

Attachment A

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Definitions

Reference to the singular also includes the plural when the context so requires.

Actively employed or Active employment

means an Employee is attending their usual place of employment with You or a Participating employer in a multi-employer group, is performing all the normal and customary duties for a full working day or shift, or is on paid vacation or statutory holiday or on a regular non-working day, and is capable of being at work.

It does not mean:

- 1) working less than the required minimum number of hours per week specified in the *Conditions of Coverage*, or
- 2) employment not at the usual place of employment or business unless at a location to which the business requires the Employee to travel.

Acute

means a medical condition having a sudden occurrence with severe symptoms and lasting less than 60 consecutive days from the date of diagnosis by a Physician, but does not include a condition due mainly to chronic illness or infirmity.

Benefit amount

means the reimbursement payable upon satisfaction of all conditions of this 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.

Benefit year

means a year commencing September 1 and ending August 31.

Business information

means information about Your business, employment practices and benefits activity, and includes information about individuals which is anonymous and aggregated in statistical form, but excludes Personal information.

Calendar year

means a year commencing January 1 and ending December 31.

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.

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 portion of the Eligible expenses the Member must incur before We pay any Benefit amount.

Dental hygienist

means a hygienist who, at the time the service is provided, is qualified and licensed to perform specific services in the jurisdiction where the service is provided. The service provided must be within the scope of the license.

Dental specialist

means a Dentist who practices in one of the following specialties: oral and maxillofacial surgery, endodontics, pediatric dentistry, periodontics, oral medicine and prosthodontics.

Dentist

means a doctor of dentistry duly qualified and licensed to practice dentistry in the area where the services are provided and is acting within the scope of that license.

Denturist

means a Denturist duly qualified and licensed to perform specific dental services in the area where these services are provided and is acting within the scope of that license.

Dependent

means any of the following individuals actively enrolled under a Government plan who is covered under this Contract and continues to meet Our eligibility requirements:

- 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 22 and financially dependent on the Member or the 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 disabled child under 26 years of age who is living with and is financially dependent on the Member and/or Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by Us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

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

Dispensing fee

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

Eligible 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 Contract as a benefit that:

- 1) subject to Our Benefit review, and 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, Dentist, or Nurse practitioner, 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) was incurred while the Member or Dependent was covered under this Contract 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. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this Contract.

Emergency

means a sudden unexpected occurrence of an Acute condition demanding immediate medical attention.

Evidence of insurability

means written proof, satisfactory to Us, that the Member is an insurable risk under the terms of this Contract.

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.

Fee guide

means the Canadian provincial/territorial dental Fee guide for Dentists, Dental hygienists, Dental specialists, and Denturists that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule

means the applicable Pacific Blue Cross Fee schedule for Dentists, Dental hygienists, Dental specialists, and Denturists 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.

Grace period

means the period, after the due date, which We allow for payment of each contribution after the first contribution.

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 purposes of this Contract, the chronic beds of a Hospital are not considered part of that Hospital.

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 manufacture'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.

Member

means an enrolled student in the Alma Mater Society of University of British Columbia.

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 the Member or 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.

Personal information

means any information about an identifiable individual.

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 the Member or 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.

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 the Member or 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.

Plan administrator

means an individual appointed by You to act as Your representative.

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 the Member or 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.

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/.

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 the Member or 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 the person legally married to the Member or a person who has been residing with the Member in a common-law relationship for at least 1 year and who is publicly represented as the Member's Spouse. Only one Spouse is eligible for coverage under the Contract at any one time.

Vendor

means an organization We have retained as an external Provider.

We, Us, and Our

refer to Pacific Blue Cross, and where the context so requires, any Blue Cross office paying claims and/or issuing identity cards under the direction of Pacific Blue Cross.

You and Your

refer to the Contractholder and/or the Plan administrator.

The Contract

- 1) The entire agreement between You and Us consists of this Contract, Your application for group benefits, the Fee schedule/Fee guide (when applicable), any document attached to this Contract when issued, and any amendment to this Contract written after this Contract was issued.
- 2) This Contract may be amended after at least 31 days written notice of amendment.
- 3) Only an officer of Pacific Blue Cross may approve a change.
- 4) Notice given to You is considered notice given to any subsidiary, affiliated company, branch, or division covered by this Contract.
- 5) Notice to Us shall be delivered or mailed to Pacific Blue Cross as follows:

Street Address

4250 Canada Way
Burnaby, BC

Mailing Address

PO Box 7000
Vancouver, BC V6B 4E1

Contract Years

The first contract year is the period which begins at 12:01 A.M. Pacific Standard Time on the effective date to the date immediately prior to the first renewal date. Each subsequent 12 month period is considered a contract year.

Renewal of Contract

- 1) This Contract may be renewed for subsequent contract years subject to payment of required contributions.
- 2) We may change contribution rates, administration fees, or other monies payable with at least 150 days prior written notice to You.

Non-waiver of Contract Provisions

Our failure to insist upon compliance with any provision of this Contract at any given time or under any given set of circumstances will not waive, modify, or in any manner whatsoever render it unenforceable at any other time or in any other occurrence, whether or not the circumstances are the same.

Assignment

No assignment by a Member or Dependent of any interest in this Contract is valid.

Currency

All amounts payable under this Contract shall be in Canadian funds. 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.

Right of Recovery

We have the right to recover from the individual and/or Provider to whom payment was made any amount which should not have been paid.

Electronic Communications

We may provide and accept documents electronically from You and covered Members in accordance with applicable legislation.

Termination of the Contract

- 1) This Contract will terminate automatically on the last day of the month for which contributions should have been paid in full, if the monthly contribution or any portion of it is not paid within the Grace period (31 days).
- 2) This Contract will terminate automatically on the date Your operation terminates or ceases to function as disclosed under "nature of business" on Your application for group benefits.
- 3) We may terminate this Contract at the end of any month if the participation requirements are not maintained. We will give You at least 31 days prior written notice of termination.
- 4) We reserve the right to terminate this Contract on any contribution due date by giving You at least 31 days prior written notice of termination.
- 5) You may terminate this Contract by giving Us written notice of termination. The effective date of termination will be the first contribution due date which occurs at least 31 days after We receive Your notice, or the termination date specified in the notice, if later.
- 6) It is Your responsibility to notify all Members immediately of the cancellation of their benefit coverage.

Replacement of Group Contract

If this Contract replaces the termination of another group contract within 31 days, and this Contract covers some or all of the same Members as the previous contract, this Contract will provide coverage for a Member covered under the previous contract at the time of termination, provided (i) coverage for the Member terminated only by reason of termination of the previous contract, and (ii) the Member is eligible for coverage under this Contract.

Individual Plan Conversion Privilege

It is Your responsibility to inform the Member of the following:

- 1) Provided the Member is a resident of British Columbia, a Member is entitled to convert to a Pacific Blue Cross individual plan when their group coverage with Pacific Blue Cross terminates.
- 2) A Member resident elsewhere in Canada is entitled to purchase an individual plan offered by the Blue Cross organization in their province/territory of residence.
- 3) The individual plan will be issued subject to the following:
 - a) benefits under the individual plan may not be equivalent to the Member's group plan
 - b) the contribution rate will be the current rate for the individual plan
 - c) the Member must have had coverage for a minimum of 6 months under a group plan with the same benefits
 - d) coverage under the individual plan will become effective immediately after the Member's group coverage terminates, provided:
the first contribution and a completed application are received by Pacific Blue Cross or other Blue Cross organization within 60 days of the date the Member's group coverage terminates.
- 4) Pacific Blue Cross conversion privileges
 - a) Pre-existing condition clause
This clause in the individual plan will be waived if the Member had extended health care benefits under this Contract.
 - b) Waiting period
If the Pacific Blue Cross individual plan applied for contains vision care and/or dental benefits, We will waive the waiting period, provided the Member had comparable group coverage on the date their group coverage terminated.
- 5) Blue Cross conversion privileges
A Member living in a territory or province other than British Columbia will be granted conversion privileges prevailing at their local Blue Cross organization on the date their application for an individual plan is received.

Claims Payment Conditions

- 1) All claims must be submitted to Us in English.
- 2) Specific claim procedures and time limits are included for each benefit of this Contract.
- 3) We may reject any claim if insufficient information is 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 to which the patient is not entitled.

- 4) When requested by Us, any person making a claim for benefits shall authorize all parties with information relevant to the claim or any prior claim to release this information to Us.
- 5) We shall not pay interest on any benefits.
- 6) No action or proceeding against Us, concerning a claim under this Contract, shall begin until 60 days have elapsed from the date satisfactory proof of claim is filed with Us, nor shall any action or proceeding begin more than 2 years from the time the cause of legal action arose.
- 7) If a Member or Dependent suffers any damage from the malpractice or negligence of any Provider rendering service to such person, the Member or Dependent concerned must make claim, if any, against the Provider and not against Us. The Member or Dependent waives any claim against Us in respect of such malpractice or negligence and agrees to indemnify and save Us harmless from any such claim that may be made against Us.

Legal Action

Every action or proceeding against Us for the recovery of benefits payable under the Group Contract is absolutely barred unless commenced within the time set out in the *Insurance Act*.

Beneficiary

This Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits. Any Benefit amount owing will be paid to the Member's estate or the Member for a deceased Dependent.

If this Contract replaces another group contract and the previous contract allows the covered group persons to name a personal representative or beneficiary to receive benefits on their behalf, all designations named in the previous contract will apply to these Members covered under this Contract.

Integration with Government Plans

Benefits under this Contract are intended to supplement and not overlap benefits under Government plans. Members are required, as a condition of coverage, to take all reasonable steps to qualify for 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.

Coordination of Benefits

Extended Health Care (EHC)

Amounts payable under this plan are in excess of any amounts available or collectible under any existing plan for the same or similar benefits provided under this Contract that

is concurrently in force held by or available to the Member or Dependent. A plan includes, but is not limited to, an individual plan for out-of-country or out-of-province/territory or travel benefits, or a plan made available through an employer, trust or similar organization. The order of payment will follow the guidelines established by the Canadian Life and Health Insurance Association.

If a Member or Dependent is covered by more than one plan, Extended Health Care benefits will be paid as follows:

- 1) Where benefits available under this Contract are determined to pay first, benefits will be calculated as though other benefit plans do not exist.
- 2) Where benefits available under this Contract are determined to pay after another benefit plan has made payment, benefits will be payable to the lesser of:
 - a) the amount that would have been payable in the absence of any other benefit plans, or
 - b) 100% of the actual expenses, incurred, reduced by all other benefits payable for the same expenses by other benefit plans.

Dental Care

Amounts payable under this plan are in excess of any amounts available or collectible under any existing plan for the same or similar benefits provided under this Contract that is concurrently in force held by or available to the Member or Dependent. A plan includes, but is not limited to, an individual plan for out-of-country or out-of-province/territory or travel benefits, or a plan made available through an employer, trust or similar organization. The order of payment will follow the guidelines established by the Canadian Life and Health Insurance Association.

If a Member or Dependent is covered by more than one plan, Dental Care benefits will be paid as follows:

- 1) Where benefits available under this Contract are determined to pay first, benefits will be calculated as though other benefit plans do not exist.
- 2) Where benefits available under this Contract are determined to pay after another benefit plan has made payment, benefits will be payable to the lesser of:
 - a) the amount that would have been payable in the absence of any other benefit plans, or
 - b) 100% of the actual expenses, incurred, reduced by all other benefits payable for the same expenses by other benefit plans.

Duty to Disclose

- 1) A Member or applicant for benefits must disclose to Us in the application, on a medical examination (if applicable), and in any written statement or answers furnished as Evidence of insurability, every fact within the applicant's or person's knowledge that is material to the coverage.
- 2) We may void coverage for a Member or applicant if there is a failure to disclose, or a misrepresentation of, a fact.
- 3) In the event there is a failure to disclose or a misrepresentation referred to in subsection (1) relating to Evidence of insurability with respect to an application for (i) additional coverage under the Contract, (ii) an increase in insurance under the Contract, or (iii) any other change to insurance after the Contract is issued, We may void coverage for a Member or applicant in relation to the addition, increase, or change.

Member Information/Access to Records

- 1) Each Member must receive an identification (ID) card and a booklet outlining the benefits, the circumstances under which the coverage terminates, and the rights of the Member upon termination of coverage. We will not be liable or responsible for errors or omissions which occur when Our booklet text is altered in any way.
- 2) Only the Member and Dependent(s) are entitled to the benefits of this Contract. 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 this Contract govern if they conflict with the information on a Member's ID card and/or booklet.
- 5) Upon request, and at no charge to the Employee, We will provide the Employee with one copy of:
 - a) the Employee's application for coverage
 - b) the current Contract
 - c) any written statement or other record provided to Us as Evidence of insurability of the Employee.
- 6) An Employee's access to the documents identified in clause 5 extends only to relevant information about a claim under the Contract or denial of such a claim.
- 7) An Employee'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.

Contract Administration/Right to Audit

- 1) For all purposes of this Contract, You act on Your own behalf or as agent of the Member. Under no circumstances will You be considered Our agent.
- 2) You are responsible for maintaining adequate records and for administering this Contract according to the administration guide We provide with this Contract. You will promptly forward to Us:
 - a) the information necessary to establish minimum participation level requirements and the eligibility of applicants for coverage
 - b) applications for coverage
 - c) details of any change in status, amount of coverage, or termination of the coverage of a Member or Dependent
 - d) details of benefit changes, and
 - e) information required for assessment of claims.
- 3) We will not be liable or responsible for Your failure to supply required information or records.
- 4) While this Contract is in effect and for 1 year after its termination, at Our request, You will permit Us to inspect Your payroll records or any other records related to the coverage provided under this Contract.

Provincial/Territorial Taxes

On Your behalf, We will forward funds remitted to Us for taxes to the appropriate government authorities. We accept no liability for any assessment or reassessment of taxes, interest charges, or penalties.

Clerical Error

Clerical error in maintaining records or in providing information will not invalidate coverage that should be in force, or provide or continue coverage that should not be in force. Upon disclosure of such an error, the contributions will be adjusted, if required, and the coverage affected under the terms of this Contract.

Confidentiality of Personal and Business Information

- 1) Under this Contract, Personal information will be disclosed to Us by You, Members, Practitioners, Hospitals (and other health care institutions), the Government and others.
- 2) All Personal information, once disclosed to Us, becomes Our property and We are entitled to use such Personal information for the purposes of this Contract.
- 3) You acknowledge and agree that the individual about whom any item of Personal information relates has the right to control any other or further use or disclosure of such Personal information, beyond the use by Us contemplated under this Contract. Such right specifically includes the right not to have any Personal information disclosed by Us to You.
- 4) You agree that:
 - a) You have no ownership rights of any kind with respect to any Personal information.
 - b) You have no rights under this Contract to require disclosure of any Personal information to You.
 - c) We have no ability or obligation to disclose Personal information to You without the express written consent of the individual, which consent cannot be required as a condition of providing any benefit or service, and which consent can be withdrawn after it is given.
- 5) We agree that if and only to the extent that an individual has expressly consented in writing to disclosure of Personal information to You, We will disclose that Personal information to You on request. The parties acknowledge that the circumstances in which such disclosure is appropriate will be exceptional, and are not contemplated to be a routine aspect of the handling of Personal information under this Contract.
- 6) Our obligations to Members and Dependents with respect to Personal information will be set out in materials delivered directly to Members by Us.
- 7) For certainty, We also have the right to disclose Personal information:
 - a) in statistical form
 - b) where reasonably necessary, to determine eligibility for a benefit, or to protect Our interests against criminal activity, and misrepresentation in connection with benefits payable under this Contract
 - c) where required or permitted by law
 - d) to the appropriate governing body of the medical, pharmaceutical, or dental professions

- e) to another benefit carrier when coordinating benefit payments.
- 8) Business information
We agree to hold Your Business information in confidence and shall not disclose Your Business information to third parties, except where such Business information:
 - a) was already in Our possession or is subsequently disclosed to Us by other parties without restriction on its use or disclosure,
 - b) is or becomes available to the general public through no act or default by Us, or
 - c) is independently developed by Our employees or consultants who have not had access to Your Business information.
- 9) Termination
 - a) If this Contract is on an “ASO” arrangement, We covenant on termination of this Contract to transfer all Personal information relating to the Contract directly to a successor benefit provider designated in writing by You who is independent of You and who meets the criteria set out in guidelines established by the Canadian Life and Health Insurance Association (CLHIA).
 - b) Under no circumstances shall We be required to transmit Personal information directly to You on termination.

General Exclusions

- 1) We will not be liable for any portion of an expense for which a Member or 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) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
 - b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
 - c) 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
 - d) 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
 - e) false pretences or fraudulent misrepresentation
 - f) 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.

Third Party Liability

- 1) No benefits are payable to a Member or Dependent who suffers injury or sickness covered by Workers' Compensation or for which a third party is, or may be, directly or indirectly, either in whole or in part legally liable.

- 2) If a Member or Dependent has the right to recover money from Workers' Compensation or a third party as compensation for injury or sickness but the liability of Workers' Compensation or the third party has not yet been determined, then the Member or Dependent may apply to Us for an advance payment of any benefit which the Member or Dependent may be ultimately entitled to receive from Us.
- 3) We will not advance payment of benefits unless the Member or Dependent is otherwise eligible to receive this benefit and agrees in writing to:
 - a) take all necessary action to recover from Workers' Compensation or the third party, the total of the benefits advanced or to be advanced by Us including without limitation, directing the Member or Dependent's lawyer to repay Us the full amount of the benefits directly from any monies received pursuant to any judgement or settlement
 - b) pay all legal fees incurred in pursuing the action against Workers' Compensation or the third party
 - c) repay Us the full amount of the benefits advanced to the Member or Dependent in the event the claim against Workers' Compensation or the third party is abandoned or settled without Our written consent
 - d) enter into a reimbursement agreement with Us in a form prescribed by Us setting out the terms and conditions for repayment of the benefits
 - e) consent to the release by Workers' Compensation, the third party or Insurance Corporation of B C of all information in their possession relating to the Member or Dependent's claim.
- 4) Unless the Member or Dependent has complied with the provisions under 3a), b), and c) above, any money paid by Us in respect of the Member or Dependent's claim shall be a debt due and owing by the Member or Dependent to Us.

Interpretation

This Contract is to be interpreted and enforced in accordance with the laws of the province of British Columbia and their amendments and Regulations, and to Our By-laws.

Payment of Benefit Amount

- 1) We will reimburse the Benefit amount when We receive satisfactory written proof that a Member or Dependent has incurred Eligible expenses which are required for the treatment of an illness or injury and are included as benefits of this EHC plan.
- 2) Benefits are calculated and totalled separately for the Member and each Dependent.
- 3) To determine the Benefit amount, We assess the claim as follows:
 - a) calculate the total eligible price for the benefit by applying either
 - i) the Customary charge, drug plan design, or any applicable Fee guide price, or
 - ii) if none of the above apply, the submitted amount
 - b) apply any payment limits that are indicated as *eligible*
 - c) subtract the Deductible and copay, when applicable, then
 - d) apply the reimbursement percentage; then
 - e) apply any payment limits that are indicated as *payable*
 - f) apply the EHC plan maximum
- 4) When applicable, the Deductible, the reimbursement percentage, and the EHC plan maximum are shown in the *Benefit Summary*.
- 5) When applicable, payment and frequency limits are included in the corresponding benefit descriptions in the EHC section of this Contract. Any payment limit is considered as payable unless specifically indicated as eligible.
- 6) Eligible expenses are per person per Calendar year unless indicated otherwise in the benefit description.

In-Province/Territory Eligible Expenses

- 1) Emergency ambulance services
 - 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.
- 2) Drugs

Charges for an Eligible expense in a quantity We consider reasonable, and as approved by Our Benefit review process, 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 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 Provider legally authorized to do so, including:
 - i) Compounded drugs
 - ii) contraceptive drugs
 - iii) emergency contraceptives
 - iv) drugs for smoking cessation
 - v) vaccines Benefit year maximum
 - flu vaccines - \$25
 - all vaccines combined (including flu) - \$150
 - vi) methadone when prescribed for the treatment of pain or addiction.

The cost of flu vaccines will be cut back to the manufacturer's list price plus Markup.

Except as noted above, those drugs and medicines which are not covered by PharmaCare will not be considered an Eligible expense under this Contract without approval by You. Once approved, those drugs and medicines will be considered to a maximum of \$2,000 per Benefit year.

Reimbursement of eligible drugs will be subject to provincial/territorial plans low cost alternative and reference drug programs, inclusive of provincial/territorial plans allowed markup.

For prescription drugs not eligible under a provincial/territorial plan, the cost of multi-source drugs will be cut back to the cost of the lowest cost equivalent drug. The cost of generic drugs and single source brand named drugs are eligible.

The Markup is eligible up to 17% of the manufacturer's list price.

If We receive written confirmation from the prescribing Practitioner, that there is a specific medical requirement that prevents the Member from taking the generic drug, the full cost of the multi-source brand drug will be eligible.

Dispensing fees for flu vaccines up to \$15 are eligible.

3) Practitioners

Professional services of the following Practitioners (except psychologist, clinical counsellor, and social worker) to a maximum of \$400 per category per Benefit year, but excluding x-rays (unless indicated below), appliances and tray fees. The services of a dietitian, massage Practitioner and speech therapist require a Physician's or Nurse practitioner's referral each year. The services of a private duty nurse require a Physician's or Nurse practitioner's referral.

- a) athletic therapist\$20 per visit
- b) chiropractor\$20 per visit
- c) chiropractor x-ray 1 per benefit year
- d) dietitian.....\$20 per visit
- e) massage Practitioner.....\$20 per visit
- f) naturopath.....\$20 per visit
- g) osteopath.....\$20 per visit

- h) osteopath x-ray1 per benefit year
- i) physiotherapist.....\$20 per visit
- j) podiatrist/chiropracist.....\$20 per visit
- k) podiatrist/chiropracist x-ray1 per benefit year
- l) psychologist, clinical counsellor, social worker* and Online cognitive behavioural therapy combined.....\$500
- m) speech language pathologist.....\$20 per visit
- n) 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 to a maximum of \$25,000 in a 3 Benefit year period.

*Social workers must have a minimum of a master degree in a Social Work.

- 4) Online Cognitive Behavioural Therapy
Charges for a program through an eligible Vendor to a maximum of \$500 per Calendar year combined with services of a psychologist, clinical counsellor and social worker.

“Online cognitive behavioural therapy” means an internet-based behavioural therapy program.

- 5) Dental Accident
Dental treatment by a Dentist or Denturist, 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 apply the eligible dental services and financial limits of the Pacific Blue Cross Fee schedule and We apply the fees in the Fee guide or Fee schedule as follows:

- a) for services performed in British Columbia or outside Canada if the patient's province of residence is British Columbia, We apply the Fee schedule
- b) for services performed in Canada but outside British Columbia, We apply the Fee guide in the province/territory of service
- c) for services performed outside Canada if the patient's province/territory of residence is not British Columbia, We apply the Fee guide in the province/territory of residence.

- 6) Medical aids and supplies provided by a medical supplier (as approved by Us)
Charges for the following services and supplies:
 - a) oxygen
 - b) ostomy and ileostomy supplies
 - c) intrauterine devices (IUD's)
 - 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, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient. Myoelectrical 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 Benefit 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
 - i) when prescribed by a Physician, podiatrist, chiropractor, or a Nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear to a maximum in a Benefit year period of \$350. 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
 - ii) when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or a Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a maximum of \$350 in a Benefit year. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet
- 7) Standard durable medical equipment
- a) Our preauthorization is required for expenses in excess of \$5,000
 - b) When rented from a medical supplier, charges for standard durable medical equipment are covered. If unavailable on a rental basis or required for a long term disability, purchase of these items from a Provider may be considered. We retain the right to determine whether the patient will rent or purchase the equipment prescribed by the attending Physician or Nurse practitioner. Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment
 - c) We may also request trade-in or return of replaced equipment. Repairs to purchased items are covered. Replacement is covered only when the item can no longer be made functional
 - d) 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 subject to a maximum of \$4,000 in a 5 Benefit year period
 - iv) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
 - 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 \$100 in a 24 month period. Charges for non-prescription eyewear are not covered.
- 9) Eye Examinations
Charges for the following when performed by a Physician or legally authorized optical provider (as applicable):
 - a) routine eye examinations, and
 - b) comprehensive eye examinationsto a combined maximum of \$50 in a 2 Benefit year period.
- 10) Laser Eye Surgery
Charges for laser eye surgery when performed by a Physician to a maximum of \$150 per Benefit year.
- 11) Laboratory Tests and Ultrasound
Charges for laboratory and ultrasound tests when not covered under a Government plan and used to diagnose an illness. Tests used for pregnancy or to monitor an illness are not covered.
- 12) Tutorial Services (Members Only)
If injury or illness causes disability and results in confinement to a Hospital or the student's home, we will pay up to \$10 per hour for private tutorial services of a qualified teacher, to a maximum of \$300 per Benefit year. The Member must provide satisfactory proof from the attending Physician of disability and confinement per occurrence. Dependents are not eligible for this benefit.
- 13) Trip Cancellation
Charges for trip cancellation due to a medical emergency for a Member or immediate family to a maximum of \$1,500 per trip for pre-paid non-refundable trip expenses.
- 14) Trip Interruption
Charges for trip interruption due to a medical emergency for a Member or immediate family to a maximum of \$5,000 for each trip taken during a Benefit year.
- 15) Prostate Specific Antigen (PSA) Testing
Charges for PSA testing to a maximum of \$50 per service for persons age 45 or older.

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

We will reimburse non-emergency Eligible expenses incurred out-of-province/territory as if these expenses were incurred in the person's 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

Definitions

Reference to the singular also includes the plural when the context so requires.

Immediate family member

means the Spouse, father, mother and children (including natural or adopted), sibling, step-parent, step-child, grandparent or grandchild of the Member or Spouse.

Medical treatment

means the medically necessary advice, care, surgery (non-elective) or services provided for disease, illness, bodily injury, or acute psychosis that occurs during your trip. The treatment must be provided by a Physician, Dentist, Practitioner and/or a Hospital and cannot be reasonably delayed until your return to your province/territory of residence without endangering your health. It does not include “check-ups”, regular treatment of a chronic condition, or cases where there are no specific symptoms.

While the Member or Dependent is travelling outside their normal province/territory of residence, benefits are payable for the following Eligible expenses incurred in an Emergency only:

- 1) Local ambulance services when immediate transportation is required to the nearest Hospital equipped to provide the treatment essential to the patient.
- 2) Air ambulance charges for licensed ambulance service (or licensed airline) to the nearest appropriate medical facility or to the nearest Canadian Hospital equipped to provide the type of care essential to the patient. Air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport.
- 3) Semi-private Hospital room accommodation and charges for services and supplies when confined as a patient or treated in a Hospital.
- 4) Medical Treatment by a Physician and laboratory and x-ray services when ordered by the attending Physician as part of Emergency medical treatment.
- 5) Prescription drugs in sufficient quantity to alleviate an Acute medical condition.
- 6) Services of a physiotherapist, chiropractor, chiropodist, podiatrist, or osteopath to a maximum of \$250 per Practitioner.
- 7) Services of a private duty registered nurse.
- 8) Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when medically necessary.
- 9) Dental treatment in an Emergency to a maximum of \$2,000 when performed by a Dentist for the repair or replacement of natural teeth or prosthetics.
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.
- 10) Relief of Acute dental pain to a maximum of \$200 for Emergency treatment by a Dentist.
- 11) Charges limited to a single round-trip economy airfare from Canada, plus up to \$150 per day for the cost of meals and commercial accommodation for one Immediate family member or a close personal friend to be with the patient if the patient is travelling alone and hospitalized as the result of an Emergency. It is required that the Member or Dependent be hospitalized as an inpatient for more than 3 consecutive days outside the province or territory of residence. The attending Physician must provide written certification that the medical condition was serious

enough to warrant the visit; or where legally necessary, identify the Member's or Dependent's remains prior to their release.

- 12) Charges limited to the cost of a single one-way economy airfare for a travelling companion to return to Canada if the Member or Dependent are returned to their province/territory of residence by air ambulance or repatriation.
- 13) Charges limited to \$200 per day to an overall maximum of \$2,500 per trip for the cost of commercial accommodation and meals (including the expenses of accompanying Dependents) if a trip is extended beyond the scheduled return date due to the Member or Dependent's hospitalization.
- 14) Charges to a maximum of \$2,000 to return the vehicle (owned or rented) to the Member's residence or the nearest rental agency, if the Member, Dependent or travelling companion are unable to return the vehicle due to illness or injury.
- 15) If death is due to illness or injury, charges for the repatriation of a deceased Member and/or Dependent to their place of residence (within Canada) or for the burial or cremation of those remains at the place where the death occurred, to a maximum of \$40,000. The cost of a funeral, burial casket or urn are not covered.
- 16) There is a \$5,000,000 maximum per person per incident for out-of-province/territory Emergency Eligible expenses.

We will only cover Eligible expenses obtained within 120 days of the date the Member or Dependent left the province/territory of residence. If hospitalization occurs within the 120 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. Members and their Dependents are required to provide proof of their date of departure and return date to their country of residence, when requested by Us.

For the purpose of coverage under this plan, your province/territory of residence will be considered to be the province/territory where you are living while enrolled at a participating college or university if this is not your permanent province/territory of residence in Canada, or if you are a foreign student on a valid student visa.

Emergency Travel Assistance

In emergencies which occur while a Member and/or Dependent is travelling, during the first 120 days of travel after the Member and/or Dependent leaves the country of residence, medi-assist will coordinate the following services to:

- 1) Locate the nearest appropriate medical care.
- 2) Obtain consultative and advisory services (including second medical and surgical opinions and review of appropriateness, quality, and costs of hospitalization and outpatient procedures) from medical advisors under agreement with medi-assist.
- 3) Investigate, arrange, and coordinate medical evacuations and related transportation needs.
- 4) Investigate, arrange, and coordinate the repatriation of remains.
- 5) Replace lost passports, locate qualified legal assistance and local interpreters, and other incidental aid required by the Member and/or Dependent in distress.

Exclusions

The following are not Eligible expenses under this benefit:

- 1) Except as specifically provided in this Contract: 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.
- 2) Charges for the rental of a telephone, television, or similar equipment in a Hospital.
- 3) Except as specified under Eligible Expenses, 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 anesthetic, 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) 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 the treatment of an existing illness or injury.
 - g) any expenses identified as exclusions under the Extended Health Care Benefit.
- 4) 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.
- 5) Except as specifically provided in this Contract: 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.
- 6) 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, except as expressly provided in this Contract.
- 7) That portion of a claim normally covered by a Government plan which has been refused on the basis that the claim was not submitted within that plan's time limits.
- 8) Out-of-province/territory expenses incurred due to elective treatment and/or diagnostic procedures, or complications related to such treatment.
- 9) Any trip booked, commenced or continued against the advice of a Physician or after being diagnosed with a terminal illness.
- 10) Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic tests or charges unless We approve these procedures prior to being performed except when such surgery is performed immediately on an Emergency basis.
- 11) Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms, ultrasounds and biopsies, unless We authorize such procedures in advance.

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- 12) Out-of-province/territory expenses incurred due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 9 weeks before or after the expected delivery date or any time for a pregnancy deemed to be high risk by a Physician.
- 13) Out-of-Province/territory expenses incurred due to misuse of medication or non-compliance with a prescribed treatment or medical therapy.
- 14) Out-of-Province expenses incurred due to loss or damage to hearing devices, eyeglasses, sunglasses, contact lenses, prosthetic teeth, limbs or devices and the resulting replacement prescription.
- 15) Out-of-Province/territory expenses incurred for any drugs or medication not required as a result of an emergency.
- 16) Out-of-Province/territory expenses related to donated organs, transplanted organs or artificial organs.
- 17) Out-of-province/territory expenses incurred due to scuba diving unless the Member or Dependent holds a basic scuba designation from a certified school or other licensing body, or the Member or Dependent is accompanied by a dive master or is in water not deeper than 10 metres.
- 18) Out-of-province/territory expenses incurred due to hang gliding or parachuting unless the Member or Dependent does so in tandem with a licensed or certified instructor.
- 19) Charges incurred outside the province/territory of residence for continuous or routine medical care normally covered by the Government plan in the person's province/territory of residence.
- 20) Expenses of a Dependent hospitalized at the time of enrolment.
- 21) Services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with the Member or Dependent.
- 22) Services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross.
- 23) Fees for ambulance services when an ambulance is called but not used.
- 24) Ambulance charges for work related illness or injury assessed by Workers' Compensation Board to be the employer's responsibility.
- 25) Retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans.
- 26) Out-of-province/territory travel to another country when that country is the Member or Dependent's home country.
- 27) Medical treatment or services received in the province/territory of residence, or in the Member's home country if the Member is a foreign student studying in Canada.
- 28) Any other item not specifically included under benefits.
- 29) Legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

Claim Procedure

- 1) When submitting an electronic claim the Member 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 the Member submits the claim to Us
 - c) if the claim is selected for review by Us, the Member must submit the original receipts and supporting documentation electronically or by mail to Us within 21 calendar days. If We do not receive this information within this time, the Member's claim will be refused and their ability to submit electronic claims will be removed.

- 2) We reserve the right to remove a Member's ability to submit electronic claims if the Member provides false, incomplete or misleading claims information. In such circumstances the Member will have to submit paper claims with supporting receipts and documentation.
- 3) When submitting a paper claim the Member must:
 - a) complete the claim form and submit the claim form with original receipts and supporting documentation to Us, or
 - b) if We are not the primary paying plan, submit a paper claim with an explanation of benefits statement from the primary payer and photocopies of supporting receipts and documentation.
- 4) The Member must provide explanation or proof to support the claim or any other information We consider necessary.
- 5) Proof of claim is at the Member's expense.
- 6) We must receive an electronic or paper claim no later than 90 days after August 31st following the year in which the claims were incurred or 90 days from the date the Member's coverage terminates, whichever occurs first. To be eligible for payment, a paper claim must include the claim form with receipts and supporting documentation. We will not accept a faxed or scanned claim form and/or receipts.
- 7) Payment of the claim will be directed to the Member entitled to receive payment, unless We agree to the Member's request to assign payment directly to a third party.
- 8) When a Member has benefits which permit different Providers to submit claims for Eligible expenses directly to Us, We shall pay the Providers for these Eligible expenses.
- 9) When this Contract terminates, We must be given written notice of any eligible claim within one hundred eighty (180) days following the termination in respect of benefits relating to accidental damage to teeth arising from an accident that occurred before the termination of the Contract.

Payment of Benefit Amount

- 1) We will reimburse the Benefit amount, when We receive satisfactory proof that a Member or Dependent has incurred Eligible expense(s) included as benefits of this dental care plan.
- 2) We apply the eligible dental services and fees in in the Fee guide in the province/territory of residence.
- 3) To determine the Benefit amount, We assess the claim as follows:
 - a) calculate the total eligible price for the Eligible expense using the Fee guide or Fee schedule as indicated
 - b) apply the benefit maximum(s),when applicable
 - c) subtract the Deductible, when applicable
 - d) apply the reimbursement percentage
 - e) apply the Plan A, B or C annual or lifetime maximum, when applicable.
- 4) When applicable, the reimbursement percentage and the benefit maximum(s) are shown in the *Benefit Summary*.
- 5) We apply reasonable and Customary limits to fee items as applicable (e.g., fees listed in the Dental Fee schedule as “I.C.” or “+L”).
- 6) If referred to a Dental specialist, We apply the Fee schedule/Fee guide amount plus 10%.
- 7) If requested in writing, procedures for endodontic treatment, dentures, or crown and bridgework, commenced prior to the termination date of coverage, will be considered work in progress and will be reviewed for payment if completed within 30 days of the Member’s date of termination. Filing of treatment forms will not constitute acceptance as work in progress.
- 8) Eligible dental services will be covered when provided by a Dentist, Dental specialist, or Denturist in an emergency, while a Member or Dependent is travelling outside their province/territory of residence. Payment will be based on the Fee schedule or Fee guide as specified in 2) above.

Plan A –Preventive 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 following basic services:

- 1) Diagnostic Services
 - a) recall oral examinations – once in a 12 month period
 - b) complete oral examinations – once in a 36 month period
 - c) specific oral examinations
 - d) bitewing x-rays – once in a 6 month period to a maximum of twice per Benefit year

- e) complete series of x-rays or 1 panoramic x-ray every 36 months.
- 2) Consulting Services
Consultation between 2 Dentists – 2 units per consultation per Benefit year.
- 3) Preventive Services
 - a) scaling – 2 units per Benefit year
 - b) polishing
 - c) topical fluoride
 - d) oral hygiene instruction
 - e) pit and fissure sealants
 - f) space maintainers for missing primary teeth.Polishing, topical fluoride, and oral hygiene instruction are covered once in a 6 month period to a maximum of twice per Benefit year.
- 4) Surgical Services
Extractions of impacted teeth and related charges for anesthesia.

Plan A - Basic Services

- 1) Restorative services
 - a) fillings
 - i) amalgam fillings
 - ii) composite fillings on anterior and bicuspid teeth only
- 2) Endodontics
treatment of diseases of the pulp chamber and pulp canal (including, but not limited to, basic root canal).
- 3) Periodontics
 - a) occlusal adjustments – 8 units per Benefit year
 - b) root planning – 8 units per Benefit year.
- 4) Surgical Services
 - a) extractions of non-impacted teeth
 - b) other routine oral surgical procedures
 - c) anesthesia in conjunction with surgery.

Exclusions

The following are not Eligible expenses under this benefit:

- 1) Charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English.
- 2) Procedures performed for congenital malformations or for purely cosmetic reasons.
- 3) Charges for drugs, pantographic tracings, and grafts.
- 4) Charges for implants, and/or services performed in conjunction with implants, except as indicated in the Fee schedule.

- 5) Anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies.
- 6) Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.
- 7) Incomplete or temporary procedures.
- 8) Recent duplication of services by the same or different Dentist/Dental hygienist/Dental specialist/Denturist.
- 9) Any extra procedure which would normally be included in the basic service performed.
- 10) Items not listed in the Fee schedule and fees in excess of those listed in Fee schedule or Fee guide.
- 11) Major Restorative Services, unless Plan B has been added.
- 12) Orthodontic Services, unless Plan C has been added.
- 13) Services or items which would not normally be provided, or for which no charge would be made, in the absence of insurance.
- 14) Any other item not specifically included under benefits.
- 15) Travel expenses incurred to obtain dental treatment.

Claim Procedure

- 1) Claims should be submitted within 90 days of the completion date of services. 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, We will not pay any claim or adjustment received later than 12 months from the date the expense was incurred.
- 2) For pay patient claims (where the Member has paid the Dentist, Dental hygienist, Dental specialist, or Denturist), We will reimburse the Benefit amount to the Member when We receive:
 - a) 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
 - b) 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 Us.
- 3) For pay direct claims, We will pay the Benefit amount to the Dentist, Dental hygienist, Dental specialist, or Denturist directly for services provided under this benefit plan when We receive:
 - a) A claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
 - b) 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 Us.