British Columbia Regional Council of Carpenters Plan

Active Members

PACIFIC BLUE CROSS™

BC Life®

PACIFIC BLUE CROSS™

BC Life®

Booklet Update

Please attach this update to your Group Benefits 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.

Group Name and Number

British Columbia Regional Council of Carpenters Plan

Active Members

Extended Health Care and Dental Care
Group Numbers 901598 and 902005

BC Life Policy Numbers 901598 and 902005

Reissue Date: March 1, 2012

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.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and British Columbia Life & Casualty Company (BC 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

BC Life
Short Term Disability (STD)

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact your Plan Administrator.

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.

Table of Contents

Group Name and Number 1

Introduction 2

Schedule of Benefits 6

General Information 11

- Definitions 11
- Integration with Government Plans 13
- Effective Date of Coverage and Enrolment 13
- Late Applicants 13
- Identification (ID) Cards 13
- Claims 14
- Duplicate Coverage 14
- Coordination of Benefits 15
- General Exclusions 15
- Termination of Coverage 16
- Right of Recovery 16
- Conversion to an Individual Plan 16
- Individual Travel Benefits 17
- CARESnet 17

Extended Health Care 18

- Definitions 19
- In-Province/Territory Eligible Expenses 20
- Disease Support Programs 24

Out-of-Province/Territory Non-Emergency Eligible Expenses.... 25
Out-of-Province/Territory Emergency Eligible Expenses..... 25
Emergency Travel Assistance 26
Exclusions 27
Claims 28

Dental Care 31

Payment of Benefits 31
Plan A – Basic Preventive & Restorative Services 31
Plan B – Major Restorative Services 33
Plan C – Orthodontics 34
Emergency Treatment Outside Your Province/Territory of Residence 35
Exclusions 35
Claims 36

Short Term Disability 39

Definitions 39
Benefit 39
Recurrent Disability 40
Graduated Return to Work 40
Extended Benefit 40
Coordination with other Income Sources 41
Third Party Liability 41
Are Benefits Taxable? 41
Termination of Benefit 41
Exclusions 42
Claims 43

Notes 44

Schedule of Benefits

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

Extended Health Care		
Deductible	$100 per person or family each calendar year.	
	If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.	
Reimbursement	**In-Province Eligible Expenses:**	
	Psychologist and clinical counsellor fees	90%
	All Other Eligible Expenses	80%
	Out-of-Province Eligible Expenses:	
	Emergency	100%
	Non-Emergency	Same as In-Province
	After $1,000 has been paid for a person or family in a calendar year, further Eligible expenses for that person or family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum	The maximum amount of benefits payable for a member or Dependent is $100,000 every 24 months.	
Dependent Children	See definition of Dependent.	

Dental Care			
Deductible	No Deductible		
Reimbursement	**Plan A**	**Plan B**	**Plan C**
	Basic Services	Major Restorative Services	Ortho–dontics
	80%	60% (crowns/ bridges) 80% (dentures)	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	$1,250 Combined with Plan B	$1,250 Combined with Plan A	$1,250
Financial Limit Per Member or Spouse	$1,250 Combined with Plan B	$1,250 Combined with Plan A	$1,250
Financial Limit for Late Applicants	$250 per person for all dental services for first 12 months of coverage		
Dependent Children	See definition of Dependent.		

Short Term Disability (STD)			
Weekly Benefit Amount	$400		
Elimination Period	**Injury**	**Hospital**	**Sickness**
	0 days	0 days	3 days
Maximum Benefit Period	15 weeks with the following exception: if you reach termination age while receiving benefits and have then received payments for less than 15 weeks, benefit payments will continue during disability until you receive 15 weeks of benefits.		
Employment Insurance (EI) Carve-Out	If you are eligible for Employment Insurance (EI) sickness benefits: 1) we will pay benefits for the first 4 weeks of disability, and 2) EI will pay benefits from the 5th to the 19th week of disability, and 3) we will pay benefits for an additional 11 weeks of disability. If you are not eligible for EI sickness benefits, we will pay benefits for a maximum period of 15 weeks. *The start of your STD benefit is regulated to the first 4 weeks of your disability.* *The first 4 weeks of disability starts from the date of disability and this period runs consecutively in calendar days. See your Physician immediately to initiate the Elimination Period, confirm date of disability and to be eligible for full 4 weeks of disability payments.*		

Short Term Disability (STD)	
	You may not receive the full 4 weeks of disability payments if you do not follow the proper claim procedure: *1) See your Physician immediately to establish the date of disability.* *2) A visit with your Physician formally initiates the Elimination Period.* *3) A visit with your Physician meets contractual obligations for medical review.* *The first 4 weeks of your disability is immediately triggered by the effective date of disability (the eligible disability payment period only falls within the calendar days of the first 4 weeks of established disability).* *Your disability payment period may be shorter if you do not follow these claim procedures.* *See page 43*
Termination	Age 70 or earlier retirement

Definitions

Allowable enrolment period
means,
1) within 12 months for Extended Health Care benefits, or
2) within 4 months for Dental Care, or
3) within 31 days for BC Life benefits

from the coverage effective date.

Coverage effective date
means the date as determined by the BC Regional Council of Carpenters.

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, and
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 26 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 you or your Spouse, is financially dependent and is incapable of self-sustaining employment.

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

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

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

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

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.

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/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

Coverage effective as determined by the BC Regional Council of Carpenters.

Late Applicants

If you did not apply during the Allowable enrolment period but request coverage later (for yourself and/or your Dependents), ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan. Note: Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Identification (ID) Cards

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

Only you and your enrolled Dependents are entitled to use this card. Should you (or your Dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

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 at www.pac.bluecross.ca/caresnet
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 the BC Regional Council of Carpenters, 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 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 enrol 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 noncombatant 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.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, leave of absence, age limitation or retirement, if you terminate membership with the United Brotherhood of Carpenters, or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract/Policy.

Right of Recovery

You are financially responsible for any claims paid by us on you or your Dependent's behalf after coverage is terminated from your employer's 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 coverage is also available from us. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you 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 the enhanced services CARESnet provides. To access CARESnet, visit our website: **www.pac.bluecross.ca/caresnet/**

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.

All dollar limits included in the benefit descriptions are **claimable** unless specifically shown as **payable**.

To determine the benefit amount **claimable**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- applies the claimable limits
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the EHC plan maximum.

To determine the benefit amount **payable**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the payment limits
- applies the EHC plan maximum.

Definitions

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

1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician or Dentist, unless otherwise specified in the benefit description, and
3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

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

Physician
means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Practitioner
means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-Province/Territory 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
   Drugs and medicines dispensed by a pharmacist, Physician, or a Dentist, in a quantity we consider reasonable:
   a) drugs and medicines must be prescribed by a medical provider legally authorized to do so, and included with the above:
      i) contraceptives
      ii) fertility drugs to a lifetime maximum of $3,000
   b) insulin preparations, testing supplies, needles, and syringes for diabetics
   c) vitamin B12 for the treatment of pernicious anemia
   d) allergy serums when administered by a Physician.

   Drug plan includes a $7,500 maximum per calendar year.

   Reimbursement of eligible drugs and medicines will be subject to PharmaCare's low cost alternative and reference drug program policies.

Reimbursement of eligible drugs and medicines will be based on an 8% mark up over the manufacturer's cost and a maximum dispensing fee of $7.

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.*

a) acupuncturist $100
b) chiropractor - 6 visits to a maximum of $300
c) massage practitioner - 6 visits to a maximum of $300
d) naturopath $200
e) physiotherapist - 10 visits to a maximum of $500
f) podiatrist $200
g) psychologist/registered clinical counsellor combined $833.33
h) speech language pathologist $100
i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province/territory of residence.

5) 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.

6) Medical aids and supplies provided by a medical supplier (as approved by us)

Charges for the following services and supplies:

a) oxygen, blood, and blood plasma
b) ostomy and ileostomy supplies
c) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports
d) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
e) mastectomy brassieres to a maximum of 1 brassiere per breast prosthesis to a maximum of 2 per lifetime
f) charges for the following items to the maximum amounts indicated per calendar year:
    i) stump socks ..... no limit
    ii) surgical stocking ..... 2 pairs
g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500
h) orthopaedic shoes and orthotics
    i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, 1 pair of custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg, or
    ii) when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, 1 pair of custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet
i) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $625

j) hearing aids and repairs for Dependent children only, to a maximum of $400 in a 60 month period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

7) Standard durable medical equipment
   a) Preauthorization is required from us 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 the manual equivalent, otherwise we will pay the manual equivalent
      ii) medical heart and blood glucose monitors, and cardiac screeners
      iii) speech processors and headsets when prescribed for profound deafness to a maximum of $4,000 in a 5 calendar year period
      iv) bi-osteogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems
      v) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
      vi) insulin infusion pumps for diabetics – when basic methods are not feasible
      vii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain

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

8) 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 $200 in a 24 month period. Charges for non-prescription eyewear are not covered.

9) Prostate Specific Antigen (PSA) Testing
Charges are payable for persons age 40 years or older when ordered by a Physician

10) 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.

Out-of-Province/Territory Non-Emergency Eligible Expenses

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

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory 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.

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 EHC ID number and medi-assist group number ready for personal identification – both numbers are required.

Exclusions

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

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province/territory of residence
2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
3) except as specifically included in this booklet: contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
4) allergy testing unless rendered by a naturopath
5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests
6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan

8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
9) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
10) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date
11) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
12) expenses of a Dependent hospitalized at the time of enrolment
13) services performed by a Physician who is related to or resident with you or your Spouse
14) fees for ambulance services when an ambulance is called but not used
15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
16) retroactive coverage and payment of any expense, including drugs that receive special authorization from PharmaCare
17) any other item not specifically included as a benefit.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it 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 Spouse and/or children have coverage through another plan, your Pay Direct card cannot be used for their prescription expenses. Please refer to item 2 below for further information.

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 Union. 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 or on our website at www.pac.bluecross.ca/caresnet
   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 2012 before June 30, 2013.
   d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

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/Fee guide as follows:
   a) for services performed in British Columbia or outside Canada, if your province/territory of residence is British Columbia — the fees in the Fee schedule
   b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
   c) for services performed outside Canada if your province/territory of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

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

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

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing – 2 per calendar year
   c) topical application of fluoride – 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings 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) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.
   c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

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

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planing
   c) gingival curettage – 1 per sextant in a 5 year period
   d) osseous surgery – 1 per sextant in a 5 year period

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

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

Plan B – Major Restorative Services

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

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

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

1) Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures
   b) fixed bridges.

2) Restorative Services
   a) inlays or onlays involved in bridgework
   b) veneers
   c) crowns and related services.

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

Limitations

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

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. Plan C covers 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/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory 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) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
6) anesthesia 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. To avoid any misunderstanding, 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 **1 year** from the date the service is performed.
3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
   a) name of the Dentist
   b) name and birthdate 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 **1 year** 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 in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.
   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.

Definitions

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 his or her 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 one period of disability as outlined under *Recurrent Disability*, whether due to one or more illnesses.

In consultation with you, your union, 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 if your employer contributes to the cost of your STD Plan. Benefits are nontaxable if you pay the entire cost.

Termination of Benefit

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

1) you are no longer disabled
2) you are no longer receiving continuing 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 leave Canada, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by us.

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 retire
10) you die.

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
   a) self-inflicted injury or sickness
   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 but not limited to 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 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 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.

Notes

Company Name:	British Columbia Regional Council of Carpenters Plan
Group Number(s):	901598 & 902005
Benefit(s):	Extended Health Care

Effective January 1, 2013, your Plan has been changed as follows :

- fertility drugs have a payable lifetime maximum of $3,000

the colour of trust®

PACIFIC BLUE CROSS™ BC Life®

Dental Claims
604 419-2300

Extended Health Claims
604 419-2600

Toll-free
1 888 275-4672

Short-Term Disability Claims
604 419-8080

Life and Long-Term Disability Claims
604 419-8040

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

www.pac.bluecross.ca

CARESnet®

Plan details, claim history, direct deposit information and much more. Go to **www.pac.bluecross.ca** and activate your online access.

™* Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans. BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross. CARESnet and The colour of trust are the registered trade-marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross Plans, and are used under license to Pacific Blue Cross. Only Pacific Blue Cross/BC Life can change the information in this document. Any other modification is strictly prohibited.
0621.004 — 62-15-100 01/11 CUPE 1816