

HEALTHCARE BENEFIT TRUST



BENEFIT FROM EXPERIENCE

your

Group Benefit

P L A N

For casual employees covered by the

**Nurses' Provincial Collective Agreement
(Nurses' Agreement) 2014-2019**

Provided by your
Employer through the
Healthcare Benefit Trust

January 1, 2017

We make every effort to ensure the information that we distribute to organizations in electronic format is factual and up to date. To that effect, we have attempted to secure the integrity of the information that we distribute by releasing such information in a “read-only” format. However, in the event that such information is manipulated by anyone other than the Healthcare Benefit Trust or if organizations fail to update any new versions of the information distributed by the Healthcare Benefit Trust, the most recent version of the information distributed by the Healthcare Benefit Trust will govern any disputes. Moreover, the information provided by the Healthcare Benefit Trust regarding benefits may become out of date if changes are made to the Healthcare Benefit Trust’s Plan Document, the Healthcare Benefit Trust’s Trust Agreement, the applicable Collective Agreements in force, or the Pacific Blue Cross and Great-West Life contracts. Such changes could include, but are not limited to, increasing, decreasing or eliminating:

- a) coverage for people and benefits, or
- b) amounts for premiums and deductibles.

The governing documents are the Healthcare Benefit Trust’s Plan Document, the Healthcare Benefit Trust’s Trust Agreement, the applicable Collective Agreements in force, and the Pacific Blue Cross and Great-West Life contracts as each may be amended from time to time. In the case of any inconsistency between the terms of the information provided to organizations and placed, for example, on an organization’s Intranet and the governing documents, the governing documents prevail. If your organization has any questions regarding the benefits, we urge you to contact our office for complete and accurate information.

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Benefits are administered under the terms of the Healthcare Benefit Trust's Plan and claims are paid out of the Healthcare Benefit Trust. The Trust is funded by contributions from healthcare and community social services employers and employees in BC.

The Healthcare Benefit 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 the benefits it provides are not insured by an insurance company. The Trust is not subject to regulation under the British Columbia *Financial Institutions Act*.

This benefit booklet summarizes the group benefit plan for casual employees covered by the Nurses' Provincial Collective Agreement (Nurses' Agreement).

Dental

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

cost

You pay the cost of this Dental benefit.

eligibility

You may elect to purchase this benefit for yourself and your dependents after completing 180 hours of work provided you are not the primary member of another dental plan.

If you are the primary member of another dental plan, you and your dependents are not eligible for this Dental benefit.

Dependents: Eligible dependents are:

1. Husband or wife.
2. Common-law spouse if you have cohabited as spousal partners for 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 and have not ceased to be dependent.

effective date

You may apply for this coverage on the first day of any month after you have completed 180 hours of work

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. Late enrollments will only be accepted to a maximum of 12 months of retroactivity.

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%.

CARESnet: You can obtain on-line information on your Dental coverage and eligible dependents through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

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. two standard exams per calendar year.
 - 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 6 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 36 month 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. Periodontal 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) twice in any calendar year.
 - b. topical fluoride application twice in any calendar year.

- 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 relines 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. No benefit is payable for the replacement of lost, broken or stolen dentures.
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 or stolen bruxing guards are not eligible for payment.

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 payment.

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, procedures performed for congenital malformations, oral hygiene instruction, tissue grafts and drugs.
2. Treatment covered by WorkSafeBC, 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.

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 cancel your coverage
- You stop paying the contributions

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

If, while covered under this Dental benefit, you become the primary member of another dental plan, you will be required to terminate this coverage. This coverage must terminate at the end of the month prior to the start of the other dental coverage. Contact your employer for further information.

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.

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 604-419-2300 or 1-888-275-4672)
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CARESnet: You can obtain on-line information on your Dental claims, or obtain a Dental claim form, through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

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. If required, ask your dentist to obtain pre-approval from Pacific Blue Cross prior to beginning treatment.

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% of the claim, 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 orthodontic claims electronically through CARESnet. Keep the original receipts for your records.

Claims deadline: 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

You pay the cost of this Extended Health benefit.

eligibility

You may elect to purchase this benefit for yourself and your dependents after completing 180 hours of work.

Dependents: Eligible dependents are:

1. Husband or wife.
2. Common-law spouse if you have cohabited as spousal partners for 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 and have not ceased to be dependent.

effective date

You may apply for this coverage on the first day of any month after you have completed 180 hours of work.

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. Late enrollments will only be accepted to a maximum of 12 months of retroactivity.

amount of benefit

Deductible: There is a \$25 calendar year deductible for this benefit, per person or family.

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

- 80% of Eligible Expenses until claims totaling \$1,000 have been paid in a calendar year
- 100% of Eligible Expenses after claims totaling \$1,000 have been paid in a calendar year

- 100% of Eligible Expenses for vision care and 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 \$25 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 your coverage.

CARESnet: You can obtain on-line information on your Extended Health coverage and eligible dependents through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

Prescription drugs: Prescription drugs that are eligible for reimbursement under the Blue Rx drug formulary which is managed by Pacific Blue Cross.

The majority of prescription drugs purchased from a licensed pharmacy are automatically covered by this Extended Health benefit. This includes Prometrium, and contraceptives requiring a prescription including contraceptive injectables and medicated contraceptive devices (i.e. medicated IUD's). For a small number of select drugs, you will need to obtain pre-approval from PharmaCare (i.e. Special Authority – see below) or from Pacific Blue Cross in order to receive coverage under this Extended Health benefit.

Important: For detailed information on your coverage refer to www.pac.bluecross.ca/pca. For information on drug pre-approvals you can also contact Pacific Blue Cross' Pharmacy Services team at 1-877-PAC-BLUE.

This prescription drug benefit **does not** include morning after pills, non-medicated IUD's (e.g. copper IUD's) and other 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 (excluding methadone), or drugs which can be bought without a prescription (over-the-counter). This benefit also does not cover drugs which have not been approved under the Food & Drugs Act for sale and distribution in Canada. Reimbursement of eligible prescription drugs is subject to PharmaCare's Low Cost Alternative (LCA) and Reference Drug Program (RDP) payment policies.

All eligible prescriptions drugs are also subject to PharmaCare's dispensing fee limit and mark-up limits over the manufacturer's cost. You will be reimbursed up to 80% of these maximums after the calendar year deductible has been satisfied.

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

- **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:** Needles, syringes, 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 \$1,000 per person per ear every 5 years. 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.
- **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 \$2,000 per year; 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 5 days of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending physician, to move the patient by licensed ambulance service (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 \$400 per person per calendar year, but not including the cost 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:** See above.
- **Psychologist:** Fees of a registered psychologist or a registered clinical counselor up to a combined maximum of \$900 per person per calendar year. You will be reimbursed up to 80% of this maximum after the 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 100% 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 for batteries and re-charging devices.
11. Expenses related to the repatriation of a deceased employee and/or dependent.
12. Expenses related to pregnancy when incurred by a pregnant person while travelling outside of Canada within 21 days of the expected delivery date.
13. Expenses related to eye examinations.
14. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.
15. 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

Reasonable and Customary (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.

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 cancel your coverage
- You stop paying the contributions

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 604-419-2600 or 1-888-275-4672)
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CARESnet: You can obtain on-line information on your Extended Health claims payments, or options for the electronic submission of claims, or obtain an Extended Health claim form, through CARESnet. You can access CARESnet through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

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 CARESnet or manually.

On-line CARESnet claims: Claims for prescription drugs, vision care and the services of physiotherapists, massage therapists, etc. can be submitted electronically through CARESnet. If you have coverage under two different drug plans you must submit receipts on-line through CARESnet 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 (\$25). Then obtain a Pacific Blue Cross Extended Health Care Claim Form from CARESnet. 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 \$25 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 purchase an Eligible Expense on December 1, 2017, your claim must be received by PBC no later than June 30, 2018.

Co-ordination of benefits: 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. See also "On-line CaresNet Claims" above.

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).....	<u>200.00</u>
Total Eligible Expenses.....	\$ 750.00
Subtract the deductible (if not already applied in the year)	<u>(25.00)</u>
	\$ 725.00
Subtract your share of the coinsurance:	
Naturopathic Physician (20% x \$200) +	
Chiropractor (20% x \$200)	(80.00)
You will be reimbursed.....	\$ 645.00
<i>Note: There is no coinsurance for eyeglasses (vision care) as reimbursement is at 100%.</i>	

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 www.pac.bluecross.ca/caresnet/. If any dependents are missing, contact your employer.
- 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.

For more information, contact your employer.

This booklet is a summary only. All benefits are subject to the applicable Collective Agreements currently in force, the Pacific Blue Cross contract, and the Healthcare Benefit Trust's Plan Document.

