life benefit if you die. If you named more than one person, the payment will be divided among your beneficiaries. If you have not named a beneficiary, the benefit will be paid to your estate. You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

There are no exclusions under the Group Life benefit. The benefit is paid regardless of the cause of your death, provided you were eligible for coverage at the date of death.

continuation of coverage

Contact your employer regarding continuation of coverage while you are receiving sick pay or WCB wage loss benefits, or are on maternity or parental leave.

Coverage can continue while you are on an unpaid leave if you pay the contributions.

If you receive LTD benefits from this Plan, your Group Life coverage will continue as long as you remain an employee, at no cost to you.

termination of coverage

Your Group Life coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)

- You transfer to an ineligible status

conversion

If you cease to be eligible because of termination of employment (including retirement), your coverage will continue at no charge for 31 days. During the 31 day period you may convert your coverage to an individual policy issued by Great-West Life without providing medical evidence.

claims

Claims are processed by Great-West Life in Vancouver. If you die, your beneficiary or executor should contact your employer for assistance in filing a claim.

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advance payment program

If you are terminally ill and are expected to live less than one year, you may be eligible for an advance payment of up to 50% of your Group Life benefit (maximum payment $25,000). The remaining benefit (less interest) will be paid to your beneficiary or estate when you die. If you wish to apply for an Advance Payment, contact your employer to obtain an application form.

Accidental Death & Dismemberment

The Accidental Death benefit is paid to your beneficiary or estate in the event of your death as a result of an accident. It is paid **in addition** to the Group Life benefit.

The Accidental Dismemberment benefit is paid to you if you lose a limb, sight, hearing or speech as a result of an accident, and includes loss of use (paralysis).

eligibility

Full-time and part-time employees are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the day specified in your employer's human resources policies.

amount of accidental death benefit

("principal sum")

Refer to the *Benefits-at-a-Glance*.

amount of accidental dismemberment benefit

(includes loss of use)

If you lose:	Percentage of principal sum paid to you
• both hands, or both feet, or the sight of both eyes, or one hand and one foot, or one hand and the sight of one eye, or one foot and the sight of one eye, or hearing in both ears and speech	100%
• one arm or one leg	75%
• one hand, or one foot, or the sight of one eye, or hearing in both ears, or speech	50%
• the thumb and index finger of one hand, or all four fingers of one hand	25%
• all the toes of one foot	12.5%

Loss of an arm, leg, hand, foot or eye means the total and irrecoverable loss of its use. Loss of thumb or fingers means complete severance at or above the metacarpophalangeal joints.

Loss of toes means complete severance at or above the metatarsophalangeal joints. Loss of sight, speech or hearing must be complete and irrecoverable.

maximum benefit

The principal sum is the maximum AD&D benefit payable for all losses as a result of any one accident.

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. This person will receive the principal sum if you die accidentally, in addition to the Group Life benefit. If you named more than one person, the payment will be divided among your beneficiaries. If you have not named a beneficiary, the benefit will be paid to your estate. You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

The AD&D benefit will not be paid for losses resulting from any of the following:

1. Suicide or attempted suicide, while sane or insane.
2. Intentionally self-inflicted injury.
3. War, insurrection or hostilities of any kind, whether or not you were a participant in such actions.
4. Participating in any riot or civil commotion.
5. Bodily or mental infirmity or illness or disease of any kind, or medical or surgical treatment thereof.
6. Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current airworthiness certificate, and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only. Descent from any aircraft in flight will be deemed to be part of such flight.
7. Committing or attempting to commit a criminal offence or provoking an assault.
8. In the course of operating a motor vehicle while -
   a. under the influence of any intoxicant, or
   b. your blood alcohol concentration was in excess of 100 milligrams of alcohol per 100 millilitres of blood.

continuation of coverage

Contact your employer regarding continuation of coverage while you are receiving sick pay or WCB wage loss benefits, or are on maternity or parental leave.

Coverage can continue while you are on unpaid leave if you pay the contributions.

If you receive LTD benefits from this Plan, your AD&D coverage will continue as long as you remain an employee, at no cost to you.5

termination of coverage

Your AD&D coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

claims

Claims are processed by Great-West Life in Vancouver. If you die as a result of an accident, your beneficiary or executor should contact your employer for assistance in filing a claim. If you suffer a dismemberment or loss of use as a result of an accident, contact your employer for assistance in filing a claim.

The loss must occur within 365 days of the date of the accident. Claims must be submitted to Great-West Life within 365 days of the date of loss.

Long Term Disability

The Long Term Disability (LTD) benefit provides you with a monthly income if you are unable to work as a result of an accident or sickness.

eligibility

Full-time and part-time employees are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the day specified in your employer's human resources policies.

amount of benefit

Refer to the *Benefits-at-a-Glance*.

"Basic monthly earnings" for full-time employees = Your basic monthly earnings as at the date you become totally disabled.

"Basic monthly earnings" for part-time employees = Your average monthly hours of work for the 12 month period (or period of employment if shorter) prior to the date you become totally disabled, multiplied by your hourly pay rate as at the date you become totally disabled.

Basic monthly earnings are also called "pre-disability earnings".

qualification period

LTD benefits are payable after you have been totally disabled and unable to perform the duties of your own occupation for the "qualification period" described in the *Benefits-at-a-Glance*. Payments commence 30 days following the completion of the qualification period.

definition of total disability

To qualify for LTD benefits for the first 12 months of disability (excluding the qualification period): You must be unable, because of an accident or sickness, to perform the duties of your own occupation. This is called the "own occupation" period of disability.

To continue to qualify for LTD benefits beyond the "own occupation" period: You must be unable to perform the duties of any gainful occupation for which you have the education, training or experience, and which pays at least 85% of your rate of pay as at the date you became disabled. This is called the "any occupation" period of disability.

successive disabilities

During the qualification period: If you attempt to return to work during the qualification period, but within 31 calendar days cease work because of the same disability, you will not be required to start a new qualification period. Instead your qualification period will be extended by the number of days you worked.

After LTD benefits have been paid: If you return to work but within 6 months stop working because of the same disability, or within 31 days stop working because of a new disability, your prior LTD claim will be re-opened.

exclusions

LTD benefits will not be paid for disabilities resulting from:

1. Any period of disability when you are not under the regular and personal care of a physician.
2. War, insurrection, rebellion, or service in the armed forces of any country.
3. Voluntary participation in a riot or civil commotion, except while you are performing the duties of your regular occupation.
4. Intentionally self-inflicted injuries or illness.

continuation of coverage

Contact your employer regarding continuation of coverage while you are receiving sick pay or WCB wage loss benefits, or are on maternity or parental leave.

Coverage can continue while you are on an unpaid leave if you pay the contributions. In that event, your coverage can continue for 12 months (24 months if on educational leave).

If you receive LTD benefits from this Plan, your LTD, Group Life and AD&D coverage will continue. You can elect to continue your Dental and Extended Health coverage if you pay the contributions. Such an election must be made at the time your LTD claim is accepted and contributions must be paid to the employer monthly in advance. Note: In order for your Group Life, AD&D, Dependent Life, Dental and Extended Health coverage to continue while you are on LTD, you must remain an employee.

termination of coverage

Your LTD coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You attain age 65 (minus the qualification period)
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

claims

LTD claims are processed by Great-West Life in Vancouver.

If you are disabled, have been unable to work, are not receiving WCB wage loss benefits, and do not expect to return to work before the end of the LTD qualification period, contact your employer and obtain an LTD claim package. One form is to be completed by you, one by your employer and one by your doctor. It is important that all sections of the forms are completed, and that copies of specialists' reports, lab tests, x-ray results, etc. are submitted with your claim.

LTD claims are sent to Great-West Life at the address shown on the forms.

Late claims: Claims must be sent to Great-West Life no later than 45 days after the date your benefits would otherwise commence (e.g. the end of your qualification period, or the end of your WCB wage loss claim if later). Late claims may be accepted up to 6 months after the 45 day period, but only where it was not reasonably possible to submit the claim on time.

Income tax: LTD benefit payments are taxable if your employer pays any portion of the contributions. If they are taxable, you must submit TD1 forms with your claim. You will receive a T4-A slip from Great-West Life after the end of each calendar year.

Canada Pension Plan disability benefits: If your disability is severe and prolonged, you must also submit a claim to the Canada Pension Plan (CPP) for disability benefits. To obtain a claim form, contact Service Canada. CPP benefits are payable after 4 months of disability and will reduce the amount of your monthly LTD benefit.

Third party claims: If your disability results from a motor vehicle accident, you must also claim any wage loss benefits that you are entitled to from any third party (e.g. ICBC). Your LTD benefit may be reduced by all or a portion of these wage loss benefits.

other disability income

Your LTD benefit will not be reduced by income from private or individual disability plans. However, your LTD benefit will be reduced by 100% of any other disability income. "Other disability income" includes but is not limited to:

1. Any amounts payable under any Workers' Compensation Act (WorkSafeBC) or law or any other legislation of similar purpose; and
2. Any amount from any group insurance, wage continuation or pension plan of your employer that provides disability income; and
3. Any amount of disability income provided by any compulsory act or law; and
4. Any periodic primary benefit payment from the Canada or Quebec Pension Plans or other similar social security plan of any country to which you are entitled or to which you would be entitled if your application for such a benefit was approved; and
5. Any amount of disability income provided by a group or association disability plan to which you might belong or subscribe.

LTD benefits are reduced by the amount of other disability income to which you are entitled upon first becoming eligible for the other income.

If other disability income is available to you, you must apply for this income prior to receiving LTD benefits.

pension plan

This LTD benefit is an approved disability plan under the Municipal Pension Plan and the Public Service Pension Plan. Therefore, if you are a member of one of these pension plans and are receiving LTD benefits from this Plan, you will not be required to make contributions to the pension plan. However, you will continue to accrue contributory and pensionable service.

retirement

If you are close to retirement age when you become disabled, you may wish to contact your employer and discuss whether it would be to your financial advantage to take early retirement instead of claiming LTD benefits.

rehabilitation

If you are disabled, rehabilitation can help you return to work. If you are medically able to prepare to return to work (at your own job or another job), a rehabilitation consultant at Great-West Life can provide you with support, advice and, if needed, financial assistance for rehabilitation.

Commitment to Rehabilitation
You are required to participate and co-operate in rehabilitation.

Gradual Return to Work
It may be appropriate for you to initially return to your own job or another job at reduced hours or with modified duties. The consultant can help to co-ordinate a safe and gradual return to work plan.

Rehabilitative Employment
If you return to work in approved rehabilitative employment, your LTD claim will continue and your combined monthly income can increase up to a maximum of 85% of your pre-disability earnings. When you engage in rehabilitative employment, your LTD benefit will be reduced by 25% of your rehabilitative earnings. If your earnings plus your LTD benefit equal more than 85% of your pre-disability earnings, your LTD benefit will be further reduced by the excess.

Rehabilitative employment continues until you are earning more than 85% of your pre-disability earnings.

Note: If you receive earnings that are not from approved rehabilitative employment, your LTD benefit will be reduced by 100% of such earnings.

Retraining
If you will be unable to return to your own job and need to retrain, financial assistance may be available from Great-West Life as part of your Approved Rehabilitation Plan in order to help pay for your tuition and related expenses.

Medical Rehabilitation
If you first require medical rehabilitation (e.g. physical conditioning, pain or stress management) this may be arranged by the rehabilitation consultant and your doctor. Contact your rehabilitation consultant for further information.

duration of benefits

LTD benefits are paid as long as you remain totally disabled but will stop on the date you recover, reach age 65, refuse to participate in rehabilitation, die or cease to be eligible. whichever occurs first.

appeals

If Great-West Life deny or terminate your claim and if you disagree with their decision, you may appeal and submit further medical information to Great-West Life in support of your claim. Contact your employer for assistance with the appeal process.

Dental

The Dental benefit reimburses you or your dentist for many of your dental expenses.

eligibility

Full-time and part-time employees, and dependents, are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are:

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children to any age if in full-time attendance at a school, college or university, that is recognized by Pacific Blue Cross, and if mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and stepchildren, and children for whom you are the legal guardian. Legal proof of guardianship is required. "Mainly dependent" means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you and have not ceased to be dependent.

effective date

Your coverage takes effect on the day specified in your employer's human resources policies.

Dependents: Coverage for dependents takes effect on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

Orthodontics: Coverage for you and your dependents takes effect after you have been enrolled in the Dental benefit for 12 months.

amount of benefit

Refer to the *Benefits-at-a-Glance*.

eligible expenses

This Dental benefit covers those services which are routinely provided to you or your dependents in offices of general practicing dentists in BC.

The services, and the amounts paid for such services, are as set out in the current Pacific Blue Cross Dental Fee Schedule No. 2. Fees in excess of the amount shown in the fee schedule will be your responsibility. When performed by a specialist (on referral by a general practicing dentist), the fee paid is the amount paid to a general practicing dentist, plus up to 10%.

CARESnet: You can obtain on-line information on your Dental coverage and eligible dependents through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

Eligible expenses under this Dental benefit are:

Basic Services/Part "A"

Basic Services covers those services required to maintain teeth in good order and to restore teeth to good order.

1. Diagnostic services: Procedures to determine the dental treatment required, including the following -
   a. two standard exams per calendar year.
   b. one complete exam in any 3 year period, provided that no other exam has been paid by this Dental benefit, on your behalf, in the preceding 6 months.
   c. x-rays, up to the maximum established by Pacific Blue Cross for the calendar year.
   d. full mouth x-rays once in any 36 month period.
2. Endodontic services: for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals.
3. Major restorative services: Inlays, onlays and gold foils, but only when no other material can be used satisfactorily. Pre-approval by Pacific Blue Cross is recommended. If you choose gold where another material can be used, you will be responsible for any additional costs.
4. Periodontic services: Procedures for the treatment of gums and bones surrounding and supporting the teeth, but not including bone and tissue grafts.
5. Preventive services: Procedures to prevent oral disease, including the following -
   a. cleaning and polishing of teeth (prophylaxis) twice in any calendar year.
   b. topical fluoride application twice in any calendar year.
   c. fixed space maintainers intended to maintain space and regain lost space, but not to obtain more space.
   d. sealants (pit and fissure): limited to once per tooth within a 2 year period.
   e. scaling, root planing and gingival curettage.
6. Repairs to bridges and dentures (prosthetics): Procedures for the repair of bridges, as well as the repair or reline of dentures by either a dentist or a licensed denturist. Relines will not be covered more often than once in any 2 year period. Costs of temporary dentures are not eligible for payment.
7. Restorative services: Procedures for filling teeth, including metal prefabricated restorations. If you choose to have white fillings in back teeth, you will be responsible for any additional costs.
8. Surgical services: Procedures to extract teeth as well as other surgical procedures performed by a dentist.

Major Reconstruction Services/Part "B"

Major Reconstruction Services covers those services required for major reconstruction or replacement of deteriorated or missing teeth. A service provided under Part B is eligible for payment only once in any 5 year period.

1. Restorative Services:
   a. Crowns: Rebuilding natural teeth where other basic material cannot be used satisfactorily. Certain materials will not be authorized for use on back teeth. Pre-approval by Pacific Blue Cross is recommended.

   b. Inlays and onlays involved in bridgework.
   c. Veneers.
2. Removable Prosthetics: The artificial replacement of missing teeth with dentures. Full upper and lower dentures or partial dentures of basic, standard design and materials. Full or partial dentures may be obtained from either a dentist or a licensed denturist. No benefit is payable for the replacement of lost, broken or stolen dentures.
3. Fixed Prosthetics: The artificial replacement of missing teeth with a crown or bridge.
4. Periodontal appliances including bruxing guards: 2 (one upper and one lower) every 5 years. No benefit is payable for the cost of lost or stolen bruxing guards.

Orthodontic Services/Part "C"

Orthodontic Services covers those services required to straighten abnormally arranged teeth. Pre-approval by Pacific Blue Cross is necessary.

Braces: up to the lifetime maximum specified in the *Benefits-at-a-Glance*. Costs of lost or stolen braces are not eligible for payment.

To be eligible for orthodontic services, you must have been enrolled in this Dental benefit for 12 months.

pre-approval

It is recommended that, before beginning treatment, your dentist contact Pacific Blue Cross to confirm that:

1. You and your dependents are covered by the Plan.
2. The proposed dental services are Eligible Expenses under this Plan.
3. You or your dependents have not reached the coverage limits (e.g. the lifetime orthodontics maximum; the 5 year limit on a crown or dentures).

If the cost of the treatment is significant, your dentist should also send a treatment plan to Pacific Blue Cross for approval.

exclusions

The Dental benefit does not cover the following:

1. Cosmetic dentistry, temporary dentistry, procedures performed for congenital malformations, oral hygiene instruction, tissue grafts and drugs.
2. Treatment covered by WorkSafeBC, Medical Services Plan of BC (MSP), or other publicly supported plans.
3. Services required as a result of an accident for which a third party is responsible.
4. Charges for completing forms, written reports, communication costs, or charges for translating documents into English.
5. Implants and/or services performed in conjunction with implants.
6. Fees in excess of the current Pacific Blue Cross Dental Fee Schedule No. 2, or fees for services which are not set out in the Dental Fee Schedule.
7. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
8. Expenses resulting from intentionally self-inflicted injuries, while sane or insane.
9. Charges for unkept appointments.

10. Charges necessitated as a result of a change of dentist or denturist, except in special circumstances.
11. Room charges and some anaesthetics.
12. Expenses incurred prior to eligibility date or following termination of coverage.
13. Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.
14. Expenses for a dental accident that are paid or payable by your Extended Health benefit.
15. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.
16. Travel expenses incurred to obtain dental treatment.
17. Services, medical supplies or equipment purchased from practitioners or providers who are considered by Pacific Blue Cross to be ineligible or where Pacific Blue Cross refuses the claim based on their qualifications or conduct.

continuation of coverage

Contact your employer regarding continuation of coverage while you are receiving sick pay or WCB wage loss benefits, or are on maternity or parental leave.

Coverage can continue while you are on an unpaid leave if you pay the contributions. Coverage can also continue while you are on an LTD claim if you remain an employee and if you pay the contributions.

termination of coverage

Your Dental coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

Dependents: Coverage for a dependent ceases on the earlier of the above or at the end of the calendar month in which he/she no longer qualifies as a "dependent" under the Dental benefit.

conversion

If you cease to be eligible because of termination of employment, during the 60 day period following termination of coverage, you may convert your coverage to an individual policy issued by Pacific Blue Cross. Contact your employer or Pacific Blue Cross for further information.

claims

Dental claims are processed by:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1
(phone 604-419-2300 or 1-888-275-4672)

CARESnet: You can obtain on-line information on your Dental claims through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

If you or your dependents require dental services, visit the dentist of your choice and take your Pacific Blue Cross ID card. Discuss the services that will be provided, the cost of those services, and any amounts that are not covered by this benefit and that you will be required to pay.

When your dentist has completed the treatment, payment may be obtained by either of the following methods:

1. Your dentist can submit a claim to Pacific Blue Cross on your behalf for amounts up to the levels specified in this Dental benefit. Pacific Blue Cross will then pay accepted claims directly to your dentist. If the services are covered at a level below 100%, you must pay the balance to your dentist, or
2. You can pay the dentist and then submit your own claim to Pacific Blue Cross up to the levels specified in this Dental benefit. Pacific Blue Cross will then pay accepted claims directly to you. For information on how to submit your own claim, contact Pacific Blue Cross.

Claims must be received by Pacific Blue Cross within 12 months of the date of treatment.

Co-ordination of claims: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits, subject to the maximums set out in the Pacific Blue Cross Dental Fee Schedule No. 2, so that the total payments will not exceed the expenses actually incurred.

Treatment outside of BC: If you require dental care elsewhere in Canada and you obtain services from a qualified dentist, you will be reimbursed at the rates in effect in the province where the services were provided. Where services are obtained outside of Canada from a qualified dentist, you will be reimbursed up to the amount that this Plan would have paid had the services been provided in BC. To obtain payment, obtain an itemized statement from the dentist and submit it to Pacific Blue Cross.

Change of dentist: If you find it necessary to change your dentist after you have commenced dental work, advise Pacific Blue Cross and both dentists. Claims will be paid by Pacific Blue Cross where there has been no duplication of services.

Extended Health

The Extended Health benefit reimburses you for many of your medical expenses.

eligibility

Full-time and part-time employees, and dependents, are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are:

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children to any age if in full-time attendance at a school, college or university that is recognized by Pacific Blue Cross, and if mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and stepchildren, and children for whom you are the legal guardian. Legal proof of guardianship is required. "Mainly dependent" means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you and have not ceased to be dependent.

effective date

Your coverage takes effect on the day specified in your employer's human resources policies.

Dependents: Coverage for dependents takes effect on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

amount of benefit

Refer to the *Benefits-at-a-Glance*.

If your Plan has an annual deductible and if, in a calendar year, your eligible expenses do not exceed the deductible, your expenses during the last 3 months of that year may be applied against the deductible for the next calendar year.

eligible expenses

This Extended Health benefit covers the following expenses when incurred by you or your dependents as a result of the necessary treatment of an illness or injury. For any items not specifically listed in this booklet, it is recommended you check with Pacific Blue Cross, prior to purchase, to determine the extent of any coverage.

CARESnet: You can obtain on-line information on your EHC coverage and eligible dependents through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

- **Acupuncturist:** Fees of an approved acupuncturist up to the amount specified in the *Benefits-at-a-Glance*.

- **Ambulance:** Cost of an ambulance in an emergency from the place where the sickness or injury occurs to the nearest acute care hospital with adequate facilities to provide the required treatment (including transportation by railroad, boat or airplane, or air-ambulance in an acute emergency). This benefit also covers transportation for one attending person (doctor, nurse, first aid attendant) where necessary.

- **Chiropractor:** Fees of a registered chiropractor up to the amount specified in the *Benefits-at-a-Glance* but not including the cost of x-rays taken by a chiropractor.

- **Dentist:** Fees of a dentist for repairs, including replacement, of natural teeth or prosthetics which have been injured accidentally while the person is covered by this Extended Health benefit. The treatment needed must be obtained within one year of the date of the accident. This Extended Health benefit does not cover orthodontic services or any dental charges which exceed the dental fee schedule in effect in the province where the service was provided. Where services are obtained outside of Canada from a qualified dentist, you will be reimbursed up to the amount that would have been paid had the services been provided in BC. "Accidental" means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

- **Diabetic supplies:** Needles, syringes and testing supplies; insulin infusion pumps when basic methods are not feasible (physician's letter required). Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Employment medicals:** Charges of a physician for a medical examination required by a statute or regulation of government for employment purposes, providing such charges are not payable by your employer.

- **Hearing aids:** Cost of purchasing hearing aids when prescribed by a certified Ear, Nose and Throat Specialist or when recommended by an audiologist. The maximum is the amount specified in the *Benefits-at-a-Glance*. This benefit includes repairs, but does not include payment for maintenance, batteries, re-charging devices or other such accessories. Note: Coverage for dependent students ceases at age 25.

- **Hospital room charges:** Charges for occupying a private or semi-private room in a BC acute care hospital, but not including rental of TV, telephone, etc.

- **Massage Therapist:** Fees of a registered massage therapist up to the amount specified in the *Benefits-at-a-Glance*.

- **Medical equipment:** Rental costs, unless purchase is more economical, of durable medical equipment including hospital beds. Wheelchairs or scooters are eligible expenses only if a physician certifies that these appliances are the sole means of mobility. Electric wheelchairs

are covered only when the physician certifies that the patient cannot operate a manual chair. TENS and TEMS when prescribed for intractable pain. Continuous glucose monitors to a maximum of $2,000 per year; you will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied. Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Medical Referral Transportation:** Where determined by the attending physician and when adequate medical treatment is not available locally (within a 100 km radius), transportation by a scheduled public air, rail or bus service will be covered for the employee or dependent (and, if certified necessary by the attending physician, for an attendant), to and from the nearest locale equipped to provide the required treatment. The referred medical treatment must be performed by a physician. Travel must be completed within 2 months of the date of referral. Reimbursement for transportation will be based on the least expensive available fare. Where transportation by car is a reasonable alternative to public transport, mileage will be paid at the current allowance but limited to the amount that would have been paid for the least expensive form of public transportation. Bus or taxi service to and from the airport to the downtown locale for medical treatment will be allowed. When required, the cost of accommodation in a commercial facility will be provided up to a maximum of $60 per day for 7 days. The maximum lifetime benefit is $10,000 per person.

- **Naturopathic Physician:** Fees of a registered naturopathic physician up to the amount specified in the *Benefits-at-a-Glance*, but not including the cost of x-rays taken by a naturopathic physician.

- **Orthopedic shoes and orthotics:** One pair of custom made orthopedic shoes (including repairs) or one pair of custom made orthotics and replacements thereafter when necessitated by normal wear and tear.
  i) custom made orthopedic shoes when diagnosed and prescribed by a physician, podiatrist, primary healthcare nurse practitioner or chiropractor as medically necessary. A custom made orthopedic shoe is one made of raw materials specifically designed for the patient, and manufactured from a three-dimensional image of the patient's foot and lower leg.
  ii) custom made orthotics when diagnosed and prescribed by a physician, podiatrist, primary healthcare nurse practitioner, chiropractor or physiotherapist as medically necessary. A custom made orthotic is one fabricated from raw material using a three-dimensional volume metric model of the patient's feet.

- **Out-of-province/out-of-country emergencies:** In the event of an emergency while traveling outside of BC/outside of Canada, the Extended Health benefit covers:
  1. While you or your family are traveling outside your province of residence, benefits are payable for the following eligible expenses incurred in an emergency only and when ordered by the attending physician:
     a. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
     b. The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days. If reasonably possible, Pacific Blue Cross should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending physician, to move the patient by licensed ambulance service (by surface or air at the discretion of Pacific Blue Cross) to the hospital nearest the patient's home which is equipped and has space available to

provide further medical treatment. Where transportation would endanger the health of the patient, the 90 day limit may be extended with the expressed written consent of Pacific Blue Cross.

c. Services of a physician and laboratory and x-ray services.
d. Prescription drugs in sufficient quantity to alleviate an acute medical condition.
e. Other emergency services and/or supplies that Pacific Blue Cross would cover in your province of residence.

2. Worldwide Emergency Medical Assistance (Medi-Assist): In emergencies which occur while you (and your dependents) are traveling, Medi-Assist will coordinate the following services:
   a. Locate the nearest appropriate medical care.
   b. Obtain consultative and advisory services and supervision of medical care by qualified licensed physicians.
   c. Investigate, arrange and coordinate medical evacuations and related transportation needs.
   d. Arrange and coordinate the repatriation of remains.
   e. Replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your dependents may require when in distress.

Your Pacific Blue Cross worldwide emergency Medi-Assist card provides information on how to contact Medi-Assist. Call the nearest Medi-Assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call. Have your Pacific Blue Cross ID number and Medi-Assist group number ready for personal identification as both numbers are required. For further information, refer to Pacific Blue Cross' website at www.pac.bluecross.ca/corp/mediassist/.

Note: Emergencies and non-emergency referrals to other provinces (except Quebec) are covered by MSP, if pre-approved by MSP, as if the expenses had been incurred in BC. Other out of province non-emergency Eligible Expenses are covered by this Extended Health benefit as if those expenses had been incurred in the person's province of residence, subject to any deductible, coinsurance and maximums.

- **Paramedical items and prosthetic devices:** Oxygen, artificial limbs or eyes, ostomy and ileostomy supplies, walkers, canes and cane tips, crutches, splints, casts, collars (but not elastic or foam supports), trusses, and rigid support braces. Myoelectrical limbs are excluded but Pacific Blue Cross will pay the equivalent of a standard prosthesis.

- **Physiotherapist**: Fees of a registered physiotherapist up to the amount specified in the *Benefits-at-a-Glance*.

- **Podiatrist**: Fees of a registered podiatrist up to the amount specified in the *Benefits-at-a-Glance*, but not including the costs of x-rays taken by a podiatrist.

- **Prescription drugs:** Cost of prescription drugs purchased from a licensed pharmacy. This benefit includes oral contraceptives, but does not include contraceptive devices and preventative vaccines. This benefit does not include vitamin injections, food supplements, lifestyle drugs as determined by Pacific Blue Cross, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation except methadone, drugs which can be bought without a prescription, drugs which have not been authorized for payment by the Director of the PharmaCare Program or drugs not approved under the Food & Drugs Act for sale and distribution in Canada. Reimbursement of eligible drugs and medicines is subject to

PharmaCare's Low Cost Alternative and Reference Drug Program payment policies. All eligible prescription drugs are subject to PharmaCare's current dispensing fee limit and mark-up limit over the manufacturer's cost. You will be reimbursed up to 80% of these maximums after the calendar year deductible has been satisfied.

- **Psychologist:** Services of a registered psychologist, clinical counselor or registered social worker up to the amount specified in the *Benefits-at-a-Glance* [combined maximum].

- **Registered Nurse:** Fees of a Registered Nurse (who is not related to you) for special duty nursing in acute cases where the service is recommended by a physician.

- **Speech Therapist:** Fees of a registered speech therapist, when referred by a physician, up to the amount specified in the *Benefits-at-a-Glance*.

- **Surgical stockings and brassieres**: 2 pairs of stockings per person per calendar year; 1 brassiere per person per calendar year when required as a result of medical treatment for injury or illness.

- **Vision care:** Cost of prescribed eyeglasses or repair of eyewear and/or frames or prescribed contact lenses. The maximum is the amount specified in the *Benefits-at-a-Glance*. Note: Coverage for dependent students ceases at age 25.

- **Wigs or hairpieces:** Cost of wigs or hairpieces when required as a result of medical treatment or injury, alopecia areata, alopecia universalis or alopecia totalis. The lifetime maximum per person is the amount specified in the *Benefits-at-a-Glance*.

exclusions

The Extended Health benefit does not cover the following:

1. Charges for benefits, care or services payable by or under MSP, PharmaCare, Hospital Programs, or any public or tax supported agency. This applies in all cases, whether a claim is made or not.
2. Charges for benefits, care or services payable by or under any other authority such as ICBC, travel insurance plans, etc. This applies in all cases, whether a claim is made or not.
3. Charges for a physician except as described in Eligible Expenses for Out-of-Province/Out-of-Country Emergencies.
4. Charges for Dental services except as described in Eligible Expenses for Dentist.
5. Expenses attributed to, or caused by, occupational disabilities which are covered by WorkSafeBC.
6. Charges for services and supplies of an elective (cosmetic) nature.
7. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
8. Expenses resulting from an injury or illness which was intentionally self-inflicted, while sane or insane.
9. Any portion of a specialist's fee not allowable under MSP due to non-referral, or any amount of fees charged by any practitioner in excess of the recognized fees for such service.
10. Charges for batteries and re-charging devices.
11. Expenses related to the repatriation of a deceased employee and/or dependent.
12. Expenses related to pregnancy when incurred by a pregnant person while travelling outside of Canada within 21 days of the expected delivery date.

13. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.
14. Services, medical supplies or equipment purchased from practitioners or providers who are considered by Pacific Blue Cross to be ineligible or where Pacific Blue Cross refuses the claim based on their qualifications or conduct.
15. Expenses related to eye examinations.

reasonable and customary limits

Reasonable and Customary (R&C) limits are financial or frequency limits which are deemed, by Pacific Blue Cross, to be the normal or average amount that is expected to be charged for a product or service being claimed. These limits can be set using fee guides published by provider associations, market research, historical claims experience or a combination of any of these methods. Reasonable and customary limits are used by all insurance carriers to ensure plans are paying only for what is considered medically necessary. More information about Pacific Blue Cross's reasonable and customary limits can be found online at www.pac.bluecross.ca.

continuation of coverage

Contact your employer regarding continuation of coverage while you are receiving sick pay or WCB wage loss benefits, or are on maternity or parental leave.

Coverage can continue while you are on an unpaid leave if you pay the contributions. Coverage can also continue while you are on an LTD claim if you remain an employee and if you pay the contributions.

termination of coverage

Your Extended Health coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

Dependents: Coverage for a dependent ceases on the earlier of the above or at the end of the calendar month in which he/she no longer qualifies as a "dependent" under the Extended Health benefit. Vision care and hearing aid coverage for dependent students ceases at the end of the calendar month in which the student attains age 25.

conversion

If you cease to be eligible because of termination of employment, during the 60 day period following termination of coverage, you may convert your coverage to an individual policy issued by Pacific Blue Cross. Contact your employer or Pacific Blue Cross for further information.

claims

Extended Health claims are processed by:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1
(phone 604-419-2600 or 1-888-275-4672)

CARESnet: You can obtain on-line information on your Extended Health claims payments, or on options for the electronic submission of claims, or obtain an Extended Health claim form, through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

Pay-direct claims: Check with your pharmacist or service provider to confirm they coordinate claims on-line directly with Pacific Blue Cross. When you are purchasing a prescription drug or service, give the provider your policy and ID numbers along with the necessary identification requested by the provider. The pharmacist or provider will be able to determine, at the time you purchase your prescription or eligible expense, the amount that your Extended Health benefit will cover. The Extended Health benefit will reimburse this amount directly to the pharmacy or provider, and you will only pay your portion. For pharmacies that are not on-line or that are outside of BC, you must pay for the prescriptions, collect the receipts and submit them to Pacific Blue Cross on-line through CARESnet or manually.

On-line CARESnet claims: Claims for prescription drugs, vision care and the services of physiotherapists, massage therapists, etc. can be submitted electronically through CARESnet. If you have coverage under two different drug plans you must submit receipts on-line through CARESnet or manually, unless both drug plans are provided through Pacific Blue Cross. Keep the original receipts for your records for 12 months from date of service.

Manual claims: If you require an item or service which is covered under this Extended Health benefit, visit the supplier of your choice and discuss the cost. Pay the supplier and obtain a receipt. The receipt should identify the date, item/service purchased, name and address of the supplier, price paid, quantity (where applicable) and the name of the person receiving the item/service (i.e. you or your dependent). Hold all your receipts until they exceed the annual deductible (if applicable). Then obtain a Pacific Blue Cross Extended Health Care Claim Form from CARESnet. Complete your claim by carefully following the instructions on the claim form. Send your completed claim form and original receipts to Pacific Blue Cross at the address shown on the form. Keep a copy of the receipts for your records, as Pacific Blue Cross will not return the originals.

Claim payments: When your claim has been processed, Pacific Blue Cross will send a cheque to your home address, or via direct deposit if you have selected that option. You may wish to save the "Explanation of Benefits" that accompanies the claim payment, for income tax purposes.

Annual deductible: The annual deductible is applied only once per person or family in a calendar year. Once the deductible has been exceeded, you may submit a claim at any time. You may also submit additional claims during the year.

Claim filing deadline: Claims must be received by Pacific Blue Cross no later than June 30th of the following year. Example: If you purchase an Eligible Expense on December 1, 2017, your claim must be received by PBC no later than June 30, 2018.

Co-ordination of benefits: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits so that the total payments will not exceed the expenses actually incurred. See also "On-line CARESnet Claims" above.

Out-of-country medical expenses: Send your claim directly to Pacific Blue Cross instead of to MSP. Claims must be submitted to Pacific Blue Cross within 60 days of the date the expenses were incurred.

Benefits Checklist

Here are some things you can do to manage your benefits:

- Keep this booklet as a reference.
- Discuss your benefits with your family.
- Ensure all your eligible dependents, including newborns, are enrolled in Dental and Extended Health within 60 days of the date they become eligible. To check your dependents' coverage, refer to www.pac.bluecross.ca/caresnet/. If any dependents are missing, contact your employer.
- During the year, save your receipts for expenses covered under the Extended Health benefit. Send your Extended Health claims to Pacific Blue Cross periodically. Claims must be received by Pacific Blue Cross no later than June 30th of the following year.
- Remind your dependents to take your Pacific Blue Cross ID card to the pharmacy in order to access the pay-direct claims process.
- Review your beneficiary designation periodically for Group Life and AD&D to make sure it is still appropriate. Contact your employer to review your most recent Appointment/Change of Beneficiary form.

For more information, contact your employer.

This booklet is a summary only. All benefits are subject to the Pacific Blue Cross and Great-West Life contracts, and the Healthcare Benefit Trust's Plan Document.