

<b>Group Name and Number</b>
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**TRIUMF**

**Retirees under age 70 – Group 002936**

**Retirees age 70 or older – Group 002937**

**Effective: September 1, 2012**

## Introduction

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

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

**The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits.**

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) is referred to as “we”, “us”, or “our” in this booklet. We will refer to you, the retiree/Member, as “you” or “your” in this booklet.

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

Coverage is provided through:

**Pacific Blue Cross**  
Extended Health Care (EHC)  
Dental Care

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

## Privacy Policy

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

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

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## **Schedule of Benefits**

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

<b>Extended Health Care</b>	
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*Deductible*

**Prescription Drugs:** \$5 per prescription.

**All other Eligible Expenses:** No Deductible

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*Reimbursement*

**In-Province/Territory Eligible Expenses:**

PharmaCare approved drugs 80%

Non-PharmaCare drugs 50%

Travel Vaccines 50%

Semi-Private Hospital Room 100%

All other Eligible Expenses 80%

**Out-of-Province/Territory Eligible Expenses:**

Emergency 100%

Non-Emergency Same as In-Province

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*Prescription Drugs*

The maximum is \$2,000 for a Member or Dependent per calendar year.

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*Plan Maximum*

The lifetime maximum amount of benefits payable for a Member or Dependent is \$100,000 (including Out-of-Province coverage).

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*Dependent Children*

See definition of Dependent.

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<b>Dental Care</b>		
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<i>Deductible</i>	No Deductible	
<i>Reimbursement</i>	<b>Plan A</b>	<b>Plan B</b>
	Basic Services	Major Restorative Services
	70%	50%
<i>Frequency Plan Limits</i>	<b>Each Calendar Year</b>	<b>Each Calendar Year</b>
<i>Financial Limit Per Dependent Child</i>	\$1,500 Combined with Plan B	\$1,500 Combined with Plan A
<i>Financial Limit Per Member or Spouse</i>	\$1,500 Combined with Plan B	\$1,500 Combined with Plan A
<i>Financial Limit for Late Applicants</i>	\$250 per person for all dental services for first 12 months of coverage	
<i>Dependent Children</i>	See definition of Dependent.	



## **Definitions**

### **Allowable enrolment period**

means within 12 months from the coverage effective date.

### **Coverage effective date**

means the day after your coverage terminates under your Employer's Plan for active employees, provided you apply for Benefits within the Allowable enrolment periods.

### **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 handicapped 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. Handicap status is subject to approval by us. The Dependent must become handicapped while covered as a Dependent under Clause 2 and 3 above.

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

**Duplicate coverage**

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

**Fee guide**

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed. For Alberta, the Fee guide means the current Alberta Blue Cross Usual and Customary fee guide.

**Fee schedule**

means Schedule 3 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

**Member**

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

**Spouse**

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

## Member Information/Access to Records

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

## Integration with Government Plans

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

## Effective Date of Coverage and Enrolment

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

You should apply for Dependent coverage (when applicable):

- 1) on the same date you apply for your own coverage, or
- 2) within the Allowable enrolment period if you have a new Dependent.

If we do not receive your application card within the required time limits, please refer to the Late Application section.

Coverage begins on the coverage effective date shown on your identification (ID) card(s), provided you and your Plan Administrator have complied with our enrolment rules.

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

## Late Applicants

If you did not apply during the Allowable enrolment period but request coverage later (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 – health evidence or retroactive premium payment. In some instances, coverage may be denied.

## Designation of Beneficiary under Replacement Contract/Policy

If this Group Contract/Policy replaces another group contract/policy, and this Contract/Policy covers some or all of the same Members as the previous contract/policy, all personal representatives or beneficiaries named by Members covered by the previous contract/policy will apply to these Members covered under this Group Contract/Policy.

## 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.

- 4) The necessary claim forms are available from your Plan Administrator or on our website at [www.pac.bluecross.ca/caresnet](http://www.pac.bluecross.ca/caresnet)
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

## Duplicate Coverage

If you and your Spouse are eligible for Member coverage through the same employer, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

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

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

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

## Coordination of Benefits

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

- 1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
- 2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
- 3) In situations of separation or divorce, the following order applies:
  - a) the plan of the parent with custody of the child

- b) the plan of the Spouse of the parent with custody of the child
  - c) the plan of the parent not having custody of the child
  - d) the plan of the Spouse of the parent in c) above.
- 4) Total reimbursement shall never exceed 100% of the Eligible expenses.

## General Exclusions

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

## Legal Action

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

## **Termination of Coverage**

Generally, your coverage (and any Dependent coverage) terminates if you cease to be covered under the government plan (ie. Medical Services Plan of BC), or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract.

## **Right of Recovery**

You are financially responsible for any claims paid by us on you 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) 6 months after your death
- 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
- 4) the date your Dependent becomes eligible for coverage under a similar group plan.

## **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 604 419-2200 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 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

## **CARESnet**

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

## Extended Health Care

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

### Definitions

#### **Eligible expense**

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

- 1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
- 2) was ordered or referred by a Physician 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 drug program will not be applied unless specified in this booklet.

#### **Physician**

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

## **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/Territory Eligible Expenses**

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

- 1) Hospital
  - a) the additional charge for semi-private room accommodation in a hospital or the extended care unit of a hospital.
  - b) the charge for semi-private room accommodation, board charges, and any other use fees incurred in a convalescent or chronic facility to a maximum of \$3 per day for 120 days, for the same illness or injury.

Charges for rental of a telephone, television, or similar equipment are not covered.

Convalescent care must be certified as medically necessary by a Physician. The patient must be admitted within 48 hours of discharge from a hospital where he or she has been confined for a minimum of 5 days for the same illness or injury.

- 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 and medicines

Charges for drugs and medicines in a quantity we consider reasonable, and

- a) which are dispensed by a pharmacist, Physician, or a Dentist, including:
  - i) insulin preparations, testing supplies, needles, and syringes for diabetics
  - ii) vitamin B12 for the treatment of pernicious anemia
  - iii) allergy serums when administered by a Physician, or
- b) which legally require a prescription from a medical provider legally authorized to do so, including
  - i) drugs and supplies for smoking cessation to a lifetime maximum of \$250
  - ii) contraceptives
  - iii) travel vaccines for yellow fever, polio, typhoid, hepatitis A, tetanus, malaria, and diphtheria, limited to 1 immunization per lifetime (Member and Spouse only) to a maximum of \$50 per immunization

*Prescription drugs are subject to a maximum of \$2,000 per calendar year.*

4) Practitioners

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

- a) acupuncturist .....\$350
- b) audiologist .....\$350
- c) chiropractor and 1 chiropractic x-ray combined.....\$350
- d) dietician .....\$350
- e) massage practitioner .....\$350
- f) naturopath.....\$350
- g) osteopath.....\$350
- h) physiotherapist.....\$350
- i) podiatrist and 1 podiatrist x-ray combined .....\$350
- j) psychologist and social worker combined.....\$350
- k) speech language pathologist .....\$350
- l) 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/territory of residence, limited to a

maximum of \$10,000 per calendar year or \$25,000 per lifetime, whichever occurs first.

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, blood, and blood plasma
- b) ostomy and ileostomy supplies
- c) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports
- d) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
- e) charges for the following items to the maximum amounts indicated per calendar year:
  - i) mastectomy brassieres ..... \$250
  - ii) stump socks ..... \$250
  - iii) surgical stocking..... \$250
- f) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of \$500

- g) orthopaedic shoes and orthotics
    - i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. 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, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet to a combined maximum in a calendar year of \$300.
  - h) hearing aids and repairs to a maximum of \$500 in a 60 month 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 and blood glucose monitors, and cardiac screeners
  - iii) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
  - iv) bi-osteogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems
  - v) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
  - vi) insulin infusion pumps for diabetics – when basic methods are not feasible
  - vii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
  - viii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.
- 8) Eye Examinations  
Charges for routine eye examinations every 24 months to a maximum of \$70 when performed by a Physician or legally authorized optical provider.

## **Out-of-Country Medical Referral Eligible Expenses**

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

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

### **Conditions and Limitations**

- 1) The treatment must be medically necessary, not available in Canada, and referred by a Physician resident in your province/territory of residence.

- 2) The government plan must authorize the treatment and accept the appropriate financial responsibility.
- 3) Preauthorization is required from us for expenses in excess of \$1,000.
- 4) The maximum benefit is \$50,000 per calendar year.

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

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

## **Out-of-Province/Territory Emergency Eligible Expenses**

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

- 1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
- 2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.

If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has



space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.

- 3) Services of a Physician and laboratory and x-ray services.
- 4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
- 5) Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.
- 6) Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to his or her place of residence in Canada in the event you and/or your Spouse is hospitalized and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.
- 7) Charges, limited to the cost of one-way economy fare air transportation, for the delay of the return trip of you or your Spouse due to the hospitalization of another insured person with whom you or your Spouse are travelling.
- 8) Charges, limited to return economy fare air transportation, for one immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.
- 9) Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of \$5,000 per family per medical emergency.
- 10) Charges for accommodation for convalescence following hospitalization to a maximum of \$75 per day per patient for a maximum of 5 days per medical emergency.
- 11) Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized member or Dependent to a maximum of \$100 per day up to 7 days per family per medical emergency.

Limitation:

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

- 12) Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of \$500 per medical emergency.
- 13) Charges for the repatriation of a deceased member and/or Dependent to their place of residence to a maximum of \$5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to \$1,500.
- 14) The maximum benefit is \$50,000 per calendar year.

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 EHC ID number and

medi-assist group number ready for personal identification – both numbers are required.

## Exclusions

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

- 1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province/territory of residence
- 2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
- 3) except as specifically included in this booklet: contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
- 4) allergy testing unless rendered by a naturopath
- 5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests
- 6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English

- 7) any payment to a pharmacy, a Practitioner, 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
- 8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
- 9) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
- 10) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
- 11) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
- 12) expenses of a Dependent hospitalized at the time of enrolment
- 13) services performed by a Physician who is related to or resident with you or your Spouse
- 14) fees for ambulance services when an ambulance is called but not used
- 15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
- 16) retroactive coverage and payment of any expense, including drugs that receive special authorization from PharmaCare
- 17) any other item not specifically included as a benefit.

## Claims

### Electronic Claims

- 1) When submitting an electronic claim you must:
  - a) complete the claim form online and submit it electronically to us
  - b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
  - c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation to us within

21 calendar days. If we do not receive this information within this time, your claim will be refused.

- 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 31<sup>st</sup> 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 31<sup>st</sup> deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.
- 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.

**Please Note:** If your Spouse and/or children have coverage through another plan, your Pay Direct card cannot be used for their prescription expenses. Please refer to item 2 below for further information.

### **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 government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. 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 Plan Administrator or on our website at [www.pac.bluecross.ca/caresnet](http://www.pac.bluecross.ca/caresnet)
  - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
  - c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **December 31<sup>st</sup>** 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 2012 before December 31, 2013.
  - d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

## Payment of Benefits

- 1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.
- 2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
  - a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee schedule
  - b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
  - c) for services performed outside Canada if your province/territory of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
- 3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

## Plan A – Basic Preventive & Restorative Services

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

- 1) Diagnostic services
  - a) examinations:
    - i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3 year period
    - ii) recall – 2 in a 12 month period
    - iii) specific – 2 per calendar year
    - iv) consultations (as a separate appointment)
  - b) x-rays
    - i) diagnostic
    - ii) panoramic – 1 per 3 year period
    - iii) complete mouth series – 1 per 3 year periodAll x-rays combined shall not exceed the dollar limit for a complete mouth series.
  - c) diagnostic models – 1 set per calendar year.
- 2) Preventive services
  - a) scaling, root planing, and gingival curettage – a combined yearly limit shown in our Fee schedule
  - b) polishing – 2 in a 12 month period
  - c) topical application of fluoride – 2 in a 12 month period
  - d) denture cleaning – 2 in a 12 month period
  - e) fixed space maintainers
  - f) 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) inlays – paid to the equivalent non-bonded rate
    - iii) composite (tooth coloured) 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, but including the following:
  - a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
  - b) root planing, scaling, and gingival curettage – a combined yearly limit shown in our Fee schedule
  - c) osseous surgery – 1 per sextant in a 5 year period
  - d) bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).
  
- 6) Prosthetic repairs
  - a) removal, repairs, and recementation of fixed appliances
  - b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
  - c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
  - d) gold foil – only when used to repair existing gold restorations.
  
- 7) Surgical services
  - a) extractions
  - b) other routine oral surgical procedures
  - c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

## **Plan B – Major Restorative Services**

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

Mounted x-rays and/or diagnostic casts may be required for our approval.

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

- 1) Prosthodontic Services

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

#### Limitations

- 1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
- 2) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- 3) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- 4) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

## **Emergency Treatment Outside Your Province/Territory of Residence**

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

## **Exclusions**

The following are not Eligible expenses under your dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule

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

## Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **1 year** 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 group, ID, 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 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.

Notes

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