Millwrights Local 2736 Health Benefits Plan

Plan Booklet

Effective July 1, 2023

POLICY NO.2736 (PACIFIC BLUE CROSS - ACTIVES)
POLICY NO. 43524 (PACIFIC BLUE CROSS - RETIREES)
GROUP NO. 6270326 (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 covered members information about the change, including an updated Summary of Benefits.

WHO TO CONTACT

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

PLAN OFFICE / PLAN ADMINISTRATOR
D.A. Townley (A wholly owned subsidiary of Pacific Blue Cross)
Telephone: 604-299-7482
Toll Free: 1-800-663-1356
E-mail: mw2736admin@datownley.com
Web page: mw2736benefits.com

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

FSEAP
1.800.667.0993
TTY 1.888.234.0414
Online resources at: www.fseap.bc.ca
password: 2bwell

LETTER FROM THE TRUSTEES

TO OUR MEMBERS:

The Millwrights Local 2736 Health Benefits Plan was established effective April 1, 1998, to provide health and welfare benefits for all eligible members and their covered dependents. It is funded under the terms of collective agreements negotiated between Millwrights, Machine Erectors and Maintenance Union Local 2736 and participating employers.

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 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,
Millwrights Local 2736 Health Benefits Plan

- *Miro Maras (Chair)*
- *John Fisler*
- *Carey Simpson*
- *Adam Wittmeier*

LIST OF BENEFITS

The following benefits are provided under the Millwrights 2736 Health Benefits Plan. Further details are provided throughout this booklet.

Benefit	Provider
Employee and Family Assistance Program	Family Services Employee Assistance Programs (FSEAP)
Bereavement Leave	Self-Insured and paid by Trustees*
Jury Duty	
Residential Rehabilitation	
Group Life	Insured by Blue Cross Life, Policy #2736
Spouse Life	
Child Life	
Accidental Death & Dismemberment	
Long Term Disability	
Short Term Disability**	Self-Insured by Trustees* and paid by Pacific Blue Cross, Policy #2736
Extended Health	Insured by Pacific Blue Cross, Policy #2736
Dental	Self-Insured by Trustees* and paid by Pacific Blue Cross, Policy #2736
Health Spending Account	
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)."

** LTD benefits are payable after a 26-week waiting period. Claim EI Sickness benefits for weeks 1-26. Short Term Disability (STD) benefits may be payable from Blue Cross Life if you are not eligible for EI Sickness benefits. STD may also be payable for disabled members who are over 65 and not eligible for LTD or who reach age 65 before receiving at least 41 weeks of combined EI/STD/LTD. Additional STD benefits may also be payable for disabled members who are denied LTD benefits under the pre-existing condition clause.

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.

Eligibility for all other benefits is through the Hour Bank. You must:

1. Be a member in good standing of the Millwrights Machine Erectors and Maintenance Union Local 2736;
2. Be employed by an employer signatory to an agreement with the local union; and
3. Have a minimum of 220 hours, within a period of eleven consecutive months, reported and paid into the Plan by your employer(s).

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 Enrolment

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 that are not used within 11 consecutive months to establish eligibility for coverage (that is, hours that are 12 or more months old) go into the Plan's general fund.

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

Please complete and return enrolment 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 could be 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, 110 hours are deducted for your coverage.

You may accumulate up to 1,320 hours (12 months of future coverage) in your hour bank to carry you through periods of low employment or vacation, providing you remain a member in good standing of Local 2736. Any hours in excess of 1,320 go into the Plan's general fund.

If your hour bank falls below 110 hours, you may use the self-payment option to remain covered, as explained below.

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.

Note additional requirements or restrictions may apply for Dependent Life.

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?

When your hour bank has less than 110 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 110-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.

You may self-pay for up to 18 months.

For Example:

Monthly coverage required	110 hours
Your hour bank balance is	45 hours
Therefore, you are short	65 hours

To retain coverage for that month, you must pay $100.10 (65 hours @ $1.54 per hour). The maximum shortage payment is $169.40 a month, based on 110 hours @ $1.54 per hour. *(Rate as of January 1, 2022. The rate will be adjusted periodically, based on plan financial status and a target of 70% of actual cost of benefits.)*

NOTES: You do not have Jury Duty OR Bereavement Leave coverage while self-paying. However, you DO remain covered for Long Term Disability and Short-Term Disability while self-paying. For your own protection in case of disability, we strongly urge you to continue your coverage by self-payment when you are unemployed.

Employee and Family Assistance Program During Self-Pay

If you are a member in good standing of Local 2736, you have coverage under the Employee and Family Assistance Program (through FSEAP). Hour bank rules do not apply to this program.

Reduced Rate for "Mini-Plan"

There is a "Mini-Plan" available, ***covering only Extended Health Care and reduced Life and Spousal Life***. If you choose to go on the Mini-Plan, you will pay a reduced shortage rate of $0.50 per hour. The maximum shortage payment is $55.00 per month, based on 110 hours @ $0.50 per hour.

If you choose to go on the Mini-Plan at any time, ***you cannot go back to full coverage*** until you re-qualify when your employer(s) remit contributions for 220 hours within an 11-month period.

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.

Get reimbursed through the Health Spending Account

No additional Health Spending Account funding is being provided after December 31, 2022. However, if you have funds remaining in your Health Spending Account from prior years, you may be eligible for reimbursement of your self-payments. You must first pay the shortage notice, then request a receipt from the Plan Office and submit that receipt to Pacific Blue Cross along with a completed claim form.

Can I self-pay for coverage after retirement?

After you retire, you can remain covered until your hour bank runs out, but you are not eligible to self-pay. See the Member Retirement section of this booklet for more information.

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 110 hours, and you fail to make a self-payment by the specified date to bring your hour bank up to the required 110 hours;
- You reach the maximum number of self-payments;
- You cease to be a member in good standing of the Union;
- Upon your death. However, if you die while a covered member, the "Survivor" provision covers your dependents for Dental and Extended Health for 24 months after your death, or the date they cease to be dependents, or the date they become eligible for other coverage. Dependents of deceased members are not allowed to self-pay to continue coverage beyond that time.

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, you may contact the Plan Office or Union office **immediately** and pay the actual number of hours you were short, plus the full 110 hours to ensure continued coverage for the following month.

WHEN WILL COVERAGE START AGAIN?

If your coverage is terminated, it can start again when 220 hours have been worked and reported to the Plan. This is the same as new member start date outlined at the beginning of this section.

You may not re-qualify by self-payment.

IN CASE OF INJURY OR ILLNESS

See your doctor **promptly** after becoming disabled, to ensure your disability is documented and you are receiving the treatment you need.

Read the timeline below for non-occupational or non-occupational disabilities and follow the guidelines. If in doubt about your eligibility or what you need to do, contact the Plan Office or the Union Office **promptly** to get help or advice.

Your Long-Term Disability, WCB or CPP claim may be delayed or denied unless you see your doctor promptly, follow your doctor's treatment plan, and file your claim on time.

DISABILITY TIMELINE - NON-OCCUPATIONAL DISABILITY

1. **Weeks 1 to 26 – EI Sickness Benefits**
   a. Apply to Service Canada for EI Sickness Benefits.
      - If you have an unemployment claim open when you become disabled, you should convert it to a Sick Benefit claim. If you are disabled from working but collect unemployment benefits, you could lose your rights to future benefits, and you could have to repay EI.
      - **File your claim promptly** to avoid delays in receiving payments.

   b. If you are not eligible for EI Sickness Benefits, contact your Union office or Plan Office **immediately** to find out whether you are entitled to Short Term Disability (STD) benefits. If you are, the claim form will be sent to you. If you do not qualify for EI Sickness benefits, provide proof of rejection to Blue Cross Life and you will be eligible for up to 26 weeks of STD benefits.

   c. **Week 12 or earlier** – if your disability is "severe and likely to be prolonged", submit your claim for CPP Disability Benefits. CPP Disability Benefits can be paid starting after 3 months of disability, but only if you apply! These benefits are deductible from your LTD, but they are very important to protect your future CPP retirement pension.

d. **Week 20 or earlier** - Unless you are confident you will be fit to return to work at 26 weeks or earlier, contact your Union Office or Plan Office to ask for an **LTD claim form**.

- You and your doctor should **complete and submit this form promptly** to avoid delays in your LTD claim.
- You may submit directly to Blue Cross Life, or through the Plan Office. If you submit through the Plan Office, we can help by checking that forms have been completed properly.
- **You must** submit your LTD claim to Blue Cross Life within 9 months of the start of your disability (90 days after your STD/EI Sickness benefits end), or they will deny your claim. **We recommend** you submit the claim within 5 to 6 months to ensure prompt payment of benefits.

2. Week 27 – 2 years – Long Term Disability Paid by Blue Cross Life

a. You must be **disabled from "your own occupation"**.

b. While you remain disabled, LTD is paid up to age 65. However:

- If you are 65 or older after 26 weeks of disability, contact the Plan Office. Blue Cross Life may pay up to 41 weeks of STD, reduced by any STD or EI Sickness benefits you received in weeks 1 – 26.
- If you reach your 65th birthday after receiving less than 41 weeks of LTD, contact the Plan Office. Blue Cross Life may pay up to 41 weeks of STD, reduced by the number of weeks LTD you received, and by any STD or EI Sickness benefits you received in weeks 1 –26.

c. If you can be rehabilitated back to your own job or retrained to another job, Blue Cross Life's rehabilitation consultants will work with you to help that happen.

3. Years 3, 4 and 5 – LTD Paid by Blue Cross Life

a. You must be **disabled from "any occupation"**.

b. While you remain disabled, LTD is paid up to age 65 or 5 years, whichever comes first.

DISABILITY TIMELINE - OCCUPATIONAL DISABILITY

1. **Weeks 1 to Recovery, Rehabilitation, or Permanent Award – Wage Loss Paid by WCB**
    a. **File your WCB claim promptly** to avoid delays in receiving payments
    b. Notify the Union and Plan Office that you have a disability. This may help if the disability runs a long time and other benefits such as LTD and Life Insurance Waiver of Premium become applicable. At least, the Plan Office can help you remember what you should be doing to protect your benefits, as outlined in "2" below.
2. **The WCB process is outside the Health & Welfare Plan.** BUT, even if you have an occupational disability, there are things you should be doing to protect your benefits.
    a. **Week 12 or earlier** – if your disability is "severe and likely to be prolonged", submit your claim for CPP Disability Benefits. CPP Disability Benefits can be paid starting after 3 months of disability, but only if you apply! This is an important step to protect your future CPP retirement pension.
    b. **Week 20** - If you have informed the Plan Office about your WCB claim, you will receive a letter from the Plan Office, with an LTD claim form.
        - Unless you are confident you will be fit to return to work at 26 weeks or earlier, complete your part of the form, have your doctor complete the Attending Physician's Statement, and submit the claim.
        - Even if your WCB claim is going smoothly, and even though an LTD claim could be 100% offset by WCB, **you must apply** within the proper time frame to qualify for Life Insurance continuation and protect yourself if your WCB claim ends in the future while you are still disabled.
        - You may submit directly to Blue Cross Life, or through the Plan Office. If you submit through the Plan Office, we can

help you by checking that everything has been completed properly.

- **You must** submit your LTD claim to Blue Cross Life within 9 months of the start of your disability (90 days after your STD/EI Sickness benefits end), or they will deny your claim. **We recommend** you submit the claim within 5 to 6 months to ensure prompt payment of benefits.

3. **After WCB Wage Loss Ends** – Long Term Disability benefits paid up to 5 years of disability by Blue Cross Life as described under "non-occupational". If you are receiving a WCB pension, it will be integrated with LTD.

CONTINUATION OF FULL COVERAGE (SHORT-TERM)

You will receive full credit of 110 hours a month (3.7 hours/day based on a 7-day week) to maintain your hour bank and coverage in the Plan if you are disabled and receiving one of the following benefits:

- Employment Insurance (EI) Sickness benefits or Blue Cross Life Short Term Disability (STD),
- Workers Compensation (WCB) Wage Loss (including income continuity or rehabilitation) and Long Term Disability (LTD), up to 10 months,

Blue Cross Life will automatically advise the Plan Office when you are receiving STD or LTD. You must provide cheque stubs or other documentation as proof of WCB or EI Sickness benefits.

CONTINUATION OF SELECTED COVERAGE (LONG-TERM)

Upon request to the Plan Office, coverage for Extended Health Care (EHC) and Dental may be extended free of charge to members who are receiving Long Term Disability from this Plan.

To qualify the member must contact the Plan Office to apply for coverage and certify that he or she is not eligible for similar benefits through coverage under his or her spouse, or some other arrangement outside of this Millwright's Local 2736 plan.

Hour Bank

If you are covered through your spouse, coverage under the Plan will end. If you are not eligible for coverage through your spouse, plan coverage continues as described above.

Either way, your hour bank will be "frozen". That is, the hours in your bank when LTD starts will be there to continue coverage when LTD ends.

Group Life Insurance

Your life insurance may be continued to age 65 without further payment if you become disabled while covered. See the Group Life section of this booklet for more information. This is called "Waiver of Premium" since coverage continues without further premiums being paid.

Canada Pension Plan

Pensions may be 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. Apply for these benefits through Service Canada – either online, by mail, or in person.

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 24 months, 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 24-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, 2020, then coverage for eligible dependants continues up to May 31, 2022, and EHC or Dental receipts for January 1 to May 31, 2022, could be submitted up to June 30, 2023.

MEMBER RETIREMENT

When you make the decision to retire, the Union will ask you to complete a retirement declaration form, confirming the date you wish to retire and selecting whether or not you wish to continue to pay Union dues. In order to deplete your hourbank or transition onto the retired members benefit plan, you must continue to pay Union dues.

After you retire, as long as you continue to pay union dues and have hours in your hourbank, your benefit coverage will continue. However, since you will no longer be working, you will not be eligible for jury duty, bereavement leave, or disability benefits.

Once your hourbank runs out, you will not be entitled to self-pay for coverage if you are retired.

Following retirement and depletion of your hourbank, you will be offered the opportunity to enroll in the Millwrights' Retired Members Benefit Plan (PBC Policy 43521). In order to be eligible, you must be actively covered on the Millwrights' Local 2736 Health Benefits Plan when you retire, with no break in coverage.

The Retired Members Benefit Plan includes coverage for Extended Health Care only (Dental and other benefits are not included) and is not subsidized – members pay the full cost of coverage.

If you are eligible, the Plan Office will send you more information regarding the Retired Members Plan, including the monthly costs. If you are reaching the end of your active coverage, and have not received that information, please contact the Plan Office directly.

In order to keep premiums affordable, some of the Extended Health benefits are reduced from the active member plan. Differences include:

- Lifetime Maximum of $100,000
- No coverage for birth control pills, drugs for smoking cessation or erectile dysfunction, or IUDs.
- Reduced coverage for practitioners such as acupuncture, chiropractor, physiotherapist.
- Vision care limit is $280 per 2 years.

To protect the lifetime maximum on your retiree plan, it is strongly recommended that you purchase individual out-of-province emergency medical coverage before leaving Canada and ensure the individual coverage you buy is first payer.

RETIREE SCHEDULE OF BENEFITS

The following Schedule of Benefits contains a summary of the benefits provided under the retired member benefit plan. Please refer to the separate Pacific Blue Cross booklet posted to the Plan Office website for a more detailed benefit description. Contact the Plan Office to have a copy of the retiree Extended Health Care booklet sent to you.

Retiree Extended Health Care		
Deductible	$100 per person or family each calendar year. The Deductible does not apply to Medical Travel expenses.	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Medical Travel	100%
	All Other Eligible Expenses	80%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency Eligible Expenses	100%
	Non-Emergency Eligible Expenses	Same as In-Province/ Territory
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is $100,000.	

CLAIMS INFORMATION

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 enrolment 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, Disability, Life Insurance). But for faster reimbursement, send claims in through the year**.**

TAXATION

Your employer contributes to the Plan as required by the collective agreement. This cost is bargained as part of the total compensation package, but it is not deducted from your wages. For the same reason, your employer's contributions to the Plan are NOT a tax deduction for you.

PREMIUMS

Some premiums paid by the Plan on your behalf are a taxable benefit to you. You will receive a T4A near the beginning of each year for the premiums paid by the Plan on your behalf Group Life and Accidental Death and Dismemberment Insurance in the prior year.

Your taxable income is automatically reduced by the amount of your self-payments.

The Trustees consider the overall total hours and funding for the year. Within each coverage year, the Trustees have deemed all self-payments to apply first to taxable premium costs. This means that if you self-paid to continue your coverage at any time during the prior year, we automatically deduct the amount of your cash payment from your taxable benefits in that year.

BENEFITS

If you received Long Term Disability (LTD) or Short-Term Disability (STD) Benefits in the prior year, you will receive a T4A from the insurer for those payments. If you later repay Blue Cross Life due to a successful WCB or third-party claim, you will receive an adjustment letter for the repayment.

If you received Jury Duty or Bereavement Leave Benefits in the prior year, you will receive a T4A from the Plan Office for those payments.

In each case, you must include the amount in your taxable income for the year.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

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 will 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

JURY DUTY AND BEREAVEMENT LEAVE

JURY DUTY

If you are selected for jury duty, the Plan will pay you $80/day, five days a week, while you are serving as a juror.

BEREAVEMENT LEAVE

Benefits are payable to any covered member who was employed at the time of leave with an Employer that does not provide paid bereavement leave. Bereavement 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.

The Plan will compensate up to a maximum of three (3) days hours scheduled leave from work at 75% of the journeyman's rate.

GENERAL INFORMATION

To be eligible for these benefits, you must be fully covered (not on the mini-plan and not covered by self-payment).

To make a claim, you must complete and submit the Jury Duty Claim Form or Bereavement Leave Claim Form, available from the Plan Office, or the Plan Office web site. Complete the form and have your supervisor sign confirming the days of work you missed. Obtain the required proof: have the Sheriff complete the main part of the Jury Duty Claim Form or obtain proof of death for a bereavement claim. Submit the completed form with required proof to the Union office for checking and approval. When that is complete, the Union will pass it on to the Plan Office for processing.

Jury Duty and Bereavement Leave benefits are taxable income. The Plan will issue you a T4A form showing the amounts as "Other Income". Be sure to include this as income when you file your taxes for the year in which you took the leave.

RESIDENTIAL REHABILITATION ASSISTANCE

Residential Rehabilitation Assistance is available to Union Members in good standing, who are also covered under the hourbank plan.

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 July 1, 2023, this Plan's maximum payment for residential rehabilitation available is $10,000 per member per lifetime.
- Payment can be paid by the Plan in advance to the provider of the rehabilitation service. Alternatively, 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.

OPTIONAL TRAVEL COVERAGE

When you travel outside BC, your Health Benefits Plan covers many of your most essential out-of-province medical expenses in case of an emergency. This includes emergency hospital stays, doctor's bills and drugs to alleviate an emergency medical condition. Please refer to the Extended Health Care section of the Pacific Blue Cross portion of this booklet for details. ***Note you must maintain your MSP-BC coverage to be eligible for emergency out-of-province medical coverage under the Plan.***

Note, the lifetime maximum for Extended Health Care is $3 Million. Even with that coverage level, a serious medical emergency while travelling could use up your lifetime maximum.

You may want to consider purchasing additional travel protection. If so, you will find that it is available through many outlets, including insurance brokers; therefore, it can pay to shop around.

Besides emergency medical expenses and assistance, individual travel insurance may offer benefits that are not included in the coverage provided under your Health Benefits Plan such as:

- Trip cancellation or interruption
- Accidental death
- Air flight accident
- Emergency return
- Baggage loss, delay, or damage

Covered members of the Plan are eligible for a 20% discount if you purchase travel protection through Pacific Blue Cross.

Go to http://pac.bluecross.ca/travel/ for more information. Pre-existing conditions and age limitations may apply.

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

MILLWRIGHTS LOCAL 2736 HEALTH BENEFITS PLAN

Active Members

Policy Number 2736

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
Health Spending Account (HSA)

Blue Cross Life
Group Life
Dependent Life
Accidental Death & Dismemberment (AD&D)
Short Term Disability (STD)
Long Term Disability (LTD)

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.

BLUE CROSS SCHEDULE OF BENEFITS

The Schedule of Benefits contains a summary of your benefits with Pacific Blue Cross / Blue Cross Life. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care		
Deductible	No Deductible (as of January 1, 2023)	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Medical Travel	100%
	All Other Eligible Expenses	80%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency	100%
	Non-Emergency	Same as In-Province/ Territory
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is $3,000,000.	
Termination	Age 85	
Dependent Children / Spouse	See definition of Dependent.	

Dental Care			
Deductible	No Deductible		
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan C** Ortho–dontics
	Preventative & Diagnostic – 100% Restorative – 80%	60%	60%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	$3,000 Combined with Plan B	$3,000 Combined with Plan A	$3,000
Financial Limit Per Member or Spouse	$3,000 Combined with Plan B	$3,000 Combined with Plan A	$3,000
Termination	Age 85		
Dependent Children / Spouse	See definition of Dependent.		

Health Spending Account	
Deductible	No Deductible
Reimbursement	100%
Annual Credit	Contact your Plan Administrator
Dependent Children / Spouse	See definition of Dependent.

Group Life	
Benefit Amount	$100,000
Living Benefit Amount	50% of the Group Life Benefit Amount, to a maximum of $50,000
Non Evidence Limit	$100,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 75

Dependent Life	
Benefit Amount	Spouse: $15,000 Dependent Child: $15,000
Dependent Children/Spouse	See definition of Dependent
Termination	Dependent life insurance terminates on your 70th birthday.

Accidental Death & Dismemberment (AD&D)	
Principal Sum	An amount equal to the amount payable under your current group life insurance.
Aggregate Limit	$3,000,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65.
Termination	Age 75

Short Term Disability (STD)				
The STD plan is integrated with Employment Insurance (EI) Sickness benefits. STD benefits are payable only if you do not qualify for EI Sickness Benefits. See Section "In Case of Injury or Illness" earlier in this booklet.				
Weekly Benefit Amount	The current Employment Insurance (EI) maximum.			
Elimination Period	**Injury**	**Hospital**	**Sickness**	**Day Surgery**
	0 days	0 days	3 days	3 days
Maximum Benefit Period	26 weeks with the following exception: If you reach STD termination age while receiving benefits and have then received payments for less than 26 weeks, benefit payments will continue during disability until you receive 26 weeks of benefits (EI Sickness and STD combined).			
Termination	Age 71			

Long Term Disability (LTD)	
Benefit Amount	$2,500
Non-Evidence Limit	$2,500
Elimination Period	105 days
Maximum Benefit Period	5 years up to age 65
Termination	Age 65 less the Elimination period

BLUE CROSS GENERAL INFORMATION

DEFINITIONS

Benefit amount
means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review
means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Customary
means usual or traditional and well-established as determined by us.

This refers to:

1) the charges for products, services or supplies; and/or

2) the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is incurred for a medical condition comparable in nature and severity to that being treated. The term "area" means a region large enough to obtain a representative cross section of similar Providers.

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.

Eligible drug
means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

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

1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and
3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and

4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by us.

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 or in any PBC Provider agreement.

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.

Government plan

means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital
means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

Life event
means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

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

Non evidence limit
means the maximum amount of insurance we will provide without evidence of insurability as indicated in the Schedule of Benefits.

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, 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 Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner
means a person legally licensed, certified, or registered to practice a profession 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 that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider
means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. This excludes a Provider related to or residing with you or your Dependent. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

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.

Vendor
means an organization we have retained as an external Provider.

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 ENROLMENT

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 enrolment 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 and your Spouse are Members of Millwrights Local 2736, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse work for different employers/unions and you are both enrolled for similar benefits, Duplicate coverage is allowed.

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

The termination date of your coverage will be determined by your Plan Administrator based on the eligibility rules.

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.

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 on our website: 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

   Charges for drugs and medicines in a quantity we consider reasonable, and as approved by our Benefit review, and

   a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, legally licensed, certified, or registered to practice 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, including:
      i) life sustaining drugs non-prescription drugs
      ii) insulin preparations, diabetic test strips, lancets, needles, and syringes for diabetes management
      iii) injectable vitamin B12 for the treatment of pernicious anemia
      iv) allergy serums when administered by a Practitioner, or

b) which legally require a prescription from a medical provider legally authorized to do so, including:
    i) compounded drugs
    ii) contraceptive drugs
    iii) drugs indicated for weight loss
    iv) drugs for smoking cessation to a maximum of $300 in a 24-month period
    v) drugs indicated for sexual dysfunction to a calendar year maximum of $1,000
    vi) vaccines

to a combined maximum of $10,000 per calendar year

The ingredient cost of multi-source brand drugs plus Markup will be reduced to the ingredient cost of the lowest cost equivalent generic plus Markup. The ingredient cost of generic drugs and single source brand drugs plus Markup are eligible.

If we receive written confirmation from the prescribing Practitioner that there is a specific adverse effect that prevents the Member from taking the generic, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

The Markup is eligible up to our Customary level, as updated from time-to-time.

Specific high-cost BC PharmaCare limited coverage drugs are identified by us as our Special Authority Enforcement list. We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority approval for the drug. Once the BC PharmaCare approval is confirmed, we will consider this drug as eligible based on the approval period determined by BC PharmaCare.

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) occupational therapist..... $1,000

f) physiotherapist..... no calendar year limit

g) podiatrist..... $1,000

h) psychologist, clinical counsellor, and Online cognitive behavioural therapy combine $1,000

i) speech language pathologist..... $1,000

j) private duty care by a registered nurse for a person with an acute condition in the person's home, limited to a maximum of $10,000 per calendar year or $25,000 per lifetime, whichever occurs first.

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 or unintentionally being placed in the mouth.

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

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

b) ostomy and ileostomy supplies

c) intrauterine contraceptive devices (IUDs)

d) walkers, canes and cane tips, crutches, casts, and trusses

e) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when 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

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

   i) mastectomy brassieres $250

   ii) stump socks $250

   iii) surgical stockings $250

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 to a combined maximum of one pair in a 5 calendar year period.

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

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

i) audiologist fees and custom hearing protection to a combined maximum of $200 per 24 month period.

j) hearing aids (excluding batteries, recharging devices, or other such accessories) and repairs to a maximum in a 60-month period of:

   i) $640 for adults, or

   ii) $320 for Dependent children.

   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

   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.

9) Vision Care

Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical Provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical Provider, to a maximum of $1,000 in a 2-calendar year period. Charges for non-prescription eyewear are not covered.

10) Eye Examinations

Charges for one routine eye examination in a calendar year period when performed by a Physician or legally authorized optical Provider, for persons between the ages of 19 and 64.

11) 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.

DISEASE SUPPORT PROGRAMS

This benefit offers you and your Dependents faced with a cancer diagnosis the opportunity to obtain tools to improve recovery and survival during and after cancer treatment. A team of Physicians and health care practitioners work with the patient to assist in recovery, improve quality of life and help prevent cancer recurrence. The programs are supported by current research and are intended to integrate with conventional treatments.

Services available, including but not limited to:

1) Support groups.
2) Tools for patient to take charge of their health.
3) Natural approaches to prevention and treatment.
4) Multidisciplinary team of Physicians and health care practitioners.
5) Individualized cancer survivorship plan.

Conditions and Limitations:

1) Diagnosis of cancer by patient's Physician.
2) The cancer diagnosis must have occurred within 24 months of referral by the Physician to the program.
3) Any service covered by the Government plan is ineligible for reimbursement.
4) The lifetime maximum benefit is $300 per covered person.

For additional information visit the website at www.inspirehealth.ca or to arrange an appointment call 604 734-7125.

IN-PROVINCE/TERRITORY MEDICAL TRAVEL ELIGIBLE EXPENSES

When ordered by the attending Physician, Dentist, or Nurse practitioner, because, in their opinion, adequate medical treatment or medically required oral surgical treatment is not available locally (locally is defined to be within 250 kilometres of your or your Dependent's residence), the following are included as Eligible expenses:

1) Transportation for a patient and attendant if medically required, to and from the nearest locale, within the province/territory of residence or border province/territory, equipped to provide the required treatment by:
    a) scheduled economy air (including Airport Improvement fee where applicable), rail, ferry, or bus
    b) private automobile, reimbursement based on the allowable CRA
    c) local limousine and taxi service:
        i) to and from the airport, rail station, ferry terminal, or bus station
        ii) to and from the treatment facility and accommodation
    d) parking:
        i) at the airport of departure
        ii) Hospital, accommodation, and doctor's office parking at the destination of the referral for the patient
        iii) limited to a combined maximum of $10 per day
        iv) receipts are required.
2) Where transportation has been provided under 1) above, accommodation and meals in a commercial facility for the patient and attendant, before and after medical treatment, to a combined maximum of $150 per day for the patient and attendant, for a maximum of 7 days.
3) Transportation must take place within a reasonable time period of the Physician's, Dentist's, or Nurse practitioner's referral.
4) Benefit amounts paid for medical travel will not be included in the EHC lifetime plan maximum.
5) All the above are subject to a $2,000 calendar year maximum per covered patient.

OUT-OF-PROVINCE ELIGIBLE EXPENSES

Out-of-Province Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) 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

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 treatment essential to the patient.
2) The Hospital room charge and charges for services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days.
   If reasonably possible, we should be notified within 5 days of the patient's admission to Hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the Hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90-day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies if we would have covered them inside your province/territory of residence.

6) Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to their place of residence in Canada in the event you and/or your Spouse is hospitalized, and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.

7) Charges, limited to the most economical cost of one-way economy fare air transportation, less any amount reimbursed for unused return tickets, when the covered person's hospitalization delays the return trip. The coverage is for both your airfare and the airfare of your Spouse, if required.

8) Charges, limited to return economy fare air transportation, for 1 immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a Hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.

9) Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of $5,000 per family per medical emergency.

10) Charges for accommodation for convalescence following hospitalization to a maximum of $75 per day per patient for a maximum of 5 days per medical emergency.

11) Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized Member or Dependent to a maximum of $100 per day up to 7 days per family per medical emergency.

12) Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of $500 per medical emergency.

13) Charges for the repatriation of a deceased Member and/or Dependent to their place of residence to a maximum of $5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to $1,500.

We will only cover Eligible expenses obtained within 60 days of the date you or your Dependent left the country of residence. If hospitalization occurs within the 60-day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

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

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 Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

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, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2) except as specifically included in this booklet, we pay no drug expenses for:
    a) food replacements, food supplements, and infant foods
    b) administrative charges for injectable medications or infusions
    c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital
    d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility
    e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process
    f) any expenses identified as exclusions under the Extended Health Care Benefit
3) 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, or Experimental purposes, public ward accommodation, rest cures, and medical laboratory tests

4) except as specifically included in this booklet: 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
5) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse 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
6) 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
7) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
8) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
9) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence
10) expenses of a Dependent hospitalized at the time of enrolment
11) services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse
12) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
13) fees for ambulance services when an ambulance is called but not used
14) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
15) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
16) any other item not specifically included as a benefit
17) legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

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 – 1 per lifetime by a general Practitioner and 1 per lifetime by a specialist
      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 60-month period
      iii) complete mouth series – 1 per 36-month 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, root planing, and gingival curettage – a combined yearly limit shown in our Fee schedule
   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 on permanent front (anterior and bicuspid) teeth only

      On permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
   b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period.

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

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planing, scaling, and gingival curettage – a combined yearly limit shown in our Fee schedule
   c) osseous surgery – 1 per sextant in a 5 year period
   d) bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

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

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

PLAN B – MAJOR RESTORATIVE SERVICES

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

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

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

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

Limitations

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

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 dental plan:

1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3) procedures performed for congenital malformations or for purely cosmetic reasons
4) charges for drugs, pantographic tracings, and grafts
5) 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. It is important to ask if your dental benefits will cover the entire cost of your treatment. We suggest that your Dentist submit an outline of the proposed services to us **before you start treatment.** This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **12 months** 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 (this information is on your ID card)

    d) your home mailing address

    e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

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

   a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:
      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental provider showing the services performed and the fee charged, or
      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

   b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or
      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

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 **12 months** of the due date.

c) Treatment plan

i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the 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.

HEALTH SPENDING ACCOUNT (HSA)

DEFINITIONS

Your Health Spending Account (HSA) covers any item or service allowed under the Income Tax Act of Canada as a medical expense, excluding any item or service that is available without charge in the absence of insurance or similar benefits.

An eligible amount under this HSA Plan means that portion of a medical expense which is not covered by any government plan, benefits plan, insurer, benefits carrier, or liable third party from whom a covered person has received or is entitled to receive benefits.

CLAIM PROCEDURE

Claim forms are available from your Plan Administrator or on our website www.pac.bluecross.ca/member under forms.

Claims are paid only up to the total number of credits to which you are entitled in a calendar year in which the eligible expense is incurred. In terms of unused credits, current rules allow for unused credits in your HSA to be carried forward to the next calendar year. Such credits will be forfeited if not used in the calendar year into which they are carried forward.

Your HSA Plan is the last payer. Payment will be made only after all applicable Extended Health Care (EHC) and Dental Plans have paid benefits for you or your Dependents. You are expected to claim benefits from all other sources, including any applicable coverage under your Spouse's plan, prior to submitting a claim under your HSA.

When you indicate on the claim form that other coverage is available, payments from your HSA will be made only after the government plan and/or other carrier(s) have processed such claim. When you indicate no other available coverage on the claim form, we will pay from your HSA on the basis that no other coverage exists for you or your Dependents.

We must receive your claim for medical expenses incurred in a calendar year no later than 90 days from the end of that calendar year.

Pease contact your Plan Administrator for additional information.

GROUP LIFE

PAYMENT OF BENEFIT

If you die while insured, we will pay the amount of your group life insurance to your beneficiary.

When you designate more than one person as beneficiary, we will assume the benefit amount is to be divided equally, unless you specify otherwise. If your designated beneficiary is under age 18, you should appoint a trustee for this beneficiary and have a trust agreement drawn up and signed. This trustee will receive and give discharge for any benefit amount which becomes payable while your beneficiary is a minor. If no beneficiary survives you, the benefit amount will be paid to your estate.

LIVING BENEFIT

Terminal condition
means an injury or sickness from which there is no reasonable prospect of recovery, as determined by us, and which is expected to result in your death within 12 months.

If you have a Terminal condition, we will pay you the living Benefit amount shown in the Schedule of Benefits. You or your legal representative must submit a written request for this benefit and include written consent from your beneficiary (release form) and written proof of your medical condition from your attending Physician.

This Benefit amount is payable once. The amount of your group life insurance benefit or the amount of insurance you can convert outlined under the conversion option is reduced by the amount you receive under this benefit.

WAIVER OF PREMIUM

Should you become totally disabled prior to your 65th birthday and remain so for 105 days, the premium for your group life insurance will be waived.

CONVERSION OPTION

You will be eligible to convert your group life insurance coverage to a personal life insurance policy issued by Blue Cross Life Insurance Company of Canada without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

The maximum coverage you can purchase will be the lesser of:

1) $200,000, or
2) the amount of group life insurance you had with us, or
3) the difference between the amount of group life insurance you had with us and the amount that is available through your new employer's group plan – provided you become insured within 31 days following the termination of your coverage under this policy.

You may purchase less than the maximum amount of life insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy. You will have a choice of 2 policies:

1) a term life insurance policy for 1 year, or
2) a term life insurance policy to age 65.

Your premium will be based on the prevailing standard rate charged by Blue Cross Life on the date your personal policy is issued.

CLAIMS

In the event of your death, we must receive notice of your death within **30 days**, and a completed claim form along with any proof required, as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

DEPENDENT LIFE

PAYMENT

Because you must enrol your Dependents for the dependent life insurance benefit, when one of your eligible Dependents dies, we will pay the Benefit amount to you.

WAIVER OF PREMIUM

If your group life insurance premium is waived because you are totally disabled, your premium for the dependent life insurance benefit will also be waived.

EXCLUSIONS

Dependents not residing in Canada or the USA or Dependents who are members of the armed forces in any country are not eligible for the dependent life insurance benefit.

CLAIMS

We must receive notice of the death within **30 days** and a completed claim form along with any proof required as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

ACCIDENTAL DEATH & DISMEMBERMENT

PAYMENT OF BENEFIT

1) When death or loss occurs because of an accidental injury and within 365 days of the accident date, we will pay the Benefit amount in the absence of any Policy exclusions being found applicable:
   a) to your beneficiary, for loss of life
   b) to you, for any other loss.
2) Loss of use is covered, but only if such loss is permanent, total, and irrecoverable and has been continuous for 365 days from the date of the accident. In either of the following circumstances we will also consider your loss to be the result of injury:
   a) when, due to an accident, you are unavoidably exposed to the elements and, as a result of this exposure and within 365 days of the date of the accident, you suffer a loss included in the table
   b) when, due to the accidental wrecking, sinking, or disappearance of a conveyance in which you are riding, you disappear and your body is not found within 365 days, we will presume that you lost your life in the accident.
3) The Benefit amount will be paid according to the following table. Only 1 of the amounts, the largest specified, will be paid for all injuries resulting from any 1 accident. The principal sum (the amount for which you are insured) is shown in the Schedule of Benefits.

TABLE OF LOSSES AND BENEFIT AMOUNTS *LOSS (INCLUDES LOSS OF USE)*	*Benefit as portion of the Principal Sum*
Life	100%
Both Hands or Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing	100%
One Arm or One Leg	75%
One Hand or One Foot	66.6%
Entire Sight of One Eye	66.6%
Speech or Hearing	50%
Thumb and Index Finger of the Same Hand	33.3%
Four Fingers of the Same Hand	33.3%
Hearing in One Ear	25%
All Toes of the Same Foot	25%
Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

REPATRIATION BENEFIT

If you die due to an accident that occurs at least 150 kilometres from your normal place of residence, we will pay the actual expenses incurred (excluding the cost of a coffin) for:

1) preparing your remains for burial or cremation and the shipment of your body to the place of burial or cremation, or
2) the actual expense incurred (excluding the cost of a coffin) for burial or cremation at the place of death,

to a maximum of $10,000.

REHABILITATION BENEFIT

If you suffer a covered loss which requires you to take special training to enable you to work in an occupation for which you were not qualified prior to the loss, we will pay the reasonable and necessary expenses incurred within 3 years of the date of the accident, to a maximum of $10,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

OCCUPATIONAL TRAINING BENEFIT FOR THE SPOUSE

If you die due to an accident which requires your Spouse to take a formal training program to enable them to gain active employment in any occupation in which they would not otherwise be qualified, we will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of your death, to a maximum of $10,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

EDUCATION BENEFIT

If you die due to an accident, we will pay an education benefit for each Dependent child who enrols full-time in a recognized post-secondary institution within 365 days of your death. We will pay the necessary and reasonable expenses actually incurred, subject to the lesser of 5% of the principal sum or $5,000 for each year your child continues their education on a full-time basis, for a maximum of 5 years or until the age of 26, whichever occurs first.

To be eligible for this benefit, your unmarried child (including any stepchild, legally adopted child, or legal ward, but not a foster child) must be financially dependent on you or your Spouse at the time of your death. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

FAMILY TRAVEL BENEFIT

If you suffer a covered loss and are confined as an inpatient in a Hospital, or if you suffer from any illness or injury resulting in Hospital confinement for at least 4 days, and the confinement occurs more than 150 kilometres from your normal place of residence, we will pay the reasonable and necessary travelling expenses of 1 or more family members to visit you. The maximum benefit for all family members is

$3,000 for return transportation and commercial accommodation costs combined. If personal transportation is used instead of public transportation, a rate of $0.20 per kilometre will apply.

WAIVER OF PREMIUM

If your group life insurance premium is waived because you are totally disabled, your premium for this coverage will also be waived, provided this benefit remains in effect.

EXCLUSIONS

No payment will be made for any loss that results from or is caused directly or indirectly, wholly or in part by any of the following:

1) suicide or any other self-inflicted injury whether intentional or unintentional
2) participation in an assault or criminal offense, or an act incident thereto
3) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
4) travel or flight in or descent from any kind of aircraft as a member of the aircraft crew or having duties relating to the operation, maintenance, or control of the aircraft
5) riding as a passenger, pilot, operator, or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated, or leased by the Policyholder
6) self-inflicted injury, whether intentional or unintentional, sustained while under the influence of any addictive or intoxicating substances unless as administered on the advice of a Physician
7) any disease or sickness either mental or physical, or medical procedure.

CLAIMS

In the event of any loss for which this benefit is payable, we must receive notice within **30 days** of the date of loss, and a completed claim form along with any required proof as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of accident.

SHORT TERM DISABILITY

DEFINITIONS

Day surgery
means admission to a public general Hospital for a surgical procedure where the patient is released from the Hospital the same day. Note: diagnostic procedures do not qualify as a surgical procedure.

Hospitalization
means admission to a public general Hospital for at least 1 overnight stay as an in-patient.

Recurrent disability
means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

BENEFIT

We will pay short term disability (STD) benefits when you are disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a Physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under their regular care and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a Physician.

The weekly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

RECURRENT DISABILITY

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

GRADUATED RETURN TO WORK

If you return to work on a gradual rehabilitative basis, you will have your benefit reduced by 50% of any income earned from the rehabilitative employment. The combined total of your benefit plus the rehabilitative income will not exceed 100% of your earnings prior to the date your disability started.

Benefits will continue for a maximum of 1 period of disability as outlined under *Recurrent Disability*, whether due to 1 or more illnesses.

In consultation with you, your Plan Administrator, and with your Physician's agreement, we will determine your eligibility for this program and its duration.

EXTENDED BENEFIT

If you are disabled when this insurance terminates, your STD benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

COORDINATION WITH OTHER INCOME SOURCES

Your STD payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became disabled.

THIRD PARTY LIABILITY

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

ARE BENEFITS TAXABLE?

Benefits are taxable.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer receiving continuing medical care and treatment from your Physician
2) you fail to submit satisfactory proof of continuing disability as required by us
3) you refuse a medical examination by a Physician chosen by us
4) you are no longer following the treatment recommended for your disability
5) you are not entitled to benefits payable by the Employment Insurance Sickness benefit because you are not in Canada
6) you are no longer disabled
7) you perform any work for compensation or profit
8) the end of the maximum benefit period indicated in the Schedule of Benefits
9) you die.

EXCLUSIONS

Benefits are not payable for any period of disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
    b) participation in a criminal offense
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
    d) a pregnancy related sickness
        i) during any period of formal maternity leave and/or parental leave
        ii) during any period in which Employment Insurance (EI) benefits are being paid

e) substance abuse, including alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician
f) medical or surgical care, which is cosmetic, unless such care is rendered as a result of injury or sickness

2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing

3) while you are
   a) in a jail or penitentiary
   b) on leave of absence or paid vacation
   c) receiving benefits for the same or related disability from WCB or similar legislation

4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

CLAIMS

1) Obtain a claim form from your Plan Administrator, as soon as possible after you become disabled.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail.
6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.
7) Incomplete claim forms will cause a delay in the payment of your benefits.

LONG TERM DISABILITY

DEFINITIONS

Disability
means that during the Elimination period and the subsequent 24 months of Disability you are prevented, by injury or sickness, from performing each of the essential duties of your own occupation. After that you are prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

Eligible survivor
means your Spouse, if living, otherwise your children under age 25. If there are no Eligible survivors, payment will be made to your estate.

Elimination period
means a period of time, when you are continuously disabled, which must be completed before your claim will be considered. It will be calculated from the date Disability begins.

Indexed pre–disability earnings
means your basic earnings adjusted (on each anniversary of the LTD benefit payments) by the lesser of 10% or the current annual percentage increase in the all item Consumer Price Index (CPI) Canada.

Partial disability
means that within 31 days of the end of a period when you received an LTD benefit payment under the Disability definition above, and as a result of the same injury or sickness, you are incapacitated to the extent that, although unable to perform all the essential duties of your own occupation on a full-time basis, you are currently:

1) participating in a rehabilitation program, or
2) performing at least 1 of the essential duties of your own or any occupation on a part-time or full-time basis, and
3) earning at least 20% less per month than your Indexed pre-disability earnings, due to that same injury or sickness.

Availability of work is not considered when assessing Disability.

Recurrent disability
means a Disability that is related to or due to the same cause(s) as a prior Disability for which you received benefit payments.

BENEFIT

We will pay long term disability (LTD) benefits when Disability, as defined below, begins while you are insured for the LTD benefit.

Benefits commence on the day after the Elimination period expires and will be paid only during periods when you are receiving, from your Physician, regular care which is appropriate for the condition causing your Disability and following the treatment prescribed. We may require consultation and/or treatment by a Physician who specializes in the treatment of your condition.

The monthly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

REHABILITATION PROGRAM

While you are disabled, we may suggest a rehabilitation program to help you return to the work force. This program requires the agreement of your Physician and pre-approval by us. It may include, but is not limited to, a return to work on a part-time or full-time basis, therapy, vocational evaluation, or job preparation. Income you receive under this program will be integrated with your monthly benefit.

RECURRENT DISABILITY

A Recurrent disability will be considered part of the prior Disability if, after receiving LTD benefits, you returned to any occupation on a full-time basis and were able to perform all the essential duties of this occupation for less than 6 months. If you return to any occupation on a full-time basis for 6 months or more, a recurrence of Disability will be treated as a new period of Disability, and you must complete another Elimination period.

EXTENDED BENEFIT

If you are disabled when your insurance terminates, your LTD benefit will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

SURVIVOR BENEFIT

If you die after being disabled for 180 or more consecutive days and while receiving a monthly Benefit amount, a payment equal to 3 times your gross monthly Benefit amount will be made to your Eligible survivor.

COORDINATION WITH OTHER INCOME SOURCES

Your monthly LTD benefit may be reduced by any amount of Disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of:

1) your monthly basic earnings if benefits are taxable
2) your take-home pay if benefits are non-taxable.

For details of other income sources and how your monthly benefit is calculated, contact your Plan Administrator.

WAIVER OF PREMIUM

The premiums for your LTD benefit will be waived while you are receiving monthly benefits.

THIRD PARTY LIABILITY

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

ARE BENEFITS TAXABLE?

Benefits are taxable.

PRE-EXISTING CONDITIONS LIMITATION

Increased amount of insurance
means an increased amount of insurance due to a change in either the non-evidence limit or the maximum Benefit amount.

Pre-existing condition
means a sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures), or consumed prescribed drugs within 3 months:

1) prior to the date you became insured under this benefit, or
2) prior to the date of any Increased amount of insurance.

This exclusion will not apply if you become disabled more than 12 months:

1) after you became insured under this benefit, or
2) after you became eligible for any Increased amount of insurance.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer Disabled
2) you are no longer receiving regular medical care and treatment from your Physician
3) you fail to submit satisfactory proof of continuing Disability as required by us
4) you refuse a medical examination by a Physician chosen by us
5) you are no longer following the treatment recommended for your Disability
6) you refuse to participate in a rehabilitation program
7) your current earnings exceed 80% of your Indexed pre-disability earnings
8) you reach age 65
9) the end of the maximum benefit period indicated in the Schedule of Benefits
10) you die.

EXCLUSIONS

Benefits are not payable for any period of Disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile, or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
    b) participation in an assault or criminal offense, or an act incident thereto
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
    d) a pregnancy related sickness
        i) during any period of formal maternity leave and/or parental leave
        ii) during any period in which Employment Insurance (EI) benefits are being paid
    e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are confined in a public general Hospital, or you are satisfactorily participating in a withdrawal program approved by us
    f) medical or surgical care, which is cosmetic, unless considered medically necessary as a result of injury or sickness
2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
    a) in a jail or penitentiary
    b) on leave of absence
    c) involved in a strike or lockout, if the Disability commenced after notice of strike or lockout was given
    d) receiving sick pay, vacation pay, or any other salary or wage from your normal or any occupation (except as provided under the rehabilitation program).

CLAIMS

1) We must receive written notice of claim within **30 days** of the date Disability begins. On receipt of written notice of claim, we will provide you with a claim form.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) Forward the claim form (satisfactory proof of claim) to us within **90 days** following the end of the Elimination period.
6) We may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

Note: Incomplete claim forms will cause a delay in the payment of your benefits.