Benefits Booklet

For the Employees of

School District No. 52
(Prince Rupert)

Employee Class

Teachers

Important

This booklet summarizes the insurance benefits provided for you and your family through your Employer. Benefit coverage is subject to change. Revised booklets will be produced periodically. If there is a discrepancy between this booklet and the Group Policies, then the terms and provisions of the Group Policies shall prevail. The Group Policies are available for your inspection. Please contact your Employer for details.

Your Extended Health Care benefits are governed by **Pacific Blue Cross** Group Policy No. **E020052** effective January 1, 1972.

Your Dental Care benefits are governed by **Pacific Blue Cross** Group Policy No. **D909912** effective January 1, 1988.

Your benefits were arranged with the assistance of:

GroupHEALTH Global Benefit Systems
Ocean Pointe, Second Floor
1688 – 152nd Street
White Rock, BC V4A 4N2

Introduction

This booklet summarizes the features and benefits of your coverage and should be kept in a safe place known to you and your family. The exact conditions, limitations, and exclusions of the coverage are included in the Group Policy (ies) issued by the insurer(s) to your Employer. Please read the booklet carefully.

Defined terms are capitalized (e.g. Dependent). GroupHEALTH Global Benefit Systems is referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/member, as "you" or "your" in this booklet.

Coverage and claims information can be obtained by contacting the appropriate insurance company listed below:

Benefit	Insurance Company	Policy Number	Toll Free Claims Number
Extended Health Care	Pacific Blue Cross	E020052	1-888-275-4672
Dental Care	Pacific Blue Cross	D909912	1-888-275-4672

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact your Plan Administrator.

Table of Contents

The Schedule of Benefits contains a brief summary of your benefits. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care

Eligibility Period	1st of the month coincident with or next following date of employment	
Annual Deductible	$25 single or $25 family each calendar year.	
Reimbursement	In-Province Eligible Expenses:	80%
	Out-of-Province Non-Emergency Eligible Expenses:	80%
	Out-of-Province Emergency Eligible Expenses:	100%
	Medi-Assist - Basic	Included
	After $1,000 has been paid for a member in a calendar year, further eligible expenses within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Summary of Eligible Expenses:		
Prescription Drugs	Excluding contraceptives and fertility drugs	
Hospital	Semi-Private or Private accommodation	
Private Duty Care	720 hours per person per calendar year	
Paramedical Services:	The following five (5) paramedicals* are limited to a maximum $10 per visit benefit for the first 12 visits (15 visits for seniors age 65 and older) up to the plan's calendar year maximum.	
Chiropractor and Naturopath* (combined)*	$200 per person per calendar year (excluding x-rays)	
Massage Practitioner and Physiotherapist* (combined)*	$250 per person per calendar year	
*Podiatrist**	$100 per person per calendar year (excluding x-rays)	
Acupuncturist	$100 per person per calendar year	
Speech Language Pathologist	$100 per person per calendar year	
Psychologist	$100 per person per calendar year (excluding Clinical Counselors)	
Orthopaedic shoes (Including repairs)	$400 in a calendar year for an adult $200 in a calendar year for a Dependent Child	
Hearing Aids (Excluding batteries)	$300 per adult per 3 calendar years $300 per Dependent Child per 3 calendar years	
Stump Socks	$200 per person per calendar year	
Mastectomy brassieres	$150 per person per calendar year	
Wigs and Hairpieces	$500 per person per lifetime	
Vision Care	$200 per person per 2 calendar years	
Plan Maximum	The maximum amount of benefits payable per insured person is unlimited.	

Dental Care

Eligibility Period	1st of the month coincident with or next following one month of employment		
Deductible	Nil		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C** Orthodontics
	100%	60%	50%
Financial Limit Per Person:	Unlimited per calendar year	Unlimited per calendar year	Unlimited per lifetime

Summary of Eligible Services:
Services covered by the Plan are those services that are routinely performed in the offices of general practicing dentists. Covered services are those services listed in the applicable Fee Schedules and are reimbursed as specified within those Fee Schedules. Please note there may be further limitations in the Fee Schedules than those listed here. We suggest contacting the carrier for any limitations regarding Dental services prior to having services performed.

Oral Examinations:	
Complete	Once every 36 months
Standard	Twice every calendar year
X-rays Full Mouth/Complete	Once every 36 months
Preventative Services:	
Prophylaxis	Twice every calendar year
Topical Fluoride	Twice every calendar year
Prosthetic Repairs	Reline of fixed or removable appliances once every 24 months
Upper & Lower Dentures	1 (Complete or Partial) every 5 years

Eligibility

You are eligible for group benefits if you

- Are a full-time or part-time Teacher of SCHOOL DISTRICT NO. 52 (PRINCE RUPERT); and
- Work at least 20 hours per week; and
- Are younger than the Termination Age; and
- Are residing in Canada; and
- Have completed the Eligibility Period specified in the Schedule of Benefits.

The Termination Age and Eligibility Period may vary from benefit to benefit. For information, please refer to each benefit under the Schedule of Benefits. Your dependents are eligible for insurance on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for insurance for yourself in order for your Dependents to be eligible.

Effective Date of Coverage

If Evidence of Insurability is not required, your group benefits will be effective on the date you are eligible.

If Evidence of Insurability is required, your group benefits will be effective on the date you become eligible or the date on which the evidence is approved in writing by the insurance company, whichever is later.

You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

Your Dependent's insurance becomes effective on the date the Dependent becomes eligible or the date any required Evidence of Insurability on the Dependent is approved in writing by the insurance company, whichever is later.

If one of your dependents (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Once you are insured for dependent coverage, additional dependents will be insured from the date eligible, regardless of hospital confinement.

Your Dependent's insurance will not be effective prior to the date your insurance becomes effective.

Evidence of Insurability

Medical evidence may be required if you and/or your Dependent is a Late Applicant.

Late Applicant

If you did not apply within 31 days of becoming eligible and later request coverage for yourself and/or your dependents, ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan.

Note: Different benefits may have different requirements – medical evidence or retroactive premium payment. In some instances, coverage may be denied.

Updating your Records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- Change of dependents.
- Change of name.

Termination of Coverage

Your Extended Health and Dental Care benefits will terminate on the earliest of:

- the last day of the month you cease to be an eligible employee;
- the last day of the month you retire;
- the last day of the month you terminate employment;
- the date the Group Policy terminates;
- the date you enter the armed forces of any country on a full-time basis; or
- the end of the period for which premiums have been paid.

Termination of Dependent Insurance

Coverage for your eligible dependents will terminate on the earliest of:

- the date your coverage terminates or the date you cease to qualify for Dependent Coverage;
- the date your eligible dependents cease to qualify for coverage;
- the end of the period for which premiums have been paid for your Dependent Coverage; or
- the date Dependent Coverage under the group policies cancel.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan to replace your Extended Health Care and Dental Care.

To convert coverage you must ensure that your application and full payment is received by the insurance company within 60 days of the date your group plan terminates. Coverage will become effective immediately after your group coverage terminates.

If you qualify for an individual plan under the conversion option, the pre-existing condition and health evidence requirement contained in the individual plan will be waived.

Refer to the appropriate individual benefit section for further details on conversion or if you are converting to an individual plan, contact GroupHEALTH Global Benefit Systems at 604-542-4100 or 1-877-542-4110 before your coverage terminates.

Pre-existing Condition for Extended Health Care and Dental Care

Means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12-month period before you apply for the individual plan.

Individual Travel Benefits

Individual Extended Health coverage is also available for additional medical emergency coverage or if your travel plans extend beyond the time limitation specified in your benefit description. For further information contact GroupHEALTH Global Benefit Systems at 604-542-4100 or 1-877-542-4110.

Actively at Work

Means you are working at your usual place of employment and performing all of the usual and customary duties of your occupation on a regular full-time or part-time basis.

Benefits

Means any amounts which become payable under a coverage.

Calendar Year

Means January 1 through December 31.

Co-insurance

The percentage of covered expenses that is payable by the insurer.

Covered Expenses

Are expenses that will be considered in the calculation of payment due under your Extended Health Care and Dental Care benefits.

Deductible

The amount of covered expenses that must be incurred and paid by you, or your dependents, before benefits are payable by the insurer.

Dependent

Your Spouse or Child who is insured under the Provincial Plan.

Spouse

Your legal spouse or a person who has been continuously living with you in a role like that of a marriage partner for at least 1 consecutive year. Only one spouse is eligible for coverage under the contract at any one time.

Child

Your natural or adopted child, or stepchild, who is:

- unmarried;
- under age 21 and is mainly dependent on and is living with you and/or your spouse;
- under age 25 (for Extended Health Care) and up to any age (for Dental Care) if a full-time student and is mainly dependent on you and/or your spouse;
- a child who is incapacitated on the date he or she reaches the age when insurance would normally terminate will continue to be an eligible dependent. However, the child must have been insured under this Benefit Program immediately prior to that date.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical handicap.

The Insurance Company may require written proof of the child's condition as often as may reasonably be necessary.

Drug

Medications that have been approved for use by the Federal Government of Canada and have a Drug Identification Number.

Duplicate coverage

Means that you and/or your dependents are eligible to claim certain benefits under more than one plan.

Medically Necessary

Broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Provincial Plan

Any plan which provides hospital, medical or dental benefits established by the government in the province where the insured person lives and which is governed by the Canada Health Act.

Reasonable and Customary

Within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Contact your Plan Administrator for the proper form to make a claim. There may be time limits for making claims. These limits are outlined under the appropriate benefit section.

Claim forms available from your Plan Administrator must be correctly completed, dated and signed. Remember to always provide your Group Policy Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Please ensure that you retain photocopies of your claim and the receipts before sending them to the insurer for reimbursement.

Your Plan Administrator can assist you in properly completing the forms or answer any questions that you may have about your claims or the claim process. You may contact the appropriate insurance company listed in the Contacts section of this booklet.

Subrogation (Third Party Liability)

If your medical and/or dental expenses or your disability is a result from an injury caused by another person and you have the legal right to recover damages, the insurance company may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the insurance company as per the subrogation reimbursement agreement.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are insured for similar benefits under another Plan, the insurance company will consider this when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured medical and dental expenses from all Plans, up to 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs;
- any other arrangement of coverage for individuals in a group; and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expense):

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

For Claims incurred by you or your Dependent Spouse:

The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

For claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
- The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

If the insured person is also covered under an individual travel insurance plan, benefits will be coordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies:

- Determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt.

Once the Primary Carrier has settled your claim, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and photocopies of the original receipts to the Secondary Carrier for further consideration of payment, if applicable.

Out-of-Province and Out-of-Country Medical Claims

If you are travelling outside British Columbia, you should be aware of the need to purchase additional medical/travel insurance.

For information on the Out-of-Province and Out-of-Country medical expenses covered through the provincial government, please refer to the BC Medical Services Plan website at:

Medical Care Outside B.C. - http://www.hlth.gov.bc.ca/msp/infoben/benefits.html#outsidebc
Out of Province Emergency Medical Care - http://www.hlth.gov.bc.ca/msp/infoben/benefits.html#outofp
Out of Country Emergency Medical Care - http://www.hlth.gov.bc.ca/msp/infoben/benefits.html#outofc

Additional coverage for these expenses may be offered under an Extended Health Care plan or a travel insurance plan.

Dental Care – Pre-authorization

Should you require dental work in excess of $300.00, please request your Dentist to submit a Pre-authorization to the Insurer prior to commencement of work. This will advise you of any expenses not covered by the plan. It is your responsibility to ensure you are covered at the time the work is done and that you have not reached any plan maximums.

The Extended Health Care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax-supported agency.

Definitions

Eligible expense
Means a charge for any service and/or supply included in this booklet as a benefit that:

1. In Pacific Blue Cross' assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
2. was ordered or referred by a Physician or Dentist, unless otherwise specified in the benefit description, and
3. is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
4. is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan. Pharmacare's low cost alternative and reference based pricing will not be applied unless specified under the Schedule of Benefits in this booklet.

Physician
Means an individual who is duly qualified and licenced to practice medicine or surgery, or both, in the area where the service is provided, but excludes a person residing with or related to you or your Dependent.

Practitioner
Means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-Province Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

1. Hospital

   The additional charge for the accommodation specified in the Schedule of Benefits, in a hospital or extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2. Emergency ambulance services
   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport

c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities

d) charges for an attendant when medically necessary.

3. Drugs and medicines dispensed by a licensed pharmacist or a Physician, in a quantity Pacific Blue Cross considers reasonable:

a) drugs and medicines which legally require a prescription from a Physician or Dentist

b) insulin preparations for diabetics

c) vitamin B12 for the treatment of pernicious anemia

d) allergy serums when administered by a Physician.

4. Professional services of specified Practitioners to the maximum amounts indicated in the Schedule of Benefits, and unless indicated in the schedule of benefits, excluding x-rays, appliances, and tray fees. The services of a massage practitioner and private duty nurse require referral by a Physician.

5. Private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence. Your plan may contain a maximum or limitation that is specified in the Schedule of Benefits. The services of a private duty nurse require referral by a Physician.

6. Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. Payment will be based on the Pacific Blue Cross dental fee schedule. No payment will be made for temporary, duplicate, or incomplete procedures or for correcting unsuccessful procedures.

Accidental injury

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.

We apply the eligible dental services and financial limits of the Pacific Blue Cross Fee schedule and We apply the fees in the Fee guide or Fee schedule as follows:

a) for services performed in British Columbia or outside Canada if the patient's province of residence is British Columbia, We apply the Fee schedule

b) for services performed in Canada but outside British Columbia, We apply the Fee guide in the province/territory of service

for services performed outside Canada if the patient's province/territory of residence is not British Columbia, We apply the Fee guide in the province/territory of residence.

7. Medical Aids and Supplies

Charges for the following services and supplies:

a) testing supplies, needles, and syringes for diabetics

b) oxygen, blood, and blood plasma

c) ostomy and ileostomy supplies

d) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports

e) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but Pacific Blue Cross will pay the equivalent of a standard prostheses.

f) stump socks to a maximum shown in the Schedule of Benefits.

g) mastectomy brassieres to a maximum shown in the Schedule of Benefits.

h) wigs and hairpieces required as a result of medical treatment or injury to a maximum shown in the Schedule of Benefits.

i) when prescribed by a Physician or podiatrist as medically necessary, custom fitted orthopedic shoes (including repairs) and modifications to stock item footwear to the maximums specified in the Schedule of Benefits

j) Hearing aids to the maximum specified in the Schedule of Benefits. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

8. Standard durable medical equipment

Preauthorization is required from Pacific Blue Cross for expenses in excess of $5,000.

Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a Provider may be considered.

Repairs to purchased items. Pacific Blue Cross will replace the item when it can no longer be made functional. Pacific Blue Cross may request trade in or return of replaced equipment.

Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

Standard durable equipment includes:

a) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise Pacific Blue Cross will pay the manual equivalent

b) medical monitors including heart and blood glucose monitors, and cardiac screeners

c) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems

d) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators

e) insulin infusion pumps for diabetics – when basic methods are not feasible

f) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain

g) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Vision Care

If Vision Care is listed under the Schedule of Benefits, the cost of purchasing lenses and frames or contact lenses when prescribed by a physician or optometrist are covered up to the limit specified in the Schedule of Benefits.

Charges for safety goggles and sunglasses (plain or prescription) are not covered.

Out-of-Province Non-Emergency Eligible Expenses

While traveling outside your province of residence, non-emergency Eligible expenses incurred by you (and/or your dependents) will be reimbursed subject to the Deductible, in-province reimbursement percentage, and maximums. Any expenses payable or provided under a government plan will not be reimbursed.

Out-of-Province Emergency Eligible Expenses

While travelling outside your province of residence, benefits are payable for the following expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

1. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
2. 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, the insurance company 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 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 patient's health, the 90-day limit may be extended.
3. Services of a Physician and laboratory and x-ray services.
4. Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5. Other emergency services and/or supplies, that would have been an eligible expense inside your province of residence.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, medi-assist will coordinate the following services:

1. locate the nearest appropriate medical care.
2. obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians.
3. investigate, arrange and coordinate medical evacuations and related transportation needs.
4. arrange and coordinate the repatriation of remains.
5. replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your worldwide emergency medi-assist card provides instant 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 to medi-assist. Have your Extended Health Care ID number and medi-assist group number ready for personal identification – both numbers are required.

Exclusions

Unless otherwise specified in the Schedule of Benefits, the following are not included as Eligible expenses under your Extended Health Care plan:

1. any other item not specifically included as a benefit
2. except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamin preparations, contraceptives, fertility drugs, medications used to treat or replace an addiction or habituation, support stockings, arch supports, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence
3. general anesthetic, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
4. any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
5. allergy testing or therapy unless rendered by a naturopath
6. personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures
7. charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
8. any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
9. that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
10. expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
11. expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
12. charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence
13. transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind
14. expenses of a Dependent hospitalized at the time of enrolment
15. services performed by a Physician who is related to or resident with you or your Spouse
16. fees for ambulance services when an ambulance is called but not used
17. ambulance charges for work-related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility.
18. retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare

How to Make a Claim

1. Because receipts will not be returned after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit for reimbursement. A remittance statement for your records will be sent to you each time you submit a claim.

2. If you have duplicate coverage, please review the Coordination of Benefits section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on Pacific Blue Cross' files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3. Certain medical expenses are covered under the government plan. If you submit your claim to Pacific Blue Cross before you submit your claim to the government plan, the insurance company will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your Extended Health Care claim. The balance of the Extended Health Care claim is then paid according your Extended Health Care plan. Information for claiming Pharmacare expenses may be obtained from your pharmacist.

4. Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

   a) Obtain a claim form from your Employer.

   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

   c) We suggest you submit claims within 90 days from the date the expense was incurred. However, you must submit the claim form by December 31st of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

   Example: Your 2007 receipts must be submitted before December 31, 2008.

Integration with Government Plans

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair Pharmacare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

Services covered by the Plan are those services that are routinely performed in the offices of general practicing dentists. Covered services are those services listed in the Pacific Blue Cross Fee Schedules.

Please contact Pacific Blue Cross for any limitations regarding Dental services prior to having services performed.

Definitions

Dental Fee Guide
Means the Canadian provincial/territorial Dental Fee Guide that contains dental services and fees in effect on the date the dental services are performed.

Fee Schedule
Means Schedule 2 of the Pacific Blue Cross Fee Schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Payment of Benefits

1) Pacific Blue Cross will pay benefits based on dental services, financial limits and treatment frequencies in the Fee Schedule.

2) Pacific Blue Cross applies the reimbursement percentage shown in the Schedule of Benefits to the fees shown in the Fee Schedule/Fee Guide as follows:

   a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee Schedule.

   b) for services performed in Canada but outside British Columbia —the fees in the Fee Guide in the province/territory of service.

   c) for services performed outside Canada if your province of residence is not British Columbia—the fees in the Fee Guide in your province/territory of residence.

3) Fees in excess of the amount shown in the applicable Fee Schedule/Fee Guide will be your responsibility.

Note: Should you require dental work in excess of $300.00, please request your Dentist submit a Pre-Authorization to the service provider (insurer, as noted above) prior to the commencement of work. This will advise you of any expenses not covered by the plan and any personal expenses you may have to incur.

Plan A – Basic Preventative & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below:

1. Diagnostic services

   a) Examinations:

      i) complete – provided Pacific Blue Cross has not paid for any other exam by the same Dentist in the period specified in the Schedule of Benefits

      ii) recall – maximum is specified in the Schedule of Benefits

      iii) specific – provided Pacific Blue Cross has not paid for any other exam by the same Dentist in the past 60 days

   b) X-rays

      i) diagnostic

      ii) panoramic

      iii) complete mouth series – maximum shown in the Schedule of Benefits

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.

   c) diagnostic models – 1 set per calendar year

2. Preventive services

   a) scaling

   b) polishing – maximum shown in the Schedule of Benefits

   c) topical application of fluoride – maximum shown in the Schedule of Benefits

   d) fixed space maintainers

   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3. Restorative services

   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:

      i) amalgam (silver coloured) fillings

      ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth only

      iii) inlays and onlays

   On permanent posterior (molar) teeth and all primary teeth, Pacific Blue Cross will pay the bonded amalgam rate for composite fillings.

   b) stainless steel crowns on primary and permanent teeth -- once per tooth in a 2 year period

4. Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited, to root canals – 1 per tooth in a 5 year period.

5. Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts unless specified in the Schedule of Benefits but including the following:

   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee Schedule

   b) root planing

   c) gingival curettage – 1 per sextant in a 5 year period

   d) osseous surgery – 1 per sextant in a 5 year period

   e) bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards)

6. Prosthetic repairs

   a) removal, repairs, and recementation of fixed appliances

   b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period

   c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period

7. Surgical services

   a) Extractions

   b) other routine oral surgical procedures

   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in the Pacific Blue Cross Fee Schedule

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for Pacific Blue Cross approval.

Plan B services include, but are not limited to, the following:

1. Prosthodontic Services

   a) removable

      i) complete upper and lower dentures

      ii) partial upper and lower dentures

   b) fixed bridges.

2. Restorative Services

   a) veneers

   b) crowns and related services

Plan B Limitations

Unless specified in the Schedule of Benefits, Plan B is limited to the following:

1. Only 1 major restorative service on the same tooth will be covered in a 5 year period.

2. Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

3. Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.

4. No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5. Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in the Pacific Blue Cross Fee Schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

6. Gold foil is covered only when used to repair existing gold restorations.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage as specified in the Schedule of Benefits. Plan C is designed to cover orthodontic services provided to maintain, restore or establish a functional alignment of the upper and lower teeth.

Plan C Limitations

Unless specified in the Schedule of Benefits, Plan C is limited to the following:

1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.

2) No benefit is payable for the replacement or repair of appliances which are lost, broken, or stolen.

3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to the Pacific Blue Cross Fee Schedule.

Exclusions

Unless specified in the Schedule of Benefits, the following are not Eligible expenses under your dental plan:

1. items not listed in the Pacific Blue Cross Fee Schedule and fees in excess of those listed in the Fee Schedule

2. any item not specifically included as a benefit

3. charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English

4. procedures performed for congenital malformations or for purely cosmetic reasons

5. charges for drugs, pantographic tracings, and grafts

6. charges for implants and/or services performed in conjunction with implants, except as indicated in the Pacific Blue Cross Fee Schedule

7. anesthesia, except as indicated in the Pacific Blue Cross Fee Schedule

8. charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint

9. incomplete or temporary procedures

10. recent duplication of services by the same or different Dentist

11. any extra procedure which would normally be included in the basic service performed

12. services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits

13. travel expenses incurred to obtain dental treatment.

How to Make a Claim

1. Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to Pacific Blue Cross before you start treatment. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2. We suggest that you submit claims within 90 days of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will Pacific Blue Cross pay any claim or adjustment submitted later than 1 year from the date the service is performed.

3. Pacific Blue Cross will require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

   a) name of the Dentist

b) name and birthdate of the person receiving the dental care

c) your group, social insurance, and Dependent(s) numbers (this information is on your ID card)

d) your home mailing address

e) Whether you have coverage through another plan. Claims information regarding the other carrier is not retained on Pacific Blue Cross's files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4. Before your Dentist starts treatment, please ask them how billing is made. Pacific Blue Cross may pay in either of two ways:

a) Pacific Blue Cross will pay the Dentist directly for services provided under this dental plan when Pacific Blue Cross receives a claim form signed by the Dentist, certifying these services were performed and the fee charged.

b) If you have paid your Dentist directly, Pacific Blue Cross will reimburse you the benefit amount when Pacific Blue Cross receives a claim form or receipts signed by your Dentist. Pacific Blue Cross will send you a cheque when the claim is processed.

5. Orthodontic Claims Procedures

a) Receipts

Because Pacific Blue Cross does not return original receipts, Pacific Blue Cross will accept photocopies. Do not hold receipts until the completion of treatment.

b) Claiming deadlines

i) We suggest that you submit orthodontic claims within 90 days of the date the payment was due to your orthodontist (the due date).

ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. **However, no benefit is payable for claims not received within 1 year of the due date.**

c) Treatment plan

i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts.

ii) If the payment schedule or treatment changes, Pacific Blue Cross requires a revised treatment plan for review.

iii) Pacific Blue Cross will retain your treatment plan on file. If Pacific Blue Cross does not have your treatment plan on file Pacific Blue Cross is unable to pay:

- your initial fee/down payment
- your monthly/quarterly fees
- one time appliance fees

iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees

i) Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.

ii) The amount paid will be prorated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be on the treatment plan.

iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Due to the constant change in federal and provincial legislation regarding government benefits and to ensure you receive the most up-to-date information on benefit eligibility and coverages, we have listed below telephone numbers and web site addresses to the various government agencies overseeing these benefits. The information provided is for reference only. Should you have questions regarding the availability of government benefits, please contact the applicable government agency. Local government agency telephone numbers can be found in the blue pages of your telephone book.

Survivor Benefits

In the event of death, surviving dependents may be eligible for benefits through:

Canada Pension Plan Web: http://www.hrdc-drhc.gc.ca/isp/common/home.shtml
Toll Free 1-800-277-9914

Disability Income

Disabilities due to an occupational injury or illness may be eligible for benefits through your provincial **Workers' Compensation Board**.

BC Workers' Compensation Board Web: http://www.worksafebc.com
Vancouver Tel: (604) 244-6181
Toll Free 1 888 WORKERS

Links and addresses to all provincial WCB sites:
Web: http://www.benefitsworld.com/AA/Dis/WCB/Cdn_WCB.asp

Should you become totally disabled, you may be eligible for disability benefits through:

Canada Pension Plan Web: http://www.hrdc-drhc.gc.ca/isp/common/home.shtml
Toll Free 1-800-277-9914

In addition, there is a disability benefit available through **Employment Insurance (E.I.)** should you not have a disability plan through your employer or you do not qualify for disability benefits through your group plan.

Employment Insurance Web: http://www.hrdc-drhc.gc.ca/ae-ei/employment_insurance.shtml
Vancouver Tel: (604) 682-5400
Prince George Customers (250) 561-7981
Toll Free 1-800-206-7218

Retirement Benefits

Retirement benefits are available through the **Canada Pension Plan, Old Age Security** and **Guaranteed Income Supplement**.

Human Resources Development Canada Web: http://www.hrdc-drhc.gc.ca/isp/common/home.shtml
Toll Free 1-800-277-9914

Additional Links

For additional links and on-line benefits information visit: http://www.benefitsworld.com.

Health Care Benefits

Each provincial government has basic health care benefits available to residents of that province. The Extended Health Care benefit provided by your Employer covers medical expenses not fully reimbursed or covered by the provincial plan. The ***Provincial Medical Plans*** pay the cost of hospital ward accommodation, standard doctors' fees, all medically required surgical procedures and a portion of the cost for prescribed drugs and medicines. These services are offered through the Medical Services Plan of B.C. (MSP) and B.C. Pharmacare.

If you are eligible for benefits during an absence from B.C., the Medical Services Plan will help pay for unexpected medical services you receive anywhere in the world, provided the services are medically required, rendered by a licensed medical practitioner and normally insured by MSP (subject to certain restrictions). Reimbursement is made in Canadian funds and does not exceed the amount payable had the same service been performed in B.C. Be aware that physician's fees can be much higher outside Canada and if there is a difference in payment, that difference is your responsibility. Additional health insurance is advisable. For information on coverage outside the province and outside Canada, contact MSP or view their website at: http://www.hlth.gov.bc.ca/msp/infoben/benefits.html

BC Medical Services Plan Web: http://www.hlth.gov.bc.ca/msp/index.html

- *Registration and Premium Billing*
  - Vancouver & Lower Mainland (604) 683-7151
  - Other areas within B.C. (toll free) 1-800-663-7100
- *Coverage Information*
  - Vancouver & Lower Mainland (604) 669-6667
  - Other areas within B.C. (toll free) 1-800-742-6165
- *Claims Information*
  - Vancouver & Lower Mainland (604) 806-0234 listen for instructions and then press 1
- *Out-of-Country Claims*
  - Vancouver & Lower Mainland (604) 806-0234 listen for instructions and then press 4

BC Pharmacare Web: http://www.hlth.gov.bc.ca/pharme/index.html

Vancouver & Lower Mainland (604) 682-6849
Other areas within B.C. (toll free) 1-800-554-0250

The Government of British Columbia has introduced a new, income-based method for determining deductible levels for reimbursement of prescription drug costs for British Columbia residents. Beginning May 1, 2003, the government, through its ***Fair PharmaCare*** program, will pay the costs of designated prescription drugs above an annual deductible *determined by family income*. Drug costs below this deductible amount are paid by you and your Group Extended Health Care (EHC) benefit plan. As a result of these changes to PharmaCare, **the government requires all BC residents to register in order to receive maximum financial assistance under the Fair PharmaCare program**. If you do not register, your *Fair PharmaCare* deductible will be **$10,000** per calendar year.

Registration By Phone: 1 800 387-4977
Registration Online: http://www.healthservices.gov.bc.ca/pharme/plani/planiinfo.html

BC Ambulance Service (BCAS) Web: http://www.hlth.gov.bc.ca/bcas/

Vancouver & Lower Mainland (non-emergency) (604) 872-5151
Provincial Administrative headquarters (250) 952-0888
Billing Enquiries – toll free 1-800-665-7199