

HEALTHCARE BENEFIT TRUST



BENEFIT FROM EXPERIENCE

your

Group Benefit P L A N

For employees covered by the

GENERAL SERVICES COLLECTIVE
AGREEMENT (2019-2022)

Provided by your
Employer through the
Healthcare Benefit Trust

Effective: April 1, 2021

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 Moreover, the information provided by the Healthcare Benefit Trust regarding benefits may become out of date if changes are made to the Healthcare Benefit Trust’s Plan Document, the Healthcare Benefit Trust’s Trust Agreement, the applicable Collective Agreements in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 Canada 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 Canada 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.

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Group benefit plan for employees covered by the

GENERAL SERVICES COLLECTIVE AGREEMENT 2019-2022

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Benefits are administered under the terms of the Healthcare Benefit Trust's Plan and claims are paid out of the Healthcare Benefit Trust. The Trust is funded by contributions from healthcare and community social services employers and employees in BC.

The Healthcare Benefit Trust is a trust that is exclusively dedicated to providing certain employee benefits and services related to those benefits. The Trust is not an insurance company and the benefits it provides are not insured by an insurance company. The Trust is not subject to regulation under the British Columbia *Financial Institutions Act*.

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HIGHLIGHTS

group life

If you die from any cause, \$50,000 (\$25,000 for ages 65 to 69) will be paid to your beneficiary or estate. If you are terminally ill, up to 50% (maximum payment \$25,000) may be paid to you in advance. Coverage terminates at age 70.

accidental death and dismemberment

If you die accidentally, \$50,000 (\$25,000 for ages 65 to 69) will be paid to your beneficiary or estate. Coverage terminates at age 70.

If you suffer an accidental dismemberment or loss of use, a scheduled amount will be paid to you.

long term disability

If you are totally disabled beyond 6 months, you will receive a monthly benefit based on a percentage of your earnings. The benefit is taxable.

dental

You will be reimbursed for:

- 100% of basic services
- 60% of major reconstruction services
- 60% of orthodontic services (\$2,750 lifetime maximum)

Coverage is for you and your eligible dependents.

extended health

You pay the first \$45 in a calendar year (deductible). Then you will be reimbursed for 80% of eligible expenses until claims totaling \$1,000 have been paid in a calendar year and thereafter you will be reimbursed 100% of eligible expenses; and 100% of eligible out-of-province/out-of-country emergency expenses. The lifetime maximum, per person, is unlimited.

Coverage is for you and your eligible dependents.



GROUP LIFE

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

cost

Your employer pays the cost of the Group Life benefit.

The contributions your employer pays are taxable income to you, and will be included on your annual T4 slip.

amount of benefit

If you die, \$50,000 will be paid to your beneficiary (or to your estate if you have not named a beneficiary).

Coverage reduces to \$25,000 at age 65 and terminates at age 70.

eligibility

If you are a regular full-time or regular part-time employee scheduled to work twenty (20)* regular hours or more per week, you are eligible for this benefit as a condition of employment.

*fifteen (15) or more for part-time employees hired prior to April 1, 2004.

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.

effective date

Your coverage takes effect on the first day of the month after you have successfully completed your probationary period (not to exceed 3 months).

Changing your beneficiary: You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Appointment/Change of Beneficiary forms may be obtained from your

employer's Human Resources or Benefits department. 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

Your employer will continue to pay the Group Life contributions while you are receiving sick pay, are on an Employment Standards Act leave including compassionate, maternity or parental leave, or during the first 20 work shifts of any other unpaid leave in any calendar year.

Coverage can continue while you are receiving WorkSafeBC (WSBC) benefits or are on an unpaid leave beyond 20 work shifts if you pay the contributions.

If you receive LTD benefits from this Plan, your Group Life coverage will continue

without cost to you as long as you remain an employee.

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 beyond 20 work shifts in any calendar year and elect not to pay the contributions (or elect to pay contributions and then stop paying them);
- You transfer to an ineligible status;
- You are laid off;
- You attain age 70.

conversion

If you cease to be eligible because of termination of employment (excluding 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 Canada Life without providing medical evidence.

claims

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

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).

cost

Your employer pays the cost of this Accidental Death & Dismemberment (AD&D) benefit.

The contributions your employer pays are taxable income to you, and will be included on your annual T4 slip.

eligibility

If you are a regular full-time or regular part-time employee scheduled to work twenty (20)* regular hours or more per week, you are eligible for this benefit as a condition of employment.

*fifteen (15) or more for part-time employees hired prior to April 1, 2004.

effective date

Your coverage takes effect on the first day of the month after you have successfully completed your probationary period (not to exceed 3 months).

amount of accidental death benefit

("principal sum")

If you die as a result of an accident, \$50,000 will be paid to your beneficiary (or to your estate if you have not named a beneficiary).

Coverage reduces to \$25,000 at age 65 and terminates at age 70.

amount of accidental dismemberment benefit

(includes loss of use)

- If you lose 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% of the principal sum will be paid to you.
- If you lose one arm or one leg: 75% of the principal sum will be paid to you.
- If you lose one hand, or one foot, or the sight of one eye, or hearing in both ears, or speech: 50% of the principal sum will be paid to you.
- If you lose the thumb and index finger of one hand, or all 4 fingers of one hand: 25% of the principal sum will be paid to you.
- If you lose all the toes of one foot: 12.5% of the principal sum will be paid to you.

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. 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.

Changing your beneficiary: You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Appointment/Change of Beneficiary forms may be obtained from your employer's Human Resources or Benefits department. 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

Your employer will continue to pay the AD&D contributions while you are receiving sick pay, are on an Employment Standards Act leave including compassionate, maternity or parental leave, or during the first 20 work shifts of any other unpaid leave in any calendar year.

Coverage can continue while you are receiving WorkSafeBC (WSBC) benefits or are on an unpaid leave beyond 20 work shifts if you pay the contributions.

If you receive LTD benefits from this Plan, your AD&D coverage will continue without cost to you as long as you remain an employee.

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 beyond 20 work shifts in any calendar year and elect not to pay the contributions (or elect to pay contributions and then stop paying them);
- You transfer to an ineligible status;
- You are laid off;
- You attain age 70.

claims

Claims are processed by Canada Life. 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 Canada 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. There is a 6 month qualification period.

cost

Your employer pays the cost of this LTD benefit.

eligibility

If you are a regular full-time or regular part-time employee scheduled to work twenty (20)* regular hours or more per week, you are eligible for this benefit as a condition of employment.

*fifteen (15) or more for part-time employees hired prior to April 1, 2004.

effective date

Your coverage takes effect on the first day of the month after you have successfully completed your probationary period (not to exceed 3 months).

early intervention program

Your LTD benefit includes the Community Social Services Early Intervention Program (CSSEIP). If you are a regular full-time or part-time employee and are absent from work due to illness or a non-work-related injury for more than 5 consecutive working days, your employer will refer you to Canada Life (your disability management provider). Canada Life will contact you to collect information on your injury or sickness to determine if they can provide support and assist with your recovery and return to work.

You are required to participate and co-operate in the CSSEIP.

amount of benefit

If you are disabled and qualify for LTD benefits, you will receive 70% of the first \$2,800* of basic monthly earnings;

+ 50% of basic monthly earnings in excess of the above limit;

+ adjustments every 4 years based on increases in the weighted average wage

rate (also called "indexing"). If you are eligible for indexing, you will receive a letter from Canada Life explaining the calculation.

OR the benefit will be 66-2/3% of basic monthly earnings if this calculation produces a greater benefit.

*adjusted annually for new claims based on increases in the weighted average wage rate.

"Basic monthly earnings" for full-time employees = Your basic monthly earnings as at the date you became 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 became totally disabled, multiplied by your hourly pay rate as at the date you became totally disabled.

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

qualification period

LTD benefits are payable after you have been totally disabled and are unable to perform the duties of your own occupation for 6 months. These 6

months are the "qualification period". 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 6 month 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 after 12 months of disability (excluding the 6 month qualification 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 70% of the current rate of pay for your job 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 stop working because of

the same disability, you will not be required to start a new qualification period. Your qualification period may 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 and you will not have to complete a new qualification period.

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

Your employer will continue to pay the LTD contributions while you are receiving sick pay, are on an Employment Standards Act leave including compassionate, maternity or parental leave, or during the first 20 work shifts of any other unpaid leave in any calendar year.

Coverage can continue while you are receiving WorkSafeBC (WSBC) benefits or are on an unpaid leave beyond 20 work shifts for up to 12 months (24 months if on an educational leave), if you pay the contributions.

If you receive LTD benefits from this Plan, your LTD, Group Life and AD&D coverage will continue without cost to you. (See also "duration of benefits" section.) You can elect to continue your Dental and/or Extended Health coverage as long as you remain an employee and if you pay 50% of the contributions. The decision to continue these benefits can only 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, 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 commence an unpaid leave beyond 20 work shifts in any calendar year and elect not to pay the contributions (or elect to pay the contributions and then stop paying them);
- You transfer to an ineligible status;
- You are laid off;
- You attain age 64 years and 6 months.

claims

LTD claims are processed by Canada Life.

If you are disabled, have been unable to work for 4 months, are not receiving WorkSafeBC (WSBC) wage loss benefits, and do not expect to return to work within the 6 month 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 Canada Life at the address shown on the forms.

Late claims: Claims must be sent to Canada Life no later than 45 days after the date your benefits would otherwise commence (e.g. the end of your qualification period). 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. Therefore, you must submit tax forms with your claim. You will receive a T4-A slip from Canada 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. If you meet CPP definition of disability, 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. Your LTD benefits may be reduced by all or a portion of those wage loss benefits, other than benefits paid by the Insurance Corporation of BC (ICBC) for motor vehicle accidents on or after May 17, 2018.

Other Disability Income: Your LTD benefit will not be reduced by income from private or individual disability plans, or from ICBC for motor vehicle accidents on or after May 17, 2018. However your LTD benefit will be reduced by 100% of any other disability income you receive as a result of the same disability that caused you to be eligible for LTD benefits. "Other disability income" includes but is not limited to:

1. Any amounts payable under any Workers' Compensation Act 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.

If you become eligible for such other disability income, the LTD Plan is entitled to be repaid for the period of overlap.

Your LTD benefits will not be reduced by income from private or individual disability plans, or certain association plans.

LTD benefits are reduced by the amount of other disability income to which you are entitled upon first becoming eligible for the other income. Future increases in the other income (e.g. based on Canadian Consumer Price Index or similar indexing arrangements) will not further reduce your LTD benefits until your LTD benefit is re-calculated based on current wage rates (i.e. every 4 years).

Pension Plan

This LTD benefit is an approved disability plan under the Municipal Pension Plan

(MPP) and the Public Service Pension Plan (PSPP). Therefore, if you are a member of one of those pension plans and are receiving LTD benefits from this Plan, you will not be required to make contributions to the pension plan and you may continue to accrue contributory and pensionable service. In that event, contact your employer to confirm your pension status.

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 Canada Life can provide you with support, advice and, if needed, financial assistance for rehabilitation.

Approved Rehabilitation Plan

The rehabilitation consultants offer many opportunities to help you return to work through return to work programs, vocational assessment, work conditioning, counselling, rehabilitative employment and/or retraining for another job. These services will be part

of an Approved Rehabilitation Plan (ARP) which is created jointly by you and your rehabilitation consultant (and your union, if you choose). Your LTD benefits will continue until you have successfully completed the Approved Rehabilitation Plan, provided you continue to participate and cooperate in the ARP.

Commitment to Rehabilitation

You are required to participate and cooperate in rehabilitation.

Rehabilitation Review Committee

If you do not agree with the recommended rehabilitation plan, or if you feel you are medically unable to participate, you must either be able to demonstrate why you cannot participate, or you can appeal to a Rehabilitation Review Committee. The Committee is made up of 3 rehabilitation specialists. During the appeal process your LTD benefits will continue. However if the Committee approves the rehabilitation plan, but you do not accept their decision, your LTD benefit payments will be suspended.

Rehabilitative Employment

If you return to work in rehabilitative employment that is part of an ARP, your LTD claim will continue. You can receive all earnings from rehabilitative employment, plus your LTD benefit, provided your combined income does

not exceed 100% of the current rate of pay for your job at date of disability. If your earnings plus your LTD benefit exceed 100%, your LTD benefit will be reduced by the excess.

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

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,
- die,
- refuse to participate in an Approved Rehabilitation Plan that has been approved by a Rehabilitation Review Committee, or elect early retirement, whichever occurs first.

If your employment terminates while receiving LTD benefits, only the payment of the LTD benefit will continue. All other health and welfare coverage will end.

Appeals

If Canada Life deny or terminate your claim and if you disagree with their decision, you may appeal and submit further medical information to Canada Life in support of your claim. If Canada Life do not change their decision, you

may request that your LTD claim be reviewed by a Claims Review Committee, which is made up of 3 medical doctors. You must appeal a decision within 2 years of Canada Life's last decision letter, unless there are good and sufficient reasons to extend the time period. You may wish to contact your union for assistance with the appeal process.



DENTAL

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

cost

Your employer pays the cost of this Dental benefit.

eligibility

If you are a regular full-time or regular part-time employee scheduled to work twenty (20)* regular hours or more per week, you are eligible for this benefit as a condition of employment.

*fifteen (15) or more for part-time employees hired prior to April 1, 2004.

Dual coverage restriction: If you and/or your dependents are enrolled in another comparable dental plan (normally a spouse's plan), you are not eligible for this Dental benefit. Contact your employer for details.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse if you have cohabited as spousal partners for one year.

3. Unmarried children until the end of the month in which they attain age 19 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children until the end of the month in which they attain age 25 if they are in full-time attendance at a recognized school, college or university and if they are 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 first day of the month after you have successfully completed your probationary period (not to exceed 3 months).

Dependents: Dependents must be enrolled 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. Late enrollments will only be accepted to a maximum of 12 months of retroactivity.

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

amount of benefit

The Dental benefit will reimburse you or your dentist for the following:

- 100% of Basic Services (Part "A")
- 60% of Major Reconstruction Services (Part "B")

- 60% of Orthodontic Services (Part "C"); lifetime maximum is \$2,750 per person.

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%.

PBC Member Profile: You can obtain on-line information on your Dental coverage and eligible dependents through PBC's Member Profile website PBC's Member Profile website at:

service.pac.bluecross.ca/member.

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.

The Dental benefit will pay 100% of:

1. Diagnostic services: Procedures to determine the dental treatment required, including the following:
 - a. one standard exam for adults every 9 months and twice per calendar year for children under 19 years of age.
 - 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 9 months for adults or preceding 6 months for children under 19 years of age. .
 - 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) once every 9 months for adults, and twice per calendar year for children under 19 years of age.
 - b. topical fluoride application once every 9 months for adults, and twice per calendar year for children under 19 years of age.
 - 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 relines 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. The Dental benefit will pay 60% of:

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, broken 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.

The Dental benefit will pay 60% of:

Braces: Up to a lifetime maximum of \$2,750 per person. Cost 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.
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 (WSBC), ICBC 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 anesthetics.
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 muscle, 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

Your employer will continue to pay the Dental contributions while you are receiving sick pay, are on an Employment Standards Act leave including compassionate, maternity or parental leave. or during the first 20 work shifts of any other unpaid leave in a calendar year.

Coverage can continue while you are receiving WorkSafeBC (WSBC) benefits or are on an unpaid leave beyond 20 work shifts if you pay 100% of the contributions.

Coverage can continue while you are on an LTD claim as long as you are receiving LTD benefits and remain an employee and if you pay 50% of 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 beyond 20 work shifts in any calendar year and elect not to pay the contributions (or elect to pay the contributions and then stop paying them);
- You transfer to an ineligible status;
- You are laid off.

Dependents: Coverage for a dependent ceases on the earlier of the date your coverage terminates, or at the end of the calendar month in which they no longer qualify as a "dependent" under the Dental benefit.

Dual dental restriction: If, while covered under this Dental benefit, you and/or your dependents become insured under another comparable dental plan (normally a spouse's plan), you will be required to terminate this coverage. In that event, contact your employer for further information. This coverage must

terminate at the end of the month prior to the start of the other dental coverage.

conversion

If you cease to be eligible because of termination of employment, you may convert your coverage to an individual policy issued by Pacific Blue Cross within 60 days of date of termination. 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 604-419-2000 or 1-877-722-4583) |
|--|

PBC Member Profile: You can obtain on-line information on your Dental claims through PBC's Member Profile website at: service.pac.bluecross.ca/member.

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. If required, ask your dentist to

obtain pre-approval from Pacific Blue Cross prior to beginning treatment. 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 your 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 your Dental Benefit. Pacific Blue Cross will then send a cheque to your home address, or via direct deposit if you have selected that option. For information on how to submit your own claim, contact Pacific Blue Cross. You can submit monthly orthodontic claims electronically through PBC's Member Profile website at: service.pac.bluecross.ca/member. Keep the original receipts for your records.

Claims deadline: 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 based on the dental fee schedule 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 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.

cost

Your employer pays the cost of this Extended Health benefit.

eligibility

If you are a regular full-time or regular part-time employee scheduled to work twenty (20)* regular hours or more per week, you are eligible for this benefit as a condition of employment.

*fifteen (15) or more for part-time employees hired prior to April 1, 2004.

Dual Coverage Restriction: If you and/or your dependents are enrolled in another extended health plan (normally a spouse's plan), you are not eligible for this Extended Health benefit.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse if you have cohabited as spousal partners for one year.
3. Unmarried children until the end of the month in which they attain age

19 if they are mainly dependent on, and living with, you or your spouse.

4. Unmarried children until the end of the month in which they attain age 25 if they are in full-time attendance at a recognized school, college or university and if they are 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 step children, 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 first day of the month after you have successfully completed your probationary period (not to exceed 3 months).

Dependents: Dependents must be enrolled 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. Late enrollments will only be accepted to a maximum of 12 months of retroactivity.

amount of benefit

Deductible: There is a \$45 calendar year deductible for this benefit, per person or family.

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.

Reimbursement: Keep your receipts for eligible expenses (see Eligible Expenses

section). Once the annual deductible is satisfied, you will be reimbursed for Eligible Expenses as follows:

- 80% of claims paid, per family, up to \$1,000 in a calendar year
- 100% of of claims paid, per family, over \$1,000 in a calendar year.
- 100% of eligible expenses for Hearing Aids* and out-of-province/out-of-country emergency expenses.

*Claims for hearing aids do not apply to your \$1,000 threshold.

Lifetime maximum: The maximum lifetime amount payable per person is unlimited.

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.

PBC Member Profile: You can obtain on-line information on your EHC coverage and eligible dependents through PBC's Member Profile website at:

service.pac.bluecross.ca/member.

Eligible expenses under this Extended Health benefit are:

Acupuncturist: Fees of an approved acupuncturist up to \$500 per person per calendar year. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

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 \$500 per person per calendar year, but not including the cost of x-rays taken by a chiropractor. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

Dentist: Fees of a dentist for repairs, including replacement, of natural teeth 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 and equipment: Needles, syringes and testing supplies; blood glucose monitors (lifetime maximum \$250 **Error! Bookmark not defined.**); insulin infusion pumps when basic methods are not feasible (physician's letter required). Pre-authorization from the carrier 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.

Eye examinations: \$100 per person per 24 months. You will be reimbursed 80% of

this maximum after the calendar year deductible has been satisfied.

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 \$1,500 per adult every 48 months and \$1,500 per child every 12 months. You will be reimbursed up to 100% of this maximum after the calendar year deductible has been satisfied. This benefit includes repairs, but does not include payment for maintenance, batteries, re-charging devices or other such accessories. Claims for Hearing Aids do not apply to your \$1,000/calendar year threshold.

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 \$500 per person per calendar year. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

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 are covered when prescribed for intractable pain. Continuous glucose monitors to a maximum of \$2,000 per year; you will be reimbursed 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.

Naturopathic Physician: Fees of a registered naturopathic physician up to \$500 **Error! Bookmark not defined.** per person per calendar year, but not including the cost of testing or of x-rays taken by a naturopathic physician. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

Orthopedic shoes and orthotics: One pair of custom made orthopedic shoes (including repairs) or one pair of custom made orthotics, including replacements thereafter when necessitated by normal wear and tear or a change in condition:

- 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.

The combined annual maximum for orthopedic shoes and orthotics is \$500 per year for adults and \$300 per year for children. You will be reimbursed 80% of the maximums after the calendar year deductible has been satisfied.

Out-of-province/out-of-country

emergencies: In the event of an emergency while travelling outside of BC/outside of Canada, the Extended Health benefit covers:

- 1. While you or your dependents are travelling 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 24 hours 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 travelling, 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 Policy and ID numbers 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: 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.

Out-of-province/out-of-country non-emergencies:

- 1. Out-of-province non-emergency eligible expenses, that are incurred within Canada, are covered by this Extended Health benefit as if those expenses had been incurred in the person's province of residence, subject to the deductible, coinsurance and maximums.

Note: 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.

- 2. Out-of-country non-emergency eligible expenses are covered by this Extended Health benefit as if

those expenses had been incurred in BC, subject to the 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 \$700 per person per calendar year. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

Podiatrist: Fees of a registered podiatrist up to \$500 per person per calendar year, but not including the costs of x-rays taken by a podiatrist. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

Prescription drugs: Cost of prescription drugs purchased from a licensed pharmacy and that are authorized for payment under the BC PharmaCare Formulary. This benefit includes oral contraceptives, but does not include contraceptive devices, preventative

vaccines, 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, fertility drugs, or drugs not approved under the Food & Drugs Act for sale and distribution in Canada.

Psychologist: Fees of a registered psychologist, including a registered clinical counselor and registered social worker, up to \$500 (combined annual maximum) per person per calendar year. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

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 \$500 per person per calendar year. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

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 and/or frames or prescribed contact lenses; or equivalent corrective laser surgery. The maximum is \$350 per person every 24 months. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

Wigs or hairpieces: Cost of wigs or hairpieces when required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of \$500 per person. You will be reimbursed 80% of this maximum after the calendar year deductible has been satisfied.

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 (WSBC).
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 the 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.

reasonable and customary limits

Extended Health claims may be subject to Reasonable and Customary (R&C) limits. 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

Your employer will continue to pay the Extended Health contributions while you are receiving sick pay, on an Employment Standards Act leave including compassionate, maternity or parental leave, or during the first 20 work shifts in any other unpaid leave in a calendar year.

Coverage can continue while you are receiving WorkSafeBC (WSBC) benefits or are on an unpaid leave beyond 20 work shifts if you pay 100% of the contributions.

Coverage can continue while you are on an LTD claim as long as you are receiving LTD benefits and remain an employee and if you pay 50% of 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 beyond 20 work shifts in any calendar year and elect not to pay the contributions (or elect to pay the contributions and then stop paying them);
- You transfer to an ineligible status;
- You are laid off.

Dependents: Coverage for a dependent ceases on the earlier of the date your coverage terminates, or at the end of the calendar month in which they no longer qualify as a "dependent" under the Extended Health benefit.

Dual extended health restriction: If, while covered under this Extended Health benefit, you and/or your dependents become insured under another extended health plan (normally a spouse's plan), you will be required to terminate this coverage. In that event, contact your employer for further information. This coverage must terminate at the end of the month prior to the start of the other extended health coverage.

conversion

If you cease to be eligible because of termination of employment, you may convert your coverage to an individual policy issued by Pacific Blue Cross within 60 days of date of termination. 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 604-419-2000 or 1-877-722-2583) |
|--|

PBC Member Profile: You can obtain on-line information on your Extended Health claims payments, or options for the electronic submission of claims, or obtain an Extended Health claim form, through PBC's Member Profile website at: service.pac.bluecross.ca/member.

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 PBC Member Profile or manually.

On-line PBC Member Profile claims: You can submit claims for prescription drugs, vision care and the services of physiotherapists, massage therapists, etc. electronically through PBC's Member Profile. If you have coverage under two different drug plans you must submit receipts on-line through PBC Member Profile 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 (\$45). Then obtain a Pacific Blue Cross Extended Health Care Claim Form from PBC's Member Profile. 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.

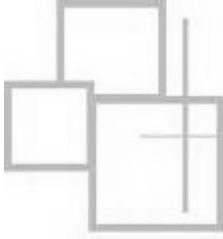
Annual deductible: The \$45 annual deductible is applied only once per person or family in a calendar year. Once the deductible has been exceeded, you may submit a claim at any time. You may also submit additional claims during the year.

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 PBC's Reasonable and Customary limits or expenses actually incurred. See also "reasonable and customary limits and "On-line PBC Member Profile 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.



Sample Extended Health Claim Calculation

Eligible Expenses

| | |
|--|---------------|
| Prescription Drugs | \$ 80.00 |
| Speech Therapist (maximum claimable) | 500.00 |
| Acupuncturist | <u>150.00</u> |

Total Eligible Expenses..... \$ 730.00

Subtract the deductible

(if not already applied in the year) (45.00)
\$ 685.00

Subtract your share of the coinsurance:

20% x \$685.00 = (137.00)

You will be reimbursed \$ 548.00



BENEFITS CHECKLIST

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

- Keep this booklet as a reference.
- Discuss your benefits with your dependents.
- 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 service.pac.bluecross.ca/member. If any dependents are missing, contact your employer.
- If your status changes (e.g. you switch to casual status, or commence an unpaid leave of absence), contact your employer to confirm your ongoing eligibility for benefits.
- If your spouse obtains dental and/or Extended Health coverage through his/her work, check with your employer to make sure you are still eligible for dental and Extended Health coverage under your group benefit plan.
- 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 confirm your current beneficiary designation.

For more information, contact your employer.

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