HEALTHCARE BENEFIT TRUST

HBT

BENEFIT FROM EXPERIENCE

Level 1 Staff (#829)
Standard Benefit Plan

Provided by your
Employer through the
Healthcare Benefit Trust

Effective: January 1, 2015 (3)

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 Moreover, the information provided by the Healthcare Benefit Trust regarding benefits may become out of date if changes are made to the Healthcare Benefit Trust's Plan Document, the Healthcare Benefit Trust's Trust Agreement, the applicable Collective Agreements in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.

Healthcare Benefit Trust
#1180 – 1333 West Broadway
Vancouver, BC V6H 4C1
Phone: (604) 736-2087 or 1-888-736-2087

Benefits-at-a-Glance

LEVEL 1 STAFF (#829)
STANDARD BENEFIT PLAN

HEALTHCARE BENEFIT TRUST
HBT
BENEFIT FROM EXPERIENCE

GROUP LIFE

» Up to age 64: $10,000.
» Ages 65–70: Coverage reduces to $5,000.
» Age 71: Coverage ceases.
» Includes Advance Payment program for terminally ill employees.

DENTAL

» **Basic Services "Part A"**
(exams, fillings, etc.) 100%
» **Major Services "Part B"**
(crowns, bridges, etc.) 50%
» **Termination Age** **71**

EXTENDED HEALTH

» **Annual Deductible** $100
» **Reimbursement of Eligible Expenses**
- under $1,250/calendar year 80%
- over $1,250/calendar year 100%

» **Lifetime Maximum** ..... unlimited
» **Annual Maximum:**
- Acupuncturist $400
- Chiropractor $400
- Dietitian/Nutritionist $400
- Massage Therapist $400
- Naturopathic Physician $400
- Physiotherapist $400
- Podiatrist $400
- Psychologist $400
  Includes Clinical Counsellor and Psychological Associate
- Speech Therapist $400

» **Orthopedic Shoes and Orthotics**
- Adults ..... $400 per calendar year
- Children ..... $200 per calendar year

» **Out-of-Province/ Out-of-Country Emergencies** 100%
» **Prescription Drugs**
- BlueNet Pay Direct Drug Card
- Includes oral contraceptives
- Reimbursement is subject to Pharmacare's Low Cost Alternative and Reference Based Pricing payment policies

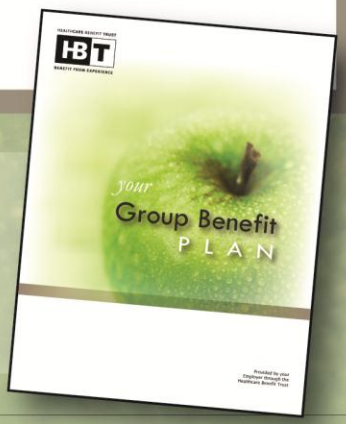
» **Hearing Aids** ..... $600 every 48 months
» **Vision Care** ..... $225 every 24 months
» **Wigs or Hairpieces** ..... $500 per lifetime
» **Termination Age** **71**

CARESnet

You can obtain online information on your Dental and Extended Health coverage and claims through CARESnet. You can access CARESnet through the Healthcare Benefit Trust's website at www.hbt.ca or through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

Benefits-at-a-Glance is intended as a summary only.

For more information, please refer to your benefits booklet.



All benefits are subject to the applicable Collective Agreements currently in force, the Pacific Blue Cross and Great-West Life contracts, and the Healthcare Benefit Trust's Plan Document.

Effective: January 1, 2015

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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.

eligibility

If you work 15 hours or more per week, and if you are a temporary full-time/part-time employee with a temporary employment contract of 6 consecutive months or more, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first date of employment.

amount of benefit

Refer to the *Benefits-at-a-Glance*.

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. If you have not named a beneficiary, the benefit will be paid to your estate. 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 employer will continue to pay the Group Life coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave.

Coverage can continue while you are on an unpaid leave if you pay the contributions.

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 and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

- You attain age 71

conversion

If you cease to be eligible because of termination of employment, 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 Great-West Life without providing medical evidence. Conversion is not available upon attainment of age 65.

claims

Claims are processed by Great-West 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 24 months, you may be eligible for an advance payment of up to 50% of your Group Life benefit (maximum payment $5,000). 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.

Dental

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

eligibility

If you work 15 hours or more per week, and if you are a temporary full-time/part-time employee with a temporary employment contract of 6 consecutive months or more, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
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 under age 30 if in full-time attendance at a school, college or university, that is recognized by Pacific Blue Cross, and if 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 stepchildren, 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

Your coverage takes effect on the first date of employment.

Dependents: Coverage for dependents takes effect 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

Refer to the *Benefits-at-a-Glance*.

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. 3. 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 the Healthcare Benefit Trust's website at www.hbt.ca or 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.

1. Diagnostic services: Procedures to determine the dental treatment required, including the following -
   a. two standard exams per calendar year.
   b. consultation, as a separate appointment, twice per calendar year.
   c. two complete exams per lifetime.
   d. x-rays, up to the maximum established by Pacific Blue Cross for the calendar year.
   e. full mouth x-rays once in any 3 year period.
2. Endodontic services: Root canals: once per tooth per lifetime.
3. Periodontic services: Procedures for the treatment of gums.
4. Preventive services: Procedures to prevent oral disease, including the following -
   a. cleaning and polishing of teeth (prophylaxis) twice in any calendar year.
   b. fluoride application twice in any calendar year.
   c. fixed band and loop space maintainers intended to maintain space and regain lost space, but not to obtain more space.
5. Restorative services:
   a. Procedures for filling teeth, including stainless steel crowns (limited to once per tooth per two-year period). Filling materials include amalgam, silicate, resin or composite material. White composite fillings are an eligible expense on front teeth only.
   b. Gold inlays or onlays (once per tooth per five-year period) but only when there are three or more surfaces of the tooth to be restored, decay is evident on pre-treatment x-rays and one or more cusps are involved. If less than three surfaces are treated, the amalgam equivalent for restoration will be paid. X-rays and study models are required by Pacific Blue Cross prior to start of treatment when an onlay or inlay or a series of onlays or inlays is planned.
   c. Relining or repairing, but not remaking, of bridgework and dentures.
   d. Gold foil, but only in cases of repair to existing gold restorations.
   e. Emergency Basic Services treatment which is incurred while traveling or on vacation outside the province or Canada.
6. 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. These items will only be replaced if the item cannot be repaired.

1. Major Restorative: 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.

2. Prosthetics:
   a. Dentures (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 dentures may be obtained from either a dentist or a denturist. Partial dentures may only be obtained from a dentist. Lost, stolen or broken dentures will not be replaced.
   b. Crowns and bridges (fixed prosthetics): The artificial replacement of missing teeth with a crown or bridge.

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 under this Plan.
3. You or your dependents have not reached the coverage limits (e.g. 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. Orthodontic services.
2. Cosmetic dentistry, temporary dentistry, oral hygiene instruction, drugs and medicines.
3. Treatment covered by WorkSafeBC, Medical Services Plan of B.C. (MSP), or other publicly supported plans.
4. Services required as a result of an accident for which a third party is responsible.
5. Charges for completing forms.
6. Implants.
7. Fees in excess of the current Pacific Blue Cross Dental Fee Schedule No. 3, or fees for services which are not set out in the Dental Fee Schedule.
8. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
9. Expenses resulting from intentionally self-inflicted injuries, while sane or insane.
10. Charges for unkept appointments.
11. Charges necessitated as a result of a change of dentist or denturist, except in special circumstances.
12. Travel expenses for treatment.
13. Room charges and some anaesthetics.
14. Expenses incurred prior to eligibility date or following termination of coverage.
15. Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.
16. Incomplete, unsuccessful or temporary procedures, recent duplication of services by the same or different dentists, drugs, pantographic tracings, osseous or tissue grafts.
17. Expenses for a dental accident that are paid or payable by your Extended Health benefit.
18. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.

continuation of coverage

Your employer will continue to pay the Dental coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave.

Coverage can continue while you are on an unpaid leave if you pay 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:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status
- You attain age 71

Dependents: Coverage for a dependent ceases on the earlier of the above or at the end of the calendar month in which he/she no longer qualifies as a "dependent" under the Dental plan.

conversion

If you cease to be eligible because of termination of employment, during the 60 day period following termination of coverage, you may convert your coverage to an individual policy issued by Pacific Blue Cross. 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)

CARESnet: You can obtain on-line information on your Dental claims through CARESnet. You can access CARESnet through the Healthcare Benefit Trust's website at www.hbt.ca or 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 are not covered by this benefit and 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 this 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 this Dental benefit. Pacific Blue Cross will then pay accepted claims directly to you. For information on how to submit your own claim, contact Pacific Blue Cross.

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. 3, 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 at the rates 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 this Plan would have paid had the services been provided in your province of residence. 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.

eligibility

If you work 15 hours or more per week, and if you are a temporary full-time/part-time employee with a temporary employment contract of 6 consecutive months or more, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
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 under age 30 if in full-time attendance at a school, college or university that is recognized by Pacific Blue Cross, and if 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 stepchildren, 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

Your coverage takes effect on the first date of employment.

Dependents: Coverage for dependents takes effect 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

Refer to the *Benefits-at-a-Glance*.

If your Plan has an annual deductible, and 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.

CARESnet: You can obtain on-line information on your EHC coverage and eligible dependents through CARESnet. You can access CARESnet through the Healthcare Benefit Trust's website at www.hbt.ca or through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

- **Acupuncturist:** Fees of an approved acupuncturist up to the amount specified in the *Benefits-at-a-Glance*.

- **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 the round trip fare for one attending person (doctor, nurse, first aid attendant) where necessary.

- **Chiropractor:** Fees of a registered chiropractor up to the amount specified in the *Benefits-at-a-Glance* but not including the cost of x-rays taken by a chiropractor.

- **Dietitian:** Fees of a registered dietitian or nutritionist up to the amount specified in the *Benefits-at-a-Glance*.

- **Dentist:** Fees of a dentist for repairs, including replacement, of natural teeth which have been injured accidentally while the person is covered under this Extended Health benefit. The treatment needed must be obtained within one year of the date of the accident. Orthodontic services are not covered under this Extended Health benefit, neither are any amounts paid or payable by a Dental benefit or any charges which exceed the Pacific Blue Cross Dental Fee Schedule No. 3.

- **Diabetic supplies and equipment:** Needles, syringes, testing supplies and blood glucose monitors. 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.

- **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 the amount specified in the *Benefits-at-a-Glance*. This benefit includes repairs, but does not include payment for maintenance, batteries, re-charging devices or other such accessories.

- **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. Hospital co-insurance charges of the extended care unit of an approved hospital.

- **In-home nursing and/or home support services:** When recommended by the attending physician. The combined maximum benefit is $10,000 per person per calendar year.

- **Massage Therapist:** Fees of a registered massage therapist up to the amount specified in the *Benefits-at-a-Glance*.

- **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 by a physician. Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Naturopathic Physician:** Fees of a registered naturopathic physician up to the amount specified in the *Benefits-at-a-Glance*, but not including the cost of testing or of x-rays taken by a naturopathic physician. Does not include remedies prescribed by a naturopathic physician.

- **Orthopedic shoes and orthotics:** One pair of custom made orthopedic shoes (including repairs) or one pair of custom made orthotics per person when diagnosed and prescribed by a physician, podiatrist, chiropractor or physiotherapist as medically necessary and replacements thereafter when necessitated by normal wear and tear. 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; a custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet. The maximum is the amount specified in the *Benefits-at-a-Glance*.

- **Out-of-province/out-of-country emergencies:** In the event of an emergency while traveling outside of BC/outside of Canada, the Extended Health benefit covers:
  1. While you or your family are traveling 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 room, board 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 by 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 traveling, 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.

- **Paramedical items and prosthetic devices:** Oxygen, blood, blood plasma, artificial limbs or eyes, crutches, splints, casts, trusses, braces and ostomy or ileostomy supplies, rigid support braces and permanent prostheses (artificial limbs and eyes, and mastectomy forms) when ordered by the attending physician. Repair or replacement of worn prostheses and braces is included. Myoelectric limbs are excluded but Pacific Blue Cross will pay the equivalent of a standard prosthesis.

- **Physiotherapist**: Fees of a registered physiotherapist up to the amount specified in the *Benefits-at-a-Glance.*

- **Podiatrist**: Fees of a registered podiatrist up to the amount specified in the *Benefits-at-a-Glance*, but not including the costs of x-rays taken by a podiatrist. Does not include remedies prescribed by a podiatrist.

- **Prescription drugs:** Cost of prescription drugs purchased from a licensed pharmacy. This benefit includes oral contraceptives, but does not include contraceptive devices and preventative vaccines. This benefit does not include, vitamin injections, food supplements, lifestyle drugs and medicines as determined by Pacific Blue Cross, erectile dysfunction drugs, fertility drugs, obesity drugs, medications used to treat or replace an addiction or habituation, drugs which can be bought without a prescription (except as noted herein), or drugs not 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 Referenced Based Pricing payment policies.

- **Psychologist:** Services of a registered psychologist, clinical counsellor or psychological associate up to the amount specified in the *Benefits-at-a-Glance*.

- **Registered Nurse:** Fees of a Registered Nurse for special duty nursing in acute cases when designated a registered bed patient in an approved hospital and where the service is recommended by the attending physician. This benefit does not cover the fees of a Registered Nurse who is employed by the hospital. The maximum benefit is 720 hours per person per calendar year.

- **Speech Therapist:** Fees of a registered speech therapist, when referred by a physician, up to the amount specified in the *Benefits-at-a-Glance*.

- **Surgical stockings and brassieres**: 2 pairs of stockings per person per calendar year to a maximum of $250; 1 brassiere to a maximum of $150 per person per calendar year when required as a result of medical treatment for injury or illness.

- **Vision care:** Cost of prescribed eyeglasses (including prescribed sunglasses), and/or frames or prescribed contact lenses. The maximum is the amount specified in the *Benefits-at-a-Glance.*

- **Wigs or hairpieces:** Cost of wigs or hairpieces when required as a result of medical treatment or injury. The lifetime maximum per person is the amount specified in the *Benefits-at-a-Glance*.

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. Expenses resulting from suicide or attempted suicide.
10. 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.
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 incurred while outside your province of residence for pre-existing conditions requiring continuous or routine medical care.
15. Transportation charges incurred for health reasons (except as outlined), health examinations of any kind, elective treatment and/or diagnostic procedures and charges incurred for purely preventative purposes.
16. HCG injections.
17. Services performed by any person who is related to or residing with you or your spouse.
18. Expenses related to eye examinations.
19. Charges for completion of claim forms or written reports.
20. Services of the Health & Home Care Society of BC, Graduate or Licensed Practical Nurses (except for in-home nursing), services of religious or spiritual healers, occupational therapy and rest cures.
21. Charges of a physician for a medical examination required by a statute or regulation of government for employment purposes.
22. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.

continuation of coverage

Your employer will continue to pay the Extended Health coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave.

Coverage can continue while you are on an unpaid leave if you pay 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:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status
- You attain age 71

Dependents: Coverage for a dependent ceases on the earlier of the above or at the end of the calendar month in which he/she no longer qualifies as a "dependent" under the Extended Health benefit.

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, during the 60 day period following termination of coverage, you may convert your coverage to an individual policy issued by Pacific Blue Cross. 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)

CARESnet: You can obtain on-line information on your EHC claims payments, or obtain an EHC claim form, through CARESnet. You can access CARESnet through the Healthcare Benefit Trust's website at www.hbt.ca or through Pacific Blue Cross' website at www.pac.bluecross.ca/caresnet/.

Electronic submission of prescription drug claims (BlueNet): Check with your pharmacist to confirm the pharmacy is on-line with Pacific Blue Cross. Information on which pharmacies are on-line can also be obtained by calling Pacific Blue Cross. When you purchase a prescription drug, present your Pacific Blue Cross ID card to the pharmacist. The pharmacist will be able to determine, at the time you purchase your prescription, the amount that your Extended Health benefit will cover. The Extended Health benefit will reimburse this amount directly to the pharmacy, and you will only pay your portion.

For pharmacies that are not on-line, you must pay for the prescriptions, collect the receipts and submit them manually to Pacific Blue Cross (see next section). You must also submit receipts

manually where you have coverage under two different drug plans. As your original receipts will not be returned, make a copy to send to your second carrier.

Other 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 (if applicable). Then obtain a Pacific Blue Cross Extended Health Care Claim Form from your employer or from CARESnet. Complete your claim by carefully following the instructions on the 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.

When your claim has been processed, Pacific Blue Cross will send a cheque to your home address. You may wish to save the "Explanation of Benefits" that accompanies the claim payment, for income tax purposes.

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.

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

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.

Benefits Checklist

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

- Keep this booklet as a reference.
- Discuss your benefits with your family.
- 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.
- Review your beneficiary designation periodically for Group Life to make sure it is still appropriate. Contact your employer to review your most recent Appointment/Change of Beneficiary form.

For more information, contact your employer.

This booklet is a summary only. All benefits are subject to the Pacific Blue Cross and Great-West Life contracts, and the Healthcare Benefit Trust's Plan Document.