Benefits Booklet

For the Employees of
School District 75 (Mission)

Employee Class
Teachers

Teachers

Important

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

Your Basic Life Insurance benefits are governed by **Manulife Financial** Group Policy No. **G96958-B** effective April 1, 1998.

Your Basic AD&D benefits are governed by **Industrial Alliance Pacific (IAP)** Group Policy No. **100006546** effective April 1, 1998.

Your Extended Health Care and Dental Care benefits are governed by **Pacific Blue Cross** Group Policy No. **E/D824320** effective May 1, 1998.

Your benefits were arranged with the assistance of:

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

This booklet summarizes the features and benefits of your coverage and should be kept in a safe place known to you and your family. The exact conditions, limitations, and exclusions of the coverage are included in the Group Policy (ies) issued by the insurer(s) to your Employer. Please read the booklet carefully. If there is a discrepancy between this booklet and the Group Policies, then the terms and provisions of the Group Policies shall prevail.

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

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

Benefit	Insurance Company	Policy Number	Toll Free Claims Number
Basic Life Insurance	Manulife Financial	G96958-B	1-877-542-4110
Basic AD&D	Industrial Alliance Pacific	100006546	1-877-542-4110
Extended Health Care	Pacific Blue Cross	E824320	604-419-2000 or 1-888-275-4672
Dental Care	Pacific Blue Cross	D824320	604-419-2000 or 1-888-275-4672

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

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.grouphealthglobal.com. 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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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.

Basic Life Insurance

Eligibility Period	One month following your date of employment	
Benefit Amount		
	Age	**Amount of Insurance**
	Under age 35	3 times annual earnings
	Age 35 to age 44	2 ½ times annual earnings
	Age 45 to age 54	2 times annual earnings
	Age 55 or over	1 ½ times annual earnings
Maximum Benefit	$170,000	
Qualifying Period for Waiver of Premiums	182 days	
Conversion Privilege	Included	
Termination	If your employment terminates prior to age 65 or you retire between September 1 to May 31, coverage will terminate at the end of the month following the month of termination or retirement. However, if your employment terminates in the month of June, or you retire in the month of June, or you attain age 65 between September 1st to June 30th, coverage is extended to September 30th.	

Basic AD&D

Eligibility Period	One month following your date of employment
Principal Sum	An amount equal to the Basic Life Insurance amount.
Maximum Benefit Amount	$170,000
Waiver of Premium Benefit	Included
Conversion Privilege	Included
Spousal Occupational Retraining Benefit	$15,000
Repatriation Benefit	$15,000
Rehabilitation Benefit	$15,000
Family Transportation Benefit	$15,000
Home Alteration & Vehicle Modification Benefit	$15,000
Seat Belt Benefit	Additional 10% of benefit payable
Day Care Benefit	The lessor of 5% of the Principal Sum or $5,000 per year to a maximum of 4 years
Special Education Benefit	The lessor of 5% of the Principal Sum or $5,000 per year to a maximum of 4 years
Termination	If your employment terminates prior to age 65 or you retire between September 1 to May 31, coverage will terminate at the end of the month following the month of termination or retirement. However, if your employment terminates in the month of June, or you retire in the month of June, or you attain age 65 between September 1st to June 30th, coverage is extended to September 30th.

Extended Health Care

Eligibility Period	One month following your date of employment	
Annual Deductible	$25 single or $25 family each calendar year. – Deductible does not apply to vision care	
Reimbursement	In-Province Eligible Expenses Out-of-Province Non-Emergency Eligible Expenses	80% 80%
	Vision Care and Hospital Expenses	100%
	Out-of-Province Emergency Eligible Expenses	100%
	Medi-Assist Basic	Included
Summary of Eligible Expenses:		
Prescription Drugs	Including fertility drugs to a lifetime maximum of $15,000, drugs for contraceptive purposes, IUD's and injectible serums, vaccines and vitamins	
Hospital	Semi-Private or Private accommodation	
Private Duty Nursing	$25,000 per person per 12 consecutive months	
Acupuncturist	$350 per person per calendar year	
Chiropractor	$350 per person per calendar year, plus one x-ray	
Massage Practitioner	$350 per person per calendar year, plus one x-ray	
Naturopath	$350 per person per calendar year, plus one x-ray	
Physiotherapist	Unlimited per person per calendar year	
Podiatrist	$350 per person per calendar year, plus one x-ray	
Registered Psychologist	$350 per person per calendar year (Excluding Clinical Counselors)	
Speech Therapist	$350 per person per calendar year	
Orthopaedic shoes (including repairs)	$200 for one pair per calendar year	
Orthotics (excluding arch supports)	$500 per person per calendar year	
Hearing Aids (Excluding batteries)	$500 per adult per 60 months $400 per Dependent Child per 60 months	
Surgical Stockings (for varicose veins)	$200 per person per calendar year	
Prosthesis and supplies required as a result of a mastectomy	$200 per person per calendar year	
Glucometer (for diabetics)	$400 per person per lifetime	
Wigs and Hairpieces	$500 per person per lifetime	
Transcutaneous Electric Nerve Stimulator	$3,000 per person per lifetime	
Vision Care	$250 per person per 24 months (includes cost of repairs) Deductable does not apply	
Survivor Benefits	24 months	
Plan Maximum	The lifetime maximum amount of benefits payable per insured person is unlimited	

Termination	If your employment terminates prior to age 65 or you retire between September 1 to May 31, coverage will terminate at the end of the month following the month of termination or retirement. However, if your employment terminates in the month of June, or you retire in the month of June, or you attain age 65 between September 1st to June 30th, coverage is extended to September 30th.

Dental Care

Eligibility Period	One month following your date of employment		
Deductible	Nil		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C** Orthodontics
	100%	60%	60%
Financial Limit Per Dependent Child:	Unlimited per calendar year	$1,000 per calendar year	$2,500 per lifetime
Financial Limit Adult:	Unlimited per calendar year	$1,000 per calendar year	No Coverage

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

Oral Examinations:	*Complete*	Once every 24 months
	Standard	Once every 6 month period
X-rays:	*Full mouth*	Once every 24 months
Preventative Services:		
	Polishing	Twice every calendar year
	Topical Fluoride	Twice every calendar year
Prosthetic Repairs		Reline of fixed or removable appliances once every 24 months
Upper & Lower Dentures		Once (Complete or Partial) every 60 months
Dependent Children		Orthodontic coverage covers dependent children under the age of 19
Survivor Benefits		24 months
Termination		If your employment terminates prior to age 65 or you retire between September 1 to May 31, coverage will terminate at the end of the month following the month of termination or retirement. However, if your employment terminates in the month of June, or you retire in the month of June, or you attain age 65 between September 1st to June 30th, coverage is extended to September 30th.

Eligibility

You are eligible for group benefits if you

- are an active full-time teacher working a minimum of .5 of a full-time* equivalent (FTE) for School District No. 75 (Mission); or
- are an active contract teacher on a 10 month contract from September to June working a minimum of .5 of a full-time equivalent (FTE) for School District No. 75 (Mission); or
- are an active full-time teacher granted a continuing appointment and are placed on the re-engagement list**, working a minimum of .5 of a full-time equivalent (FTE) for School District No. 75 (Mission); and
- are younger than the Termination Age; and
- are residing in Canada; and
- have completed the Eligibility Period specified in the Schedule of Benefits.

* Full-time is based on 25 hours per week.

** Benefit coverage shall continue for a maximum of 27 months for teachers on the re-engagement list provided they are working a minimum of .5 FTE.

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

Effective Date of Coverage

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

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

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

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

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

Late Applicant

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

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

Termination of Coverage

Your coverage will terminate on the earliest of:

- If your employment terminates prior to age 65 or you retire between September 1 to May 31, coverage will terminate at the end of the month following the month of termination. However, if your employment terminates in the month of June, or you retire in the month of June, or you attain age 65 between September 1st to June 30th, coverage is extended to September 30th;
- the date the Group Policy terminates;
- the date you enter the armed forces of any country on a full-time basis, or
- the end of the period for which premiums have been paid.

If you are terminated without notice, your Employer may consider your coverage to continue, but not beyond the minimum notice period required by statute.

If your coverage ends because of leave of absence, lay off or disability and you are re-employed within 6 months of the date of termination, you will be eligible for coverage on your date of rehire. If you are employed after six months you will be considered a new applicant.

Termination of Dependent Insurance

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

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

Extension of Benefits

- Benefit coverage may be extended for Teachers and Exempt Teaching Staff receiving disability benefits under SIP for a maximum of 30 months.
- Benefit coverage may be extended for Teachers and Exempt Teaching Staff receiving part-time SIP and working part-time for a maximum of 30 months. Salaries are frozen as of the last day worked.
- Benefit coverage may be extended for Teachers on a short-term personal leave of absence for a maximum of 5 months.
- Teaching Staff on an Educational Leave, Deferred Leave or Incentive Plan Leave may continue benefit coverage for a maximum of 12 calendar months. Salaries are frozen as of the last day worked.
- Benefit coverage may be extended for Teachers on maternity leave for an additional 20 months beyond the Employment Insurance maternity maximum benefit of 17 weeks.

If you cease to be actively at work due to an injury or illness, coverage may continue until the policy holder terminates the coverage.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan to replace your Basic Life Insurance, AD&D, Extended Health Care and Dental Care.

To convert coverage you must ensure that your application and full payment is received by the insurance company within 31 days of the date your group plan terminates (60 days for Extended Health Care and Dental Care). Coverage will become effective immediately after your group coverage terminates.

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

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

Pre-existing Condition for Extended Health Care and Dental Care

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

Individual Travel Benefits

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

Beneficiary Designation

You may name a beneficiary for your Basic Life Insurance, Basic and Optional AD&D and change that beneficiary at any time by completing a form available from your employer.

Co-insurance

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

Covered Expenses

Are expenses that will be considered in the calculation of payment due under your Basic and Optional Accidental Death & Dismemberment, Extended Health Care or Dental Care benefits.

Deductible

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

Dependent

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

Spouse

Your legal spouse or a person who has been continuously living with you in a role like that of a marriage partner. Discontinuance of cohabitation for a period of more than thirty (30) consecutive days shall terminate the eligibility for benefits of a common-law spouse. Only one spouse is eligible for coverage at the same time.

Child

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

- unmarried;
- under age 21 and is mainly dependent on and is living with you and/or your spouse;
- under age 26 if a full-time student and is mainly dependent on you and/or your spouse;
- age 21 and is mainly dependent on you and/or your spouse by reason of continued and demonstrable mental or physical infirmity.

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

Drug

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

Duplicate coverage

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

Earnings

Your regular rate of pay from your employer (prior to deductions), excluding regular bonuses and overtime pay or other additional compensation. Earnings may include other income as agreed to in writing by your employer and the insurance company.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be based on the actual earnings in effect as of the date of death or disability. Where recent salary adjustments have not been reported in the event of a claim, premiums will be required to be adjusted retroactively.

Medically Necessary

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

Non-Evidence Limit

You must submit satisfactory medical evidence to the insurance company for Benefit Amounts greater than the amount given under the Schedule of Benefits.

Provincial Plan

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

Qualifying Period

A period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

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

Total Disability

For the purpose of the waiver of premium benefit under the Basic Life Insurance and Basic AD&D, the term "Total Disability" or "Totally Disabled" herein shall mean disability resulting from accident or sickness which:

a. prevents you from engaging in any occupation or employment for which you are reasonably fitted, or could so become, by reason of education, training or experience, and that you are not performing any work for remuneration or profit; and

b. has existed continuously for a period of at least 6 months or is in accordance with the waiver of premium requirements under the group Basic Life Insurance policy.

Insurance, continued under any Waiver of Premium provision, will be subject to any reductions in amount or termination due to age stated in the policy on the date the disability commenced.

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

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

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

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

Subrogation (Third Party Liability)

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

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

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

For Claims incurred by you or your Dependent Spouse:

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

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

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

For claims incurred by your Dependent Child:

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

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

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

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

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

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

Submitting a Claim for Co-ordination of Benefits

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

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

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

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

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

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

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

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

Dental Care – Pre-authorization

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

If you die while insured for this benefit, the amount of life insurance shown in the Schedule of Benefits will be paid to your beneficiary in a lump sum, or by any income settlement method then offered by Manulife Financial.

Beneficiary

You may designate a beneficiary and may change that designation at any time by completing the Change of Beneficiary section on the back of your enrolment card. If there is no living beneficiary at the date of your death, benefits will be paid to your estate.

Waiver Of Premium

If you should become totally disabled prior to age 65 and remain disabled for at least 6 months, your Group Life Insurance coverage will remain in force, without further payment of premiums, as long as you continue to be totally disabled. The insurance will remain in force until the time it would normally have ceased if you were not totally disabled. Proof of disability must be submitted within 12 months of the commencement of disability and when requested thereafter.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Qualifying Period. If your disability is not continuous, Manulife Financial will apply separate periods of disability towards satisfying the Qualifying Period, provided:
    - no interruption between periods of disability is longer than 3 weeks, and
    - the disabilities are due to the same or related illness or injury.
- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial.
- The application for Waiver of Premium must be submitted to the insurers no later that 12 months from the date of disability.

At any time, Manulife Financial may require you to submit a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit.
- The date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.
- The date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial.
- The date you do not attend an examination by an independent expert chosen by Manulife Financial.
- The date of your 65th birthday.
- The date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife Financial will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of the Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Conversion Privilege

If your Group Benefits terminates or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Life Insurance. If you die during this 31 day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The effective date of the Individual Policy will be the 32nd day after the date of termination of the Group Insurance under this plan.

For more information on the conversion privilege, please see your Plan Administrator.

How To Make A Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Employer.

Documents necessary to submit with the form are listed on the form. Upon completion of the form, the necessary documents should be attached and the form returned to your Employer for mailing to Manulife Financial. A completed claim form must be submitted within 90 days from the date of loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form. Upon completion, submit the form to your Employer for processing and submission to Manulife Financial. A completed claim form must be submitted within 90 days from the end of the qualifying period.

Payment of Benefit

If such injuries shall result in any one of the specific losses listed in the Schedule of Benefits within one year from the date of accident, Industrial Alliance Pacific will pay the sum set opposite such loss provided. However not more than one (the largest) of such benefits shall be paid with respect to all injuries resulting from one accident.

With respect to air travel, the insurance afforded shall apply to loss caused by or resulting from travel or flight in any aircraft, or any other device for aerial navigation, including boarding or alighting therefrom, except:

1) while being used for any test or experimental purpose; or
2) while you are operating, learning to operate or serving as a member of the crew thereof; or
3) while being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Canadian Armed Forces Air Transport Command or the similar air transport service of any other country; or
4) any such aircraft or device which is owned or leased by or on behalf of the Policyholder or any subsidiary or affiliate of such Policyholder, or by an Insured Person or any member of his/her household; or
5) while being used for fire fighting, pipeline inspection, powerline inspection, aerial photography or exploration.

Definitions

"Loss" shall mean

- with respect to hand or foot, the actual severance through or above the wrist or ankle joint;
- with respect to arm or leg, the actual severance through or above the elbow or knee joint;
- with respect to eye, the total and irrecoverable loss of sight;
- with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;
- with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device;
- with respect to thumb and index finger, the actual severance through or above the first phalange;
- with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand;
- with regard to toes, the actual severance of both phalanges of all toes of the same foot.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Industrial Alliance Pacific to be permanent.

Schedule of Losses

Loss	Benefit
Loss of Life	The Principal Sum
Loss of Both Hands or Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and Entire Sight of One Eye	The Principal Sum
Loss of One Foot and Entire Sight of One Eye	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of Both Feet	The Principal Sum
Quadriplegia	Two Times The Principal Sum
Paraplegia	Two Times The Principal Sum
Hemiplegia	Two Times The Principal Sum
Loss of One Arm or One Leg	Three-Quarters of The Principal Sum
Loss of Use of One Arm or One Leg	Three-Quarters of The Principal Sum
Loss of One Hand or One Foot	Three-Quarters of The Principal Sum
Loss of Entire Sight of One Eye	Two-Thirds of The Principal Sum
Loss of Use of One Hand or One Foot	Two-Thirds of The Principal Sum
Loss of Speech or Hearing	Two-Thirds of The Principal Sum
Loss of Thumb and Index Finger of Same Hand	One-Third of The Principal Sum
Loss of Four Fingers of Same Hand	One-Third of The Principal Sum
Loss of Hearing in One Ear	One-Quarter of The Principal Sum
Loss of All Toes of Same Foot	One-Eighth of The Principal Sum

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which the Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that the Insured Person suffered loss of life resulting from bodily injuries sustained in the accident and covered under this policy.

Rehabilitation Benefit

When injuries shall result in a payment being made by Industrial Alliance Pacific under any benefit EXCLUDING the Loss of Life benefit provided by the policy, Industrial Alliance Pacific will pay in addition, the reasonable and necessary expenses actually incurred up to a limit specified in the Schedule of Benefits for special training of the Insured Employee, provided:

- such training is required because of such injuries and in order for the Insured Employee to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;
- expenses be incurred within two years from the date of the accident;
- no payment will be made for ordinary living, travelling, or clothing expenses.

Repatriation Benefit

When injuries covered by this policy result in loss of life of an Insured Person outside 150 km from their city of permanent residence or outside Canada and within 365 days from the date of the accident, Industrial Alliance Pacific will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed the maximum specified in the Schedule of Benefits.

Family Transportation Benefit

When injuries covered by this policy result in an Insured Person being confined as an in-patient in a hospital outside 150 km from the Insured Person's city of permanent residence or outside Canada and requires personal attendance of a member of the Insured Person's immediate family as recommended by the attending physician, in writing, Industrial Alliance Pacific will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to the confined Insured Person, but not to exceed the maximum specified in the Schedule of Benefits.

"Member of the immediate family" means the spouse, legal or common-law, parents, grandparents, children over age 18, brother, or sister of the Insured Person.

Spousal Occupational Training Benefit

When injuries to the Insured Employee shall result in a payment being made by Industrial Alliance Pacific under the Loss of Life benefit section of this policy, Industrial Alliance Pacific will pay in addition, the expense actually incurred, within 365 days from the date of the accident, by the spouse of the Insured Employee for a formal occupational training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications.

The maximum payable is specified in the Schedule of Benefits.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses of this policy, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Industrial Alliance Pacific will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to the Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by the Insured Person to make the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:

a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both Items 1 and 2 combined will not exceed the maximum specified in the Schedule of Benefits.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity", the Insured Person's amount of Principal Sum will be increased by the amount specified in the Schedule of Benefits if, at the time of the accident, the Insured Person was driving or riding in a Vehicle and wearing a properly fastened Seat Belt.

Due proof of Seat Belt use must be provided as part of the written proof of Loss.

Day Care Benefit

If an Insured Person suffers loss of life in a covered accident while the policy is in force as to such Insured Person, Industrial Alliance Pacific will pay, in addition to all other benefits payable under the policy, a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the maximum specified in the Schedule of Benefits, on behalf of any Dependent Child of the Insured Person who is enrolled in a legally licensed Day Care center on the date of the accident or who enrolls in a legally licensed Day Care center within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four (4) consecutive years, but only upon receipt of satisfactory proof that the child is enrolled in a legally licensed Day Care center.

"Dependent Child" means either a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with the Insured Person and who is unmarried, twelve (12) years of age and under and dependent upon the Insured Person for maintenance and support.

If at the time of the accident, there are no Dependent Children who qualify, Industrial Alliance Pacific will pay an additional benefit of $2,500 to the designated beneficiary.

Special Education Benefit

If an Insured Employee suffers loss of life in a covered accident while the policy is in force, the Company will pay, in addition to all other benefits payable under the policy, a "special education benefit" equal to 5% of the Insured Employee's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any institution of higher learning beyond the 12th or 13th grade level, or was at the 12th or 13th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The "special education benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

If, at the time of the accident, there are no dependent children who qualify, the Company will pay an additional benefit of $5,000 to the designated beneficiary.

Continuance of Coverage

In the case of employees of the Policyholder who are (1) laid-off on temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period allowed under the Basic Life Insurance policy, subject to payment of premiums.

If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Waiver of Premium

If an Insured Employee, under age 65, is totally disabled while this policy is in force and the Insured Employee provides satisfactory evidence of total disability to the Company on an annual basis, Industrial Alliance Pacific will then waive the payment of each premium which falls due with respect to the Insured Employee. Subject to all the terms and conditions of the policy, except with respect to non-payment of premium or the termination of the master Policy, waiver of any premium as herein provided will continue with respect to the Insured Employee until age 65. If the Insured Employee ceases to be disabled and he/she returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to the Insured Employee may be continued upon resumption of premium payments by the Insured Employee or the Policyholder.

"Total Disability" as used herein shall mean disability resulting from accident or sickness which:

1. prevents engagement in any business or occupation and performance in any work for compensation or profit; and
2. has existed continuously for a period of at least twelve (12) months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

Conversion Privilege

On the date of termination of employment or during the 31 day period following termination of employment, you may convert your Accidental Death and Dismemberment Insurance to an individual insurance policy of the Insurance Company. The individual policy will be effective either as of the date that the Insurance Company receives the application or on the date that the coverage under the group policy ceases, whichever occurs later. The premium will be the same as a person would ordinarily pay when applying for an individual policy at that time.

The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Exclusions

This policy does not cover loss caused by or resulting from any one or more of the following:

1. Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. Declared or undeclared war or any act thereof;
3. Accident occurring while the Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by Industrial Alliance Pacific pro-rata for any such period of full-time active duty);
4. Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the policy.

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

Definitions

Eligible expense

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

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

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

Physician

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

Practitioner

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

In-Province Eligible Expenses

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

1. Hospital

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

2. Emergency ambulance services

   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient

   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport

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

   d) charges for an attendant when medically necessary.

3. Drugs and medicines dispensed by a licensed pharmacist or a Physician, in a quantity Pacific Blue Cross considers reasonable:
   a) drugs and medicines which legally require a prescription from a Physician or Dentist
   b) insulin preparations for diabetics
   c) vitamin B12 for the treatment of pernicious anemia
   d) allergy serums when administered by a Physician.
4. Professional services of specified Practitioners to the maximum amounts indicated in the Schedule of Benefits, and unless indicated in the schedule of benefits, excluding x-rays, appliances, and tray fees. The services of a massage practitioner and private duty nurse require referral by a Physician. There is a statutory limit (for residents of British Columbia) which allows PBC to pay only the government prescribed patient visit fee portion of the first 12 visits (under age 65) and first 15 visits (age 65 and over) for the Practitioner per Calendar year. Further Practitioner visits in that Calendar year will be payable subject to the maximum benefit amount specified in the Schedule of Benefits.
5. Charges made by a physician for a medical examination required by law for employment purposes, provided the charges are not covered by the Employer under a collective agreement.
6. Private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence. Your plan may contain a maximum or limitation that is specified in the Schedule of Benefits. The services of a private duty nurse require referral by a Physician.
7. Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. Payment will be based on the Pacific Blue Cross dental fee schedule. No payment will be made for temporary, duplicate, or incomplete procedures or for correcting unsuccessful procedures.

   Accidental injury

   Means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.
8. Medical Aids and Supplies

   Charges for the following services and supplies:
   a) testing supplies (excluding alcohol and alcohol swabs), needles, and syringes for diabetics
   b) oxygen, blood, and blood plasma
   c) ostomy and ileostomy supplies
   d) surgical stockings to a maximum shown in the Schedule of Benefits
   e) walkers, canes and cane tips, crutches, splints, casts, collars, shoulder harnesses, trapeze bars, and trusses, but not elastic or foam supports
   f) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but Pacific Blue Cross will pay the equivalent of a standard prostheses.
   g) medical supplies required for the treatment of burns – Jobst Pressure garments.
   h) mastectomy brassieres to a maximum shown in the Schedule of Benefits.
   i) wigs and hairpieces required as a result of medical treatment or injury to a maximum shown in the Schedule of Benefits.
   j) when prescribed by a Physician or podiatrist as medically necessary:

i) custom fitted orthopedic shoes (including repairs) and modifications to stock item footwear to the maximums specified in the Schedule of Benefits

ii) orthotics to a maximum specified in the Schedule of Benefits in a calendar year.

Replacements shall only be covered when necessitated by normal wear or when there is a change in medical condition as prescribed by a physician.

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

9. Standard durable medical equipment

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

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

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

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

Standard durable equipment includes:

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

b) medical monitors including heart monitors and cardiac screeners

c) Glucometer to the maximum specified in the Schedule of Benefits, for the management of diabetes.

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

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

f) Intermittent positive pressure breathing machines – BI-Pap

g) aerosol equipment, mist tents, nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma

h) apnea monitors for respiratory irregularity (CPAP)

i) insulin infusion pumps for diabetics – when basic methods are not feasible and when prescribed by a physician and **upon approval** by Pacific Blue Cross. Charges for repairs and replacements to be considered only after expiration of warranty

j) Shoulder harnesses and Trapeze bars

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

Vision Care

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

Out-of-Province Medical Referral

When ordered by the attending Physician because, in his or her opinion, adequate medical treatment is not available in the patient's province of residence, the following are included as Eligible expenses:

1) The hospital room charges and charges for services and supplies when confined as a patient or treatment in a hospital, over and above that covered by the government plan or any other underwriter.
2) Services of a Physician and laboratory and x-ray services.

Conditions and Limitations

- The treatment must be medically necessary on the referral of the attending Physician.
- The medical treatment is not available in the patient's province of residence.
- The government plan (i.e. Medical Services Plan of BC) pays a portion of the charges for both hospital and professional services.
- Preauthorization is required from PBC for expenses exceeding $1,000.

Out-of-Province Non-Emergency Eligible Expenses

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

Medical Referral Outside Canada

When a covered person is referred by a Physician in Canada to a hospital outside Canada for medical services which are unavailable in Canada, and for which there is not medically sufficient alternative available in Canada, and prior approval is obtained from the Basic Medical Plan, the following charges shall be reimbursed by Pacific Blue Cross under the same conditions and limits as if these changes were incurred in the Member's province of residence:

1. Charges made by a hospital for medical services and supplies, but not charges for the rental of telephones, televisions, radios or similar equipment.
2. Fees for the services of Physicians to the extent that these fees are not provided for or exceed the amounts allowed under the current Medical Association Schedule of Fees in the Member's province of residence.

Out-of-Province Emergency Eligible Expenses

While travelling outside your province of residence, benefits are payable for the following expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.
Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.

1. The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.

   If reasonably possible, the insurance company should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90-day limit may be extended.

2. Services of a Physician and laboratory and x-ray services.
3. Prescription drugs in sufficient quantity to alleviate an acute medical condition.
4. Other emergency services and/or supplies, that would have been an eligible expense inside your province of residence.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, medi-assist will coordinate the following services:
locate the nearest appropriate medical care.

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

Your worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your Extended Health Care ID number and medi-assist group number ready for personal identification – both numbers are required.

Survivor Benefit

Extended Health Care benefits will continue for your survivors who were insured as Dependents prior to your death **without payment of premium**, until the earliest of the following occurs:

- the period specified in the Schedule of Benefits following the date of your death;
- the person ceases to be a dependent other than as a result of your death;
- the contract is terminated;
- the dependent becomes eligible for coverage under another group contract.

Exclusions

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

1. any other item not specifically included as a benefit
2. except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamin preparations, contraceptives, fertility drugs, medications used to treat or replace an addiction or habituation, support stockings, arch supports, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence
3. general anesthetic, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
4. Non-prescription drugs. Drugs which do not by law require a prescription, drugs not approved under the Food and Drugs Act for sale and distribution in Canada. Any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury.

5. Cosmetic services or supplies or elective surgery
6. allergy testing or therapy unless rendered by a naturopath
7. personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures
8. 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
9. any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
10. 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
11. expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
12. expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date
13. charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence
14. transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind
15. expenses of a Dependent hospitalized at the time of enrolment
16. services performed by a Physician who is related to or resident with you or your Spouse
17. fees for ambulance services when an ambulance is called but not used
18. services required because of war, riot, or self-inflicted injury, while sane or insane
19. services required because of participation in, attempt or commission of a criminal act
20. charges for batteries and re-charging devices
21. ambulance charges for work-related illness or injury assessed by the Workers' Compensation Board to be your employer’s responsibility.

How to Make a Claim

1. Because receipts will not be returned after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit for reimbursement. A remittance statement for your records will be sent to you each time you submit a claim.
2. If you have duplicate coverage, please review the Coordination of Benefits section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on Pacific Blue Cross' files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
3. Certain medical expenses are covered under the government plan. If you submit your claim to Pacific Blue Cross before you submit your claim to the government plan, the insurance company will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your Extended Health Care claim. The balance of the Extended Health Care claim is then paid according your Extended Health Care plan. Information for claiming Pharmacare expenses may be obtained from your pharmacist.
4. Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Employer.
   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
   c) We suggest you submit claims within 90 days from the date the expense was incurred. However, you must submit the claim form by December 31st of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

   Example: Your 2008 receipts must be submitted before December 31, 2009.

Integration with Government Plans

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

CARESNet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefits 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 the Pacific Blue Cross website: http://www.pac.bluecross.ca/caresnet/

Services covered by the Plan are those services that are routinely performed in the offices of general practicing dentists. Covered services are those services listed in the BC Fee Guide.

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

Definitions

Dental Fee Guide

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

Payment of Benefits

1) Pacific Blue Cross will pay benefits based on dental services, financial limits and treatment frequencies in the BC Fee Guide.
2) Pacific Blue Cross applies the reimbursement percentage shown in the Schedule of Benefits to the fees shown in the BC 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 BC Fee Guide.
   b) for services performed in Canada but outside British Columbia - the fees in the Fee Guide in the province/territory of service.
   c) for services performed outside Canada if your province of residence is not British Columbia - the fees in the Fee Guide in your province/territory of residence.
3) Fees in excess of the amount shown in the applicable Fee Guide will be your responsibility.

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

Plan A – Basic Preventative & Restorative Services

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

1. Diagnostic services
   a) Examinations:
      i) complete – provided Pacific Blue Cross has not paid for any other exam by the same Dentist in the period specified in the Schedule of Benefits
      ii) standard – maximum is specified in the Schedule of Benefits
      iii) specific – provided Pacific Blue Cross has not paid for any other exam by the same Dentist in the past 60 days

b) X-rays

i) diagnostic

ii) panoramic

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

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

c) diagnostic models – 1 set per calendar year

2. Preventive services

a) scaling

b) polishing – maximum shown in the Schedule of Benefits

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

d) fixed space maintainers

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

3. Restorative services

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

i) amalgam (silver coloured) fillings

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

iii) inlays and onlays

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

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

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

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

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

b) root planing

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

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

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

6. Prosthetic repairs

a) removal, repairs, and recementation of fixed appliances

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

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

7. Surgical services
   a) Extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in the Pacific Blue Cross Fee Schedule

Plan B – Major Restorative Services

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

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

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

1. Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures
   b) fixed bridges.
2. Restorative Services
   a) veneers
   b) crowns and related services

Plan B Limitations

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

1. Only 1 major restorative service on the same tooth will be covered in a 5 year period.
2. Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
3. Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
4. No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
5. Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in the Pacific Blue Cross Fee Schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage as specified in the Schedule of Benefits.

For dependent child under the age of 21 or to age 26 if a student however treatment must commence after the age of 6 and before age 18.

Plan C Limitations

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

1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement or repair of appliances which are lost, broken, or stolen.
3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

Emergency Treatment Outside Your Province of Residence

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

Extension of Coverage

1) In the event that your insurance under this benefit terminates, allowable expenses incurred after the date of such termination shall not be payable notwithstanding that a treatment plan had been filed and written pre-certification by PBC was granted, unless dental treatment is rendered within 31 days following the termination of insurance in connection with the following procedures:
   a) where an impression for dentures has been taken before the insurance was terminated and the dentures are installed after the termination of insurance.
   b) Dental restoration in connection with crowns or bridges for which the tooth was prepared prior to the termination of insurance.
   c) Root canal therapy where the pulp chamber was opened prior to the termination of insurance.
2) Dental treatment following accidental dental injury to insured dependent children, shall be considered an allowable expense for a 90 day period following termination of insurance, if such treatment was deferred on the recommendation of the dentist because of the age of the patient.
3) Where the company has commenced to pay for a series of treatment in respect to orthodontic services at the date of termination of insurance, benefits shall continue to be payable for a period of 90 days following such termination of insurance but shall be limited to expenses which would have been paid had the insurance remained in force.

Survivor Benefit

Dental benefits will continue for your survivors who were insured as Dependents prior to your death **without payment of premium**, until the earliest of the following occurs:

- the period specified in the Schedule of Benefits following the date of your death;
- the person ceases to be a dependent other than as a result of your death;
- the contract is terminated;
- the dependent becomes eligible for coverage under another group contract.

Exclusions

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

1. items not listed in the Pacific Blue Cross Fee Schedule and fees in excess of those listed in the Fee Schedule
2. any item not specifically included as a benefit
3. charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
4. procedures performed for congenital malformations or for purely cosmetic reasons
5. charges for drugs, pantographic tracings, and grafts
6. charges for implants and/or services performed in conjunction with implants, except as indicated in the Pacific Blue Cross Fee Schedule
7. anesthesia, except as indicated in the Pacific Blue Cross Fee Schedule
8. charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
9. incomplete or temporary procedures
10. recent duplication of services by the same or different Dentist
11. any extra procedure which would normally be included in the basic service performed
12. services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
13. travel expenses incurred to obtain dental treatment.

How to Make a Claim

1. Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to Pacific Blue Cross before you start treatment. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
2. We suggest that you submit claims within 90 days of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will Pacific Blue Cross pay any claim or adjustment submitted later than 1 year from the date the service is performed.
3. Pacific Blue Cross will require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
   a) name of the Dentist
   b) name and birthdate of the person receiving the dental care
   c) your group, social insurance, and Dependent(s) numbers (this information is on your ID card)
   d) your home mailing address
   e) Whether you have coverage through another plan. Claims information regarding the other carrier is not retained on Pacific Blue Cross's files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

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

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

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

5. Orthodontic Claims Procedures

   a) Receipts

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

   b) Claiming deadlines

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

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

   c) Treatment plan

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

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

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

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

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

   d) Monthly or quarterly fees

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

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

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

CARESNet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefits 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 the Pacific Blue Cross website: http://www.pac.bluecross.ca/caresnet/

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

Survivor Benefits

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

Canada Pension Plan
Web: http://www.hrsdc.gc.ca/en/isp/cpp/survivor.shtml#requirements
Toll Free 1-800-277-9914

Disability Income

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

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

Links and addresses to all provincial WCB sites:
Web: http://www.worksafebc.com/links/default.asp

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

Canada Pension Plan
Web: http://www.hrsdc.gc.ca/en/oas-cpp/index.shtml
Toll Free 1-800-277-9914

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

Employment Insurance
Web: http://www.servicecanada.gc.ca/en/sc/ei/benefits/regular.shtml
Toll Free 1-800-206-7218

Retirement Benefits

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

Human Resources Development Canada
Web: http://www.hrsdc.gc.ca/en/oas-cpp/index.shtml
Toll Free 1-800-277-9914

Additional Links

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

Health Care Benefits

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

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

Health Insurance BC: Medical Services Plan and Pharmacare
Web: http://www.health.gov.bc.ca/insurance/index.html
Vancouver & Lower Mainland 604-683-7151
Other areas within B.C. (toll free) 1-800-663-7100

BC Medical Services Plan
Web: http://www.health.gov.bc.ca/msp/index.html
Claims Coverage Inquiries Unit
Other areas within B.C. (toll free) 1-800-742-6165
Out-of-Area Claims
Contact Health Insurance BC by phone (see above)
Online: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html

BC Pharmacare
Web: http://www.health.gov.bc.ca/pharme/index.html
Vancouver & Lower Mainland 604-683-7151
Other areas within B.C. (toll free) 1-800-663-7100
Listen for instructions then press 6, then 5 to reach Pharmacare

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

Registration By Phone:
Vancouver & Lower Mainland 604-683-7151
Other areas within B.C. (toll free) 1-800-663-7100
Registration Online: https://pharmacare.moh.hnet.bc.ca/PPIBroker?ExternalAction=JppiChecklist

BC Ambulance Service (BCAS)
Web: http://www.health.gov.bc.ca/bcas/
General Inquires (604) 660-6897
Vancouver & Lower Mainland (non-emergency) (604) 872-5151
Provincial Administrative headquarters (604) 660-6897
Billing Enquiries – toll free 1-800-665-7199