Your Benefits

Island Sheet Metal Workers Association

First Year Members

PACIFIC BLUE CROSS®

Group Name and Policy Number

Island Sheet Metal Workers' Association

First Year Members

Dental Care & Extended Health Care
Policy Number 39085
BC Life Policy Number 88353

Reissue Date: May 1, 2019

Introduction

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

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

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

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and British Columbia Life & Casualty Company (BC Life) are referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/Member, as "you" or "your" in this booklet.

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

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

BC Life
Group Term Life
Dependent Life
Short Term Disability (STD)

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.

Table of Contents

Schedule of Benefits

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

Extended Health Care		
Deductible	$25 per person or family each calendar year.	
	If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.	
Reimbursement	**In-Province/Territory** Eligible Expenses and **Out-of-Province/Territory** Non-Emergency Eligible Expenses	100%
	Out-of-Province/Territory Emergency Eligible Expenses:	100%
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is $3,000,000.	
Dependent Children	See definition of Dependent.	

Dental Care	
Deductible	No Deductible
Reimbursement	**Plan A** Basic Services
	50%
Frequency Plan Limits	**Each Calendar Year**
Financial Limit Per Dependent Child	$2,000
Financial Limit Per Member or Spouse	$2,000
Dependent Children	See definition of Dependent.

Group Term Life	
Benefit Amount	$75,000
Living Benefit Amount	50% of the Group Term Life Benefit Amount, to a maximum of $50,000
Non Evidence Limit	$75,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 70 or earlier retirement

Dependent Life – Spouse Only	
Benefit Amount	$10,000
Termination	Your Spouse's insurance terminates on your 65th birthday or earlier retirement.

Short Term Disability (STD)			
Weekly Benefit Amount	The current Employment Insurance (EI) maximum.		
Elimination Period	**Injury**	**Hospital**	**Sickness**
For Members eligible for EI insurance	85 working days	85working days	85 working days
For Members not eligible for EI insurance	10 working days	10working days	10 working days
Maximum Benefit Period	26 weeks, with the following exception: if you reach termination age while receiving benefits and have then received payments for less than 15 weeks, benefit payments will continue during disability until you receive 15 weeks of benefits.		
Termination	Age 70 or earlier retirement		

Definitions

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

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

Customary
means usual or traditional and well-established charges for products, services or supplies and/or the use of products, services or supplies during the course of treatment for a medical condition which do not exceed the level made by Providers in the area where the treatment is incurred for a medical condition comparable in nature and severity to that being treated, and within the same geographical area.

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.

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

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

1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and

3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and
4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by 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 or in any PBC Provider agreement. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Fee guide
means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule
means 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.

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

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

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

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

Member
means an employee or other person who has coverage under the Contract.

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

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

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

from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

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

Spouse
means your legal Spouse or a person who has been living with you in a common-law relationship for at least 6 months 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 legislation or other applicable law.

Effective Date of Coverage and Enrolment

Your effective date of coverage will be determined by your Plan Administrator.

You should apply for Dependent coverage (when applicable):

1) on the same date you apply for your own coverage, or
2) within one month if you have a new Dependent.

Welfare Plan Text

The Island Sheet Metal Workers and Roofers Welfare Plan has been created for the members of Local 276. A Board of Directors administers the Plan.

Signatory employers contribute to the Plan, on behalf of eligible Members, an amount set out in the current collective agreement. These employers and their office staff may also participate in the Plan as Associate Members.

The following text, to the end of page 23 of this booklet, is a summary of the Plan. The official text is available for examination at the Welfare office. In the event of any inconsistency or misunderstanding, the benefits will be administered according to the Plan Document and the applicable contract issued by Pacific Blue Cross.

Please read through this booklet carefully so that you can understand how the Plan works for the benefit of yourself and your family.

Eligibility for Coverage

Any member of Local 276 covered by a collective agreement, which requires contributions to the Welfare Plan, may be eligible for coverage. Employers signatory to Local 276 and the office staff of such employers may join the Plan as Associate Members. Any person who has attained age 65 is not eligible to join the Plan as an Associate Member.

Qualifying for Benefits

Sheet Metal Apprentices

Under the terms of the current collective agreement effective May 1, 2004, benefits are set out for apprentices depending on the hours they have worked. Apprentices in their probationary period, who have worked less than 800 hours, are not eligible for benefits under this plan. Employers will begin remitting payments on behalf of Sheet Metal Apprentices upon completion of 800 hours.

Regular Members:
In order to be eligible for benefits, a Member must have worked and had reported by their employer, 260 hours within a six month period. Once eligible, the Welfare office will send out the necessary enrolment forms for Plan coverage. These enrolment forms, along with required documentation must be completed and returned within the time stipulated, to the Administrator of the Welfare Plan.

Commencement of Coverage

Coverage will begin on the first of the month following the month in which the necessary enrolment cards are completed and returned to the Plan office.
You will be issued identity cards for Dental and Extended Health coverage. BC Medical will issue you a new "Care Card" only if you have never been enrolled with BC Medical or if there have been changes to your personal information, otherwise you can continue to use the permanent card issued by BC Medical.

Hour Bank
Each Member has an "Hour Bank" account. When you are employed, your employer must remit to the Welfare Plan, the hours you have worked each month, along with the funds as set out in the collective agreement. These hours are due in the Welfare Plan office by the 15th day of the month following that in which they are worked. (As an example hours you work in May are received in this office on June 15th.) Each month hours reported for you are deposited to your welfare "hour bank" When you are covered under the plan, 130 hours are withdrawn from your "hour bank" account each month in order to provide for your coverage. Members can accumulate a maximum of 1,560 hours in their account. The accumulated hours may be used during periods of poor employment, illness or vacations. Any hours in excess of 1,560 are transferred to the Welfare General Account.

Maintaining Coverage

Once enrolled on the Plan, your coverage is maintained as long as you have sufficient hours in your hour bank. Should your hour bank drop below 130 hours, you may maintain coverage by "self - payment". An information letter setting out your options and eligibility along with a bill are sent out at the beginning of each month to those Members who have insufficient hours. Coverage will continue provided your payment is received in the Welfare Plan office by the 20th day of the billing month. You can continue to "self-pay" for coverage for up to six continuous months. At that time coverage with the Plan will cease.

Maintaining Coverage – Roofing Material Handlers –
In order to maintain coverage, you must have regular employment with an employer signatory to our collective agreement.

Termination of Coverage

Your coverage will terminate when your hour bank falls below 130 hours and the welfare office does not receive the required payment, or when you have self paid for coverage for the maximum period of six consecutive months.

Retirement
Upon retirement, a Member is no longer eligible for coverage under the Welfare Plan. Coverage will cease at the end of the month in which you retire.

Suspension of Union Membership
If you are suspended as a union member from Sheet Metal Workers International Association, Local 276, and are covered by the Plan, coverage may continue for the month in which such suspension takes place provided that there are sufficient hours in your hour bank. Coverage will cease at the end of that month. Any remaining hour bank balance will be maintained for a period of one year. After that time any hour bank balance will be transferred to the Welfare General Account.

Withdrawal from Union Membership

If you are issued and maintain a valid withdrawal card from Sheet Metal Workers International Association, Local 276, you may continue to be covered until such time as your hour bank account is depleted.

Transfer Card

If you transfer from this Local to another within the International Association, you may continue to be covered for the month in which your transfer takes place. You may also be covered for an additional two months, provided there are sufficient hours in your hour bank. Any balance in your hour bank may be transferred to your new local upon the written request of that local's administrator.

Conversion (Medical Services Plan)

If your coverage with this plan is cancelled, you must contact the Medical Services Plan of BC in order to be covered for basic medical. Please refer to *Conversion to an Individual Plan* on page 18 of this booklet for complete information on converting your Dental and Extended Health Care Benefits to an individual plan or contact the Welfare Plan office for further information.

Reinstatement of Coverage

If your coverage is cancelled, you must requalify for coverage as set out in *Qualifying for Benefits*.

Membership Responsibilities

When completing your enrolment cards, you must list all your eligible dependants that you want covered. If you wish to add a dependent after coverage has started we may require proof of insurability. If you wish to add a common law spouse after your coverage has started there will be a three month waiting period.

If you receive a notice for self-payment of coverage do not ignore it. If you think it is incorrect, contact the Plan administration office immediately. If a required payment is not received, this office must assume you do not wish to continue coverage and your coverage will be cancelled. In order to re-enrol, you must requalify as set out above.

All changes made to your coverage must be done through the Welfare Plan office.

Please keep the Welfare Plan office advised of any change of address. If you lose your ID cards, please contact this office for replacements. BC Medical will replace a Care Card for a fee. If you need to replace a Care Card please contact this office for an order form.

Notification of Plan Changes

The directors of the Welfare Plan have the right to make changes to the Plan that they deem necessary. If changes are made to the Plan, written notification will be sent by regular mail to the Member's last recorded address as shown in the Administrators records. Notification will be deemed to have been given at the earlier of:

1. actual receipt of notification
2. 72 hours following the mailing of such notice.

General Information

Please keep your own pay slips. Errors may occur in reporting, tabulating or entering your hours. Keep a record of your employers; their address and hours worked each month.

Should you have any questions regarding the general operation of the Welfare Plan or information regarding entitlement to benefits don't hesitate to contact the Union office, which is also the Welfare Plan office.

You can reach the Welfare Plan office at:
Phone # 250 727-3458
Fax # 250 727-7154
Toll Free # 1 800-448-4177
Address:
302-791 Goldstream Ave., Victoria, BC V9B 2X5
email: smwia276@shaw.ca

Beneficiary

1) To the extent permitted by law, you have the right to name a personal representative or beneficiary for Life benefits or change this personal representative or beneficiary, by written request in a form satisfactory to us. If your designated personal representative or beneficiary does not survive you, any Benefit amount due will be payable to your estate.
2) For all other benefits this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits.

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/member

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 are members of the same association, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse are members of different associations 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) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
   e) false pretences or fraudulent misrepresentation
   f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

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

Termination of Coverage

The termination date of your coverage will be determined by your Plan Administrator.

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.

Survivor Benefit

If you die while covered under this plan, coverage for your Dependents will continue until the earliest of the following occurs:

1) the last day of the month in which there is less than 130 hours left in your hour account
2) the date your Dependent ceases to be a Dependent other than as a result of your death
3) the date the Contract is terminated.

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.

Member Profile

Your Pacific Blue Cross Member Profile is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in you will be able to make and track online claims, get information on benefit coverage and downloadable claim forms. To login, visit: **www.pac.bluecross.ca/member/**

Extended Health Care

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

Definitions

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

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

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

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

Markup
means the total of all amounts added to the manufacturer's list price, meaning the published price at which the drug is available for purchase

from the manufacturer in the applicable province/territory, and including any wholesale upcharge, retail markup, and any other amounts in excess of the manufacturer's list price.

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

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

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

In-Province/Territory Eligible Expenses

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

1) Hospital
   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.

   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 an Eligible expense in a quantity we consider reasonable, and as approved by our Benefit review, and
   a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, including:
      i) Life sustaining non-prescription 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 Practitioner, or
   b) which legally require a prescription from a Provider legally authorized to do so, including:
      i) Compounded drugs

ii) contraceptive drugs
iii) drugs indicated for weight loss
iv) all vaccines excluding flu and hepatitis vaccine.

The ingredient cost of multi-source brand drugs, plus Markup will be reduced to the ingredient cost of the lowest cost equivalent generic plus Markup. The ingredient cost of generic and single source brand drugs plus Markup are eligible.

If we receive written confirmation from the prescribing Practitioner that there is a specific adverse effect that prevents the Member from taking the generic the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

The maximum allowable Markup is 15% of the manufacturer's list price.

Specific high cost BC PharmaCare limited coverage drugs are identified by us as our Special Authority Enforcement list. We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once the BC PharmaCare decision (approved or declined) is on file with us, we will consider this drug as eligible based on:

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

4) Practitioners

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

a) acupuncturist $500
b) chiropractor/naturopath combined.....$500
c) massage Practitioner/physiotherapist combined.....$500
d) podiatrist.....$500
e) psychologist/clinical counsellor combined.....$500
f) speech language pathologist $500

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) ostomy and ileostomy supplies
c) hyaluronic acid injections when administered by a Physician or Nurse practitioner
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 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) charges for the following items to the maximum amounts indicated per calendar year:
    i) mastectomy brassieres $150
    ii) stump socks $200
g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500

h) orthopaedic shoes and orthotics
   i) when prescribed by a Physician, podiatrist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear to a maximum in a calendar year period of $400 per adult and $200 per 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 Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a maximum of $250 in a calendar year. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

i) hearing aids and repairs to a maximum of $1,000 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) medical heart monitors and cardiac screeners
   iii) continuous glucose monitors and supplies and blood glucose monitors
   iv) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
   v) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon
   vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
   vii) insulin infusion pumps for diabetics – when basic methods are not feasible
   viii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
   ix) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Vision Care and Laser Eye Surgery
Charges for the following when prescribed or performed by a Physician or legally authorized optical Provider (as applicable):
   a) purchase of eyewear and/or repair of eyewear and charges for contact lens fittings, and
   b) laser eye surgery

to a combined maximum of $400 in a 2 calendar year period. Charges for non-prescription eyewear are not covered.

9) Eye Examinations
Charges for routine eye examinations every 2 calendar years to a maximum of $100 when performed by a Physician or legally authorized optical Provider, for persons between the ages of 19 and 64.

10) Prostate Specific Antigen (PSA) Testing
Charges for PSA testing.

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 of residence subject to the Deductible, in-province 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 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 of residence.

We will only cover Eligible expenses obtained within 60 days of the date you or your Dependent left the country of residence. If hospitalization occurs within the 60 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 60 days after you initially leave your country of residence, medi-assist will coordinate the following services:
1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

Exclusions

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

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, Hospital coinsurance, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2) except as specifically included in this booklet, we pay no drug expenses for:
    a) food replacements, food supplements, and infant foods
    b) administrative charges for injectable medications or infusions
    c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital
    d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility
    e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process
    f) any expenses identified as exclusions under the Extended Health Care Benefit
3) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate 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

4) except as specifically included in this booklet: charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals, or charges for translating documents into English
5) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government plan
6) that portion of a claim normally covered by the Government plan which has been refused on the basis that the claim was not submitted within the Government plan's time limits
7) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
8) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
9) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence
10) expenses of a Dependent hospitalized at the time of enrolment
11) services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse
12) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
13) fees for ambulance services when an ambulance is called but not used
14) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer’s responsibility
15) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
16) any other item not specifically included as a benefit
17) legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it electronically 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 Government plan, 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/member
    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 2019 before December 31, 2020.
    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 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 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
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment).
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 60 month period
      iii) complete mouth series – 1 per 36 month period
      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.

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
   c) topical application of fluoride – 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

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.

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 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) major restorative services, unless dental Plan B has been added
4) orthodontics, unless dental Plan C has been added
5) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
6) procedures performed for congenital malformations or for purely cosmetic reasons
7) charges for drugs, pantographic tracings, and grafts
8) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
9) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
10) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
11) incomplete or temporary procedures
12) recent duplication of services by the same or different Dentist
13) any extra procedure which would normally be included in the basic service performed
14) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
15) 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 starts treatment, please ask them how billing is made. We may pay in either of two ways:
   a) If you have paid your Dentist 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 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.

Payment of Benefit

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

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

Living Benefit

Terminal condition
means an injury or sickness from which there is no reasonable prospect of recovery, as determined by us, and which is expected to result in your death within 12 months.

If you have a Terminal condition, we will pay you the living Benefit amount shown in the Schedule of Benefits. You or your legal representative must submit a written request for this benefit and include written consent from your beneficiary (release form) and written proof of your medical condition from your attending Physician.

This Benefit amount is payable once. The amount of your group term life insurance benefit or the amount of insurance you can convert outlined under the conversion option is reduced by the amount you receive under this benefit.

Waiver of Premium

Should you become totally disabled prior to your 65th birthday and remain so for six months, the premium for your group term life insurance will be waived.

Conversion Option

You will be eligible to convert your group life insurance coverage to a personal life insurance policy issued by Blue Cross Life Insurance Company of Canada without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

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

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

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

Claims

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

Payment

Because you must enrol your Spouse for the dependent life insurance benefit, when your Spouse dies, we will pay the Benefit amount to you.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for the dependent life insurance benefit will also be waived.

Exclusions

A Spouse not residing in Canada or the USA or a Spouse who is a member of the armed forces in any country is not eligible for the dependent life insurance benefit.

Claims

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

Definitions

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

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

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

Benefit

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

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a Physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under his or her regular care

and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a Physician.

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

Recurrent Disability

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

Graduated Return to Work

If you return to work on a gradual rehabilitative basis you will have your benefit reduced by 50% of any income earned from the rehabilitative employment. The combined total of your benefit plus the rehabilitative income will not exceed 100% of your earnings prior to the date your disability started.

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

In consultation with you, your association, and with your Physician's agreement, we will determine your eligibility for this program and its duration.

Extended Benefit

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

Coordination with other Income Sources

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

Third Party Liability

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

Are Benefits Taxable?

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

Termination of Benefit

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

1) you are no longer disabled
2) you are no longer receiving continuing medical care and treatment from your Physician
3) you fail to submit satisfactory proof of continuing disability as required by us

4) you refuse a medical examination by a Physician chosen by us
5) you are no longer following the treatment recommended for your disability
6) you leave Canada for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the Government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by us.
7) you perform any work for compensation or profit
8) the end of the maximum benefit period indicated in the Schedule of Benefits
9) you retire
10) you die.

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
    b) participation in a criminal offense
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
    d) a pregnancy related sickness
        i) during any period of formal maternity leave and/or parental leave
        ii) during any period in which Employment Insurance (EI) benefits are being paid
    e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician

f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness

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

Claims

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

Notes

PACIFIC BLUE CROSS®

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0621.004 — 62-15-100 05/18 CUPE 1816