Your Benefits

Boilermakers Lodge 359

Active Shop Members & Apprentices

My PBC Benefits

Group Name and Policy Number

Boilermakers Lodge 359

Active Shop Members & Apprentices

Policy Number 52805

Effective: May 1, 2025

Introduction

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy.

The Group Policy contains a provision removing or restricting the right of the Member to designate persons to whom or for whose benefit insurance money is to be payable.

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits, except for Life benefits.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC), Blue Cross and Blue Cross Life Insurance Company of Canada (Blue Cross Life) are 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.

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

Blue Cross Life
Group Term Life
Short Term Disability (STD)
Long Term Disability (LTD)

Extended Health, Dental, and Drug claims are processed by us or a Third party claims processor.

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.

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: www.pac.bluecross.ca. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

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Schedule of Benefits

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		
Deductible	No Deductible	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Medical Travel and Out-of-Country Medical Referral	50%
	All Other Eligible Expenses	100%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency	100%
	Non-Emergency	Same as In-Province/ Territory
Plan Maximum	There is a $1,000,000 lifetime maximum per person for in-province/territory Eligible expenses and a $5,000,000 lifetime maximum per person for out-of-province/territory emergency Eligible expenses, subject to the terms and conditions of the Group Contract	
Dependent Children	See definition of Dependent.	

Dental Care			
Deductible	No Deductible		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C*** Ortho–dontics
	100%	70%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	$4,000 combined with Plan B	$4,000 combined with Plan A	$2,000
Financial Limit Per Member or Spouse	$4,000 combined with Plan B	$4,000 combined with Plan A	No Coverage
Dependent Children	See definition of Dependent.		

**Orthodontic coverage is a benefit for those Members with one or more years of service*

Group Term Life	
Benefit Amount	$75,000
Non Evidence Limit	$75,000

Short Term Disability (STD)				
Weekly Benefit Amount	The current Employment Insurance (EI) maximum.			
Elimination Period	**Injury**	**Hospital**	**Sickness**	**Day Surgery**
	0 days	0 days	3 days	0 days
Maximum Benefit Period	52 weeks with the following conditions: 1) you must apply for Employment Insurance (EI) sickness benefits at the beginning of the 1st week of disability. 2) if you are eligible for (EI) sickness benefits, STD benefits are not eligible during the period in which EI sickness benefits are paid. 3) if you are not eligible for EI sickness benefits or if you are eligible for less than 26 weeks of EI sickness benefits, you may be eligible for STD benefits up to the balance of the 52 week period.			
Termination	Insurance terminates when employment terminates.			

Long Term Disability (LTD)	
Benefit Amount	$2,000
Non Evidence Limit	$2,000
Elimination Period	52 Weeks
Maximum Benefit Period	Age 65 or earlier retirement
Termination	Age 65 less the Elimination period or earlier retirement

Definitions

Benefit amount
means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review
means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Coverage effective date
means the date coverage becomes effective as determined by The Trustees of the Boilermakers Lodge 359 Health & Welfare Trust Fund.

Customary
means usual or traditional and well-established as determined by us or the Third party claims processor.

This refers to:
1) the charges for products, services or supplies; and/or
2) the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is incurred for a medical condition comparable in nature and severity to that being treated. The term “area” means a region large enough to obtain a representative cross section of similar Providers.

Deductible
means the initial portion of the Eligible expenses, which you must pay before charges are reimbursed for any Eligible expense.

Dentist
means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Dependent
means any of the following persons for whom coverage is provided under this Plan:

1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute (Note: for Quebec residents, full-time students are covered for prescription drug benefits until age 26), and
4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

You must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

Duplicate coverage
means that you (and your Dependents) are eligible to claim certain benefits under more than 1 plan.

Eligible drug
means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

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

1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and
3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and
4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by the Third party claims processor.

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 or in the Third party claims processor's Provider agreement. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

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

Government plan
means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital
means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

Life event
means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

Member
means an individual who has coverage under the Contract.

Non evidence limit
means the maximum amount of insurance we will provide without evidence of insurability as indicated in the Schedule of Benefits.

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Plan administrator
means the company that has been appointed by The Trustees of the Boilermakers Lodge 359 Health & Welfare Trust Fund to administer the plan.

Practitioner
means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider
means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. This excludes a Provider related to or residing with you or your Dependent. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse
means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

Third Party Claims Processor
means an organization we have retained as an external claims and/or payment processor.

Vendor
means an organization we have retained as an external Provider.

Member Information/Access to Records

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.
2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with 1 copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy
   c) any written statement or other record provided to us as evidence of insurability of the Member.
6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

Extended health care benefits are intended to supplement and not overlap benefits under Government plans. 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. Payment will also be made only where permitted by provincial/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card within the enrolment grace period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):
1) on the same date you apply for your own coverage, or
2) within the enrolment grace period if you have a new Dependent.

Limitations:
1) If you are not actively at work on your coverage effective date, your coverage effective date will be delayed until you return to active full-time employment.

Provided you and your Plan administrator have complied with our enrolment rules, your coverage effective date is shown on our website at www.mypbcbenefits.onlineclaimsaccess.net or from your Plan administrator.

Should you require additional information about when your coverage starts, please contact your Plan administrator.

Beneficiary

1) To the extent permitted by law, you have the right to name a personal representative or beneficiary for Life benefits or change

this personal representative or beneficiary, by written request in a form satisfactory to us. If your designated personal representative or beneficiary does not survive you, any Benefit amount due will be payable to your estate.

2) For all other benefits this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits. Any Benefit amount owing will be paid to your estate or to you for a deceased Dependent.

Identification (ID) Cards

We will issue identification (ID) cards.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

Claims

1) All claims must be submitted in English or, where applicable, French.
2) Eligible claims will be paid when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if your claim is received after the time limits described in this booklet.
3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.
4) The necessary claim forms are available from your Plan administrator or on our website at www.pac.bluecross.ca/mypbcbenefits.
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which

the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your Spouse work for the same employer, please check with your Plan administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse work for different employers and you are both enrolled for similar benefits, Duplicate coverage is allowed.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enrol under more than 1 plan.

Your Plan administrator will advise you if you are eligible to waive certain benefits under this group plan.

Coordination of Benefits

If Duplicate coverage is allowed, claims are paid based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1) The Member is always the primary claimant. The Spouse is always the secondary claimant.
2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.
4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.
2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
   e) false pretences or fraudulent misrepresentation
   f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

Every action or proceeding against us for the recovery of benefits payable under the Group Contract/Policy is absolutely barred unless commenced within the time set out in the *Insurance Act*.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, leave of absence, age limitation or retirement, if you terminate your employment, or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan administrator refer to the Group Contract/Policy.

Right of Recovery

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your employer's benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for 1 of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition
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.

Call our Individual Products Department at 604 419-2000 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2000 or 1 877 PAC-BLUE (722-2583) outside the Lower Mainland for information.

My PBC Benefits Online Portal

My PBC Benefits Online Portal is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in, you will be able to make and track online claims, obtain benefit coverage information, and download claim forms. To login, visit: www.pac.bluecross.ca/mypbcbenefits.

Extended Health Care

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

Compounded drug
means a drug prepared in a pharmacy following the National Association of Pharmacy Regulatory Authorities for pharmacy compounding, and meeting eligibility criteria as determined by us.

Dispensing fee
means a Pharmacy's fee for dispensing a prescription including professional and technical services as defined by the applicable provincial/territorial legislation.

Experimental
means not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate, and essential treatment of an illness or injury.

Life-sustaining non-prescription drugs
means drugs that are necessary to sustain life, do not legally require a prescription and that meet eligibility criteria as determined by our Benefit review.

Markup
means the price set by the Third party claims processor.

Nurse practitioner
means a person legally licensed, certified, or registered to deliver specific health care services, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Nurse practitioners. This excludes a Nurse practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Nurse practitioner based on ineligibility, or based on the Nurse practitioner's qualifications or conduct.

Nursing home
means an institution or part of an institution that:
1) offers in-patient accommodation,
2) has staff of 1 or more Physicians available at all times, and
3) continuously provides 24-hour medical care by or under the supervision of professional nurses.

Facilities established primarily as residences for senior citizens or which provide personal rather than medical care are not included.

PBC National formulary
means a list of Eligible drugs as determined by us through Benefit review, including:
1) drugs that require our prior approval before being eligible, and
2) drugs that may be eligible for coverage through government funded programs, including but not limited to:

Provincial drug plan coverage, with or without requiring prior approval through the program, and other government funded programs or agencies.
We reserve the right on an ongoing basis to add, delete or amend the list of Eligible drugs at our discretion.

Pharmacist
means a person legally licensed, certified, or registered to practice pharmacy and/or dispense drugs, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of

competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Pharmacists. This excludes a Pharmacist residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Pharmacist based on ineligibility, or based on the Pharmacist's qualifications or conduct.

Preferred pharmacy

means a pharmacy that participates in our preferred Provider network. A list of current participating pharmacies is available on our website: **www.pac.bluecross.ca/member-privileges/preferred-pharmacy-network/**

In-Province/Territory Eligible Expenses

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

1) Hospital
   The additional charge for semi-private room accommodation in a Hospital or the extended care unit of a Hospital. Hospital facility fees related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person's home province are covered. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Nursing home
   Charges for accommodation and care are covered if:
   a) confinement starts while the person is covered under this EHC plan, and
   b) the person requires acute care, convalescent care, or palliative care

   to a maximum of $100 in a 12 month period beginning on the first day of confinement.

3) Emergency ambulance
   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.

4) Drugs
   Charges for an Eligible expense on the PBC National formulary in a quantity we consider reasonable, and as approved by our Benefit review process, and
   a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, legally licensed, certified, or registered to practice by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license, including:
      i) Life-sustaining non-prescription drugs
      ii) insulin preparations, diabetic test strips, lancets, needles, and syringes for diabetes management
      iii) injectable vitamin B12 for the treatment of pernicious anemia
      iv) allergy serums when administered by a Practitioner, or
   b) which legally require a prescription from a Provider legally authorized to do so, including:
      i) Compounded drugs
      ii) contraceptive drugs
      iii) drugs for smoking cessation to a lifetime maximum of $300
      iv) drugs indicated for sexual dysfunction to a calendar year maximum of $1,800
      v) vaccines.

   The cost of prescription drugs plus Markup is eligible.

The Markup is eligible up to the Third party claims processor's Customary level, as updated from time-to-time.

Claims for specific high-cost BC PharmaCare limited coverage drugs are handled differently based on the Member's province/territory of residence.

For Members who are BC Residents:
We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once BC PharmaCare's decision (approved or declined) is on file with us, we will consider this drug as eligible based on:

a) if the BC PharmaCare approval is confirmed, the approval period determined by BC PharmaCare, or
b) if the BC PharmaCare decision is to decline, and if the request otherwise meets our definition of an Eligible drug, the approved period as determined by us.

For Members who are not BC Residents:
PBC will integrate with public funding in the Member's province/territory of residence where available and appropriate. If public funding is not available, PBC will conduct manual review of the drug claim and determine eligibility on a case-by-case basis.

For Members residing in Quebec, this plan satisfies the requirements of the Quebec Prescription drug program (RAMQ).

Dispensing fees up to a Customary level as determined by the Third party claims processor are eligible.

5) Practitioners
Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Nurse practitioner.*

a) acupuncturist and naturopath combined $500
b) chiropractor, chiropractic x-rays, and massage Practitioner combined .....$1,200 (x-rays limited to $50)
c) physiotherapist.....$750

d) podiatrist, chiropodist, and podiatrist and chiropodist x-rays combined ..... $500 (x-rays limited to $50)
e) psychologist, social worker, clinical counsellor, and Online cognitive behavioural therapy combined $1,000
f) speech language pathologist $500
g) private duty care by a registered nurse, registered practical nurse, licensed practical nurse, and *personal support worker, for a person requiring acute, convalescent, or palliative care in the person's home, limited to a combined maximum of $10,000 per calendar year.
*Personal support worker is limited to a maximum of $100 in a one month period.

6) Online Cognitive Behavioural Therapy
Charges for a program through an eligible Vendor to a maximum of $1,000 per calendar year combined with services of a psychologist, social worker, and clinical counsellor.

"Online cognitive behavioural therapy" means an internet-based behavioural therapy program.

7) Dental Accident
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. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

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.
Benefits are paid based on eligible dental services and financial limits in our current Pacific Blue Cross National Fee schedule, and the fees in our current Pacific Blue Cross National Fee schedule or, if applicable, the Fee guide in the province/territory of service.

8) Medical aids and supplies provided by a medical supplier (as approved by us)
   Charges for the following services and supplies:
   a) oxygen
   b) ostomy and ileostomy supplies
   c) incontinence supplies to a maximum of $1,000 per calendar year
   d) food substitutes that must be administered through a tube feeding process
   e) hyaluronic acid injections, when administered by a Physician or Nurse practitioner, to a maximum of $1,000 per calendar year
   f) intrauterine contraceptive devices (IUD's)
   g) walkers, canes and cane tips, and crutches to a lifetime maximum of $1,000 (combined with scooters, wheelchairs, wheelchair repairs, and necessary accessories)
   h) casts and trusses
   i) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, and larynxes), when prescribed by a Physician, physiotherapist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient
   j) myoelectrical arms to a maximum of $10,000 per prosthesis (repairs are not covered). Myoelectrical limbs other than arms are excluded, but the equivalent of a standard prosthesis will be paid
   k) mastectomy forms limited to one prosthesis in a 12 month period
   l) charges for the following items to the maximum amounts indicated per calendar year:
      i) mastectomy brassieres $250
      ii) stump socks $250
      iii) surgical stockings ..... 2 pairs
   m) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500
   n) orthopaedic shoes and orthotics
      i) when prescribed by a Physician, podiatrist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes

(including repairs) and modifications to stock item footwear to a maximum of $250 in a calendar year. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg

ii) when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a maximum of $250 every 2 calendar years. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

o) hearing aids, tubing, batteries, ear molds, and repairs to a maximum of $4,000 every 3 calendar years. Recharging devices and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

9) Standard durable medical equipment

a) Preauthorization is required from us for expenses in excess of $5,000

b) 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.

c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.

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

e) Standard durable equipment includes:

i) manual wheelchairs, electric wheelchairs, scooters, and necessary accessories to a lifetime maximum of $1,000 (combined with walkers, canes, cane tips, and crutches) – electric wheelchairs and scooters will be covered only when the patient is incapable of operating the manual equivalent, otherwise the manual equivalent will be paid

ii) manual type hospital beds and necessary accessories – electric hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise the manual equivalent will be paid
iii) outdoor wheelchair ramp – limited to 1 ramp per lifetime to a maximum of $2,000
iv) mechanical or hydraulic patient lifter – limited to 1 lifter per 5 year period to a maximum of $2,000 (repairs are not covered)
v) medical heart monitors and cardiac screeners
vi) blood glucose monitors limited to one in a 4 year period
vii) continuous glucose monitors and supplies to a maximum of $4,000 in a calendar year period
viii) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
ix) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
x) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
xi) continuous positive airway pressure machines (CPAP) and automatically adjusting positive airway pressure machines (APAP) including supplies to a combined maximum of $3,000 every 5 years
xii) extremity pump for lymphedema – limited to 1 pump per lifetime to a maximum of $1,500
xiii) insulin infusion pumps for diabetics – when basic methods are not feasible
xiv) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain and transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost, to a combined lifetime maximum of $700.

10) Vision Care
Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical Provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical Provider, to a maximum of $700 every 2 calendar years. Charges for non-prescription eyewear are not covered.

11) Eye Examinations
Charges for routine eye examinations when performed by a Physician or legally authorized optical Provider, to a maximum of $110 every 2 calendar years.

12) Laser Eye Surgery
Charges for laser eye surgery when performed by a Physician or legally authorized optical Provider, to a lifetime maximum of $1,500.

13) Lens Implants
Charges for lens implants when performed by a Physician or legally authorized optical Provider, to a lifetime maximum of $500.

14) Contact Lenses for Special Conditions
Charges for contact lenses to a maximum of $200 every 2 calendar years, when the following conditions are met:
   a) they are prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus, or aphakia, and
   b) vision in the better eye cannot be corrected to the 20/40 level by glasses.

15) Prostate Specific Antigen (PSA) Testing
Charges for PSA testing limited to once per calendar year.

In-Province/Territory Medical Travel Eligible Expenses

When ordered by the attending Physician, Dentist, or Nurse practitioner, because, in their opinion, adequate medical treatment or medically required oral surgical treatment is not available locally (locally is defined to be within 500 kilometres of your or your Dependent's residence), the following are included as Eligible expenses:

1) Transportation for a patient and attendant if medically required, to and from the nearest locale, equipped to provide the required treatment by:
   a) scheduled economy air, rail, ferry, or bus
   b) private automobile, reimbursement based on the allowable CRA guidelines.
2) Where transportation has been provided under 1) above, accommodation and meals in a commercial facility for the patient and attendant, before and after medical treatment.
3) Transportation must take place within a reasonable time period of the Physician's, Dentist's, or Nurse practitioner's referral.
4) Car rental charges and automobile repairs are not covered.
5) All the above are subject to a $500 lifetime maximum per covered patient.

Out-of-Country Medical Referral Eligible Expenses

Benefits are payable for the following expenses incurred by you or your Dependent outside Canada:

1) Hospital Benefits - while confined as a patient or treated in a Hospital, the Hospital room charge and charges for services and supplies over and above that covered by the Government plan.
2) Professional Services - charges for Physician's services, and laboratory and x-ray services when ordered by the attending Physician over and above the amount allowed under the regulations of the Government plan.

Conditions and Limitations:

1) The treatment must be medically necessary, not available in Canada, and referred by a Physician resident in your province/territory of residence.
2) The Government plan must authorize the treatment and accept the appropriate financial responsibility.
3) Preauthorization is required from us for expenses in excess of $1,000.
4) The maximum benefit is $3,000 every 3 calendar years.

Out-of-Province/Territory Non-Emergency Eligible Expenses

Non-emergency Eligible expenses incurred while travelling outside your province/territory of residence will be reimbursed for you (and your Dependents) subject to the Deductible, in-province/territory reimbursement percentage, and maximums. Any expenses payable or provided under a Government plan will not be reimbursed.

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory of residence, benefits are payable for the following Eligible 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, we should be notified within 5 days of the patient's admission to Hospital. When the patient's condition has

stabilized, we have 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 with our expressed written consent.

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, if they normally would have been covered in the province/territory of residence.
6) Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to their place of residence in Canada in the event you and/or your Spouse is hospitalized and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.
7) Charges, limited to the most economical cost of one-way economy fare air transportation, less any amount reimbursed for unused return tickets, when the covered person's hospitalization delays the return trip. The coverage is for both your airfare and the airfare of your Spouse, if required.
8) Charges, limited to return economy fare air transportation, for 1 immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a Hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.
9) Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of $5,000 per family per medical emergency.
10) Charges for accommodation for convalescence following hospitalization to a maximum of $75 per day per patient for a maximum of 5 days per medical emergency.
11) Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized Member or Dependent to a maximum of $100 per day up to 7 days per family per medical emergency.

Limitation:
Expenses only apply if the immediate family member had to travel to visit the patient, or if the immediate family member had to extend their stay beyond the scheduled date of their return trip.

12) Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of $500 per medical emergency.
13) Charges for the repatriation of a deceased Member and/or Dependent to their place of residence to a maximum of $5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to $1,500.
14) There is a $5,000,000 lifetime maximum per person for out-of-province/territory emergency Eligible expenses.

Only expenses obtained within 180 days of the date you or your Dependent left the country of residence will be covered. If hospitalization occurs within the 180 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 180 days after you initially leave your country of residence, 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 Pacific Blue Cross 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 Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

Exclusions

The following are not included as Eligible expenses under your EHC plan:

1) 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, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2) except as specifically included in this booklet, neither we, nor Third party claims processor pay drug expenses for:
    a) food replacements, food supplements, and infant foods
    b) administrative charges for injectable medications or infusions
    c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital
    d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility
    e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process
    f) any expenses identified as exclusions under the Extended Health Care Benefit

3) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or Experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
4) except as specifically included in this booklet: 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
5) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse 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
6) 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
7) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
8) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy (including infant care) occurring after the 34th week of pregnancy.
9) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence
10) expenses of a Dependent hospitalized at the time of enrolment
11) services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse
12) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross or the Third party claims processor
13) fees for ambulance services when an ambulance is called but not used
14) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer’s responsibility

15) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
16) any other item not specifically included as a benefit
17) legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it electronically
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim.
2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3) You must provide explanation or proof to support the claim or any other information we consider necessary.
4) We must receive an electronic claim within 12 months from the date the expense was incurred.
5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to the Third party claims processor's electronic processing system, they may be paid directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the Pharmacist your EHC ID card.

The Pharmacist will charge you only for amounts not covered by your plan. If you or the pharmacy do not have access to this system, or for other types of expenses, please follow the instructions below.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. A remittance statement will be sent for your records each time you submit a claim.
2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. 2 separate claim forms (1 for the primary plan and 1 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 our 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 provincial/territorial plans. If you submit your claim to us or the Third party claims processor before you submit your claim to the provincial/territorial plans, we will deduct what the provincial/territorial plans would normally pay from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer.
4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Plan administrator or on our website at www.pac.bluecross.ca/mypbcbenefits
   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, your claim must be received within 12 months from the date the expense was incurred. If not, your claim will not be paid under any circumstances.
   d) The original claim form and original receipts must be received. Faxed or scanned claim form and/or receipts will not be accepted.

Dental Care

Payment of Benefits

1) Benefits are paid based on dental services, financial limits and treatment frequencies in the applicable Fee schedule. We apply Customary limits to fee items as applicable.
2) We apply the reimbursement percentage shown in the *Schedule of Benefits*.

Plan A – Basic Preventive & 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 we have not paid for any other exam by the same Dentist in the past 6 months - 1 per 36 month period
      ii) standard and recall – 2 per calendar year except that only 1 is covered in any calendar year that a complete examination is also performed
      iii) periodontal – 2 per calendar year
      iv) specific – 2 per calendar year
      v) consultations (as a separate appointment)

b) x-rays
   i) diagnostic
   ii) panoramic
   iii) complete mouth series – 1 per 36 month period
   All x-rays combined shall not exceed the dollar limit for a complete mouth series.
c) diagnostic models – 1 set per calendar year
d) microbiological, histological, and cytological tests.

2) Preventive services
   a) scaling and root planing - a combined limit of 12 units per calendar year
   b) polishing – 2 per calendar year
   c) topical application of fluoride – 2 per calendar year
   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.
   f) oral hygiene instruction – limited to 1 per lifetime.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay –limited to a maximum of once per surface in a 24 month period on the same tooth:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings on permanent teeth only
      On all primary teeth, the bonded amalgam rate is paid for composite fillings.
   b) metal prefabricated restorations 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 an 18 month period. Root canal therapy is not eligible for primary teeth.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, including the following:
   a) occlusal adjustment and recontouring – a combined limit of 8 units per calendar year
   b) root planing and scaling – a combined limit of 12 units per calendar year
   c) gingival curettage – 1 service per sextant in a 60 month period
   d) osseous surgery – 6 services in a 60 month 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)
   f) grafts (excluding surgical grafts).

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances are limited to a combined limit of 4 units per calendar year
   b) rebase of removable appliances – a limit of 1 per upper and 1 per lower prosthesis in a 24 month period
   c) reline of removable appliances – a limit of 1 per upper and 1 per lower prosthesis in a 36 month period
   d) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
   e) gold foil – only when used to repair existing gold restorations
   f) palatal obturators.

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery is limited to $390 per patient per calendar year
   d) treatment of fractures including related bone grafts to the jaw
   e) treatment of maxillofacial deformities including related bone grafts to the jaw and cheiloplasty.

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 our 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
   c) stents.

2) Restorative Services
   a) inlays and onlays
   b) veneers
   c) crowns and related services.

3) Periodontics
   a) extensions of mucous folds
   b) surgical grafts.

Limitations:
1) Only 1 major restorative service involving 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 our 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.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage for children under age 19 only. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations
1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement of appliances which are lost 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/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. This will not apply to the services of a dental hygienist.

Exclusions

The following are not Eligible expenses under your dental plan:
1) items not listed in our Fee schedule
2) charges for broken appointments, nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3) procedures performed for congenital malformations or for purely cosmetic reasons
4) charges for drugs and pantographic tracings
5) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule

6) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
7) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
8) incomplete or temporary procedures
9) recent duplication of services by the same or different Dentist
10) any extra procedure which would normally be included in the basic service performed
11) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
12) any item not specifically included as a benefit
13) travel expenses incurred to obtain dental treatment.

Claims

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 us **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, no payment will be made for any claim or adjustment received later than **12 months** from the date the service is performed.
3) We 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 policy and ID 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 our files. If you or your Dependents are covered by 2 plans, your Dentist must complete 2 separate dental claim forms (1 for each plan). Incomplete claims will be returned for clarification.

4) Before your Dentist starts treatment, please ask them how billing is made. Payment will be made in either of 2 ways:
   a) If you have paid your Dentist directly, the Benefit amount will be reimbursed to you when we receive:
      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information.
   b) For pay direct claims, the Benefit amount will be paid to the Dentist directly for services provided under this benefit plan when we receive:
      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information.
5) Orthodontic Claims Procedures
   a) Receipts
      Please submit original receipts as photocopies are not accepted. 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 # months of the due date. However, no benefit is payable for claims not received within **12 months** 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. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
   ii) If the payment schedule or treatment changes, we require a revised treatment plan for review. We will retain your treatment plan on file. If we do not have your treatment plan on file, we or the Third party claims processor are unable to pay:
      - your initial fee/down payment
      - your monthly/quarterly fees
      - 1 time appliance fees
   iii) 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) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us or the Third party claims processor which are over 12 months old will not be reimbursed.
   ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
   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.

Payment of Benefit

If you die while insured, we will pay the amount of your group term life insurance to your beneficiary.

When you designate more than 1 person as beneficiary, we will assume the Benefit amount is to be divided equally, unless you specify otherwise. If your designated beneficiary is under age 18, you should appoint a trustee for this beneficiary and have a trust agreement drawn up and signed. This trustee will receive and give discharge for any Benefit amount which becomes payable while your beneficiary is a minor. If no beneficiary survives you, the Benefit amount will be paid to your estate.

Waiver of Premium

Should you become disabled prior to your 65th birthday, the premium for your group term life insurance will be waived on the date your claim under long term disability is approved.

Conversion Option

You will be eligible to convert your group life insurance coverage to a personal life insurance policy issued by Blue Cross Life Insurance Company of Canada without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates.

This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

The maximum coverage you can purchase will be the lesser of:
1) $200,000, or the maximum amount prescribed by applicable provincial/territorial legislation, or
2) the amount of group life insurance you had with us, or
3) the difference between the amount of group life insurance you had with us and the amount that is available through your new employer's group plan – provided you become insured within 31 days following the termination of your coverage under this policy.

You may purchase less than the maximum amount of life insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy. You will have a choice of 2 policies:
1) a term life insurance policy for 1 year, or
2) a term life insurance policy to age 65.

Your premium will be based on the prevailing standard rate charged by Blue Cross Life on the date your personal policy is issued.

Claims

In the event of your death, we must receive notice of your death within **30 days**, and a completed claim form along with any proof required, as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

Short Term Disability

Definitions

Day surgery
means admission to a public general Hospital for a surgical procedure where the patient is released from the Hospital the same day. Note: diagnostic procedures do not qualify as a surgical procedure.

Hospitalization
means admission to a public general Hospital for at least 1 overnight stay as an in-patient.

Recurrent disability
means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

Rehabilitation program
means medical, employment, or vocational activities recommended by us, which can be expected to facilitate a disabled Member's return to gainful employment.

Benefit

We will pay short term disability (STD) benefits when you are disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will

be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a Physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under their regular care and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a Physician.

The weekly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Recurrent Disability

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Graduated Return to Work

If you return to work on a gradual rehabilitative basis, your benefit will not be reduced by any earnings until the gross weekly benefit plus income from all sources have exceeded 100% of your earnings prior to the date your disability started.

Benefits will continue for a maximum of 1 period of disability as outlined under *Recurrent Disability*, whether due to 1 or more illnesses.

In consultation with you and your employer, we will determine your eligibility for this program and its duration.

Rehabilitation Program

While you are disabled, we may suggest a Rehabilitation program to help you return to the work force. It may include, but is not limited to, a return to work on a part-time or full-time basis, or any other employment, medical care or treatment, diagnostic measures or any medications prescribed, vocational evaluation, job preparation, re-training, or work for the purposes of rehabilitation. Income you receive under this program will be integrated with your monthly benefit.

Extended Benefit

If you are disabled when this insurance terminates, your STD benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

Coordination with other Income Sources

Your STD payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became disabled.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable if your employer contributes to the cost of your STD Plan. Benefits are nontaxable if you pay the entire cost.

Termination of Benefit

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer receiving continuing medical care and treatment from your Physician
2) you fail to submit satisfactory proof of continuing disability as required by us
3) you refuse a medical examination by a Physician chosen by us
4) you are no longer following the treatment recommended for your disability
5) you are not entitled to benefits payable by the Employment Insurance Sickness benefit because you are not in Canada
6) you are no longer disabled
7) you perform any work for compensation or profit and/or volunteer work, excluding work in an approved Rehabilitation program or graduated return to work plan
8) the end of the maximum benefit period indicated in the Schedule of Benefits
9) you retire
10) you die.

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
    b) participation in a criminal offense
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation

d) a pregnancy related sickness
   i) during any period of formal maternity leave and/or parental leave
   ii) during any period in which Employment Insurance (EI) benefits are being paid
e) substance abuse, including alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician
f) medical or surgical care which is cosmetic, unless such care is rendered as a result of injury or sickness

2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
   a) in a jail or penitentiary
   b) on leave of absence or paid vacation
4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Claims

1) Obtain a claim form from your Plan administrator, as soon as possible after you become disabled.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail.
6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.
7) Incomplete claim forms will cause a delay in the payment of your benefits.

Long Term Disability

Definitions

Disability
means that during the Elimination period and the subsequent 24 months of Disability you are prevented, by injury or sickness, from performing each of the essential duties of your own occupation. After that you are prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

Eligible survivor
means your Spouse, if living, otherwise your children under age 25. If there are no Eligible survivors, payment will be made to your estate.

Elimination period
means a period of time, when you are continuously disabled, which must be completed before your claim will be considered. It will be calculated from the date Disability begins.

Indexed pre–disability earnings
means your basic earnings adjusted (on each anniversary of the LTD benefit payments) by the lesser of 10% or the current annual percentage increase in the all item Consumer Price Index (CPI) Canada.

Partial disability
means that within 31 days of the end of a period when you received an LTD benefit payment under the Disability definition above, and as a result of the same injury or sickness, you are incapacitated to the extent that, although unable to perform all the essential duties of your own occupation on a full-time basis, you are currently:

1) participating in a rehabilitation program, or
2) performing at least 1 of the essential duties of your own or any occupation on a part-time or full-time basis, and
3) earning at least 20% less per month than your Indexed pre-disability earnings, due to that same injury or sickness.

Availability of work is not considered when assessing Disability.

Recurrent disability
means a Disability that is related to or due to the same cause(s) as a prior Disability for which you received benefit payments.

Benefit

We will pay long term disability (LTD) benefits when Disability, as defined above, begins while you are insured for the LTD benefit.

Benefits commence on the day after the Elimination period expires and will be paid only during periods when you are receiving, from your Physician, regular care which is appropriate for the condition causing your Disability and following the treatment prescribed. We may require consultation and/or treatment by a Physician who specializes in the treatment of your condition.

The monthly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Rehabilitation Program

While you are disabled, we may suggest a Rehabilitation program to help you return to the work force. It may include, but is not limited to, a return to work on a part-time or full-time basis, or any other

employment, medical care or treatment, diagnostic measures or any medications prescribed, vocational evaluation, job preparation, re-training, or work for the purposes of rehabilitation. Income you receive under this program will be integrated with your monthly benefit.

Recurrent Disability

A Recurrent disability will be considered part of the prior Disability if, after receiving LTD benefits, you returned to any occupation on a full-time basis and were able to perform all the essential duties of this occupation for less than 6 months. If you return to any occupation on a full-time basis for 6 months or more, a recurrence of Disability will be treated as a new period of Disability and you must complete another Elimination period.

Extended Benefit

If you are disabled when your insurance terminates, your LTD benefit will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

Survivor Benefit

If you die after being disabled for 180 or more consecutive days and while receiving a monthly Benefit amount, a payment equal to 3 times your gross monthly Benefit amount will be made to your Eligible survivor.

Coordination with other Income Sources

Your monthly LTD benefit may be reduced by any amount of Disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of:

1) your monthly basic earnings, if benefits are taxable
2) your take-home pay, if benefits are nontaxable.

For details of other income sources and how your monthly benefit is calculated, contact your Plan administrator.

Waiver of Premium

The premiums for your LTD benefit will be waived while you are receiving monthly benefits.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable if your employer contributes to the cost of your LTD Plan. Benefits are nontaxable if you pay the entire cost.

Pre-existing Conditions Limitation

Increased amount of insurance
means an increased amount of insurance due to a change in either the non evidence limit or the maximum Benefit amount.

Pre-existing condition
means a sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures), or consumed prescribed drugs within 3 months:
1) prior to the date you became insured under this benefit, or
2) prior to the date of any Increased amount of insurance.

This exclusion will not apply if you become disabled more than 12 months:
1) after you became insured under this benefit, or
2) after you became eligible for any Increased amount of insurance.

Termination of Benefit

Your benefit payments will cease on the earliest date 1 or more of the following occurs:
1) you are no longer Disabled
2) you are no longer receiving regular medical care and treatment from your Physician
3) you fail to submit satisfactory proof of continuing Disability as required by us
4) you refuse a medical examination by a Physician chosen by us
5) you are no longer following the treatment recommended for your Disability
6) you refuse to participate in a rehabilitation program
7) your current earnings exceed 80% of your Indexed pre-disability earnings
8) you reach age 65
9) the end of the maximum benefit period indicated in the Schedule of Benefits
10) you retire
11) you die.

Exclusions

Benefits are not payable for any period of Disability:

1) arising from any of the following:
   a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
   b) participation in an assault or criminal offense, or an act incident thereto
   c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
   d) a pregnancy related sickness
      i) during any period of formal maternity leave and/or parental leave
      ii) during any period in which Employment Insurance (EI) benefits are being paid
   e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are confined in a public general Hospital or you are satisfactorily participating in a withdrawal program approved by us
   f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
   a) in a jail or penitentiary
   b) on leave of absence
   c) involved in a strike or lockout, if the Disability commenced after notice of strike or lockout was given
   d) receiving sick pay, vacation pay, or any other salary or wage from your normal or any occupation (except as provided under the rehabilitation program).

Claims

1) We must receive written notice of claim within **30 days** of the date Disability begins. On receipt of written notice of claim, we will provide you with a claim form.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) Forward the claim form (satisfactory proof of claim) to us within **90 days** following the end of the Elimination period.
6) We may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

Note: Incomplete claim forms will cause a delay in the payment of your benefits.

Notes

My PBC Benefits

Dental and Extended Health Claims

Local

604 419-2381

Toll-free

1 866 366-0430

Mailing Address

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

My PBC Benefits member portal

Plan details, claim history, direct deposit information and much more. Download the My PBC Benefits app from the Apple App or Google Play stores or go to mypbcbenefits.onlineclaimsaccess.net to activate your online access.

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