HEALTHCARE BENEFIT TRUST

HBT

BENEFIT FROM EXPERIENCE

Standard Benefit Plan for Management Staff (#820)

Provided by your
Employer through the
Healthcare Benefit Trust
Effective: January 1, 2015

We make every effort to ensure the information that we distribute to organizations in electronic format is factual and up to date. To that effect, we have attempted to secure the integrity of the information that we distribute by releasing such information in a "read-only" format. However, in the event that such information is manipulated by anyone other than the Healthcare Benefit Trust or if organizations fail to update any new versions of the information distributed by the Healthcare Benefit Trust, the most recent version of the information distributed by the Healthcare Benefit Trust will govern any disputes. Moreover, the information provided by the Healthcare Benefit Trust regarding benefits may become out of date if changes are made to the Healthcare Benefit Trust's Plan Document, the Healthcare Benefit Trust's Trust Agreement, the applicable Collective Agreements in force, or the Pacific Blue Cross and Great-West Life contracts. Such changes could include, but are not limited to, increasing, decreasing or eliminating:

a) coverage for people and benefits, or
b) amounts for premiums and deductibles.

The governing documents are the Healthcare Benefit Trust's Plan Document, the Healthcare Benefit Trust's Trust Agreement, the applicable Collective Agreements in force, and the Pacific Blue Cross and Great-West Life contracts as each may be amended from time to time. In the case of any inconsistency between the terms of the information provided to organizations and placed, for example, on an organization's Intranet and the governing documents, the governing documents prevail. If your organization has any questions regarding the benefits, we urge you to contact our office for complete and accurate information.

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

Benefits-at-a-Glance

STANDARD BENEFIT PLAN FOR MANAGEMENT STAFF (#820)

HEALTHCARE BENEFIT TRUST
HBT
BENEFIT FROM EXPERIENCE

GROUP LIFE

» Up to age 64: 3x basic annual earnings to a maximum benefit of $700,000.
» Ages 65–70: Coverage reduces to $50,000.
» Age 71: Coverage ceases.
» Includes Advance Payment program for terminally ill employees.

DEPENDENT LIFE

» $10,000 for spouse; $5,000 for dependent child(ren)
» Coverage ceases at the earlier of the employee or dependent attaining age 70.

ACCIDENTAL DEATH & DISMEMBERMENT

» Up to age 64: 3x basic annual earnings to a maximum benefit of $700,000.
» Ages 65–70: Coverage reduces to $50,000.
» Age 71: Coverage ceases.
» Scheduled amount paid for dismemberment or loss of use.

LONG TERM DISABILITY

» 70% of monthly earnings to a maximum monthly benefit of $14,000. The benefit is taxable.
Your gross monthly benefit will be increased annually, related to the increase in the Consumer Price Index. The maximum increase is 5% annually.
» Qualification Period: 120 days
» Own Occupation: 24 months
» Any Occupation: after 24 months (excluding qualification period)

DENTAL

» **Basic Services "Part A"**
(exams, fillings, etc.)..... 100%
» **Major Services "Part B"**
(crowns, bridges, etc.).....75%
» **Orthodontic Services "Part C"**
(braces) 75%
lifetime maximum $3,000
No 12 month waiting period for orthodontic coverage
» **Termination Age**.....**71**

EXTENDED HEALTH

» **Annual Deductible**..... $100
» **Reimbursement of Eligible Expenses** 100%
» **Lifetime Maximum**..... unlimited
» **Annual Maximum:**
- Acupuncturist..... $500
- Chiropractor..... $500
- Dietitian/Nutritionist $500
- Massage Therapist..... $500
- Naturopathic Physician $500
- Physiotherapist $500
- Podiatrist $500
- Psychologist $500
Includes Clinical Counsellor and Psychological Associate
- Speech Therapist $500

» **Eye Exams**.....$75 every 2 years
» **Orthopedic Shoes and Orthotics**
- Adults .....$400 per calendar year
- Children.....$200 per calendar year

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

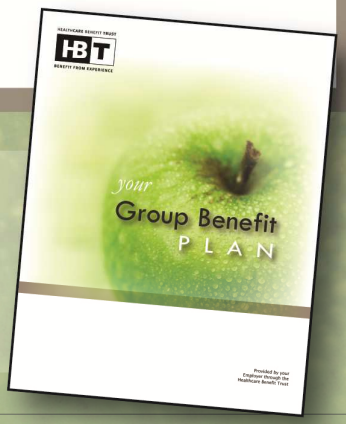
» **Hearing Aids** ..... $600 every 48 months
» **Vision Care**..... $300 every 24 months
» **Wigs or Hairpieces** ..... $500 per lifetime
» **Termination Age**.....71

CARESnet

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

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

For more information, please refer to your benefits booklet.



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

Effective: January 1, 2015

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Group Life

The Group Life benefit is paid to your beneficiary or estate in the event of your death from any cause.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first date of employment.

amount of benefit

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

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. This person will receive your Group Life benefit if you die. If you named more than one person, the payment will be divided among your beneficiaries. If you have not named a beneficiary, the benefit will be paid to your estate. You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

There are no exclusions under the Group Life benefit. The benefit is paid regardless of the cause of your death, provided you were eligible for coverage at the date of death.

continuation of coverage

Your employer will continue to pay the Group Life coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage can continue beyond 20 work days of unpaid leave if you pay the contributions.

If you receive LTD benefits from this Plan, your Group Life coverage will continue at the level in force on the date of your disability.

termination of coverage

Your Group Life coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire

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

conversion

If you cease to be eligible because of termination of employment, your coverage will continue at no charge for 31 days. During the 31 day period you may convert your coverage to an individual policy issued by Great-West Life without providing medical evidence. You may convert up to $200,000 of your insurance provided you apply and submit the premium to Great-West Life within 31 days of termination. Conversion is not available upon attainment of age 65.

claims

Claims are processed by Great-West Life in Vancouver. If you die, your beneficiary or executor should contact your employer for assistance in filing a claim.

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advance payment program

If you are terminally ill and are expected to live less than 24 months, you may be eligible for an advance payment of up to 50% of your Group Life benefit (maximum payment $100,000). The remaining benefit (less interest) will be paid to your beneficiary or estate when you die. If you wish to apply for an Advance Payment, contact your employer to obtain an application form.

optional life

If you are interested in purchasing Optional Life coverage for you, your spouse and/or your dependent children, contact your employer for more information.

Dependent Life

The Dependent Life benefit is paid to you in the event of the death of your spouse or dependent child(ren) from any cause.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse if you have cohabited as spousal partners for one or more years.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children under age 30, if in full-time attendance at a recognized school, college or university and if mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children and includes adopted and stepchildren, and children for whom you are the legal guardian. You must be prepared to prove that persons claimed as dependents are actually dependent upon you and have not ceased to be dependent. Children must be at least 14 days old in order to be eligible for Dependent Life coverage.

effective date

Your coverage takes effect on the first date of employment.

amount of benefit

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

your beneficiary

You are the beneficiary.

exclusions

There are no exclusions under the Dependent Life benefit. The benefit is paid regardless of the cause of death, provided your dependent was eligible for coverage at the date of death.

continuation of coverage

Your employer will continue to pay the Dependent Life coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage can continue beyond 20 work days of unpaid leave if you pay the contributions.

If you receive LTD benefits from this Plan, your Dependent Life coverage will continue.

termination of coverage

Your Dependent Life coverage terminates on the date you or your dependents cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status
- You cease to have any eligible dependents
- You or your dependent attains age 70

Your coverage for a dependent terminates on the earlier of the above, or on the date on which he/she no longer qualifies as a "dependent" under the Dependent Life benefit.

conversion

If you cease to be eligible because of termination of employment, your spouse's coverage will continue at no charge for 31 days. During the 31 day period you may convert your spouse's coverage to an individual policy issued by Great-West Life without your spouse providing medical evidence. Conversion is not available for your dependent child(ren). Conversion is not available upon attainment of age 65.

claims

Claims are processed by Great-West Life in Vancouver. In the event of the death of your dependent, contact your employer for assistance in filing a claim.

Accidental Death & Dismemberment

The Accidental Death benefit is paid to your beneficiary or estate in the event of your death as a result of an accident. It is paid **in addition** to the Group Life benefit.

The Accidental Dismemberment benefit is paid to you if you lose a limb, sight, hearing or speech as a result of an accident, and includes loss of use (paralysis).

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first date of employment.

amount of accidental death benefit
("principal sum")

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

amount of accidental dismemberment benefit
(includes loss of use)

- If you become quadriplegic, paraplegic or hemiplegic: 200% of the principal sum will be paid to you.
- If you lose both hands, or both feet, or the sight of both eyes, or one hand and one foot, or one hand and the sight of one eye, or one foot and the sight of one eye, or hearing in both ears and speech: 100% of the principal sum will be paid to you.
- If you lose one arm or one leg: 75% of the principal sum will be paid to you.
- If you lose one hand, or one foot, or the sight of one eye: 66 2/3% of the principal sum will be paid to you.
- If you lose hearing in both ears or speech: 50% of the principal sum will be paid to you.
- If you lose the thumb and index finger of one hand: 33 1/3% of the principal sum will be paid to you.
- If you lose all 4 fingers of one hand: 25% of the principal sum will be paid to you.
- If you lose hearing in one ear: 16 2/3% of the principal sum will be paid to you.
- If you lose all the toes of one foot: 12 1/2% of the principal sum will be paid to you.

Loss of an arm, leg, hand, foot or eye means the total and irrecoverable loss of its use. Loss of thumb or fingers means complete severance at or above the metacarpophalangeal joints.

Loss of toes means complete severance at or above the metatarsophalangeal joints. Loss of sight, speech or hearing must be complete and irrecoverable.

maximum benefit

The principal sum is the maximum AD&D benefit payable for all losses as a result of any one accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the principal sum.

your beneficiary

Your beneficiary is the person (or persons) named on your most recently completed Appointment/Change of Beneficiary form. See also the "Group Life" section of this booklet. This person will receive the principal sum if you die accidentally, in addition to the Group Life benefit. If you named more than one person, the payment will be divided among your beneficiaries. If you have not named a beneficiary, the benefit will be paid to your estate. You may change your beneficiary at any time by completing a new Appointment/Change of Beneficiary form. Periodically, you should contact your employer to ensure that your beneficiary designation is still appropriate.

exclusions

The AD&D benefit will not be paid for losses resulting from any of the following:

1. Suicide or attempted suicide, while sane or insane.
2. Intentionally self-inflicted injury.
3. War, insurrection or hostilities of any kind, whether or not you were a participant in such actions.
4. Participating in any riot or civil commotion.
5. Bodily or mental infirmity or illness or disease of any kind, or medical or surgical treatment thereof.
6. Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current airworthiness certificate, and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only. Descent from any aircraft in flight will be deemed to be part of such flight.
7. Committing or attempting to commit a criminal offence or provoking an assault.
8. In the course of operating a motor vehicle while -
   a. under the influence of any intoxicant, or
   b. your blood alcohol concentration was in excess of 100 milligrams of alcohol per 100 millilitres of blood.

continuation of coverage

Your employer will continue to pay the AD&D coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage can continue beyond 20 work days of unpaid leave if you pay the contributions.

If you receive LTD benefits from this Plan, your AD&D coverage will continue at the level in force on the date of your disability.

termination of coverage

Your AD&D coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

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

claims

Claims are processed by Great-West Life in Vancouver. If you die as a result of an accident, your beneficiary or executor should contact your employer for assistance in filing a claim. If you suffer a dismemberment or loss of use as a result of an accident, contact your employer for assistance in filing a claim.

The loss must occur within 365 days of the date of the accident. Claims must be submitted to Great-West Life within 365 days of the date of loss.

optional ad&d

If you are interested in purchasing Optional AD&D for you, your spouse and/or your dependent children, contact your employer for more information.

Long Term Disability

The Long Term Disability (LTD) benefit provides you with a monthly income if you are unable to work as a result of an accident or sickness.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

effective date

Your coverage takes effect on the first date of employment.

amount of benefit

Refer to the *Benefits-at-a-Glance*. The benefit is taxable. Your gross monthly benefit will be increased annually, related to the increase in Consumer Price Index. The maximum increase is 5% annually.

"Basic monthly earnings" = Your basic monthly earnings as at the date you become totally disabled. Basic monthly earnings are also called "pre-disability earnings".

qualification period

LTD benefits are payable after you have been totally disabled and unable to perform the duties of your own occupation for the "qualification period" described in the *Benefits-at-a-Glance*. Payments commence 30 days following the completion of the qualification period.

definition of total disability

To qualify for LTD benefits for the first 24 months of disability (excluding the qualification period): You must be unable, because of an accident or sickness, to perform the duties of your own occupation. This is called the "own occupation" period of disability.

To continue to qualify for LTD benefits beyond the "own occupation" period: You must be unable, because of an injury or sickness, to perform the duties of any gainful occupation for which you are reasonably qualified by education, training or experience, and which pays at least 60% of your pre-disability earnings, indexed for inflation. This is called the "any occupation" period of disability.

successive disabilities

During the qualification period: If you attempt to return to work during the qualification period, but within 31 calendar days cease work because of the same disability, you will not be required to start a new qualification period. Instead your qualification period will be extended by the number of days you worked.

After LTD benefits have been paid: If you return to work but within 6 months stop working because of the same disability, or within 24 months after the end of an approved rehabilitation

program, you will not have to re-qualify for benefits. However, if you suffer a different disability during these periods, you will have to re-qualify.

exclusions

LTD benefits will not be paid for disabilities resulting from:

1. Any period of disability when you are not receiving treatment considered appropriate for your condition.
2. Any period of disability when you have not resided in Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period.
3. Any period of disability when you are not under the regular and personal care of a physician approved by Great-West Life.
4. War, insurrection, rebellion, or service in the armed forces of any country.
5. Voluntary participation in a riot or civil commotion, except while you are performing the duties of your regular occupation.
6. Intentionally self-inflicted injuries or illness.

continuation of coverage

Your employer will continue to pay the LTD coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage can continue beyond 20 work days of unpaid leave if you pay the contributions. In that event, your coverage can continue for 12 months (24 months if on educational leave).

If you receive LTD benefits from this Plan, your LTD, Group Life, Dependent Life and AD&D coverage will continue. You may also elect to continue your Dental and Extended Health coverage as outlined in your human resources policies. Such an election must be made at the time your LTD claim is accepted.

termination of coverage

Your LTD coverage terminates on the date you cease to be eligible. You cease to be eligible, for example, when:

- Your employment terminates
- You retire
- You attain age 65 (minus the qualification period)
- You commence an unpaid leave and elect not to pay the contributions (or elect to pay the contributions and then stop paying them)
- You transfer to an ineligible status

claims

LTD claims are processed by Great-West Life in Vancouver.

If you are disabled, have been unable to work, are not receiving WCB wage loss benefits, and do not expect to return to work before the end of the LTD qualification period, contact your employer and obtain an LTD claim package. One form is to be completed by you, one by your employer and

one by your doctor(s). It is important that all sections of the forms are completed, and that copies of specialists' reports, lab tests, x-ray results, etc. are submitted with your claim.

LTD claims are sent to Great-West Life at the address shown on the forms.

Late claims: Claims must be sent to Great-West Life no later than 30 days after the date your benefits would otherwise commence (e.g. the end of your qualification period, or the end of your WCB wage loss claim if later). Late claims may be accepted where it was not reasonably possible to submit the claim on time.

Income tax: LTD benefit payments are taxable if your employer pays any portion of the contributions. If they are taxable, you must submit TD1 forms with your claim. You will receive a T4-A slip from Great-West Life after the end of each calendar year.

Canada Pension Plan disability benefits: If your disability is severe and prolonged, you must also submit a claim to the Canada Pension Plan (CPP) for disability benefits. To obtain a claim form, contact Service Canada. CPP benefits are payable after 4 months of disability and will reduce the amount of your monthly LTD benefit.

Third party claims: If your disability is caused by a third party (e.g. a motor vehicle accident), you must also claim any wage loss benefits that you are entitled to from any third party. Your LTD benefit may be reduced by all or a portion of these wage loss benefits.

other disability income

Your LTD benefit will not be reduced by income from private or individual disability plans.

However, your LTD benefit will be reduced by any other income you receive so that your total gross income from all sources does not exceed 70% of your pre-disability gross earnings. Income includes but is not limited to:

1. Any amounts payable under any Workers' Compensation Act (WorkSafeBC) or law or any other legislation of similar purpose; and
2. Any amounts available from any group insurance or retirement plan of any employer; and
3. Any amount of disability income provided by any compulsory act or law; and
4. Any benefit payment from the Canada or Quebec Pension Plans or other similar social security plan of any country to which you are entitled or to which you would be entitled if your application for such a benefit was approved; and
5. Any no fault auto insurance or similar law providing disability or wage loss benefits; and
6. Any salary (other than earnings from rehabilitative employment) or severance allowance.

If you receive income from a professional association plan, your LTD benefit will be adjusted so your gross income from all sources does not exceed 100% of your indexed pre-disability earnings.

Future increases in the other disability income (e.g. based on Canadian Consumer Price Index or similar indexing arrangements) will not further reduce your LTD benefits.

pension plan

This LTD benefit is an approved disability plan under the Municipal Pension Plan and the Public Service Pension Plan. Therefore, if you are a member of one of these pension plans and are

receiving LTD benefits from this Plan, you will not be required to make contributions to the pension plan. However, you will continue to accrue contributory and pensionable service.

If you are close to retirement age when you become disabled, you may wish to contact your employer and discuss whether it would be to your financial advantage to take early retirement instead of claiming LTD benefits.

rehabilitation

Rehabilitation assistance is an important benefit for ill or injured employees. If you receive LTD benefits, a rehabilitation consultant at Great-West Life is available to assist you.

You must participate in a rehabilitation program that is considered appropriate by your doctor, Great-West Life and the rehabilitation consultant.

Gradual Return to Work
It may be appropriate for you to initially return to your own job or another job at reduced hours or with modified duties. The consultant can help to co-ordinate a safe and gradual return to work plan.

Rehabilitative Employment
If you return to work in approved rehabilitative employment, you can receive all earnings plus your LTD benefit, provided your combined gross income from all sources does not exceed 100% of your indexed pre-disability earnings. When you engage in rehabilitative employment, your LTD benefit will be reduced by 50% of your rehabilitative earnings. If your earnings plus your LTD benefit exceed 100% of your indexed pre-disability earnings, your LTD benefit will be reduced by the excess.

Note: If you receive earnings that are not from approved rehabilitative employment, your LTD benefit will be reduced by 100% of such earnings.

Retraining
If you will be unable to return to your own job and need to retrain, as part of an Approved Rehabilitation plan, financial assistance may be available from Great-West Life to help pay for your tuition and related expenses.

Medical Rehabilitation
If you first require medical rehabilitation (e.g. physical conditioning, pain or stress management) this may be arranged by the rehabilitation consultant and your doctor. Contact your rehabilitation consultant for further information.

duration of benefits

LTD benefits are paid as long as you remain totally disabled but will stop on the date you recover, reach age 65, die, or cease to be eligible whichever occurs first.

appeals

If Great-West Life deny or terminate your claim and if you disagree with their decision, you may appeal and submit further medical information to Great-West Life in support of your claim.

Dental

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

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children under age 30 if in full-time attendance at a school, college or university, that is recognized by Pacific Blue Cross, and if mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and stepchildren, and children for whom you are the legal guardian. Legal proof of guardianship is required. "Mainly dependent" means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you and have not ceased to be dependent.

effective date

Your coverage takes effect on the first date of employment.

Dependents: Coverage for dependents takes effect on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

amount of benefit

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

eligible expenses

This Dental benefit covers those services which are routinely provided to you or your dependents in offices of general practicing dentists in BC.

The services, and the amounts paid for such services, are as set out in the current Pacific Blue Cross Dental Fee Schedule No. 3. When performed by a specialist (on referral by a general practicing dentist), the fee paid is the amount paid to a general practicing dentist, plus up to 10%.

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

Eligible expenses under this Dental benefit are:

Basic Services/Part "A"

Basic Services covers those services required to maintain teeth in good order and to restore teeth to good order.

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

Major Reconstruction Services/Part "B"

Major Reconstruction Services covers those services required for major reconstruction or replacement of deteriorated or missing teeth. A service provided under Part B is eligible for payment only once in any 5 year period. These items will only be replaced if the item cannot be repaired.

1. Major Restorative: Crowns. Rebuilding natural teeth where other basic material cannot be used satisfactorily. Certain materials will not be authorized for use on back teeth. Pre-approval by Pacific Blue Cross is recommended.

2. Prosthetics:
   a. Dentures (removable prosthetics): The artificial replacement of missing teeth with dentures: full upper and lower dentures or partial dentures of basic, standard design and

materials. Full dentures may be obtained from either a dentist or a denturist. Partial dentures may only be obtained from a dentist. Lost, stolen or broken dentures will not be replaced.

b. Crowns and bridges (fixed prosthetics): The artificial replacement of missing teeth with a crown or bridge.

Orthodontic Services/Part "C"

Orthodontic Services covers those services required to straighten abnormally arranged teeth. Pre-approval by Pacific Blue Cross is necessary.

Braces: up to the lifetime maximum specified in the Benefits-at-a-Glance. Costs of lost or stolen braces are not eligible for payment.

pre-approval

It is recommended that, before beginning treatment, your dentist contact Pacific Blue Cross to confirm that:

1. You and your dependents are covered by the Plan.
2. The proposed dental services are Eligible Expenses under this Plan.
3. You or your dependents have not reached the coverage limits (e.g. the lifetime orthodontics maximum; the 5 year limit on a crown or dentures).

If the cost of the treatment is significant, your dentist should also send a treatment plan to Pacific Blue Cross for approval.

exclusions

The Dental benefit does not cover the following:

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

16. Expenses for a dental accident that are paid or payable by your Extended Health benefit.
17. Expenses not specifically covered under the Pacific Blue Cross contract or this booklet.

continuation of coverage

Your employer will continue to pay the Dental coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage can continue beyond 20 work days of unpaid leave if you pay the contributions, or while you are on an LTD claim, you may also elect to continue your Dental coverage as outlined in your human resources policies. Such an election must be made at the time your LTD claim is accepted.

termination of coverage

Your Dental coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

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

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

conversion

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

claims

Dental claims are processed by:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1
(phone 604-419-2300 or 1-888-275-4672)

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

If you or your dependents require dental services, visit the dentist of your choice and take your Pacific Blue Cross ID card. Discuss the services that will be provided, the cost of those services, and any amounts that are not covered by this benefit and that you will be required to pay.

When your dentist has completed the treatment, payment may be obtained by either of the following methods:

1. Your dentist can submit a claim to Pacific Blue Cross on your behalf for amounts up to the levels specified in this Dental benefit. Pacific Blue Cross will then pay accepted claims directly to your dentist. If the services are covered at a level below 100%, you must pay the balance to your dentist, or
2. You can pay the dentist and then submit your own claim to Pacific Blue Cross up to the levels specified in this Dental benefit. Pacific Blue Cross will then pay accepted claims directly to you. For information on how to submit your own claim, contact Pacific Blue Cross.

Claims must be received by Pacific Blue Cross within 12 months of the date of treatment.

Co-ordination of claims: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits, subject to the maximums set out in the Pacific Blue Cross Dental Fee Schedule No. 3, so that the total payments will not exceed the expenses actually incurred.

Treatment outside of BC: If you require dental care elsewhere in Canada and you obtain services from a qualified dentist, you will be reimbursed at the rates in effect in the province where the services were provided. Where services are obtained outside of Canada from a qualified dentist, you will be reimbursed up to the amount that this Plan would have paid had the services been provided in your province of residence. To obtain payment, obtain an itemized statement from the dentist and submit it to Pacific Blue Cross.

Change of dentist: If you find it necessary to change your dentist after you have commenced dental work, advise Pacific Blue Cross and both dentists. Claims will be paid by Pacific Blue Cross where there has been no duplication of services.

Extended Health

The Extended Health benefit reimburses you for many of your medical expenses.

eligibility

If you work 15 regular hours or more per week, and if you are a regular full-time or part-time employee, you are eligible for this benefit as a condition of employment.

Dependents: Eligible dependents are -

1. Husband or wife.
2. Common-law spouse as defined in your Employer's human resources policies.
3. Unmarried children until the end of the month in which they attain age 21 if they are mainly dependent on, and living with, you or your spouse.
4. Unmarried children under age 30 if in full-time attendance at a school, college or university that is recognized by Pacific Blue Cross, and if mainly dependent on you or your spouse.
5. Unmarried physically or mentally handicapped children to any age if they are mainly dependent on, and living with, you or your spouse.

Note: "Children" means your children or your spouse's children, and includes adopted and stepchildren, and children for whom you are the legal guardian. Legal proof of guardianship is required. "Mainly dependent" means the child relies on you or your spouse, principally, for financial support. You must be prepared to prove that persons claimed as dependents are actually dependent upon you and have not ceased to be dependent.

effective date

Your coverage takes effect on the first date of employment.

Dependents: Coverage for dependents takes effect on the later of the date your coverage takes effect or the date they become eligible dependents (e.g. date of birth, marriage). New dependents must be enrolled within 60 days of the date they become eligible. To enroll a dependent, contact your employer.

amount of benefit

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

If your Plan has an annual deductible, and if, in a calendar year, your eligible expenses do not exceed the deductible, your expenses during the last 3 months of that year may be applied against the deductible for the next calendar year.

eligible expenses

This Extended Health benefit covers the following expenses when incurred by you or your dependents as a result of the necessary treatment of an illness or injury. For any items not specifically listed in this booklet, it is recommended you check with Pacific Blue Cross, prior to purchase, to determine the extent of any coverage.

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

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

- **Ambulance:** Cost of an ambulance in an emergency from the place where the sickness or injury occurs to the nearest acute care hospital with adequate facilities to provide the required treatment (including transportation by railroad, boat or airplane, or air-ambulance in an acute emergency). This benefit also covers the round trip fare for one attending person (doctor, nurse, first aid attendant) where necessary.

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

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

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

- **Diabetic supplies and equipment:** Needles, syringes, testing supplies and blood glucose monitors. Insulin infusion pumps when basic methods are not feasible (physician's letter required). Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Eye Exams:** Charges for eye examinations every 2 calendar years when performed by a physician or optometrist for persons aged 19 to 64, up to the amount specified in the *Benefits-at-a-Glance*.

- **Hearing aids:** Cost of purchasing hearing aids when prescribed by a certified Ear, Nose and Throat Specialist or when recommended by an audiologist. The maximum is the amount specified in the *Benefits-at-a-Glance*. This benefit includes repairs, but does not include payment for maintenance, batteries, re-charging devices or other such accessories.

- **Hospital room charges:** Charges for occupying a private or semi-private room in a BC acute care hospital, but not including rental of TV, telephone, etc. Hospital co-insurance charges of the extended care unit of an approved hospital.

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

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

- **Medical equipment:** Rental costs, unless purchase is more economical, of durable medical equipment including hospital beds. Wheelchairs or scooters are eligible expenses only if a physician certifies that these appliances are the sole means of mobility. Electric wheelchairs are covered only when the physician certifies that the patient cannot operate a manual chair. TENS and TEMS when prescribed by a physician. Pre-authorization from Pacific Blue Cross is required for any expenses in excess of $5,000.

- **Medical Referral Transportation:** Where determined by the attending physician and when adequate medical treatment is not available locally (within 100 km radius), transportation by a scheduled public air, rail, or bus service will be covered for the employee or dependent (and, if certified necessary by the attending physician, for an attendant), to and from the nearest locale equipped to provide the required treatment. The referred medical treatment must be performed by a physician. Travel must be completed within 2 months of the date of referral, unless the earliest possible date of availability of the medical specialist is beyond 2 months from the referral date. Reimbursement for transportation will be based on the least expensive available fare. Where transportation by car is a reasonable alternative to public transport, mileage will be paid at the current allowance but limited to the amount that would have been paid for the least expensive form of public transportation. Bus or taxi service to and from the airport to the downtown locale for medical treatment will be allowed. When required, the cost of accommodation will be provided up to a maximum of $60 per night for up to seven nights. Expenses for meals are not included. The maximum lifetime benefit is $10,000 per person.

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

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

- **Out-of-province/out-of-country emergencies:** In the event of an emergency while traveling outside of BC/outside of Canada, the Extended Health benefit covers:
  1. While you or your family are traveling outside your province of residence, benefits are payable for the following eligible expenses incurred in an emergency only and when ordered by the attending physician:
     a. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
     b. The hospital room charge and charges for room, board services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days. If reasonably possible, Pacific Blue Cross should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending physician, to move the patient by licensed ambulance service (by surface or air at the discretion of Pacific Blue Cross) to the hospital nearest the patient's home which is equipped and has space available to

provide further medical treatment. Where transportation would endanger the health of the patient, the 90 day limit may be extended by Pacific Blue Cross.
   c. Services of a physician and laboratory and x-ray services.
   d. Prescription drugs in sufficient quantity to alleviate an acute medical condition.
   e. Other emergency services and/or supplies that Pacific Blue Cross would cover in your province of residence.
2. Worldwide Emergency Medical Assistance (Medi-Assist): In emergencies which occur while you (and your dependents) are traveling, Medi-Assist will coordinate the following services:
   a. Locate the nearest appropriate medical care.
   b. Obtain consultative and advisory services and supervision of medical care by qualified licensed physicians.
   c. Investigate, arrange and coordinate medical evacuations and related transportation needs.
   d. Arrange and coordinate the repatriation of remains.
   e. Replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your dependents may require when in distress.

Your Pacific Blue Cross worldwide emergency Medi-Assist card provides information on how to contact Medi-Assist. Call the nearest Medi-Assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call. Have your Pacific Blue Cross ID number and Medi-Assist group number ready for personal identification as both numbers are required. For further information, refer to Pacific Blue Cross' website at www.pac.bluecross.ca/corp/mediassist/.

Note: Emergencies and non-emergency referrals to other provinces (except Quebec) are covered by MSP, if pre-approved by MSP, as if the expenses had been incurred in BC.

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

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

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

- **Prescription drugs:** Cost of prescription drugs purchased from a licensed pharmacy. This benefit includes oral contraceptives, but does not include contraceptive devices and preventative vaccines. This benefit does not include, vitamin injections, food supplements, lifestyle drugs and medicines as determined by Pacific Blue Cross, erectile dysfunction drugs, fertility drugs, obesity drugs, medications used to treat or replace an addiction or habituation, drugs which can be bought without a prescription (except as noted herein), or drugs not approved under the Food & Drugs Act for sale and distribution in Canada. Reimbursement of eligible drugs and medicines is subject to Pharmacare's Low Cost Alternative and Referenced Based Pricing payment policies.

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

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

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

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

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

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

exclusions

The Extended Health benefit does not cover the following:

1. Charges for benefits, care or services payable by or under MSP, Pharmacare, Hospital Programs, or any public or tax supported agency. This applies in all cases, whether a claim is made or not.
2. Charges for benefits, care or services payable by or under any other authority such as ICBC, travel insurance plans, etc. This applies in all cases, whether a claim is made or not.
3. Charges for a physician except as described in Eligible Expenses for Out-of-Province/Out-of-Country Emergencies.
4. Charges for Dental services except as described in Eligible Expenses for Dentist.
5. Expenses attributed to, or caused by, occupational disabilities which are covered by WorkSafeBC.
6. Charges for services and supplies of an elective (cosmetic) nature.
7. Expenses resulting from war or an act of war, participation in a riot or civil insurrection, or commission of an unlawful act.
8. Expenses resulting from an injury or illness which was intentionally self-inflicted, while sane or insane.
9. Expenses resulting from suicide or attempted suicide.
10. Any portion of a specialist's fee not allowable under MSP due to non-referral, or any amount of fees charged by any practitioner in excess of the recognized fees for such service.
11. Charges for batteries and re-charging devices.
12. Expenses related to the repatriation of a deceased employee and/or dependent.
13. Expenses related to pregnancy when incurred by a pregnant person while travelling outside of Canada within 21 days of the expected delivery date.
14. Expenses incurred while outside your province of residence for pre-existing conditions requiring continuous or routine medical care.

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

continuation of coverage

Your employer will continue to pay the Extended Health coverage while you are: receiving sick pay or WCB wage loss benefits; on maternity, parental or compassionate care leave, or during the first 20 work days of unpaid leave.

Coverage will continue beyond 20 work days of unpaid leave if you pay the contributions, or while you are on an LTD claim, you may also elect to continue your Extended Health coverage as outlined in your human resources policies. Such an election must be made at the time your LTD claim is accepted.

termination of coverage

Your Extended Health coverage terminates at the end of the calendar month in which you cease to be eligible. You cease to be eligible, for example, when:

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

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

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

conversion

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

claims

Extended Health claims are processed by:

Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1
(phone 604-419-2600 or 1-888-275-4672)

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

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

For pharmacies that are not on-line, you must pay for the prescriptions, collect the receipts and submit them manually to Pacific Blue Cross (see next section). You must also submit receipts manually where you have coverage under two different drug plans. As your original receipts will not be returned, make a copy to send to your second carrier.

Other Claims: If you require an item or service which is covered under this Extended Health benefit, visit the supplier of your choice and discuss the cost. Pay the supplier and obtain a receipt. The receipt should identify the date, item/service purchased, name and address of the supplier, price paid, quantity (where applicable) and the name of the person receiving the item/service (i.e. you or your dependent).

Hold all your receipts until they exceed the annual deductible (if applicable). Then obtain a Pacific Blue Cross Extended Health Care Claim Form from your employer or from CARESnet. Complete your claim by carefully following the instructions on the form. Send your completed claim form and original receipts to Pacific Blue Cross at the address shown on the form. Keep a copy of the receipts for your records, as Pacific Blue Cross will not return the originals.

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

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

Co-ordination of claims: If you are eligible for coverage under more than one plan, Pacific Blue Cross will co-ordinate the benefits so that the total payments will not exceed the expenses actually incurred.

Out-of-country medical expenses: Send your claim directly to Pacific Blue Cross instead of to MSP. Claims must be submitted to Pacific Blue Cross within 60 days of the date the expenses were incurred.

Benefits Checklist

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

- Keep this booklet as a reference.
- Discuss your benefits with your family.
- During the year, save your receipts for expenses covered under the Extended Health benefit. Send your Extended Health claims to Pacific Blue Cross periodically. Claims must be received by Pacific Blue Cross no later than June 30th of the following year.
- Review your beneficiary designation periodically for Group Life and AD&D to make sure it is still appropriate. Contact your employer to review your most recent Appointment/Change of Beneficiary form.
- Advise your employer if you become eligible for Dependent Life coverage.

For more information, contact your employer.

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