Teamsters Local Union No. 155 Health Benefits Plan

Plan Booklet

Effective June 1, 2025

POLICY NO. 901053 (PACIFIC BLUE CROSS - ACTIVES)

POLICY NO. 81025 (PACIFIC BLUE CROSS - SRP)

GROUP NO. G. 1007 (CO-OPERATORS)

POLICY NO. BSC 9427136 (AIG)

GROUP NO. 6186225 (MSP-BC)

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INTRODUCTION

Please review this booklet to learn about your group benefits program. The information contained in this booklet is for guidance only. All rights to benefits are governed by the group insurance contracts and the terms of the Plan.

This booklet describes your Plan as of January 1, 2022. The Plan is subject to change at any time. If the Plan changes, the Trustees will send notice to covered members.

WHO TO CONTACT

If, after reviewing this booklet, you have any questions regarding your plan, please contact the Plan Office:

PLAN OFFICE / PLAN ADMINISTRATOR
TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN

c/o Convyta Partners

501-4445 Lougheed Hwy, Burnaby BC V5C 0E4
Telephone: 1-855-832-6155
Fax: 604-433-8894
E-mail: teamsters155@convyta.com
Web page: http://te155.planoffice.ca/

PLAN SPONSOR
TEAMSTERS LOCAL UNION NO. 155

CONSULTANT
HUB INTERNATIONAL

To book an appointment under the Employee and Family Assistance Program with FSEAP, contact:

1-800-667-0993
Online resources at: www.fseap.ca

password: 2bwell

LETTER FROM THE TRUSTEES

TO OUR MEMBERS:

The Teamsters Local Union No. 155 Health Benefits Plan was established effective May 1, 1991, to provide health and welfare benefits for all eligible members and their covered dependents.

This booklet outlines benefits to which eligible members and their dependents may be entitled and outlines the procedures to be followed when making claims.

The Plan consists of the Plan Document, this booklet, the collective agreements, and any contracts the Trustees enter into from time to time with an insurer or other carrier.

The Plan will be regularly reviewed, and improvements will be made in the future, consistent with available finances.

Should you require any information on the Plan, please contact the Plan Administrator's office, or the Union office.

The Trustees,
Teamsters Local Union No. 155 Health Benefits Plan

- *David Holm (Chair)*
- *Lorrie Ward*
- *Shawn Henter*
- *Michelle Koski*
- *Mikle "Red" Murphy*
- *Courtney Tuckwood*
- *Kelly Wickstrom*

LIST OF BENEFITS

The following benefits are provided under the Teamsters Local Union No. 155 Health Benefits Plan. Further details are provided throughout this booklet.

Benefit	Provider
Employee and Family Assistance Program	Family Services Employee Assistance Programs (FSEAP)
Residential Rehabilitation	Self-Insured and paid by Trustees*
Bereavement Leave	Self-Insured and paid by Trustees*
Group Life	Insured by The Co-operators Group #G 1007
Dependent Life	
Long Term Disability	
Accidental Death & Dismemberment	Insured by AIG Policy #BSC 9427136
Extended Health Care	Self-Insured by Trustees* and paid by Pacific Blue Cross, Policy #901053
Dental	
Subsidized Retirement Plan	Self-Insured by Trustees* and paid by Pacific Blue Cross, Policy #81025
Basic Medical	BC MSP, Group #6186225 Administered by the Plan Office

* Benefits self-insured by the Trust are not insured by an insurance company regulated under the Financial Institutions Act (British Columbia). The Trust is exempt from the requirements of the Financial Institutions Act (British Columbia).

ELIGIBILITY REQUIREMENTS

HOW DO YOU ESTABLISH COVERAGE?

All Union members in good standing, and their dependents, are covered for the Employee and Family Assistance Plan through FSEAP. Residential Rehabilitation Assistance is also available to all Union members in good standing.

Eligibility for all other benefits is through the Hour Bank:

1. You must be a member in good standing of the Teamsters Local Union No. 155.
2. Your employers must report a total of 200 hours for you within 10 consecutive calendar months.

Eligibility is determined with a "reporting month". You work this month, your employers report to the Plan Office next month, and the Plan Office applies those hours to your coverage for the month following.

Coverage and Enrollment

Your coverage begins for all benefits on the first day of the month after the above conditions are met. **For Example:**

Month Worked	Member A Hours Reported	Member B Hours Reported
January	140	
February	-	140
March	-	140
April	50	reporting month
May	140	covered
June	reporting month	-
July	covered	-

Any hours reported prior to you becoming a member in good standing of Local 155 go into the Plan's General Fund. However, once you establish coverage, you are awarded enough hours for three months of coverage.

When you are eligible for coverage, the Plan Office will send you an enrollment card for EHC and Dental, an application form for MSP-BC, and a Life and AD&D insurance enrollment card on which you name your beneficiary for those benefits.

Please complete and return enrollment cards promptly. Until you do so:

- Your spouse and dependent children are not covered for EHC, Dental, or dependent life insurance.
- If you die, the life insurance is paid to your estate and is subject to delay and probate fees.

Continuing Coverage - Hour Bank System

Once you are covered, all the hours your employer reports for you accumulate in your hour bank. Each month, 100 hours are deducted for your coverage.

You may accumulate up to 1,200 hours (12 months of future coverage) in your hour bank to carry you through periods of poor employment or vacation, providing you remain a member in good standing of Local 155. Any hours in excess of 1,200 go into the Plan's General Fund.

If your hour bank falls below 100 hours, you may use the self-pay option to remain covered, as explained below.

Long Term Disability coverage will not extend beyond six months from the date you were last actively at work, even if

you have banked hours or are self-paying to remain covered.

DEPENDENT COVERAGE

Your dependents are not covered until you enrol them. A dependent for Plan benefits is defined as follows:

- Your legally married spouse.
- Your common-law spouse (a person who has lived with you for at least 12 months and is represented as your spouse).
- Your or your spouse's unmarried child under the age of 21, who is financially dependent on and living with you or your spouse.
- Your or your spouse's unmarried child under the age of 25, who is in full attendance at a recognized school, college or university and is financially dependent on you or your spouse.
- Your or your spouse's unmarried mentally or physically handicapped child to any age, who is living with, and financially dependent, on you or your spouse.

Once a dependent child ceases to be a dependent, that dependent may not be eligible again for benefits. If in doubt, check with the Plan Administrator.

HOW DO YOU MAINTAIN COVERAGE IF UNEMPLOYED? (SELF-PAY)

When your hour bank has less than 100 hours, you are no longer covered by the Plan. However, you have the option

of paying for the coverage yourself, at the current shortage rate.

You will be notified by mail when your hour bank falls below the 100-hour minimum and told the amount of self-payment required and the date by which it must be paid. You may also check your records at any time with the Plan Office.

For Example:

Monthly coverage required	100 hours
Your hour bank balance is	45 hours
Therefore, you are short	55 hours

To retain coverage for that month, you must pay $104.50 (55 hours @ $1.90 per hour). The maximum shortage payment is $190.00 a month, based on 100 hours @ $1.90 per hour. *(Rate as at June 1, 2025. The rate may be adjusted by the Trustees from time to time.)*

Note: You do not have Bereavement Leave coverage while self-paying. See below for restrictions on Long Term Disability coverage while self-paying.

Limit on shortage payments

You may self-pay for up to 12 months (or 18 months if you are on maternity/parental leave).

Your self-pay count is re-set to zero if your employer(s) report a total of 40 hours in one calendar month at least two months before the maximum 12 months (or 18 months while on maternity/parental leave) of self-pay is reached.

Do not ignore the shortage notice!

You could lose your coverage if you fail to respond. If you make a self-payment and late hours are reported or other adjustments are found later, all hours will be credited to your hour bank for future coverage.

The only sure way to continue your coverage is to pay the shortage by the date specified on the notice.

Can I self pay for coverage after retirement?

After you retire, you can remain covered until your hour bank runs out, and you can self-pay subject to the limitations described earlier in this section.

You may also be eligible for the Subsidized Retirement Plan (SRP) – refer to that section of this booklet for more information.

"Grandfathered" account balance

Do you have "grandfathered" account balance left from the conversion to Hour Bank in 2009? Such balances can be used to continue coverage if your hour bank runs low.

If you have any questions about your Plan, including your account balance, please contact the Plan Office.

Long Term Disability

Long Term Disability coverage will not extend beyond six months from the date you were last actively at work, even if you have banked hours or are self-paying to remain covered.

WHEN DOES COVERAGE END?

Coverage is always provided on a whole month basis only, and will be terminated for you and your dependents, when:

- Your hour bank falls below 100 hours and you fail to make a cash payment by the specified date to bring your hour bank up to the required 100 hours;
- You reach the maximum number of self-payments;
- Your membership in the Union is suspended; or
- Upon your death. See "Death of a Member" section.
- If you take an honourable withdrawal, your coverage may continue while your hour bank runs out, for full benefits except disability and bereavement leave, but including EFAP. When a withdrawn member's hour bank runs out, he or she cannot self-pay to continue coverage.
- When your coverage on the Joint Council Plan begins (see "Coverage of Union Officers").

You will be notified if your coverage has terminated. The notification will be sent to the address in the Plan records.

If you were terminated for failing to pay your shortage notice, contact the Plan Office **immediately** to reinstate your coverage. You may do so in the first three weeks of the month your coverage is terminated. After that, you must work 200 hours to be covered again.

WHEN WILL COVERAGE START AGAIN?

If your coverage was terminated, then it can start again once 200 hours have been worked and reported to the Plan. This is the same as new member eligibility provisions outlined at the beginning of this section.

Coverage resumes immediately for members whose coverage on this Plan was suspended while covered on the Joint Council Plan. (see “Coverage of Union Officers”).

You may not re-qualify by self-payment.

IN CASE OF INJURY OR ILLNESS

If you are injured or become ill, you should apply **immediately** for EI sick benefits. If you have an EI unemployment claim open, change it to a sick claim immediately. EI sick benefits run for up to 15 weeks after a one week waiting period.

If you think your disability may last more than 16 weeks, contact your Union office or the Plan Office to find out whether you are entitled to Long Term Disability (LTD) benefits. If you are, the claim form will be sent to you.

The LTD benefit is described in the Co-operators benefits section of this booklet.

Other disability benefits are available from this Plan and other sources as described below:

Continuation of Full Coverage (Short-Term)

If you do not have enough hours in your bank to continue coverage, you must self-pay to maintain your coverage during the LTD waiting period.

Continuation of Coverage (Long-Term)

After 16 weeks, if you are on an approved claim for EI Sickness, WorkSafe disability, or Long-Term Disability, the Plan will continue your coverage for EHC, Dental and MSP-BC at no cost to you. For EI Sickness and WorkSafe disability, you must notify the Plan Office and provide continued proof of claim. For the first two years on disability, this is administered within the general rule requiring members to be in good standing with Local 155 for coverage. Once you have been on disability for more than two years, the requirement to be in good standing with Local 155 is waived as long as you remain on claim.

OTHER DISABILITY BENEFITS

Group Life and AD&D Insurance

Both your Life and AD&D insurance may be continued to age 65 if you become "totally disabled" while covered. This is automatic if you are accepted on LTD.

If you are not eligible for LTD, or if your LTD claim is denied, you may still be eligible to have your Life and AD&D insurance continued. The Plan Office can supply and explain the application forms.

Canada Pension Plan

Pensions are available from the Canada Pension Plan (CPP) for severe and prolonged disabilities, both occupational and non-occupational, provided you meet the qualifications. There is a three-month waiting period before benefits begin, but you should apply as soon as possible if your disability is severe and likely to be prolonged. Apply at Service Canada.

DEATH OF A MEMBER

The **Life Insurance**, and if applicable, **AD&D Insurance** claim should be referred to the Plan Office as soon as possible so we can assist the beneficiary.

Dental and **Extended Health Care** coverage for surviving dependents of a deceased covered member continue for one year, without payment, regardless of the hour bank balance at time of death.

Even if a member's surviving spouse is also a member, she or he would have the 12-month coverage continuation as a dependent, while naturally her or his own coverage as a member would continue according to the usual rules.

EHC or Dental receipts for eligible expenses can be submitted to Pacific Blue Cross up to June 30 of the year following the end of coverage for those benefits. For instance, if the member dies May 15, 2025, then coverage for eligible dependants continues up to May 31, 2026, and EHC or Dental receipts for January 1 to May 31, 2026, could be submitted up to June 30, 2027.

CLAIMS INFORMATION

Claim forms are available from the Plan Office or the Union office. To help speed claims processing:

- **Enroll** all your dependents with the Plan Office. Claims for unenrolled dependents will be rejected and will have to be reprocessed after enrollment occurs.
- **Advise** the Plan Office if your address changes.
- **Claims forms** are available from the Plan Office, or on the web sites of the insurers for each type of benefit. There are links to the insurance companies on the Plan Office web site.
- Ensure your **ID number** is on all receipts or claims.
- Your **receipts** must be itemized and show that you have paid for the service.
- Pacific Blue Cross does not return receipts for your EHC and Dental claims. Be sure to keep a photocopy or scanned copy of your receipts before sending your claim.
- **Claims Deadlines.** There are claims deadlines for each type of benefit. See the "Claims" sections of the detailed benefits descriptions which follow for deadline information (Dental, Extended Health, Life Insurance). But for faster reimbursement, send claims in through the year**.**

COVERAGE OF UNION OFFICERS

Coverage is suspended while employed by the Union and reinstated when returning to the bargaining unit

When a member starts work in the Union office and qualifies on the Joint Council Plan, his or her coverage is suspended on the Teamsters Union Local No. 155 Health Benefits Plan. Plan coverage starts again when and if the member's Joint Council coverage ends and he or she returns to the Bargaining Unit.

The Plan Office "freezes" the coverage, and then "thaws" it to resume coverage when the member leaves employment in the Union office. Considering all the different possibilities which a member may be in, the Trustees have set a policy that when the coverage is "thawed" it will be **with a full hour bank**.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

All Union members in good standing, and their dependents, are covered for the Employee and Family Assistance Plan.

The Employee and Family Assistance Program (EFAP) provides Union members and their families with quick, confidential access to experienced professional counsellors and consultants who can help you resolve a broad range of personal and work-related concerns.

In addition to counselling services, your EFAP also provides a variety of work/life services to help you manage your responsibilities and reach your goals.

The program is provided through Family Services Employee Assistance Programs (FSEAP).

FULLY CONFIDENTIAL

Use of the EFAP and any information collected is completely confidential within the full limits of the law. FSEAP counsellors and consultants do not release any information without prior written consent except to protect life and when ordered to do so by a court of law.

TO ACCESS THE EFAP

Simply call the toll-free line: **1-800-667-0993**.

Your call will be answered live 24/7 by a counsellor who discuss your reason for calling and assess the level of intervention required to address your issue or need. They can provide immediate crisis support as needed, schedule you for the appropriate counselling or work/life service, or help you find specialized resources in your community.

ONLINE HEALTH & WELLNESS RESOURCES

The EFAP also offers an online health and wellness resource library, which includes articles, newsletters, e-books, learning modules and links to web resources to help you deal with life's challenges. Access these online resources at:

www.fseap.bc.ca
password: 2bwell

RESIDENTIAL REHABILITATION ASSISTANCE

Residential Rehabilitation Assistance is available to all Union members in good standing.

The Plan will pay for residential rehabilitation treatment on the following basis:

- If you contact the EFAP program (FSEAP), a counsellor can help find a program which will be effective for you.
- Effective October 23, 2019, this Plan's maximum payment for residential rehabilitation available is $20,000 per member per lifetime. The benefit can also be extended to or shared with your Spouse.
- Payment can be guaranteed in advance to the provider of the rehabilitation service. If payment is not made in advance, the member or other person who paid the provider may be reimbursed upon successful completion of the program.

For further details, or to apply for this benefit, please contact your Union or the Plan Office.

BEREAVEMENT LEAVE

Benefits are payable to any member covered on the full plan (not on self-pay) who is available for work during the time of the bereavement leave. The Plan will compensate up to a maximum of five (5) days based on the Local 155 loss time wages formula.

Bereavement Leave is available in the event of the death of a member's immediate family.

- "Immediate family" means spouse, father, father-in-law, brother, grandfather, grandchild, child, mother, mother-in-law, sister, grandmother.

To make a claim, you must complete and submit the Bereavement Leave Claim Form, available from the Plan Office of Union office. Complete the form and have the Union sign confirming the days of work you missed. Submit the completed form with required proof of death (copy of obituary or death certificate) to the Union office for checking and approval. When that is complete, the Union will pass it on to the Plan Office for processing.

Bereavement Leave is considered taxable income; members will receive a T4A slip for "other income" which must be included as income on their tax return for the calendar year in which it is received.

To be eligible for this benefits, you must be fully covered (not covered by self-payment).

SUBSIDIZED RETIREMENT PLAN (SRP)

If you're a long-serving member of Teamsters Local Union No. 155 and do not qualify for active member coverage, you may be eligible for coverage through the Subsidized Retirement Plan, or SRP (PBC Policy No. 81025). You must meet the eligibility criteria outlined below.

ELIGIBILITY

- Minimum age 55 at time of enrollment
- Minimum of 10 years of Local Union No. 155 dues at time of enrollment
- Minimum amount of lifetime Local Union No. 155 remittances paid of $20,000 at time of enrollment
- Member in good standing with Local Union No. 155 at time of enrollment
- Covered by a Teamsters Local Union No. 155 or related Teamsters sponsored group benefit plan immediately before enrollment

COST

The SRP is designed to give you access to quality coverage at a reasonable cost, even after you've stopped working. While you will be required to pay a monthly premium, the SRP premium will be subsidized by the Plan. The amount of the subsidy will depend on the financial strength of the Plan and will be reviewed annually by the Trustees.

BENEFITS INCLUDED

Coverage under the SRP includes Extended Health Care, Dental, and EFAP.

Note in order to keep premiums affordable, some of the Extended Health benefits are reduced compared to the active member plan.

Differences include:

- Extended Health Care Annual Maximum of $100,000; Lifetime Maximum of $1,000,000
- Provisions of the Extended Health Care benefits exclude out-of-country/province emergency medical coverage. It is recommended that you purchase individual medical travel coverage as needed. See the Optional Travel Coverage section of this booklet for more information.

Refer to Extended Health Care, Dental, and EFAP sections in this booklet for details of coverage.

LIMITATIONS

- Monthly premium rates are subject to change on an annual basis.
- Members are only permitted to opt into the Subsidized Retirement Plan once. To transfer back to the active plan, members must requalify as a new member would (200 hours in a 10-calendar month period).
- Coverage will cease if payments are missed.

The Plan Office will provide you with information regarding the SRP if you are approaching your maximum self-pay options under the active plan. You may also contact the Plan Office directly for information.

OPTIONAL TRAVEL COVERAGE

When travelling outside of BC, your Health Benefits Plan covers many essential emergency medical expenses, including hospital stays, doctor visits, and prescription drugs needed to treat an emergency. **To be eligible, you must maintain coverage under MSP-BC.** Please see the Extended Health Care section of the Pacific Blue Cross booklet for full details.

You may wish to purchase additional travel insurance for coverage not included in the Plan, such as:

- Trip cancellation or interruption
- Air travel accidents
- Emergency return home
- Baggage loss, delay, or damage

Additional coverage is available through various providers, including Pacific Blue Cross, which offers a discount to covered members. You are encouraged to shop around, as travel insurance is also available through other outlets such as insurance brokers or travel agents. Plan options and pricing can vary, so it may be worth comparing coverage before purchasing.

For more information on Pacific Blue Cross travel insurance, visit pac.bluecross.ca/travel

This section is from a separate booklet provided by the Co-operators and is included in your plan booklet by the Trustees

TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN

Group Number G. 1007

YOUR GROUP BENEFIT PROGRAM

We are pleased to present to you a summary of each of the coverages provided by your Plan Sponsor. This booklet is designed to answer the most common questions regarding your Group Benefits Program.

Who is eligible?

You are eligible on the first day of the month following the date your hour bank balance reaches the Minimum Balance as defined in this booklet, are a member in good standing of the Teamsters Local No. 155 and under the age of 65.

How do I apply?

By completing an application form provided by Co-operators Life or a group enrollment card provided by your Plan Sponsor, within one month of becoming eligible.

Are my dependents covered?

Yes, some benefit plans include family coverage provided your dependents meet the definition contained in the benefit summary. Coverage for your dependents becomes effective the same date your coverage is effective.

Who is a dependent?

Your spouse or common-law spouse (provided the common-law spouse has resided with you for a minimum of 12 months).

Your unmarried dependent children:

- from birth to attainment of their 21st birthday;

- up to attainment of their 25th birthday who are in full-time attendance at any accredited educational institute;
- of any age who are suffering from a permanent mental or physical infirmity and are wholly financially dependent upon you and who became disabled while otherwise eligible under either of the above two.

No person will be considered a dependent if they reside outside of Canada unless they are classified as a full-time student, and normally reside in Canada.

When do my benefits terminate?

Your insurance, under each coverage, terminates automatically at the age specified in each benefit explanation. Other reasons for termination of insurance are termination of your membership with the Teamsters, reduction of your hour bank balance below 100 hours, termination of the master policy or cessation of premium payments.

Your dependents' coverage terminates when your coverage terminates, or when the dependent no longer is a dependent.

How do I submit a claim?

Claim forms are available from your Plan Administrator or from **www.cooperators.ca** and click on ***Group >Group Benefits***. Upon completion, all claims should be sent to:

Group Claims Department
The Co-operators
1920 College Avenue

Regina, Saskatchewan S4P 1C4

Conversion Privilege

On termination of your group life insurance prior to age 65, you may obtain an individual policy with The Co-operators Life Insurance Company without providing evidence of good health on the Ordinary Life Plan, Limited Payment Life, Term to Age 65, or One Year Term Plan (non-renewable) at Co-operators Life's regular rates.

This individual policy will be limited to the lesser of $200,000, or the difference between the amount of insurance at the time of your termination and the amount of insurance for which you are eligible under a new group contract, at the time you are exercising your right to convert.

The individual policy will be issued only if application is made within 31 days after your termination.

Your life will continue to be insured during the 31 day conversion period whether or not you apply for conversion.

We ask that you review the information contained in this booklet to obtain an understanding of your group benefits program.

THE INFORMATION CONTAINED IN THIS BOOKLET IS FOR GUIDANCE ONLY. Please keep this important document in a safe place for future reference.

The master contract G. 1007 issued by The Co-operators Life Insurance Company to Trustees of Teamsters Local Union No 155 Health Benefits Plan shall be the final basis for the settlement of all claims. Where there is a

discrepancy or conflict between the description in this booklet and the Policy, the terms and conditions of the Policy prevail.

BASIC GROUP LIFE INSURANCE

The amount of insurance below will be payable to your beneficiary upon your death.

Each member under 65 years of age	$125,000
Each member 65 years of age or older	$20,000
Each member 70 years of age or older	$10,000
Each Disabled Retiree Age 65 or more	$5,000

Living Assistance Benefit

The living assistance benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill employees under age 65.

Application for this benefit must be approved by the plan, and Co-operators Life will confirm that medical evidence meets the program's requirements before approving payment.

The amount of money available as a living benefit payment is 50% of your Basic Life Insurance benefit, to a maximum of $50,000.

Total Disability Waiver of Premium

Should you become totally disabled for more than 4 months prior to age 65, the amount of your life insurance will continue without payment of premiums until age 65, or recovery.

You must apply for this benefit within twelve months of the date you become disabled – please contact the Plan Office.

Submitting a Claim

The time limit within which a group life insurance claim must be made is 180 days from the date of loss.

Termination Age

Your basic group life insurance benefit has no termination age.

DEPENDENT LIFE INSURANCE

This benefit provides life insurance coverage for your spouse and dependent children. The amount of the benefit is:

Spouse	$10,000
Child (over 15 days)	$5,000
Child (15 days or less)	$2,500

Total Disability Waiver of Premium

If you are totally disabled and the premiums for your basic life insurance coverage are being waived, then premiums for the dependent insurance will also be waived, but only so long as the policy remains in force.

Termination Age

Your dependents insurance terminates when you reach age 70.

LONG TERM DISABILITY

The purpose of this benefit is to provide coverage should you become totally disabled as the result of an accidental injury or illness and are unable to work at your own occupation for wage or profit.

Your taxable benefit is determined as follows:

Each member $2,500 per month

Benefits will commence on the later of: the 113th day of continuous/consecutive disability, or expiration of EI sickness benefits. Periods of disability interrupted by return to work of 14 consecutive days or less will be considered to be uninterrupted, but the days at work will not be included as part of the elimination period.

You are eligible for benefits for a two year period from the date benefits commence if you are unable to perform the usual and customary duties of your own job. Thereafter, benefits will continue only if you are unable to perform the duties of any occupation.

In no case shall a benefit be paid beyond:

- the date of your 65th birthday, or
- the date you are no longer totally disabled, or
- the date you engage in any work or occupation other than rehabilitative employment, or
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by the insurance company, or

- the date you refuse to participate in a rehabilitation program, whichever first occurs.

Benefit Reductions

What reductions occur when determining my Monthly Indemnity Benefit payment?

Direct Reductions

Your monthly benefit will be reduced directly by one or more of the following, which you are receiving or entitled to receive at the time your benefits commence and /or while benefits are paid:

- any workers compensation benefits (excluding cost of living increases).

Indirect Reductions

Your benefit will be further reduced if the total of the following All Source Compensation and your monthly benefit exceeds 85% of your pre-disability gross monthly salary. If it does, your monthly benefit will be reduced by the amount in excess of 85% by:

- any auto plan benefits,
- any Canada or Quebec Pension Plan disability benefits (excluding cost of living benefits),
- any Canada or Quebec Pension Plan retirement benefits you apply for, were approved for and received after your disability date.

- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.
- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply or Accept Other Benefits

Except for retirement benefits, any benefit is considered paid when you are entitled to it, whether or not it has been awarded or received. If it has not been awarded or received, Co-operators Life will have the right to estimate the income according to the terms of any plans or legislation involved. Retirement benefits are considered payable when they are actually received.

Where you do not qualify for part or all of the All Source Compensation because of failure to apply in a timely and satisfactory manner (or appeal where so advised by

Co-operators Life), Co-operators Life reserves the right to reduce your monthly benefit by the amount of All Source Compensation which you would have been eligible for or received had a proper application or appeal been made.

Lump Sum Conversion to Monthly Benefit

Where you receive or have the option of receiving part or all of the All Source Compensation as a lump sum payment, Co-operators Life will, acting reasonably, pro-rate the lump sum payment and reduce your monthly benefit as if the lump sum had been paid on a monthly basis.

The All Source Compensation used in the direct and indirect offset sections are the All Source Compensation Benefits payable for the same period as the monthly benefits are payable.

Repayment of Benefits

Where you receive All Source Compensation that includes compensation for a period for which monthly benefits have been paid, Co-operators Life will convert the payment to a monthly payment and re-calculate your monthly benefit that should have been paid. You are responsible to repay Co-operators Life any overpayment of long term disability benefits.

Recurring Disabilities

Successive periods of disability arising from the same or related cause and separated by less than six months will be treated as one period of continuous total disability.

Rehabilitation Program

Based on a determination made by Co-operators Life, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/ full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

Co-operators Life will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the services provided as part of that program. If you do not participate in a rehabilitation program provided either by Co-operators Life or by another party and approved by Co-operators Life (i.e. any worker's compensation act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or Co-operators Life withdraws approval of your program, then your disability/rehabilitation benefits under this policy will be cease.

While you participate in the rehabilitation program your disability benefit will continue, but will be reduced by 50% of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non-taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed 100% of your pre-disability income (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond the end of your own occupation period. Nothing in the rehabilitation program or provision will create any basis for any extension of the own occupation period unless an extension of the duration is recommended and approved in writing by Co-operators Life.

Third Party Liability

If you become totally disabled due to an injury or disease for which a third party is, or may be legally liable, benefits will be paid when you sign (and submit to Co-operators Life) a Subrogation Reimbursement Agreement.

You will be required to reimburse the insurance company for benefits received in accordance with the terms and conditions stated in the subrogation reimbursement agreement.

You must obtain the written consent of the insurance company before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this policy.

Total Disability Waiver of Premium

Premiums will be waived while you are receiving disability benefits commencing with the first premium that falls due after the first benefit payment is eligible to be made.

Exclusions

a. No benefit will be payable for any disability resulting from or caused by:
   - intentionally self-inflicted injury, while sane or insane;

- insurrection, war or hostilities of any kind;
- riot or civil commotion regardless of whether you were participating;
- injury occurring while committing or attempting to commit a criminal offence;
- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation of an organ or tissue will be covered;
- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment;
- injury or sickness for which a third party is liable, except as provided for in the Third Party Liability section.

b. No benefit will be payable for any disability if you are imprisoned or if you are not under continuous care and treatment of a physician who is certified by the Royal College of Physicians and Surgeons in a speciality appropriate to your sickness or injury.

c. No benefits will be payable during any period that you are on maternity leave, parental leave or any other leave of absence.

d. No further benefits will be payable from the date you refuse to participate in any rehabilitation program approved by Co-operators Life.

Submitting a Claim

The time limit within which a long term disability claim must be made is 90 days from the date the insurance company is liable.

Termination Age

Your long term disability benefit terminates at age 65.

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

When you apply for coverage or benefits, Co-operators must gather personal information about you, your spouse or dependents.

We use this personal information for the purposes of providing group benefit plan administration services and insurance products to you.

Maintaining the security of your personal information is a top priority. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security is emphasized in our Code of Ethics and extends to the contracts and agreements that we sign with external suppliers and service providers.

Co-operators does not collect, use or disclose your personal information without your consent, except where authorized by law.

Co-operators may require your medical information to administer the group benefits plan. We do not share your medical information without your express consent.

You have the right to access your personal information. Send your requests in writing and request corrections to inaccurate information. The medical information not collected directly from you may only be released directly

through your physician. For more information on how to obtain access to your file, you may write directly to:

CO-OPERATORS LIFE INSURANCE COMPANY
Attention: Group Insurance Department - Privacy
1920 College Avenue
Regina, Saskatchewan
S4P 1C4
Email: privacy@cooperators.ca

This section is from a separate booklet provided by AIG and is included in your plan booklet by the Trustees

TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN

Policy Number BSC 9427136

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to fulfill their financial responsibilities.

Your Accident Insurance coverage is underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a flat Principal Sum amount of $125,000.00.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Employee" means you, if you are a permanent, active full-time employee of the Policyholder who is under the age of 70.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your Plan's current Group Life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

BENEFITS AND COVERAGES

Accidental Death, Dismemberment, Paralysis & Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands	The Principal Sum
Loss of use of both legs	The Principal Sum
Loss of use of one hand or one foot	Three-quarters of the Principal Sum
Loss of use of one arm or one leg	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs;

"Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

"Arm" or "Leg" means the complete severance through or above the elbow or knee joint;

"Thumb and Index Finger" means the complete severance through or above the first phalange;

"Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand;

"Toes" means the complete severance of both phalanges of all the Toes of One Foot;

"The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye;

"The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing;

"Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing;

"Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds;

"Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit

Pays the expenses incurred for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a one-time benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 to your Employer if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order for you to return to work full-time.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit

Pays a benefit of up to $5,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Felonious Assault Benefit

Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.

Serious Illness Benefit (Non-Cancer)

Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- Major Burns (third degree)
- Multiple Sclerosis
- Necrotizing Fasciitis
- Parkinson's Disease
- Major Organ Failure Requiring Transplant
- Motor Neuron Disease
- Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a

result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Coma Benefit

Pays a monthly benefit of 1% of your Principal Sum for a maximum of 100 months after 6 months in a continuous coma caused by an accident. Please see the Policy for details.

Burn Benefit

Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the Policy for details.

Surgical Reattachment Benefit

Pays a percentage of the Principal Sum if, as a result of an injury a limb or an appendage or part of either a limb or appendage is completely severed and is surgically reattached. Please see the Policy for details.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

This Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

a) suicide or any attempt thereat by you while sane;

b) self inflicted injury or any attempt thereat by you while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:

i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

j) performing, learning to perform, or instructing others to perform as a pilot or crew member of any aircraft; or

k) riding as a passenger in an aircraft owned or leased by the Policyholder;

l) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

m) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

n) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

o) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in

strict accordance with the instructions of a duly licensed physician;

p) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

q) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

r) natural causes.

Effective Date

Your coverage begins on the date you satisfy the definition of "Insured Employee".

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or

4. the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

This section is from a separate booklet provided by Pacific Blue Cross and is included in your plan booklet by the Trustees

TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN

Active Members
Policy Number 901053

Subsidized Retirement Plan (SRP) Members
Policy Number 81025

INTRODUCTION

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

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

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

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

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

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

Privacy Policy

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

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

PBC SCHEDULE OF BENEFITS

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

Extended Health Care		
Deductible	None	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Hearing Aids & Vision Care	100%
	All Other Eligible Expenses	80%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency Eligible*	100%
	Non-Emergency	Same as In-Province/ Territory
	After $1,000 has been paid for a family in a calendar year, further Eligible expenses for that family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum	The lifetime maximum amount of benefits payable for an Active Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract. **For SRP members, the plan maximum is $100,000 per year and $1,000,000 lifetime.**	
Dependent Child / Spouse	See definition of Dependent.	

* ***Emergency Out-of-Province benefits are not included for Subsidized Retirement Plan (SRP) Members.***

Dental Care			
Deductible	No Deductible		
Reimbursement	**Plan A**	**Plan B**	**Plan C**
	Basic Services	Major Restorative Services	Ortho-dontics
	100%	60%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	$5,000 Combined with Plan B	$5,000 Combined with Plan A	$5,000
Financial Limit Per Member or Spouse	$5,000 Combined with Plan B	$5,000 Combined with Plan A	$5,000
Dependent Child / Spouse	See definition of Dependent.		

DEFINITIONS

Deductible

means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Dependent

means any of the following persons for whom coverage is provided under this Plan:

1) one Spouse of the Member,
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
4) any unmarried handicapped child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Handicap status is subject to approval by us. The Dependent must become handicapped while covered as a Dependent under Clause 2 and 3 above.

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

Duplicate coverage

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

Fee guide

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

Fee schedule

means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Member

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

Spouse

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

MEMBER INFORMATION/ACCESS TO RECORDS

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.

2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.

3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.

4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.

5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy

c) any written statement or other record provided to us as evidence of insurability of the Member.

6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.

7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

INTEGRATION WITH GOVERNMENT PLANS

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

EFFECTIVE DATE OF COVERAGE AND ENROLLMENT

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

You should apply for Dependent coverage (when applicable):

1) on the same date you apply for your own coverage, or

2) when you acquire a new Dependent.

Provided you and your Plan Administrator have complied with our enrollment rules, your coverage effective date is shown on your online Member Profile which can be accessed from our website at www.pac.bluecross.ca/member/login or from your Plan Administrator.

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

BENEFICIARY

This plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits. Any benefit amount owing will be paid to your estate or to you for a deceased Dependent.

IDENTIFICATION (ID) CARDS

We will issue identification (ID) cards for distribution by your Plan Administrator.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

CLAIMS

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if

we receive your claim after the time limits described in this booklet.

3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.
4) The necessary claim forms are available from your Plan Administrator or on our website www.pac.bluecross.ca
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

DUPLICATE COVERAGE

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

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

COORDINATION OF BENEFITS

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

1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.

2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).

3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.

4) Total reimbursement shall never exceed 100% of the Eligible expenses.

GENERAL EXCLUSIONS

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.

2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) active duty in the military forces of any nation or international organization, or in any civilian non-

combatant unit which serves with such forces in combat

c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
d) false pretences or fraudulent misrepresentation
e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

LEGAL ACTION

For benefits administered on an ASO (self-insured) basis, every action or proceeding against us for the recovery of benefits payable under the Group Contract/Policy is absolutely barred unless commenced within one year from the date satisfactory written proof of loss is filed with us, or within the time set out in other applicable legislation as may apply to a claim, action or proceeding for benefits.

TERMINATION OF COVERAGE

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, leave of absence, age limitation, if you terminate your employment, or if the group plan terminates, etc. For further details on termination of coverage, please contact the Plan Office.

RIGHT OF RECOVERY

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

CONVERSION TO AN INDIVIDUAL PLAN

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition

means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12-month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

INDIVIDUAL TRAVEL BENEFITS

Individual travel coverage is also available from Pacific Blue Cross. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

MEMBER PROFILE

Your Member Profile (formerly known as CARESnet) with Pacific Blue Cross offers convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are provided. To access your Member Profile visit our website: www.pac.bluecross.ca/member/login/

EXTENDED HEALTH CARE

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

DEFINITIONS

Compounded drug

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

Dispensing fee

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

Eligible expense

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

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

3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and

4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare's low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Experimental

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

Life-sustaining non-prescription drugs

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

Markup

means the total of all amounts added to the manufacturer's list price, meaning the published price at which the drug is available for purchase from the manufacturer in the applicable province/territory, and including any wholesale upcharge, retail markup, and any other amounts in excess of the manufacturer's list price.

Nurse practitioner

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

Pharmacist

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

Preferred pharmacy

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

IN-PROVINCE ELIGIBLE EXPENSES

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

1) Hospital

   The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance

   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient

   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport

   c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities

d) charges for an attendant when medically necessary.

3) Drugs and medicines

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

a) which are dispensed by a pharmacist, Physician, Dentist, or a Primary healthcare nurse practitioner, including:

   i) life sustaining drugs

   ii) insulin preparations, testing supplies, needles, and syringes for diabetics

   iii) vitamin B12 for the treatment of pernicious anemia

   iv) allergy serums when administered by a Physician, or

b) which legally require a prescription from a medical provider legally authorized to do so, including:

   i) compounded drugs

   ii) drugs indicated for weight loss

   iii) drugs indicated for the treatment of infertility to a lifetime maximum of $2,750

   iv) contraceptive drugs

   v) drugs indicated for sexual dysfunction

   vi) vaccines

Reimbursement of eligible drugs and medicines will be subject to PharmaCare's low cost alternative and reference drug program policies; however, these policies will not be applied if it has been shown that such drug or medicine does not meet the patient's needs.

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Nurse Practitioner.*

a) acupuncturist…….. .....$1,000

b) chiropractor…… $1,000

c) massage practitioner…… $1,000

d) naturopath…….. .....$1,000

e) physiotherapist…….. .....$1,000

f) podiatrist…….. .....$1,000

g) psychologist/clinical counsellor combined ….$1,000

h) speech language pathologist……. $1,000

i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

5) Online Cognitive Behavioural Therapy

Charges for a program through an eligible Vendor to a maximum of $1,000 per calendar year combined with services of a psychologist and clinical counsellor.

"Online cognitive behavioural therapy" means an internet-based behavioural therapy program.

6) Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally/unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

7) Medical aids and supplies provided by a medical supplier (as approved by Pacific Blue Cross). Charges for the following services and supplies:
   a) oxygen, blood, and blood plasma
   b) ostomy and ileostomy supplies
   c) walkers, canes/cane tips, crutches, casts, trusses

d) splints and collars (not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), if prescribed by a Physician, physiotherapist, or chiropractor as medically necessary after diagnosis of the patient. Myoelectric limbs are excluded, but we will pay the equivalent of a standard prosthesis

e) 1 mastectomy brassiere per breast prosthesis to a maximum of 2 per lifetime

f) charges for the following items to the maximum amounts indicated per calendar year:

   i) stump socks……$200

   ii) surgical stocking ……2 pairs

g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500

h) orthopaedic shoes and orthotics

   i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, 1 pair of custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a 3-dimensional volumetric model of the patient's foot and lower leg, or

ii) when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, 1 pair of custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

iii) replacements when necessitated by normal wear and tear or change in medical diagnosis

i) hearing aids and repairs for Adults and Dependent children to a maximum of $1,000 per ear in a 60 month period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

8) Standard durable medical equipment

a) Preauthorization is required from Pacific Blue Cross for expenses in excess of $5,000

b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.

c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.

d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

e) Standard durable equipment includes:

i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent

ii) medical heart monitors and cardiac screeners

iii) continuous glucose monitors and supplies and blood glucose monitors

iv) speech processors and headsets when prescribed for profound deafness to a 5 calendar year period

v) bi-oestrogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems

vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators (CPAP cleaning machines may also be covered. Contact the Plan Office for details.)

vii) insulin infusion pumps for diabetics – when basic methods are not feasible

viii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain

ix) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Vision Care and Eye Exams

Charges for the following when prescribed by a Physician or legally authorized optical provider:

a) purchase and/or repair of eyewear and charges for contact lens fittings, lens implants and laser eye surgery to a combined maximum of $400 per calendar year. Charges for non-prescription eyewear are not covered.

b) routine eye examinations up to the reasonable and customary limit, once per calendar year.

9) Medical Examinations

Charges of a Physician for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement. For example, driver's exams.

10) Second Medical Opinion

This benefit offers Members who are Actively employed and their Dependents that are faced with a serious medical condition the opportunity to obtain a second medical opinion offered by one of North America's leading medical facilities.

Serious medical conditions, which qualify for Second Opinion are diagnoses of the following:

- AIDS
- ALS
- Alzheimer's disease
- Any amputation
- Any life-threatening illness

- Benign brain tumor
- Cancer
- Cardiovascular conditions
- Chronic pelvic pain
- Coma
- Deafness
- Embolism/Thrombophlebitis
- Emphysema
- Hip/knee replacement
- Kidney failure
- Loss of speech
- Major or severe burns
- Major organ transplant
- Major trauma
- Multiple sclerosis
- Neuro-degenerative diseases
- Paralysis
- Parkinson's disease
- Rheumatoid arthritis
- Stroke
- Sudden blindness due to illness

A medical specialist reviews the patient's medical documentation and provides recommendations to the patient and their Physician. Treatment decisions are made between the patient and their Physician.

Subject to the terms and conditions, including any applicable limits and maximums, of the Contract.

OUT-OF-PROVINCE ELIGIBLE EXPENSES

Out-of-Province Non-Emergency Eligible Expenses

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

Out-of-Province Emergency Eligible Expenses

Not applicable to Subsidized Retirement Plan (SRP) Members

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

1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the essential treatment.
2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days. If reasonably possible, we should be notified within 5 days of the patient's admission. When the patient's condition has stabilized, we have the right, with approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. If transportation

would endanger the patient's health, the 90 day limit may be extended.

3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies if we would have covered them inside your province of residence.

The **maximum trip duration** to maintain your eligibility for Out-of-Province Emergency expenses is based on your maintenance of eligibility for Medical Services Plan (MSP) coverage. An individual must continue to meet the residency requirements to be covered for both MSP and Pacific Blue Cross. Residents who are absent from B.C. for six months or more in a calendar year do not meet residency requirements.

Emergency Travel Assistance

Not applicable to Subsidized Retirement Plan (SRP) Members

In emergencies which occur while you (and your Dependents) are travelling, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains

5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

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

EXCLUSIONS

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

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence

2) general anaesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription

3) except as specifically included in this booklet: contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury

4) allergy testing unless rendered by a naturopath

5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian

Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests

6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English

7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan

8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits

9) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment

10) expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date

11) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence

12) expenses of a Dependent hospitalized at the time of enrollment

13) services performed by a Physician who is related to or resident with you or your Spouse

14) fees for ambulance services when an ambulance is called but not used

15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility

16) retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare

17) any other item not specifically included as a benefit.

CLAIMS

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit electronically to us
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
   c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused.

2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.

3) You must provide explanation or proof to support the claim or any other information we consider necessary.

4) We must receive an electronic claim by June 30th of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the June 30th deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.

5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card. The pharmacist will charge you only for amounts not covered by us. If you or the pharmacy do not have access to this system, or for other types of expenses, please follow the instructions below.

Please Note: If your Dependents have coverage through another plan, your Pay Direct card cannot be used for their

prescription expenses.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.

2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your Plan Sponsor. Information for claiming Pharmacare expenses may be obtained from your pharmacist.

4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

    a) Obtain a claim form from your Plan Administrator.

b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. Example: **We must receive your receipts for 2021 before June 30, 2022.**

d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

DENTAL CARE

PAYMENT OF BENEFITS

1) We pay benefits based on dental services, financial limits, and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.

2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule as follows:
   a) for services performed in BC or outside Canada, if your province of residence is BC — the fees in the Fee schedule
   b) for services performed in Canada but outside BC —the fees in the Fee guide in the province/territory of service
   c) for services performed outside Canada if your province of residence is not BC—the fees in the Fee guide in your province/territory of residence.

3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

PLAN A – BASIC PREVENTIVE & RESTORATIVE SERVICES

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

1) Diagnostic services
   a) examinations:
      i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3 year period
      ii) recall – 2 per calendar year
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment).
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 2 year period
      iii) complete mouth series – 1 per 3 year period

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.
2) Preventive services
   a) scaling
   b) polishing – 2 per calendar year
   c) topical application of fluoride – 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services

   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:

      i) amalgam (silver coloured) fillings

      ii) composite (tooth coloured) fillings

   b) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.

   c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:

   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule

   b) root planing

   c) gingival curettage – 1 per sextant in a 5 year period

   d) osseous surgery – 1 per sextant in a 5 year period

6) Prosthetic repairs
    a) removal, repairs, and recementation of fixed appliances
    b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
    c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
    d) gold foil – only when used to repair existing gold restorations.

7) Surgical services
    a) extractions
    b) other routine oral surgical procedures
    c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

PLAN B – MAJOR RESTORATIVE SERVICES

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

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

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

1) Prosthodontic Services
    a) removable
        i) complete upper and lower dentures
        ii) partial upper and lower dentures

b) fixed bridges

c) dental implants

2) Restorative Services

a) inlays or onlays involved in bridgework

b) veneers

c) crowns and related services.

3) Periodontal Appliances

bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.

2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.

4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

PLAN C – ORTHODONTICS

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. Plan C is designed to cover orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement of appliances which are lost or stolen.
3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
4) Treatment performed solely for splinting is not covered.

EMERGENCY TREATMENT OUTSIDE YOUR PROVINCE OF RESIDENCE

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

EXCLUSIONS

The following are not Eligible expenses under your plan:

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

CLAIMS

1) Present your ID card to your Dentist's office. We suggest that your Dentist submit an outline of the proposed services to us **before you start treatment,** especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **1 year** from the date the service is performed.

3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

    a) name of the Dentist
    b) name and birth date of the person receiving the dental care
    c) your group, ID, and Dependent(s) numbers
    d) your home mailing address
    e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:

   a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:

      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental provider showing the services performed and the fee charged, or

      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

   b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when we receive:

      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or

      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

5) Orthodontic Claims Procedures

a) Receipts

Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.

b) Claiming deadlines

i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).

ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.

c) Treatment plan

i) Have your orthodontist complete a treatment plan using the "Certified Specialist in Orthodontics Standard Information Form" before treatment starts. The treatment plan must include a description of treatment to be performed, a breakdown of fees to be charged, and the estimated length of treatment.

ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.

iii) We will retain your treatment plan on file. If we do not have your treatment plan on file, we are unable to pay:

- your initial fee/down payment

- your monthly/quarterly fees
- one time appliance fees

iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees

i) If you are paying monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 1 year old will not be reimbursed.

ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.

iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.