JCBT

Joint Community Benefits Trust

Group Benefit Plan

For REGULAR FULL-TIME AND PART-TIME EMPLOYEES covered by the

Health Services & Support Community Subsector Collective Agreement

(Community Agreement) 2014-2019, 2019-2022 & 2022-2025

Provided by the Joint Community Benefits Trust

Effective: October 17, 2023

IMPORTANT PLAN MEMBER INFORMATION

As of April 1, 2017 your benefits are provided under the terms of the Joint Community Benefits Trust's Plan and claims are paid out of the Joint Community Benefits Trust (JCBT). The Trust is funded by contributions from healthcare employers in BC.

The Joint Community Benefits Trust is a trust that is exclusively dedicated to providing certain employee benefits and services related to those benefits. The Trust is not an insurance company and, except for group life and accidental death and dismemberment, the benefits it provides are not insured by an insurance company. The JCBT is not subject to regulation under the British Columbia *Financial Institutions Act*.

This booklet is not intended to define your legal entitlement to benefits under the Joint Community Benefits Trust. It is a summary document produced as a general guide only.

In case of any inconsistencies between this booklet and the Plan Text, the provisions of the Plan Text in effect at the relevant time shall govern. The terms of the Plan Text may be amended from time to time.

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Group Life

The Group Life benefit is paid to your beneficiary or estate in the event of your death from any cause.

cost

Your employer pays the cost of this Group Life benefit.

The contributions your employer pays are taxable income to you, and will be included on your annual T4 slip.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time employee, regular part-time employee or regular community health worker, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first day of the month after you have completed your probationary period.

amount of benefit

If you die, $50,000 will be paid to your beneficiary (or to your estate if you have not named a beneficiary).

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. This person will receive your Group Life benefit if you die. If you named more than one person, the payment will be divided among your beneficiaries as specified in your Appointment/Change of Beneficiary form. If you have not named a beneficiary, the benefit will be paid to your estate.

Changing your beneficiary: You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

There are no exclusions under the Group Life benefit. The benefit is paid regardless of the cause of your death, provided you were eligible for coverage at the date of death.

continuation of coverage

Your coverage for all benefits will continue without cost to you while you are receiving sick pay or WSBC wage loss benefits, or are on an Employment Standards Act leave including compassionate, maternity or parental leave.

During the first 20 work days of any other unpaid leave your coverage for all benefits will continue without cost to you. Group Life coverage can continue while you are on unpaid leave beyond 20 work days if you pay the contributions.

If you receive LTD benefits from this Plan, your Group Life coverage will continue as long as you remain an employee, without cost to you.

termination of coverage

Your Group Life coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave beyond 20 work days and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to casual status
- You are laid off.

conversion

If you cease to be eligible because of termination of employment (including retirement), your coverage will continue at no charge for 31 days. During the 31 day period you may convert your coverage to an individual policy issued by Canada Life without providing medical evidence.

claims

Claims are processed by Canada Life in Vancouver. If you die, your beneficiary or executor should contact your employer for assistance in filing a claim.

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advance payment program

If you are terminally ill and are expected to live less than one year, you may be eligible for an advance payment of up to 50% of your Group Life benefit (maximum payment $25,000). The remaining benefit (less interest) will be paid to your beneficiary or estate when you die. If you wish to apply for an Advance Payment, contact your employer to obtain an application form.

Accidental Death & Dismemberment

The Accidental Death benefit is paid to your beneficiary or estate in the event of your death as a result of an accident. It is paid **in addition** to the Group Life benefit.

The Accidental Dismemberment benefit is paid to you if you lose a limb, sight, hearing or speech as a result of an accident, and includes loss of use (paralysis).

cost

Your employer pays the cost of this Accidental Death & Dismemberment (AD&D) benefit.

The contributions your employer pays are taxable income to you, and will be included on your annual T4 slip.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time employee, regular part-time employee or regular community health worker, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first day of the month after you have completed your probationary period.

amount of accidental death benefit

If you die accidentally $50,000 ("principal sum") will be paid to your beneficiary (or to your estate if you have not named a beneficiary).

amount of accidental dismemberment benefit

(includes loss of use)

- If you lose both hands, or both feet, or the sight of both eyes, or one hand and one foot, or one hand and the sight of one eye, or one foot and the sight of one eye, or hearing in both ears and speech: 100% of the principal sum will be paid to you
- If you lose one arm or one leg: 75% of the principal sum will be paid to you
- If you lose one hand, or one foot, or the sight of one eye, or hearing in both ears, or speech: 50% of the principal sum will be paid to you
- If you lose the thumb and index finger of one hand, or all 4 fingers of one hand: 25% of the principal sum will be paid to you
- If you lose all the toes of one foot: 12.5% of the principal sum will be paid to you.

Loss of an arm, leg, hand, foot or eye means the total and irrecoverable loss of its use. Loss of thumb or fingers means complete severance at or above the metacarpophalangeal joints. Loss of toes means complete severance at or above the metatarsophalangeal joints. Loss of sight, speech or hearing must be complete and irrecoverable.

maximum benefit

The principal sum is the maximum AD&D benefit payable for all losses as a result of any one accident.

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. This person will receive the principal sum if you die accidentally. If you named more than one person, the payment will be divided among your beneficiaries as specified in your Appointment/Change of Beneficiary form. If you have not named a beneficiary, the benefit will be paid to your estate.

Changing your beneficiary: You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

The AD&D benefit will not be paid for losses resulting from any of the following:
1. Suicide or attempted suicide, while sane or insane.
2. Intentionally self-inflicted injury.
3. War, insurrection or hostilities of any kind, whether or not you were a participant in such actions.
4. Participating in any riot or civil commotion.
5. Bodily or mental infirmity or illness or disease of any kind, or medical or surgical treatment thereof.
6. Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current airworthiness certificate, and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only. Descent from any aircraft in flight will be deemed to be part of such flight.
7. Committing or attempting to commit a criminal offence or provoking an assault.
8. In the course of operating a motor vehicle while:
   a. under the influence of any intoxicant, or
   b. if your blood alcohol concentration was in excess of 100 milligrams of alcohol per 100 millilitres of blood.

continuation of coverage

Your coverage for all benefits will continue without cost to you while you are receiving sick pay or WSBC wage loss benefits, or are on an Employment Standards Act leave including compassionate, maternity or parental leave.

During the first 20 work days of any other unpaid leave your coverage for all benefits will continue without cost to you. AD&D coverage can continue while you are on unpaid leave beyond 20 work days if you pay the contributions.

If you receive LTD benefits from this Plan, your AD&D coverage will continue as long as you remain an employee, without cost to you.

termination of coverage

Your AD&D coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave beyond 20 work days and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to casual status
- You are laid off.

claims

Claims are processed by Canada Life in Vancouver. If you die as a result of an accident, your beneficiary or executor should contact your employer for assistance in filing a claim. If you suffer a dismemberment or loss of use as a result of an accident, contact your employer for assistance in filing a claim.

The loss must occur within 365 days of the date of the accident. Claims must be submitted to Canada Life within 365 days of the date of loss.

Long Term Disability

The Long Term Disability benefit provides you with a monthly income if you become totally disabled as a result of an accident or sickness.

EDMP: This LTD benefit is provided in conjunction with the union-employer sponsored Enhanced Disability Management Program (EDMP) which is described in detail in the Community Agreement. EDMP is an employee-centered, proactive disability management program. A customized and holistic case management plan (CMP) is developed for employees who participate in the EDMP. The CMP may include medical intervention, transitional work, a graduated return to work, workplace modifications, vocational rehabilitation and/or retraining. At the point that you are applying for LTD benefits, you may have a CMP that has already been developed under the EDMP to help you recover and return to work. In that event, the LTD benefit will be part of your CMP.

For additional information on EDMP visit:

http://www.commhealthdm.ca/
http://www.heabc.bc.ca/Page4257.aspx#.VG_COfnF9ic

cost

Your employer pays the cost of this Long Term Disability (LTD) benefit.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time employee, regular part-time employee or regular community health worker, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first day of the month after you have completed your probationary period.

amount of benefit

If you are disabled and qualify for LTD benefits, you will receive 70% of the first $2,800* of basic monthly earnings;

+ 50% of basic monthly earnings in excess of the above limit;
+ adjustments every 4 years based on increases in the weighted average wage rate (also called "indexing"). If you are eligible for indexing, you will receive a letter from Canada Life explaining the calculation.

OR: the benefit will be 66-2/3% of basic monthly earnings if this calculation produces a greater benefit.

*adjusted annually for new claims based on increases in the weighted average wage rate.

"Basic monthly earnings" for full-time employees = Your basic monthly earnings as at the date you become totally disabled (plus isolation allowance if applicable).

"Basic monthly earnings" for part-time employees = Your average monthly hours of work for the 12 month period (or period of employment if shorter) prior to the date you become totally disabled, multiplied by your hourly pay rate as at the date you become totally disabled (plus isolation allowance if applicable).

Basic monthly earnings are also called "pre-disability earnings".

qualification period

LTD benefits are payable after you have been totally disabled and unable to perform the duties of your own occupation for 5 months. These 5 months are the "qualification period". Payments commence at the end of the sixth month of disability.

definition of total disability

To qualify for LTD benefits for the first 19 months of disability (excluding the 5 month qualification period): You must be unable, because of an accident or sickness, to perform the duties of your own occupation or any available comparable position. This is called the "own occupation" period of disability. During this own occupation period your employer may accommodate you into an available position that pays not less than 75% of your pre-disability earnings.

To continue to qualify for LTD benefits after 19 months of disability (excluding the 5 month qualification period): You must be unable to perform the duties of any gainful occupation for which you have the education, training or experience, and which pays at least 70% of the current rate of pay for your job as at the date you became disabled. This is called the "any occupation" period of disability.

successive disabilities

During the qualification period: If you attempt to return to work during the qualification period, but within 31 calendar days cease work because of the same disability, you will not be required to start a new qualification period. However, your qualification period may be extended by the number of days you worked.

After LTD benefits have been paid: If you return to work but within 6 months stop working because of the same disability, or within 31 days stop working because of a new disability, your prior LTD claim will be re-opened and you will not have to complete a new qualification period.

exclusions

LTD benefits will not be paid for disabilities resulting from:

1. Any period of disability when you are not under the regular and personal care of a physician.
2. War, insurrection, rebellion, or service in the armed forces of any country.
3. Voluntary participation in a riot or civil commotion, except while you are performing the duties of your regular occupation.
4. Intentionally self-inflicted injuries or illness.

continuation of coverage

Your coverage for all benefits will continue without cost to you while you are receiving sick pay or WSBC wage loss benefits, or are on an Employment Standards Act leave including compassionate, maternity or parental leave.

During the first 20 work days of any other unpaid leave your coverage for all benefits will continue without cost to you. LTD coverage can continue after the 20 work day period while you are on an unpaid leave for up to 12 months (24 months if on an educational leave), if you pay the contributions.

If you receive LTD benefits from this Plan, your LTD, Group Life and AD&D coverage will continue without cost to you. You can elect to continue your Dental and/or Extended Health coverage if you pay 50% of the contributions. Such an election must be made at the time your LTD claim is accepted and contributions must be paid to the employer monthly in advance. Note: In order for your Group Life, AD&D, Dental and Extended Health coverage to continue while you are on LTD, you must remain an employee.

termination of coverage

Your LTD coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave beyond 20 work days and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to casual status
- You are laid off
- You attain age 64 years and 7 months.

claims

LTD claims are processed by Canada Life.

If you are disabled, have been unable to work for 3 months and do not expect to return to work within another month, contact your employer and obtain an LTD claim package. One form is to be completed by you, one by your employer and one by your doctor. It is important that all sections of the forms are completed, and that copies of specialists' reports, lab tests, x-ray results, etc. are submitted with your claim.

LTD claims are sent to Canada Life at the address shown on the forms.

Late claims: Claims must be sent to Canada Life no later than 45 days after the date your benefits would otherwise commence. Late claims may be accepted up to 6 months after the 45 day period, but only where it was not reasonably possible to submit the claim on time.

Income tax: LTD benefit payments are taxable. Therefore, you must submit tax forms with your claim. You will receive a T4-A slip from Canada Life after the end of each calendar year.

Canada Pension Plan disability benefits: If your disability is severe and prolonged, you must also submit a claim to the Canada Pension Plan (CPP) for disability benefits. To obtain a claim form, contact Service Canada. If you meet the CPP definition of disability, CPP benefits are payable after 4 months of disability and will reduce the amount of your monthly LTD benefit.

Third party claims: If your disability results from a motor vehicle accident, you must also claim any wage loss benefits that you are entitled to from any third party. Your LTD benefits may be reduced by all or a portion of those wage loss benefits, other than benefits paid by the Insurance Corporation of BC (ICBC) for motor vehicle accidents on or after May 17, 2018.

other disability income

Your LTD benefit will not be reduced by income from private or individual disability plans, or from ICBC for motor vehicle accidents on or after May 17, 2018. However your LTD benefit will be reduced by 100% of any other disability income you receive as a result of the same disability that caused you to be eligible for LTD benefits. “Other disability income” includes but is not limited to:

1. Any amounts payable under any Workers' Compensation Act (WorkSafeBC) or law or any other legislation of similar purpose; and
2. Any amount from any group insurance, wage continuation or pension plan of your employer that provides disability income; and
3. Any amount of disability income provided by a compulsory act or law; and
4. Any periodic primary benefit payment from the Canada or Quebec Pension Plans or other similar social security plan of any country to which you are entitled or to which you would be entitled if your application for such a benefit was approved; and
5. Any amount of disability income provided by any group or association disability plan to which you might belong or subscribe.

LTD benefits are reduced by the amount of other disability income to which you are entitled upon first becoming eligible for the other income. Future increases in the other income (e.g. based on Canadian Consumer Price Index or similar indexing arrangements) will not further reduce your LTD benefits.

pension plan

This LTD benefit is an approved disability plan under the Municipal Pension Plan (MPP) and the Public Service Pension Plan (PSPP). Therefore, if you are a member of one of those pension plans and are receiving LTD benefits from this Plan, you will not be required to make contributions to the pension plan. However you may continue to accrue contributory and pensionable service. Contact your employer to confirm your pension status.

If you are close to retirement age when you become disabled, you may wish to contact your employer and discuss whether it would be to your financial advantage to take early retirement instead of claiming LTD benefits.

rehabilitation

If you are eligible for LTD benefits, rehabilitation can help you return to work. Canada Life employs a number of rehabilitation consultants who are a resource to the Joint Community Benefits Trust’s LTD Plan. If you are medically able to prepare to return to work (at your own job or another job), the rehabilitation consultants can provide you with support, advice and, if needed, financial assistance for rehabilitation.

Approved Rehabilitation Plan
The rehabilitation consultants offer many opportunities to help you return to work through return to work programs, vocational assessment, work conditioning, counseling, rehabilitative employment and/or retraining for another job. These services will be part of an Approved Rehabilitation Plan which is created jointly by you and your rehabilitation consultant (and your union, if you choose). Your LTD benefits will continue until you have successfully completed the Approved Rehabilitation Plan.

Commitment to Rehabilitation
You are required to participate and co-operate in rehabilitation.

Rehabilitation Review Committee
If you do not agree with the recommended rehabilitation plan, or if you feel you are medically unable to participate, you must either be able to demonstrate why you cannot participate, or you can appeal to a Rehabilitation Review Committee. Appeals to a Rehabilitation Review Committee are only available when there is no further medical information to submit for internal appeal. It is recommended that you contact your union and initiate your request for a Rehabilitation Review Committee as soon as possible. The Committee is made up of 3 independent and qualified individuals who are specialists in rehabilitation of disabled individuals. During the appeal process your LTD benefits will continue. However if the Committee approves the rehabilitation plan, but you do not accept their decision, your LTD benefit payments will be suspended.

Please refer to the Appeals section for more information.

Rehabilitative Employment
Rehabilitative employment is defined in the LTD provisions of your collective agreement. If you return to work in rehabilitative employment that is part of an Approved Rehabilitation Plan, you can receive all earnings from rehabilitative employment, plus your LTD benefit, provided your combined income does not exceed 100% of the current rate of pay for your job at date of disability. If your earnings plus your LTD benefit exceed 100%, your LTD benefit will be reduced by the excess.

Note: If you receive earnings that are not part of an Approved Rehabilitation Plan, your LTD benefit will be reduced by 100% of such earnings.

early retirement incentive benefit

If you are receiving LTD benefits, you may be eligible to retire early and receive a lump sum payment from the LTD Plan to compensate you for the anticipated reduction in your pension income. The criteria for the Early Retirement Incentive Benefit (ERIB) are:

- you have been on LTD for 4 or more years;
- you are eligible for early retirement pension benefits from MPP or PSPP; and
- you are not eligible for rehabilitation.

In order to be eligible, the amount of ERIB payout cannot be more than the current reserve calculated by the Plan actuary for the duration of your claim. The ERIB administrator will contact you if you are eligible to apply, and will provide you with more information.

If you accept the ERIB and if you were enrolled in the Dental and/or Extended Health benefits while on LTD, you can continue that coverage to age 65 if you pay 50% of the contributions monthly in advance.

duration of benefits

LTD benefits are paid as long as you remain totally disabled but will stop on the date you recover, reach age 65, die, refuse to participate in an Approved Rehabilitation Plan that has been approved by a Rehabilitation Review Committee, or receive the Early Retirement Incentive Benefit, whichever occurs first.

appeals

If Canada Life deny or terminate your claim and if you disagree with their decision, you may appeal and may submit any further medical information to Canada Life in support of your claim. If Canada Life do not change their decision, and you have exhausted all avenues of internal appeal by submitting all reasonably available medical information, you may request that your LTD claim be reviewed by a Claims Review Committee, which is made up of 3 independent and qualified medical doctors. Requests for a Claims Review Committee must be initiated **within 90 days** from the date of the last decline or termination letter. You may wish to contact your union for assistance with the appeal process.

Please note that the Rehabilitation Review Committee process and the Claims Review Committee process are the only mandated dispute resolution processes under the Collective Agreement. The decision of the Committee is final and binding for all medical and vocational matters within the scope of the respective processes. The processes are governed by a Terms of Reference for the respective appeal process which have been adopted by the Trustees.

Dental

The Dental benefit reimburses you or your dentist for many of your dental expenses.

cost

Your employer pays the cost of this Dental benefit.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time employee, regular part-time employee or regular community health worker, you are eligible for this benefit as a condition of employment.

Dual coverage restriction: If you and/or your dependents are enrolled in another comparable dental plan (normally a spouse’s plan), you are not eligible for this Dental benefit.

Dependents: Eligible dependents are:

1. The spouse of an Employee.
2. A person who has cohabited with an Employee as a spousal partner for not less than one year.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children to any age if they are in full-time attendance at a school, college or university that is recognized by Pacific Blue Cross, and if they are mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and step children, and children for whom you are the legal guardian. Legal proof of guardianship is required. “Mainly dependent” means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

effective date

Your coverage takes effect on the first day of the month after you have completed your probationary period.

Dependents: Dependents must be enrolled on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

Orthodontics: Coverage for you and your dependents takes effect after you have been enrolled in this Dental benefit for 12 months.

amount of benefit

The Dental benefit will reimburse you or your dentist for the following:

- 100% of Basic Services (Part “A”)
- 60% of Major Reconstruction Services (Part “B”)
- 60% of Orthodontic Services (Part “C”); lifetime maximum is $2,750 per person.

eligible expenses

This Dental benefit covers those services which are routinely provided to you or your dependents in offices of general practicing dentists in BC.

The services, and the amounts paid for such services, are as set out in the current Pacific Blue Cross Dental Fee Schedule No. 2. Fees in excess of the amount shown in the fee schedule will be your responsibility. When performed by a specialist (on referral by a general practicing dentist), the fee paid is the amount paid to a general practicing dentist, plus up to 10%.

PBC Member Profile: You can obtain on-line information on your Dental coverage and eligible dependents through PBC’s Member Profile website at: service.pac.bluecross.ca/member.

Eligible expenses under this Dental benefit are:

Basic Services/Part "A"

Basic Services covers those services required to maintain teeth in good order and to restore teeth to good order.

The Dental benefit will pay 100% of:

1. Diagnostic services: Procedures to determine the dental treatment required, including the following -
   a. one standard exam every 9 months.
   b. one complete exam in any 3 year period, provided that no other exam has been paid by this Dental benefit on your behalf in the preceding 9 months.
   c. x-rays, up to the maximum established by Pacific Blue Cross for the calendar year.
   d. full mouth x-rays once in any 3 year period.
2. Endodontic services: for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals.
3. Major restorative services: Inlays, onlays and gold foils, but only when no other material can be used satisfactorily. Pre-approval by Pacific Blue Cross is recommended. If you choose gold where another material can be used, you will be responsible for any additional costs.
4. Periodontic services: Procedures for the treatment of gums and bones surrounding and supporting the teeth, but not including bone and tissue grafts.
5. Preventive services: Procedures to prevent oral disease, including the following -
   a. cleaning and polishing of teeth (prophylaxis) once every 9 months.
   b. topical fluoride application once every 9 months.
   c. fixed space maintainers intended to maintain space and regain lost space, but not to obtain more space.
   d. sealants (pit and fissure): limited to once per tooth within a 2 year period.
   e. scaling, root planing and gingival curettage.

6. Repairs to bridges and dentures (prosthetics): Procedures for the repair of bridges, as well as the repair or reline of dentures by either a dentist or a licensed denturist. Relines will not be covered more often than once in any 2 year period. Costs of temporary dentures are not eligible for payment.
7. Restorative services: Procedures for filling teeth, including metal prefabricated restorations. If you choose to have white fillings in back teeth, you will be responsible for any additional costs.
8. Surgical services: Procedures to extract teeth as well as other surgical procedures performed by a dentist.

Major Reconstruction Services/Part "B"

Major Reconstruction Services covers those services required for major reconstruction or replacement of deteriorated or missing teeth. A service provided under Part B is eligible for payment only once in any 5 year period.

The Dental benefit will pay 60% of:

1. Restorative Services:
   a. Crowns: Rebuilding natural teeth where other basic material cannot be used satisfactorily. Certain materials will not be authorized for use on back teeth. Pre-approval by Pacific Blue Cross is recommended.
   b. Inlays and onlays involved in bridgework.
   c. Veneers.
2. Removable Prosthetics: The artificial replacement of missing teeth with dentures. Full upper and lower dentures or partial dentures of basic, standard design and materials. Full or partial dentures may be obtained from either a dentist or a licensed denturist. Costs of lost, broken or stolen dentures are not eligible for reimbursement.
3. Fixed Prosthetics: The artificial replacement of missing teeth with a crown or bridge.
4. Periodontal appliances including bruxing guards: 2 (one upper and one lower) every 5 years. Costs of lost, broken or stolen bruxing guards are not eligible for reimbursement.

Orthodontic Services/Part "C"

Orthodontic Services covers those services required to straighten abnormally arranged teeth. Pre-approval by Pacific Blue Cross is necessary.

The Dental benefit will pay 60% of:

Braces: Up to a lifetime maximum of $2,750 per person. Costs of lost or stolen braces are not eligible for reimbursement.

To be eligible for orthodontic services, you must have been enrolled in this Dental benefit for 12 months.

pre-approval

It is recommended that, before beginning treatment, your dentist contact Pacific Blue Cross to confirm that:

1. You and your dependents are covered by the Plan.
2. The proposed dental services are Eligible Expenses.
3. You or your dependents have not reached the coverage limits (e.g. the lifetime orthodontics maximum; the 5 year limit on a crown or dentures).

If the cost of the treatment is significant, your dentist should also send a treatment plan to Pacific Blue Cross for approval.

exclusions

The Dental benefit does not cover the following:

1. Cosmetic dentistry, temporary dentistry, oral hygiene instruction, tissue grafts, procedures performed for congenital malformations, drugs and medicines.
2. Treatment covered by WorkSafeBC, ICBC, Medical Services Plan of BC (MSP), or other publicly supported plans.
3. Services required as a result of an accident for which a third party is responsible.
4. Charges for completing forms, written reports, communication costs or charges for translating documents into English.
5. Implants and/or services performed in conjunction with implants.
6. Fees in excess of the current Pacific Blue Cross Dental Fee Schedule No. 2, or fees for services which are not set out in the Dental Fee Schedule.
7. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
8. Expenses resulting from intentionally self-inflicted injuries, while sane or insane.
9. Charges for unkept appointments.
10. Charges necessitated as a result of a change of dentist or denturist, except in special circumstances.
11. Room charges and some anesthetics.
12. Expenses incurred prior to eligibility date or following termination of coverage.
13. Charges for services related to the functioning or structure of the jaw, jaw muscle, or temporomandibular joint.
14. Expenses for a dental accident that are paid or payable by your Extended Health benefit.
15. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.
16. Services, medical supplies or equipment purchased from practitioners or providers who are considered by Pacific blue Cross to be ineligible or where Pacific Blue Cross refuses the claim based on their qualifications or conduct.
17. Travel expenses incurred to obtain dental treatment.

continuation of coverage

Your coverage for all benefits will continue without cost to you while you are receiving sick pay or WSBC wage loss benefits, or are on an Employment Standards Act leave including compassionate, maternity or parental leave.

During the first 20 work days of any other unpaid leave your coverage for all benefits will continue without cost to you. Dental coverage can continue while you are on unpaid leave beyond 20 work days if you pay the contributions.

Coverage can continue while you are on an LTD claim as long as you remain an employee and if you pay 50% of the contributions. If you are on an LTD claim and accept the Early Retirement Incentive Benefit, and if you were enrolled in the Dental benefit while on LTD, you can continue your coverage to age 65 if you pay 50% of the contributions.

termination of coverage

Your Dental coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

- You retire
- You commence an unpaid leave beyond 20 work days and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to casual status and elect not to pay the contributions, if eligible (or elect to pay the contributions and then stop paying them)

If you cease to be eligible due to lay off, your Dental coverage ceases on date of lay off. If you cease to be eligible due to termination of employment, your Dental coverage ceases on the date your employment terminates.

Dependents: Coverage for a dependent ceases on the earlier of the date your coverage terminates or at the end of the calendar month in which he/she is no longer an eligible "dependent" under this Dental benefit.

Dual dental restriction: If, while covered under this Dental benefit, you and/or your dependents become insured under another comparable dental plan, you are required to terminate this coverage. In that event, contact your employer for further information. This coverage must terminate at the end of the month prior to the start of the other dental coverage.

conversion

If you cease to be eligible because of termination of employment, you may convert your coverage to an individual policy issued by Pacific Blue Cross within 60 days of date of termination. Contact your employer or Pacific Blue Cross for further information.

claims

Dental claims are processed by:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1
(phone 604-419-2000 or 1-877-722-2583)

PBC Member Profile: You can obtain on-line information on your Dental claims, or obtain a Dental claim form, through PBC's Member Profile website at: service.pac.bluecross.ca/member.

If you or your dependents require dental services, visit the dentist of your choice and take your Pacific Blue Cross ID card. Discuss the services that will be provided, the cost of those services, and any amounts that you will be required to pay.

When your dentist has completed the treatment, payment may be obtained by either of the following methods:

1. Your dentist can submit a claim to Pacific Blue Cross on your behalf for amounts up to the levels specified in your Dental benefit. Pacific Blue Cross will then pay accepted claims directly

to your dentist. If the services are covered at a level below 100%, you must pay the balance to your dentist. OR

2. You can pay the dentist and then submit your own claim to Pacific Blue Cross up to the levels specified in your Dental benefit. Pacific Blue Cross will then send a cheque to your home address or via direct deposit if you have selected that option. For information on how to submit your own claim, contact Pacific Blue Cross

You can submit monthly orthodontic claims electronically through PBC's Member Profile website at: service.pac.bluecross.ca/member. Keep the original receipts for your records.

Claims must be received by Pacific Blue Cross within 12 months of the date of treatment.

Co-ordination of claims: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits, subject to the maximums set out in the Pacific Blue Cross Dental Fee Schedule No. 2, so that the total payments will not exceed the expenses actually incurred.

Treatment outside of BC: If you require dental care elsewhere in Canada and you obtain services from a qualified dentist, you will be reimbursed based on the dental fee schedule in effect in the province where the services were provided. Where services are obtained outside of Canada from a qualified dentist, you will be reimbursed up to the amount that would have been paid had the services been provided in BC. To obtain payment, obtain an itemized statement from the dentist and submit it to Pacific Blue Cross.

Change of dentist: If you find it necessary to change your dentist after you have commenced dental work, advise Pacific Blue Cross and both dentists. Claims will be paid by Pacific Blue Cross where there has been no duplication of services.

Extended Health

The Extended Health benefit reimburses you for many of your medical expenses.

cost

Your employer pays the cost of this Extended Health benefit.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time employee, regular part-time employee or regular community health worker, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are:

1. The spouse of an Employee.
2. A person who has cohabited with an Employee as a spousal partner for not less than one year.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children to any age if they are in full-time attendance at a school, college or university that is recognized by Pacific Blue Cross, and if they are mainly dependent on you or your spouse. However, dependent students are not eligible for vision care and hearing aid coverage beyond the end of the month in which they attain age 25.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and step children, and children for whom you are the legal guardian. Legal proof of guardianship is required. “Mainly dependent” means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

effective date

Your coverage takes effect on the first day of the month after you have completed your probationary period.

Dependents: Dependents must be enrolled on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

amount of benefit

Deductible: There is a $100 calendar year deductible for this benefit, per person or family.

Reimbursement: Keep your receipts for eligible claims paid (see Eligible Expenses section). Once the annual deductible is satisfied, you will be reimbursed for Eligible Expenses as follows:

- 80% of claims paid, per family, up to $1,000 in a calendar year

- 100% of claims paid, per family, over $1,000 in a calendar year
- 100% of claims paid for out-of-province/out-of-country emergency expenses

Lifetime maximum: The maximum lifetime amount payable per person is unlimited.

If, in a calendar year, your eligible expenses do not exceed the deductible, your expenses during the last 3 months of that year may be applied against the deductible for the next calendar year.

eligible expenses

This Extended Health benefit covers the following expenses when incurred by you or your dependents as a result of the necessary treatment of an illness or injury. For any items not specifically listed in this booklet, it is recommended you check with Pacific Blue Cross, prior to purchase, to determine the extent of any coverage.

PBC Member Profile: You can obtain on-line information on your Extended Health coverage and eligible dependents through PBC's Member Profile website at: service.pac.bluecross.ca/member.

- **Acupuncturist:** Fees of an approved acupuncturist up to $100 per person per calendar year. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Ambulance:** Cost of an ambulance in an emergency from the place where the sickness or injury occurs to the nearest acute care hospital with adequate facilities to provide the required treatment (including transportation by railroad, boat or airplane, or air-ambulance in an acute emergency). This benefit also covers transportation for one attending person (doctor, nurse, first aid attendant) where necessary.

- **Chiropractor:** Fees of a registered chiropractor up to $200 per person per calendar year, but not including the cost of x-rays taken by a chiropractor. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Dentist:** Fees of a dentist for repairs, including replacement, of natural teeth or prosthetics which have been injured accidentally while the person is covered by this Extended Health benefit. The treatment needed must be obtained within one year of the date of the accident. This Extended Health benefit does not cover orthodontic services, or any dental charges which exceed the dental fee schedule in effect in the province where the service was provided. Where services are obtained outside of Canada from a qualified dentist, you will be reimbursed up to the amount that would have been paid had the services been provided in BC. "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.

- **Diabetic supplies and equipment:** Needles, syringes and testing supplies; insulin infusion pumps when basic methods are not feasible (physician's letter required). Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Employment medicals:** Charges of a physician for a medical examination required by a statute or regulation of government for employment purposes, providing such charges are not payable by your employer.

- **Hearing aids:** Cost of purchasing hearing aids when prescribed by a certified Ear, Nose and Throat Specialist or when recommended by an audiologist. The maximum is $600 per person every 48 months. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied. This benefit includes repairs, but does not include payment for maintenance, batteries, re-charging devices or other such accessories. Note: Coverage for dependent students ceases at age 25.

- **Hospital room charges:** Charges for occupying a private or semi-private room in a BC acute care hospital, but not including rental of TV, telephone, etc.

- **Massage Therapist:** Fees of a registered massage therapist up to $1,000 per person per calendar year. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Medical equipment:** Rental costs, unless purchase is more economical, of durable medical equipment including hospital beds. Wheelchairs or scooters are eligible expenses only if a physician certifies that these appliances are the sole means of mobility. Electric wheelchairs are covered only when the physician certifies that the patient cannot operate a manual chair. TENS and TEMS when prescribed for intractable pain. Continuous glucose monitors to a maximum of $4,400 per year (with effect July 1, 2022); you will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied. Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Medical Referral Transportation:** Where determined by the attending physician and when adequate medical treatment is not available locally (within a 100 km radius), transportation by a scheduled public air, rail or bus service will be covered for the employee or dependent (and, if certified necessary by the attending physician, for an attendant), to and from the nearest locale equipped to provide the required treatment. The referred medical treatment must be performed by a physician. Travel must be completed within 2 months of the date of referral. Reimbursement for transportation will be based on the least expensive available fare. Where transportation by car is a reasonable alternative to public transport, mileage will be paid at the current allowance but limited to the amount that would have been paid for the least expensive form of public transportation. Bus or taxi service to and from the airport to the downtown locale for medical treatment will be allowed. When required, the cost of accommodation and meals in a commercial facility will be provided up to a maximum of $70 per day for 3 days.

- **Naturopathic Physician:** Fees of a registered naturopathic physician up to $200 per person per calendar year, but not including the cost of x-rays taken by a naturopathic physician. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Orthopedic shoes and orthotics:** One pair of custom made orthopedic shoes (including repairs) or one pair of custom made orthotics and replacements thereafter when necessitated by normal wear and tear or a change in condition:
  i) custom made orthopedic shoes when diagnosed and prescribed by a physician, podiatrist, primary healthcare nurse practitioner or chiropractor as medically necessary. A custom made orthopedic shoe is one made of raw materials specifically designed for the patient, and manufactured from a three-dimensional image of the patient's foot and lower leg.
  ii) custom made orthotics when diagnosed and prescribed by a physician, podiatrist, primary healthcare nurse practitioner, chiropractor or physiotherapist as medically necessary. A

custom made orthotic is one fabricated from raw material using a three-dimensional volume metric model of the patient's feet.

- **Out-of-province/out-of-country emergencies:** In the event of an emergency while travelling outside of BC/outside of Canada, the Extended Health benefit covers:
  1. While you or your dependents are 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:
     a. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
     b. 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, Pacific Blue Cross should be notified within 24 hours of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending physician, to move the patient by licensed ambulance service (by surface or air at the discretion of Pacific Blue Cross) 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 health of the patient, the 90 day limit may be extended with the expressed written consent of Pacific Blue Cross.
     c. Services of a physician and laboratory and x-ray services.
     d. Prescription drugs in sufficient quantity to alleviate an acute medical condition.
     e. Other emergency services and/or supplies that Pacific Blue Cross would cover in your province of residence.
  2. Worldwide Emergency Medical Assistance (Medi-Assist): In emergencies which occur while you (and your dependents) are travelling, Medi-Assist will coordinate the following services:
     a. Locate the nearest appropriate medical care.
     b. Obtain consultative and advisory services and supervision of medical care by qualified licensed physicians.
     c. Investigate, arrange and coordinate medical evacuations and related transportation needs.
     d. Arrange and coordinate the repatriation of remains.
     e. Replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your dependents may require when in distress.

  Your Pacific Blue Cross worldwide emergency Medi-Assist card provides 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. Have your Pacific Blue Cross ID number and Medi-Assist group number ready for personal identification as both numbers are required. For further information, refer to Pacific Blue Cross' website at www.pac.bluecross.ca/corp/mediassist/.

  Note: Emergencies and non-emergency referrals to other provinces (except Quebec) are covered by MSP, if pre-approved by MSP, as if the expenses had been incurred in BC. Other out of province non-emergency eligible expenses, that are incurred within Canada, are covered by this Extended Health benefit as if those expenses had been incurred in the person's province of residence, subject to the deductible, coinsurance and maximums. Out of country non-emergency eligible expenses are covered by this Extended Health benefit as if those expenses had been incurred in BC.

- **Paramedical items and prosthetic devices:** Oxygen, artificial limbs or eyes, ostomy and ileostomy supplies, walkers, canes and cane tips, crutches, splints, casts, collars (but not elastic or foam supports), trusses and rigid support braces. Myoelectrical limbs are excluded but Pacific Blue Cross will pay the equivalent of a standard prosthesis.

- **Physiotherapist**: Fees of a registered physiotherapist.

- **Podiatrist**: Fees of a registered podiatrist up to $200 per person per calendar year, but not including the costs of x-rays taken by a podiatrist. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Prescription drugs:** Cost of prescription drugs purchased from a licensed pharmacy and authorized for payment under the BC PharmaCare Formulary. This benefit includes Prometrium and drugs approved by a Special Authority*, but does not include oral contraceptives, contraceptive devices, preventative vaccines, vitamin injections, fertility drugs, food supplements, lifestyle drugs as determined by Pacific Blue Cross, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation except methadone, drugs which can be bought without a prescription, or drugs which have not been approved under the Food & Drugs Act for sale and distribution in Canada. Reimbursement of eligible drugs and medicines is subject to PharmaCare's Low Cost Alternative and Reference Drug Program payment policies.

  *If you require a PharmaCare Special Authority for your drugs and your physician charges a fee to complete the form, refer to http://www.pac.bluecross.ca/advicecentre for information on how to obtain reimbursement.

  The eligible prescription dispensing fee is capped at $10 per prescription or the maximum reimbursed by PharmaCare, whichever is greater. All eligible prescriptions drugs are also subject to PharmaCare's current mark-up limit over the manufacturer's cost. You will be reimbursed up to 80% of these maximums after the Extended Health calendar year deductible has been satisfied.

- **Registered Nurse:** Fees of a Registered Nurse (who is not related to you) for special duty nursing in acute cases where the service is recommended by a physician.

- **Speech Therapist:** Fees of a registered speech therapist, when referred by a physician, up to $100 per person per calendar year. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied.

- **Surgical stockings and brassieres**: 2 pairs of stockings per person per calendar year; 1 brassiere per person per calendar year when required as a result of medical treatment for injury or illness.

- **Vision care:** Cost of prescribed eyeglasses or repair of eyewear and/or frames or prescribed contact lenses. The maximum is $350 per person every 24 months. You will be reimbursed up to 80% of this maximum after the calendar year deductible has been satisfied. Note: Coverage for dependent students ceases at age 25.

- **Wigs or hairpieces:** Cost of wigs or hairpieces when required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500 per person.

exclusions

The Extended Health benefit does not cover the following:

1. Charges for benefits, care or services payable by or under MSP, PharmaCare, Hospital Programs, or any public or tax supported agency. This applies in all cases, whether a claim is made or not.
2. Charges for benefits, care or services payable by or under any other authority such as ICBC, travel insurance plans, etc. This applies in all cases, whether a claim is made or not.
3. Charges for a physician except as described in Eligible Expenses for Out-of-Province/Out-of-Country Emergencies.
4. Charges for Dental services except as described in Eligible Expenses for Dentist.
5. Expenses attributed to, or caused by, occupational disabilities which are covered by WorkSafeBC.
6. Charges for services and supplies of an elective (cosmetic) nature.
7. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
8. Expenses resulting from an injury or illness which was intentionally self-inflicted, while sane or insane.
9. Any portion of a specialist's fee not allowable under MSP due to non-referral, or any amount of fees charged by any practitioner in excess of the recognized fees for such service.
10. Charges of a registered psychologist.
11. Charges for batteries and re-charging devices.
12. Expenses related to the repatriation of a deceased employee and/or dependent.
13. Expenses related to pregnancy when incurred by a pregnant person while travelling outside of Canada within 21 days of the expected delivery date.
14. Expenses related to eye examinations.
15. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.
16. Services, medical supplies or equipment purchased from practitioners or providers who are considered by Pacific blue Cross to be ineligible or where Pacific Blue Cross refuses the claim based on their qualifications or conduct.

reasonable and customary limits

Extended Health claims may be subject to Reasonable and Customary (R&C) limits. R&C limits are financial or frequency limits which are deemed, by Pacific Blue Cross, to be the normal or average amount that is expected to be charged for a product or service being claimed. These limits can be set using fee guides published by provider associations, market research, historical claims experience or a combination of any of these methods. Reasonable and customary limits are used by all insurance carriers to ensure plans are paying only for what is considered medically necessary. More information about Pacific Blue Cross's reasonable and customary limits can be found online at www.pac.bluecross.ca.

continuation of coverage

Your coverage for all benefits will continue without cost to you while you are receiving sick pay or WSBC wage loss benefits, or are on an Employment Standards Act leave including compassionate, maternity or parental leave.

During the first 20 work days of any other unpaid leave your coverage for all benefits will continue without cost to you. Extended Health coverage can continue while you are on unpaid leave beyond 20 work days if you pay the contributions.

Coverage can continue while you are on an LTD claim as long as you remain an employee and if you pay 50% of the contributions. If you are on an LTD claim and accept the Early Retirement Incentive Benefit, and if you were enrolled in the Extended Health benefit while on LTD, you can continue your coverage to age 65 if you pay 50% of the contributions.

termination of coverage

Your Extended Health coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

- You retire
- You commence an unpaid leave beyond 20 work days and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to casual status and elect not to pay the contributions, if eligible (or elect to pay the contributions and then stop paying them)

If you cease to be eligible due to lay off, your Extended Health coverage ceases on date of lay off. If you cease to be eligible due to termination of employment, your Extended Health coverage ceases on the date your employment terminates.

Dependents: Coverage for a dependent ceases on the earlier of the date your coverage terminates or at the end of the calendar month in which he/she is no longer an eligible "dependent" under this Extended Health benefit. Vision care and hearing aid coverage for dependent students ceases at the end of the calendar month in which the student attains age 25.

Claims must be received by Pacific Blue Cross no later than June 30th of the year following termination of coverage.

conversion

If you cease to be eligible because of termination of employment, you may convert your coverage to an individual policy issued by Pacific Blue Cross within 60 days of date of termination. Contact your employer or Pacific Blue Cross for further information.

claims

Extended Health claims are processed by:

Pacific Blue Cross PO Box 7000 Vancouver, BC V6B 4E1 (phone 604-419-2000 or 1-877-722-2583)

PBC Member Profile: You can obtain on-line information on your Extended Health claim payments or on options for the electronic submission of claims, or obtain an Extended Health claim form, through PBC's Member Profile website at: service.pac.bluecross.ca/member.

Pay-direct claims: Check with your pharmacist or service provider to confirm they coordinate claims on-line directly with Pacific Blue Cross. When you are purchasing a prescription drug or service, give the provider your policy and ID numbers along with the necessary identification requested by the provider. The pharmacist or provider will be able to determine, at the time you purchase your prescription or eligible expense, the amount that your Extended Health benefit will cover. The Extended Health benefit will reimburse this amount directly to the pharmacy or provider, and you will only pay your portion. For pharmacies that are not on-line or that are outside of BC, you must pay for the prescriptions, collect the receipts and submit them to Pacific Blue Cross on-line through PBC's Member Profile or manually.

On-line claims: You can submit claims for prescription drugs, vision care and the services of physiotherapists, massage therapists, etc. electronically through PBC's Member Profile. If you have coverage under two different drug plans you must submit receipts on-line through PBC Member Profile or manually, unless both drug plans are provided through Pacific Blue Cross. Keep the original receipts for your records **for 12 months from date of service.**

Manual claims: If you require an item or service which is covered under this Extended Health benefit, visit the supplier of your choice and discuss the cost. Pay the supplier and obtain a receipt. The receipt should identify the date, item/service purchased, name and address of the supplier, price paid, quantity (where applicable) and the name of the person receiving the item/service (i.e. you or your dependent). Hold all your receipts until they exceed the annual deductible. Then obtain a Pacific Blue Cross Extended Health Care Claim Form from PBC's Member Profile. Complete your claim by carefully following the instructions on the claim form. Send your completed claim form and original receipts to Pacific Blue Cross at the address shown on the form. Keep a copy of the receipts for your records, as Pacific Blue Cross will not return the originals.

Claim payments: When your claim has been processed, Pacific Blue Cross will send a cheque to your home address, or via direct deposit if you have selected that option. You may wish to save the "Explanation of Benefits" that accompanies the claim payment, for income tax purposes.

Annual deductible: The annual deductible is applied only once per person or family in a calendar year. Once the deductible has been exceeded, you may submit a claim at any time. You may also submit additional claims during the year.

Claim filing deadline: Claims must be received by Pacific Blue Cross no later than June 30th of the following year. Example: If you purchased an Eligible Expense on December 1, 2017, your claim must have been received by PBC no later than June 30, 2018.

Co-ordination of claims: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits so that the total payments will not exceed the expenses actually incurred.

Out-of-country medical expenses: Send your claim directly to Pacific Blue Cross instead of to MSP. Claims must be submitted to Pacific Blue Cross within 60 days of the date the expenses were incurred.

sample extended health claim calculation

Eligible Expenses	
Eyeglasses (maximum claimable)	$ 350.00
Naturopathic Physician (maximum claimable)	200.00
Chiropractor (maximum claimable)	200.00
Total Eligible Expenses	**$ 750.00**
Subtract the deductible (if not already applied in the year)	(100.00)
	$ 650.00
Subtract your share of the coinsurance: 20% x $650.00 =	(130.00)
You will be reimbursed	**$ 520.00**

Benefits Checklist

Here are some things you can do to manage your benefits:

- Discuss your benefits with your family.
- Ensure all your eligible dependents, including newborns, are enrolled in Dental and Extended Health within 60 days of the date they become eligible. To check your dependents' coverage, refer to service.pac.bluecross.ca/member. If any dependents are missing, contact your employer.
- If your status changes (e.g. you switch to casual status, or commence an unpaid leave of absence), contact your employer to confirm your ongoing eligibility for benefits.
- If your spouse obtains dental coverage through his/her work, check with your employer to make sure you are still eligible for Dental coverage under your group benefit plan.
- During the year, save your receipts for expenses covered under the Extended Health benefit. Send your Extended Health claims to Pacific Blue Cross periodically. Claims must be received by Pacific Blue Cross no later than June 30th of the following year.
- Remind your dependents to take your Pacific Blue Cross ID card to the pharmacy in order to access the pay-direct claims process.
- Review your beneficiary designation periodically for Group Life and AD&D to make sure it is still appropriate. Contact your employer to confirm your current beneficiary designation.

For more information, contact your union or your employer.

This booklet is a summary only. All benefits are subject to the Pacific Blue Cross and Canada Life contracts, and the Joint Community Benefits Trust's (JCBT) Plan Document.