

IWA - Forest Industry LTD Plan
89583

Group Name and Policy Number

IWA - Forest Industry LTD Plan

Long Term Disability Benefit Recipients

Policy Number 89583

Reissue Date: January 1, 2017

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.

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.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) 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.

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

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.

Dental Care			
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<i>Deductible</i>	No Deductible		
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<i>Reimbursement</i>	Plan A	Plan B	Plan C
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Basic Services

Major Restorative Services

Orthodontics

80%

60%

60%

<i>Frequency Plan Limits</i>	Each Calendar Year	Each Calendar Year	Lifetime
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Not Applicable

Not Applicable

\$4,000

<i>Financial Limit Per Dependent Child</i>	Not Applicable	Not Applicable	\$4,000
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Not Applicable

Not Applicable

\$4,000

<i>Financial Limit Per Member or Spouse</i>	Not Applicable	Not Applicable	\$4,000
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Not Applicable

Not Applicable

\$4,000

<i>Dependent Children</i>	See definition of Dependent.		
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See definition of Dependent.

Definitions

Coverage effective date

means the day after your coverage terminates under your employer's plan for active employees.

Deductible

means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges 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, 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 one plan.

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. For Alberta, the Fee guide means the current Alberta Blue Cross Usual and Customary fee guide.

Fee schedule

means Schedule 3 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.

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 employee or other person who has coverage under the Contract.

Practitioner

means a person currently 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 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. Pacific Blue Cross reserves 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. Pacific Blue Cross reserves 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.

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 one 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 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/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card 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) when you acquire a new Dependent.

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.pac.bluecross.ca/caresnet or from your Plan Administrator.

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

Beneficiary

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 for distribution by your Plan Administrator.

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 to us in English.
- 2) We pay eligible claims 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

we receive your claim 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/caresnet
- 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 have coverage under USW - Forest Industry plans, Duplicate coverage is not allowed for dental and extended health care benefits.

If you and your Spouse have coverage through 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 one 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, we pay claims 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) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
 - b) 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
 - c) 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
 - d) false pretences or fraudulent misrepresentation

- e) 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 covered under the government plan (ie. Medical Services Plan of BC), or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract.

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 one 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.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our website: www.pac.bluecross.ca/caresnet/

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

Eligible expense

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

- 1) in our 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, Dentist, or a Primary healthcare nurse practitioner (PHCNP), 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, and
- 5) is provided by a Practitioner or Provider approved by us.

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. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Markup

means 8% of the manufacturer's list price.

Physician

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

Primary healthcare nurse practitioner

means a person duly qualified and licensed to deliver specific health care services in the jurisdiction where the services are provided and is acting within the scope of that license.

In-Province/Territory 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, Dentist, or Primary healthcare nurse practitioner. Unless otherwise indicated, the maximums included here are on a per person basis.

- 1) Hospital
 - a) the additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital, and
 - b) the coinsurance charge of the extended care unit of a hospital to a maximum of \$8.50 per day.Charges for rental of a telephone, television, or similar equipment are not covered.
- 2) 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.

3) Drugs

Charges for drugs in a quantity we consider reasonable, and

- a) which are dispensed by a pharmacist, Physician, Dentist, or a Primary healthcare nurse practitioner, including:
 - i) life sustaining drugs
 - ii) insulin preparations, testing supplies, needles, and syringes for diabetics
 - iii) vitamin B12 for the treatment of pernicious anemia
 - iv) allergy serums when administered by a Physician or Primary healthcare nurse practitioner, or
- b) which legally require a prescription from a medical Provider legally authorized to do so, including:
 - i) anti-obesity drugs.

Reimbursement of eligible drugs will be subject to provincial/territorial plans low cost alternative and reference drug programs, and will be based on an 8% Markup over the manufacturer's cost.

If we receive written confirmation from the prescribing Physician, Dentist, or Primary healthcare nurse practitioner that there is a specific medical requirement that prevents the Member from taking the generic drug, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

Specific high-cost PharmaCare limited coverage drugs are identified on Pacific Blue Cross' Special Authority Enforcement list. We will reject claims for a drug on this list in British Columbia until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once the PharmaCare decision (accepted or declined) is on file with us, we will accept claims for this high-cost drug.

Dispensing fees up to \$10 are eligible.

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. .

- a) acupuncturist\$100
- b) chiropractor and naturopath combined\$600
- c) massage Practitioner and physiotherapist combined\$550
- d) podiatrist.....\$100
- e) psychologist.....\$100
- f) speech language pathologist\$100

5) 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.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

6) Medical aids and supplies provided by a medical supplier (as approved by us)

Charges for the following services and supplies:

- a) oxygen
- b) catheters, ostomy and ileostomy supplies
- c) gloves for persons using manual wheelchairs
- d) walkers, canes and cane tips, crutches, casts, and trusses
- e) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary after

diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis

- f) bath bench suction cups
 - g) charges for the following items to the maximum amounts indicated per calendar year:
 - i) mastectomy brassieres.....\$150
 - ii) stump socks\$200
 - h) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of \$500
 - i) orthopaedic shoes and orthotics
 - i) when prescribed by a Physician, podiatrist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear to a calendar year maximum of \$500 for an adult and \$300 for a Dependent child. 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 a Primary healthcare nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a calendar year maximum of \$200. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet
 - j) hearing aids and repairs to a maximum of \$550 in a 5 calendar year period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.
- 7) 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, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent
 - ii) replacement parts for wheelchairs, including tires
 - iii) hydraulic lifts for use in bathtubs
 - iv) medical heart monitors and cardiac screeners
 - v) continuous glucose monitors and supplies, and blood glucose monitors
 - vi) speech processors and headsets when prescribed for profound deafness subject to 5 calendar year period
 - vii) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
 - viii) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
 - ix) insulin infusion pumps for diabetics – when basic methods are not feasible
 - x) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
 - xi) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.
- 8) Vision Care, Laser Eye Surgery & Eye Examinations
Charges for the following when prescribed or performed by a Physician or legally authorized optical Provider (as applicable):
- a) purchase and/or repair of eyewear and charges for contact lens fittings, and
 - b) laser eye surgery, and

c) routine eye examinations to a combined maximum of \$400 in a 24 month period. Charges for safety goggles and sunglasses (plain or prescription) are not covered.

In Province/Territory Medical Travel Eligible Expenses

As used in this Medical Travel benefit,

Medical specialist

means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the services are provided and is acting within the scope of that license (i.e. a Medical specialist must be recognized by the College of Physicians and Surgeons of British Columbia, Alberta or Saskatchewan and hold a Specialist degree), but excludes a Medical specialist residing with or related to you or your Dependent.

When ordered by the attending Physician or Primary healthcare nurse practitioner, because, in his or her opinion, adequate medical treatment is not available locally (remote area), the following are included as Eligible expenses when the patient is referred to a Medical specialist:

- 1) Transportation for a patient (Member or Dependent) by
 - a) scheduled economy air, rail, bus, or ferry to and from the nearest locale equipped to provide the required treatment, within the patient's province/territory of residence
 - b) local taxi or bus between the airport and the location of treatment or accommodation
 - c) private automobile (reimbursed at \$0.30 per kilometre, but not exceeding economy airfare).
The Airport Improvement Fee is an Eligible expense when flying from Vancouver International Airport.
- 2) Transportation of an attendant for the patient being transported under 1) above, when ordered by the attending Physician or Primary healthcare nurse practitioner.
- 3) Where transportation has been provided under 1) above, accommodation for the patient and attendant before and after

medical treatment. Reimbursement will be based on the cost of reasonably priced hotels and motels in the area of the Medical specialist appointment.

Entitlement to accommodation expenses will be based on the reasonableness of the patient being unable to return home on the day of the referral.

The maximum benefit payable for transportation and accommodation expenses combined is \$1,000 per Member or Dependent per Calendar year.

Conditions and Limitations

- 1) Transportation must take place with 2 months of the Physician's, Dentist's, or Primary healthcare nurse practitioner's referral, unless the earliest possible date of availability of the Medical specialist is beyond 2 months from the referral.
- 2) Only referrals that require travel from the patient's residence in excess of 500 kilometres on a round trip basis will be covered under the Medical Travel benefit.
- 3) This round trip maximum is to be interpreted as land or surface distance from the patient's residence to the Medical specialist's office, since from some coastal locations, air distance may be less than 500 kilometres. In such cases, land or surface distance will be used for the calculation even if air travel is actually used for the medical travel.
- 4) When travelling by British Columbia ferry, the \$0.30 per kilometre allowance is not applicable for kilometres covered by the ferry trip itself, but the distance covered may be included in the calculation to determine whether the total distance of medical travel exceeds the 500 kilometre round trip minimum.
- 5) Where the patient stays at the private home of family or friends during the medical travel trip, no accommodation allowance is payable; however, the patient will be entitled to the \$0.30 per kilometre private automobile travel allowance between the private home and the location of the Medical specialist.
- 6) For the purposes of this Medical Travel benefit, the Campbell River area will not be considered a remote area.
- 7) Benefit amounts paid for Medical Travel will not be included in the EHC lifetime maximum.

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

We will reimburse you (and your Dependents) for non-emergency Eligible expenses incurred while travelling outside your province/territory of residence subject to the Deductible, in-province/territory reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a government plan.

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 we would have covered them inside your province/territory of residence.

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, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians, Dentists, or Primary healthcare nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
- 2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, infant food, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
- 3) except as specifically included in this booklet: anti-obesity drugs, sclerosing agents, contraceptives, drugs and supplies for smoking cessation, fertility drugs, and 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
- 4) allergy testing unless rendered by a naturopath
- 5) 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, or experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
- 6) 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

- 7) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Primary healthcare 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
- 8) 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
- 9) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
- 10) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
- 11) 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
- 12) expenses of a Dependent hospitalized at the time of enrolment
- 13) services performed by a Physician, Dentist, or a Primary healthcare nurse practitioner, who is related to or resident with you or your Spouse
- 14) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
- 15) fees for ambulance services when an ambulance is called but not used
- 16) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
- 17) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
- 18) any other item not specifically included as a benefit.

Claims

Electronic Claims

- 1) When submitting an electronic claim you must:
 - a) complete the claim form online and submit it electronically to us

- b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
 - c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation electronically or by mail to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused and your ability to submit electronic claims will be removed.
- 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 by December 31st of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the December 31st deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission.
 - 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 our electronic processing system, we will pay them 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 us. 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. We will send you a remittance statement 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. 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 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 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/caresnet
 - 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, we must receive your claim by **December 31st** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.
Example: We must receive your receipts for 2017 before December 31, 2018.
 - d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

Payment of Benefits

- 1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.
- 2) We apply 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/territory 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.

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 – 1 per lifetime by a general practitioner and 1 per lifetime by a specialist
 - ii) recall – 2 per calendar year for persons under age 17 and 1 per 9 month period for persons age 17 or older
 - iii) specific – 2 per calendar year
 - iv) consultations (as a separate appointment)
 - b) x-rays
 - i) diagnostic
 - ii) bitewings – 1 per 18 month period
 - iii) panoramic – 1 per 60 month period
 - iv) complete mouth series – 1 per 36 month periodAll 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, root planing and gingival curettage – a combined yearly limit shown in our Fee schedule
 - b) polishing – 2 per calendar year for persons under age 17 and 1 per 9 month period for persons age 17 or older
 - c) topical application of fluoride – 2 per calendar year for persons under age 17 and 1 per 9 month period for persons age 17 or older
 - 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 all teeth
 - b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period
 - c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. 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.

- 4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth per lifetime.
- 5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
 - a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
 - b) root planing, scaling and gingival curettage – a combined yearly limit shown in our Fee schedule
 - c) osseous surgery – 1 per sextant in a 5 year period
 - d) 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
 - d) gold foil – only when used to repair existing gold restorations.
- 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 our 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 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.
- 2) Restorative Services
 - a) inlays or onlays involved in bridgework
 - b) veneers
 - c) crowns and related services.

Limitations

- 1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
- 2) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- 3) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- 4) 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. 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. You will be reimbursed according to our Fee schedule. 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 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 our Fee schedule
- 7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 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.

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, in no event will we pay 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 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, Dental hygienist, Dental specialist, or Denturist starts treatment, please ask them how billing is made. We may pay in either of two ways:
- a) If you have paid your Dentist, Dental hygienist, Dental specialist, or Denturist directly, we will reimburse you the benefit amount 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 between the Provider and Pacific Blue Cross.
 - b) For pay direct claims, we will pay the benefit amount to the Dentist, Dental hygienist, Dental specialist, or Denturist 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 between the Provider and Pacific Blue Cross.
- 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 12 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.
 - iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are 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) 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 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.

