ATTENTION:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA

This policy has been amended effective:

1. January 1, 2023 as follows:

Provisions Modified	**Pages**
TABLE OF BENEFITS	A-TB 1, 2
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COVERAGE PROVISIONS	
• Eligibility Conditions	B 4
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• Prescription Drugs	C-HC 11
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2. February 22, 2023 as follows:

Provision Modified	**Page**
Schedule of Participating Employers	A-SCL 1

3. April 1, 2023 as follows:

Provision Modified	**Page**
Schedule of Participating Employers	A-SCL 1

April 27, 2023

PLAN DOCUMENT

PLAN NAME:	**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA**
PLAN NO.:	**50088-3**
PLAN EFFECTIVE DATE:	**January 1, 2021**
- Version effective date:	April 1, 2023
BENEFITS PROVIDED:	**Health and Dental Benefits**

This is not a contract of insurance and is not protected by Assuris.

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BENEFIT PROVISIONS

CLAIM PROVISIONS

GENERAL PROVISIONS

TRANSFER PROVISIONS

TABLE OF BENEFITS

This table must be read in conjunction with the rest of this plan.

PLAN MEMBER AND DEPENDENT BENEFITS

HEALTHCARE EXPENSE BENEFITS

ELIGIBLE CLASSES:* All plan members with the Traditional Plan

CALENDAR YEAR DEDUCTIBLE:

- plan members of class 777	none
- plan members of class 10:	
• for hearing aids, needleless insulin jet injectors, glasses, contacts and laser eye surgery expenses	none
• for all other expenses:	
o individual	$55
o family	$55
- all other plan members:	
• for hearing aids, needleless insulin jet injectors, glasses, contacts and laser eye surgery expenses	none
• for all other expenses:	
o individual	$100
o family	$100

REIMBURSEMENT LEVEL:

- plan members of class 777	100%
- plan members of class 10:	
• for out-of-country emergency care, hearing aids, the dispensing fee portion of the drug charge, needleless insulin jet injectors and glasses, contacts and laser eye surgery expenses	100%
• for all other expenses	80% until $1,000 in benefits has been paid in a calendar year and 100% for the remainder of the calendar year
- all other plan members:	
• for out-of-country emergency care, hearing aids, the dispensing fee portion of the drug charge, needleless insulin jet injectors and glasses, contacts and laser eye surgery expenses	100%
• for all other expenses	80% until $2,000 in benefits has been paid in a calendar year and 100% for the remainder of the calendar year

LIFETIME MAXIMUM:

- plan members of class 777	none
- plan members of class 10	$500,000, for all benefits except out-of-country business travel
- all other plan members	$3,000,000

* Plan members of class 777 are eligible for out-of-country emergency care benefits only.

DENTALCARE EXPENSE BENEFITS

ELIGIBLE CLASSES:	All plan members with the Traditional Plan, except plan members of class 777
DENTAL FEE GUIDE:	
- for treatment rendered in British Columbia	the British Columbia dental fee guide in effect on the date treatment is rendered
- for treatment rendered in all other provinces	the dental fee guide in effect in the plan member's province of residence on the date treatment is rendered
- for treatment rendered outside of Canada:	
• residents of British Columbia	the British Columbia dental fee guide in effect on the date treatment is rendered
• residents of all other provinces	the dental fee guide in effect in the plan member's province of residence on the date treatment is rendered
CALENDAR YEAR DEDUCTIBLE:	none
REIMBURSEMENT LEVEL:	
- for basic coverage	100%
- for major coverage	65%
- for orthodontic coverage	55%
BENEFIT MAXIMUMS:	
- for orthodontics	$3,500 lifetime
- for all other expenses	none

Schedule of Participating Employers

BRITISH COLUMBIA ENERGY REGULATOR
BRITISH COLUMBIA EXCLUDED EMPLOYEES' ASSOCIATION
BRITISH COLUMBIA FERRY SERVICES INC.
BRITISH COLUMBIA INFRASTRUCTURE BENEFITS INC.
BRITISH COLUMBIA INVESTMENT MANAGEMENT CORPORATION
BRITISH COLUMBIA SECURITIES COMMISSION
BRITISH COLUMBIA TREATY COMMISSION
BRITISH COLUMBIA UTILITIES COMMISSION
BUSINESS PRACTICES & CONSUMER PROTECTION AUTHORITY
COMMUNITY LIVING BRITISH COLUMBIA
CONSTITUENCY ASSISTANTS
FIRST PEOPLE'S HERITAGE, LANGUAGE, AND CULTURAL COUNCIL
FRESHWATER FISHERIES SOCIETY
HABITAT CONSERVATION TRUST
INBC INVESTMENT CORP.
INFRASTRUCTURE BRITISH COLUMBIA INC.
INNOVATE BC
KING'S PRINTER (UNIFOR)
LEGISLATIVE ASSEMBLY
LEGISLATIVE ASSEMBLY/MEMBERS OF (MLA'S)
LIQUOR DISTRIBUTION BRANCH
NEW DEMOCRATIC PARTY (NDP) CAUCUS
PROFESSIONAL EMPLOYEES' ASSOCIATION
PROVINCE OF BRITISH COLUMBIA
PUBLIC SERVICE PENSION BOARD OF TRUSTEES
TRANSPORTATION INVESTMENT CORPORATION

Schedule of Eligible Classes

Class	Description
1	Public Service - British Columbia Government and Service Employees' Union (BCGEU) plan members
2	Public Service - Professional Employees’ Association (PEA) plan members
3	Public Service - Nurses plan members
5	Public Service - Exempt Traditional plan members
7	King's Printer (UNIFOR) plan members
8	Participating Employers with HSA
9	Participating Employers plan members
10	British Columbia Ferry Services Inc. active plan members
13	British Columbia Ferry Services Inc. plan members on long term disability
21	Legislative Assembly (LEG) and Caucus plan members
777	Wildfire firefighter (L status) plan members

COVERAGE PROVISIONS

EMPLOYER

Employer means the employer of a group of persons who has been designated as an employer by Order of the Lieutenant-Governor in Council and whose name is listed in the Schedule of Participating Employers.

PLAN ADMINISTRATOR

Plan administrator means the organization appointed by the employer to administer the plan.

COVERAGE CLAUSE

To become covered under this plan a person must:

1. either be:
   (a) a member of the Legislative Assembly of the Province of British Columbia; or
   (b) employed by an employer;
2. be a qualified plan member;
3. be in an eligible class;
4. satisfy the eligibility conditions; and
5. satisfy the effective date of coverage provisions.

QUALIFIED PLAN MEMBER

A member of the Legislative Assembly of the Province of British Columbia qualifies for coverage during the period he is a member.

Any other plan member qualifies for coverage if he meets the following conditions:

1. he is a plan member of an employer listed in the Schedule of Participating Employers;

2. he is either covered under a bargaining agreement or is an excluded plan member; and

   (a) if he is a “M Status” auxiliary included and excluded plan member who has completed 1827 hours worked at the straight time rate within 33 pay periods. An exception to this rule is plan members in the Professional Employees’ Association (PEA) who must complete 1827 hours worked at the straight time rate within a 15 month period. These PEA plan members are also designated as "Group A" (Article 35.10).
   (b) if he is a ”K status” British Columbia Government and Service Employees' Union (BCGEU) auxiliary plan member who has worked 3 consecutive years without loss of seniority and maintains 1200 hours worked at the straight time rate within the previous 26 pay periods.

(c) if he is a “K5 status” wildfire service, park ranger or avalanche crew seasonal auxiliary plan member under the new MOA, after commencing the second consecutive year of employment with British Columbia Wildfire Service, Ministry of Environment or Ministry of Transportation and Infrastructure respectively without loss of seniority, and maintains 500 hours worked at the straight time rate within the previous 26 pay periods.

(d) if he is a British Columbia Ferry Services Inc. casual plan member, he has completed 913 hours of work.

3. he is any other plan member who is employed on a full-time or part-time and permanent and non-seasonal basis.

A plan member who is working for the employer both as a full-time plan member and at another place of business as a part-time plan member will be covered for benefits as a full-time plan member, not as a part-time plan member.

ELIGIBILITY CONDITIONS

A plan member is eligible:

1. on the first day of the month coinciding with or next following the date he completes 6 months of continuous employment as a qualified plan member, if he is hired as a regular plan member of British Columbia Ferry Services Inc. If an auxiliary plan member transfers to regular plan member status, he is eligible on the earlier of the date he would have been eligible had he remained in an auxiliary position, or after the waiting period indicated above;

2. on the first day of the month coinciding with or next following the date he completes 3 months of continuous employment as a qualified plan member, if he is hired as a regular plan member of King's Printer (Unifor) or any other regular plan member. If an auxiliary plan member transfers to regular plan member status, he is eligible on the earlier of the date he would have been eligible had he remained in an auxiliary position, or after the waiting period indicated above;

3. if he is a wildfire firefighter (L status) plan member for out-of-country emergency care coverage only, or if he is a plan member of British Columbia Investment Management Corporation, on the date his employment as a qualified plan member begins;

4. after he has worked 1827 hours in 33 pay periods, if he is hired as an auxiliary plan member. If a regular plan member transfers to auxiliary plan member status, he is eligible on the first day of the month coinciding with or next following the date on which he completes 1827 hours worked in 33 pay periods, commencing on the date of transfer, or 1200 hours worked at the straight time rate in the last 26 pay periods, where he has worked 3 consecutive years as an auxiliary without loss of seniority;

5. on the first day of the month coinciding with or next following the date he has worked 3 consecutive years on an auxiliary basis without loss of seniority and 1200 hours worked at straight time rate within the previous 26 pay periods, if he is hired as a "K" status auxiliary plan member;

6. on the first day of the month after commencing the second consecutive year of employment, without loss of seniority and maintaining 500 hours at the straight time rate within the previous 26 pay periods, if he is employed with Wildfire Management Branch, Ministry of Forests and Range, or British Columbia Wildfire Service in the Ministry of Forests, Lands, Natural Resource Operations and Rural Development, or as a park ranger in the Ministry of Environment, or as an avalanche crew plan member in the Ministry of Transportation and Infrastructure, and is a seasonal auxiliary plan member of British Columbia Government and Service Employees' Union (BCGEU);

7. if he is a plan member of British Columbia Excluded Employees' Association, British Columbia Infrastructure Benefits Inc., British Columbia Securities Commission, British Columbia Utilities Commission, Habitat Conservation Trust, Legislative Assembly (MLAs, Caucus), Constituency Assistants or Transportation Investment Corporation, Innovate BC, or Public Service Pension Board of Trustees, on the first day of the month coinciding with or next following the date his employment as a qualified plan member begins.

8. if he is a casual plan member of British Columbia Ferry Services Inc., on the first day of the month coinciding with or next following the date on which he completes 913 hours.

- continuous employment — A plan member is considered continuously employed only if he satisfies the actively at work requirement throughout the eligibility waiting period.

- eligibility limitation — A plan member is only eligible for the benefits provided for his class in the Table of Benefits.

DEPENDENT COVERAGE

A plan member is eligible to cover his dependents on the later of:

1. the date the plan member becomes eligible; and
2. the date the plan member acquires his first qualified dependent.

The effective date of coverage section determines when the coverage for a dependent actually starts.

QUALIFIED DEPENDENTS

A qualified dependent is a qualified spouse or a qualified child.

A person will not be considered a qualified dependent if he is covered under this plan as a plan member.

QUALIFIED SPOUSE

A spouse qualifies if that person is the plan member 's legal spouse or common-law spouse.

A plan member can only cover one spouse at a time. He must cover the same person for all spouse benefits provided under the employer's benefit program.

Where the plan member has more than one qualified spouse, the covered spouse is considered to be the one for whom he first submits a claim for any benefit provided under the employer's benefit program.

- legal spouse

A legal spouse means the person who is living with the plan member and lawfully married to the plan member according to applicable provincial legislation.

- common-law spouse

A common-law spouse means a person who is living with the plan member in a common-law relationship. A common-law relationship is considered to exist where two persons have lived together in a conjugal relationship for at least 12 months, or the plan member has signed an affidavit or declaration that they are living in a common-law relationship. This period is waived if the plan member has claimed the common-law spouse's child or children for income tax purposes.

- change in spouse

The plan member can change from one covered spouse to another by submitting a claim for a different spouse for any benefit provided under the employer's benefit program. The change will take effect on the later of:

1. the date of the loss claimed for the new spouse; and
2. the day after the date of the last loss claimed for the previous spouse.

A change from a common-law spouse to a legal spouse is valid only when the legal spouse is living with the plan member.

A change from one common-law spouse to another will not be effective until 12 months after the plan member has provided notice to the employer to cancel the coverage for the previous common-law spouse.

QUALIFIED CHILD

A child qualifies if he is:

1. an unmarried natural, adopted, or step child of the plan member or the covered spouse; or
2. any other unmarried child for whom the plan member or the covered spouse has been appointed guardian for all purposes by a court of competent jurisdiction.

- for plan members of class 10 and class 13

A child under age 21 must not be working more than 30 hours a week, unless he is a full-time student.

A child age 21 or over must either be:

1. a full-time student under age 25; or
2. incapacitated for a continuous period beginning:

   (a) before age 21; or
   (b) while a full-time student and before age 25.

- for all other plan members

A child under age 19 must not be working more than 30 hours a week, unless he is a full-time student.

A child age 19 or over must either be:

1. a full-time student under age 25; or
2. incapacitated for a continuous period beginning:

   (a) before age 19; or
   (b) while a full-time student and before age 25.

A child of the covered spouse does not qualify unless:

1. he is also the plan member's child; or
2. the spouse is living with the plan member and has custody of the child.

A child for whom the plan member or the covered spouse has been appointed guardian does not qualify unless:

1. the plan administrator has received satisfactory proof of guardianship; and
2. if the covered spouse is the guardian, the spouse is living with the plan member.

- student

A child is considered a full-time student if he has been in registered attendance at an elementary school, high school, university, or similar educational institution for 15 hours a week or more sometime in the last 6 months.

A child is not considered a full-time student if he is being paid to attend an educational institution, unless it is a co-op work program.

- incapacity

A child is considered incapacitated if he is incapable of supporting himself due to a physical or mental disorder.

EFFECTIVE DATE OF COVERAGE

Coverage takes effect on the date the plan member becomes eligible, subject to the actively at work requirement.

Changes in Coverage

Changes in coverage take effect as they occur, except that:

1. all increases and new benefits are subject to the actively at work requirement.

2. increases and new benefits for a dependent confined in hospital on the date a change would otherwise take effect will not take effect until his release from hospital.

Actively at Work Requirement

To satisfy this requirement, a plan member must:

1. be fully capable of performing his regular duties; and

2. be either:

   (a) actually working at the employer's place of business or a place where the employer's business requires him to work; or
   (b) absent due to vacation, weekends, statutory holidays, or shift variances.

TERMINATION OF COVERAGE

The following provisions describe when coverage terminates.

Plan Member Coverage

Coverage for a plan member terminates on the earliest of the following dates:

1. the date this plan terminates;

2. the date the employer ceases to be a participating employer under this plan;

3. the date he ceases to be in an eligible class;

4. (a) for a K status auxiliary plan member, the last day of the month in which he fails to maintain 1200 hours worked at the straight time rate within the previous 12 month period, (or 500 hours for seasonal auxiliary plan members working as wildfire firefighters, park rangers or avalanche crew), or he loses seniority;
   (b) for a regular plan member who transfers to auxiliary plan member status or a British Columbia Ferry Services Inc. plan member, the last day of the month in which he ceases to be a qualified plan member; or
   (c) for any other plan member, the date he ceases to be a qualified plan member.

5. the date he ceases to satisfy the actively at work requirement. If he is not at work because of disease or injury, temporary lay-off, or leave of absence, this date will be extended to the earliest of:

   (a) the date the employer determines that coverage has terminated. This date must be determined on the same basis for all plan members in like circumstances.

   (b) the date he starts to work in another job more than 20 hours per week.

- for disease or injury

   (c) for a disabling disease or injury, the end of the disability period. No extension will be considered for a non-disabling disease or injury.

   A plan member is considered disabled under this provision during the period he is prevented by disease or injury from performing the regular duties of his job.

- for lay-off

   (d) for temporary lay-off:

      (A) for a wildfire firefighter, park ranger or avalanche crew plan member, the last day of the month following the month in which the lay-off starts; and
      (B) for any other plan member, the last day of the month in which the lay-off starts.

   If the employer is required by law to provide coverage beyond these dates, the termination date is further extended to the end of the period required by law.

- for a leave of absence other than maternity or parental leave, or suspension of employment with or without pay, for a period of less than 1 calendar month	(e) where there is no intent to terminate for a period of less than 1 calendar month, until the earlier of the date he starts to work in another job, or the date of termination as determined by the employer, plus any further period the employer is required by law to extend coverage.
- for a leave of absence other than maternity or parental leave, for a period of more than 1 calendar month	(f) until the earlier of the date he starts to work in another job, the date of termination as determined by the employer, 12 months after the leave starts if it is under the deferred salary leave program, or 24 months after the leave starts for any other leave, plus any further period the employer is required by law to extend coverage.
- for maternity or parental leave	(g) for maternity or parental leave, the end of the leave.

Coverage for a Plan Member's Dependents

Coverage for a plan member's dependents terminates on the earliest of the following dates:

1. the date the coverage for the plan member terminates;
2. the date the plan member ceases to be in a class eligible for dependent coverage;
3. the date the dependent ceases to be a qualified dependent; or
4. for a spouse, the day before the effective date of a change to a new covered spouse.

EXTENDED BENEFITS FOR DISABILITY

- healthcare

Healthcare benefits, except for in-Canada prescription drugs, are extended for a plan member and his covered dependents if the plan member is disabled when his coverage terminates. If the plan member is not disabled when coverage for a dependent terminates, hospital and nursing care benefits are still extended for the dependent as long as he is hospital confined or receiving nursing care when the coverage terminates.

No benefits are payable for in-Canada prescription drug expenses incurred after termination of coverage.

- other benefits

There is no extension of dentalcare benefits after termination of coverage except as provided under the accidental injury provision.

Disability

A plan member is considered disabled if disease or injury prevents him from performing the regular duties of his job.

Duration

Healthcare benefits are extended to the earliest of:

1. the date the disability ends, or, where hospital and nursing care benefits are being extended for a dependent of a non-disabled plan member, the date the confinement ends or the services of a professional nurse are no longer required;
2. 6 months after the coverage terminates; or
3. the date the plan member or dependent becomes eligible for coverage under another group plan.

Benefit Limitation

Extended benefits are limited to those that would have been payable if the coverage were still in force.

EXTENDED BENEFITS FOR ACCIDENTAL INJURY

Healthcare benefits for dental accident treatment are extended for a plan member and his covered dependents after termination of coverage only when termination occurs as a result of termination of this plan. Benefits are limited to those that would have been payable for treatment of accidental injury to natural teeth or prosthetics if the coverage were still in force. No benefits are payable for treatment resulting from an accident occurring after termination of coverage.

SURVIVOR BENEFITS

If a plan member dies while his dependents are covered under this plan, their coverage will continue to the earlier of:

1. the date they cease to be qualified dependents; or
2. the last day of the month following the month in which the plan member died.

If a plan member's child is born after the plan member's death, the child is considered a qualified dependent.

Payment

Survivor benefits are paid to the surviving spouse. If there is no surviving spouse, benefits are paid as follows:

1. for a child who has reached the age of majority, to him; and
2. for a minor child, to his legal guardian.

Extended Benefits

This plan's extended benefits provisions also apply to coverage terminating under this survivor benefit.

REINSTATEMENT OF COVERAGE

Coverage will be automatically reinstated if:

1. it terminated because of leave of absence; and the plan member returns to work within 24 months after it terminated, or within any period during which the employer is required by law to reinstate the coverage.

2. it terminated because of temporary lay-off; and the plan member returns to work within 6 months after it terminated, or within any period during which the employer is required by law to reinstate the coverage.

3. it terminated because of any other break in service and the plan member returns to work within 90 days after it terminated, and did not withdraw public service pension plan contributions, or within any period during which the employer is required by law to reinstate the coverage.

If a plan member does not qualify for automatic reinstatement, he will be treated as a new plan member.

ASSESSMENT STANDARD

All services and supplies, including but not limited to drugs and drug supplies, covered under this benefit provision must represent reasonable treatment of disease or injury.

A disease is a physical or psychiatric disorder.

Reasonable Treatment

Treatment is considered reasonable if it is:

1. accepted by the Canadian medical profession;

2. proven to be effective; and

3. of a form, intensity, frequency, and duration essential to diagnosis or management of the disease or injury.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the plan administrator maintains a limited list of services and supplies that require prior authorization.

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, a person may be required to provide medical evidence to the plan administrator why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Health case management is a program recommended or approved by the plan administrator that may include but is not limited to:

1. consultation with the person and his attending physician to gain understanding of the treatment plan recommended by the attending physician;
2. comparison with the person's attending physician of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
3. identification to the person's attending physician of opportunities for education and support; and
4. monitoring the person's adherence to the treatment plan recommended by his attending physician.

In determining whether to implement health case management, the plan administrator may assess such factors as the service or supply, the person's medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

- limitation

The payment of benefits for a service or supply may be limited, on such terms as the plan administrator determines, where:

1. the plan administrator has implemented health case management and the person does not participate or cooperate; or
2. the person has not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where the plan administrator has recommended or approved health case management, the plan administrator can require that the service or supply be purchased from or administered by a provider designated by the plan administrator, and:

1. the covered expense for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be limited to the cost of the service or supply had it been purchased from or administered by the provider designated by the plan administrator; or
2. a claim for a service or supply that was not purchased from or administered by a provider designated by the plan administrator may be declined.

Patient Assistance Program

A patient assistance program means a program that provides assistance to persons with respect to the purchase of services or supplies.

A person may be required to apply to and participate in any patient assistance program to which the person may be entitled. Further, the covered expense for a service or supply may be reduced by an amount up to the amount of financial assistance the person is entitled to receive for that service or supply under a patient assistance program.

AMBULANCE SERVICES

Ambulance services, including air ambulance services, are covered if they are provided by a licensed ambulance company.

Transportation must be to the nearest centre where essential treatment is available.

- alternative benefit

If transportation is to a further centre, the plan provides alternative benefits based on coverage for transportation to the nearest centre where essential treatment is available.

HOSPITAL CARE

Hospital confinement is covered if:

1. it starts while the person is covered under this benefit provision; and
2. it represents acute care.

- acute care

Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

Hospital Care

The plan covers preferred accommodation in a hospital when provided in Canada.

For hospital accommodation, the plan covers the difference between the hospital's private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered.

The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person's home province.

Benefits for hospital services outside Canada are payable only as provided under the out-of-country care provision.

- hospital

A hospital is an institution that:

1. is legally termed a hospital;
2. is open at all times;
3. offers in-patient accommodation;
4. has a staff of one or more physicians available at all times; and
5. continuously provides 24-hour nursing by registered nurses.

Limitation

No benefits will be paid for hospital care for conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered chronic care.

OUT-OF-COUNTRY CARE

Coverage is provided for the out-of-country care described below.

Emergency Care

- for plan members of class 777

Emergency care outside Canada is covered if:

1. it is required as a result of a medical emergency arising while the plan member is outside Canada for business; and
2. the plan member satisfies the actively at work requirement; and
3. the plan member is covered by the government health plan in his home province or the government coverage replacement plan sponsored by the employer.

Business travel starts when the plan member leaves his residence or usual place of employment for the purpose of business travel, whichever occurs last, and continues until the plan member returns to his residence or usual place of employment, whichever occurs first. It does not include vacation or leave taken prior to, during or after a business trip. Any extra distance travelled or time spent on personal matters over and above what is reasonable and necessary for the completion of business travel is not covered under business travel coverage.

- for all other plan members

Emergency care outside Canada is covered if:

1. it is required as a result of a medical emergency arising while the person is temporarily outside Canada for vacation, business, or education; and
2. the person is covered by the government health plan in his home province or the government coverage replacement plan sponsored by the employer.

- medical emergency

A medical emergency is either:

1. a sudden, unexpected injury; or
2. a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the person's prior medical condition.

- emergency care

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

- covered medical treatment

The plan covers the following services and supplies when related to the initial medical treatment:

1. treatment by a physician.
2. diagnostic x-ray and laboratory services.
3. hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while the person is covered under this benefit provision.
4. medical supplies provided during a covered hospital confinement.
5. paramedical services provided during a covered hospital confinement.
6. hospital out-patient services and supplies.
7. medical supplies provided out-of-hospital if they would have been covered in Canada.
8. drugs.
9. out-of-hospital services of a professional nurse.
10. ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available. Alternative benefits are available on the same basis as they are for ambulance services provided in Canada.
11. dental accident treatment if it would have been covered in Canada.

- benefit limitations

Benefits for emergency care while the plan member is outside Canada are:

1. for a plan member of class 777, benefits for business are limited to a maximum of $3,000,000 in a person's lifetime. He is not eligible for benefits for vacation or education.

2. for a plan member of class 10, benefits for business are limited to a maximum of $3,000,000 in a person's lifetime. Benefits for vacation or education are included in the healthcare lifetime maximum.

3. for any other plan member, benefits for business, vacation or education are included in the healthcare lifetime maximum.

Based on the medical information made available, if the plan administrator determines that the person's condition permits a return to Canada, benefits are limited to the lesser of:

1. the amount payable under this plan for continued treatment outside Canada; and
2. the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

No benefits will be paid for:

1. expenses incurred due to treatment related to complications to therapeutic abortion;
2. expenses related to pregnancy and delivery, including infant care:
   (a) after the 34th week of pregnancy; or
   (b) at any time during the pregnancy if the person's medical history indicates a higher than normal risk of an early delivery or complications.

Non-emergency Care

Non-emergency care outside Canada is covered if the person is covered for a portion of the cost by the government health plan in his home province or the government coverage replacement plan sponsored by the employer.

The plan covers the following services and supplies when related to covered out-of-country non-emergency care, if benefits would have been paid for the same services and supplies had they been incurred in Canada:

1. ambulance services.
2. drugs.
3. medical supplies.
4. paramedical services.
5. visioncare.
6. dental accident treatment.

Benefits for non-emergency care are subject to the deductibles, maximums, reimbursement levels and limitations identified for the applicable in-Canada healthcare benefits.

- eligibility restriction

Plan members of class 777 are not eligible for out-of-country non-emergency care benefits.

PRESCRIPTION DRUGS

The following drugs and drug supplies are covered when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies outside Canada are payable only as provided under the out-of-country care provision.

- drugs requiring a prescription by law

1. drugs that require a prescription according to:

   (a) the Food and Drugs Act, Canada; or
   (b) provincial legislation in effect where the drug is dispensed.

   Contraceptive drugs and products containing a contraceptive drug are covered.

- injected drugs

2. drugs that must be injected, including vitamins, insulins, and allergy extracts. Syringes for self-administered injections are also covered. Vitamin B12 is covered for treatment of pernicious anemia only. Sclerosing agents are not covered.

- diabetic supplies

3. The following diabetic supplies are covered:

   (a) disposable needles for use with non-disposable insulin injection devices.
   (b) lancets.
   (c) test strips.
   (d) infusion pump supplies, including resevoirs and cartridges.
   (e) insulin infusion sets.
   (f) Dexcom G6 continuous glucose monitoring machines, including sensors and transmitters for a plan member of class 1, class 2, class 3, class 5, class 7, class 8, class 9, class 13 or class 21.

- extemporaneous preparations

4. extemporaneous preparations or compounds if one of the ingredients is a covered drug.

- prescribed drugs

5. drugs that do not require a prescription by law if:

   (a) they are listed in the current Compendium of Pharmaceuticals and Specialties; and
   (b) they are categorized as:

   Antimalarials
   Fibrinolytics
   Nitroglycerin
   Potassium replacements
   Single entity fluorides
   Single entity iron salts
   Thyroid agents
   Topical enzymatic debriding agents

- exceptions

The following non-prescription items are not covered:

(a) atomizers, appliances, prosthetic devices, or colostomy supplies.
(b) first aid or diagnostic supplies or testing equipment.
(c) non-disposable insulin delivery devices or spring loaded devices used to hold blood letting supplies.
(d) delivery or extension devices for inhaled medications.
(e) oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas, or injectable total parenteral nutrition solutions, whether or not prescribed for a medical reason, except where federal or provincial law requires a prescription for their sale.
(f) diaphragms, condoms, contraceptive jellies, foams, sponges, or suppositories, contraceptive implants, or appliances normally used for contraception, whether or not prescribed for a medical reason.

Government Drug Plans

Covered expenses for drugs eligible under any government drug plan are limited to any amounts the plan member is required to pay for himself or his family under the government plan.

Benefit Maximum for Smoking Cessation Products

Smoking cessation products are covered if the person registers with the Ministry of Health for the Quittin Time program every 6 months. The maximum amount payable for smoking cessation products is $300 in a calendar year, up to $1,000 in a person's lifetime.

Limitations

No benefits will be paid for:

1. any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada.
2. any single purchase of a drug that would not reasonably be consumed or used within 100 days.
3. drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.
4. non-injectable allergy extracts.
5. drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.
6. preventative immunization vaccines and toxoids.
7. drugs used to treat erectile dysfunction.

MEDICAL SUPPLIES

The following medical supplies are covered when prescribed by a physician or nurse practitioner. For supplies available on a rental basis, the plan covers either the rental cost or, at the employer's discretion, the cost of purchase.

Breathing Equipment

The following breathing equipment is covered:

1. oxygen and the equipment needed for its administration.
2. intermittent positive pressure breathing machines.
3. continuous positive airway pressure machines (CPAP), including initial filters and supplies, excluding masks.
4. automatic positive airway pressure machines (APAP), including initial filters and supplies, excluding masks.
5. positive airway pressure machines (BIPAP and VPAP), including initial filters and supplies, excluding masks
6. mandibular positioning devices.
7. initial and replacement masks for continuous positive airway pressure machines (CPAP), automatic positive airway pressure machines (APAP) and positive airway pressure machines (BIPAP and VPAP).
8. replacement filters for continuous positive airway pressure machines (CPAP), automatic positive airway pressure machines (APAP), positive airway pressure machines (BIPAP and VPAP).
9. apnea monitors for respiratory dysrhythmias.
10. mist tents and nebulizers.
11. chest percussors, drainage boards, and sputum stands.
12. suction pumps.
13. tracheostoma tubes.
14. respirators.

- benefit maximums

For the rental or purchase of equipment needed for oxygen administration, the maximum amount payable is:

1. portable liquid oxygen systems, $4,000 every 3 years.
2. oxygen concentrators:
   (a) for 5L, $2,500 in a calendar year;
   (b) for 8L, $3,650 in a calendar year;
   (c) for 10L, $4,500 in a calendar year; or
   (d) or a portable oxygen concentrator, $5,500 in a calendar year.

For all positive airway pressure machines and mandibular positioning devices, limited to one device every 5 years combined. The following maximums also apply:

1. continuous positive airway pressure machines (CPAP) and automatic positive airway pressure machines (APAP) are limited to a combined maximum of $2,300.
2. mandibular positioning devices are limited to a maximum of $2,650.

Orthopedic Equipment

The following orthopedic equipment is covered:

1. braces, limited to one per calendar year for each limb. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not covered.
2. custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician, podiatrist, chiropractor or nurse practitioner. Orthotics can also be prescribed by a physiotherapist. The maximum amount payable is $400 in a calendar year.
3. casts.

4. cervical collars, supports, belts, trusses, corsets and splints, including shoes attached to a splint. Intra-oral splints are not covered. The combined maximum amount payable is $500 in a calendar year.
5. external electrospinal stimulators for the correction of scoliosis.
6. non-union bone stimulators.
7. prone standers.

Prosthetic Equipment

The following prosthetic equipment is covered:

1. artificial eyes, including rebuilding and polishing of artificial eyes.
2. standard artificial limbs, including repairs, shoulder harnesses and stump socks. Stump socks are limited to $200 in a calendar year.
3. myoelectric limbs, including repairs.
4. cleft palate obturators.
5. external breast prosthesis and surgical brassieres. The maximum amount payable for all equipment combined is $1,000 in a year.

- repairs and adjustments

Repairs and adjustments to prosthetic equipment are included and are not subject to the benefit maximum.

- benefit maximum

The combined maximum amount payable for artificial eyes, standard and myoelectric artificial limbs is one unit in a calendar year and up to $1,750 in a calendar year per family.

- alternative benefit

If internal breast prostheses are provided, the plan provides alternative benefits based on coverage for external breast prostheses.

Mobility Aids

The following mobility aids are covered:

1. canes, limited to $150 every 2 years.
2. walkers, limited to $700 every 5 years. Walker accessories are covered and limited to $450 every 2 years.
3. crutches, limited to $300 every 2 years.
4. parapodiums.
5. mechanical or hydraulic patient lifters once every 5 years. The maximum amount payable is $2,000 for each lifter.
6. rechargeable batteries for covered wheelchairs.
7. outdoor wheelchair ramps once in a person's lifetime. The maximum amount payable is $2,000.
8. manual wheelchairs, including repairs, limited to once every 3 years. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.
9. electric wheelchairs, where the condition warrants one, limited to once every 5 years.
10. scooters, limited to $7,000 every 5 years.

- benefit maximum

The combined maximum amount payable for rental of manual or electric wheelchairs and scooters is $250 in a calendar year.

- alternative benefits

If power-assisted patient lifters are provided, the plan provides alternative benefits based on coverage for mechanical or hydraulic patient lifters.

Communication Aids

The plan covers hearing aids when prescibed by a physician or audiologist, including batteries, tubing, and ear molds provided at the time the hearing aid is purchased. The maximum amount payable is $1,500 for each ear every 2 years for a dependent child, and $1,500 for each ear every 4 years for any other person. Speech processors and headsets are also covered once every 5 calendar years, when prescribed for profound deafness.

Diabetic Supplies

The following diabetic supplies are covered:

1. Novolin-Pens, or similar insulin injection devices using a needle.
2. blood letting devices, including platforms but not lancets. Lancets are covered under the prescription drugs provision.
3. blood-glucose monitoring machines.
4. external insulin infusion pumps, once every 5 years.
5. needleless insulin jet injectors. The maximum amount payable is $500 every 5 years.

Other Medical Supplies

The following other medical supplies are covered:

1. hospital beds, limited to $1,885 every 10 years for combined rental or purchase. Repairs and accessories are included, but are not subject to the maximum. Air-fluidized hospital beds are not covered. Bed rails, trapeze bars, head halters, and traction apparatus are covered.
2. colostomy and ileostomy supplies.
3. catheters and catheterization supplies.
4. custom-made pressure supports for lymphedema.
5. extremity pumps for lymphedema or severe postphlebitic syndrome, once in a person's lifetime. The maximum amount payable is $1,500.
6. custom-made graduated compression hose, with a minimum graduated compression factor range of 20 mmHg. The maximum amount payable is $150 for each pair.
7. custom-made burn garments.
8. elevated toilet seats, shower chairs, bathtub rails, and standard commodes.
9. wigs and hairpieces for patients undergoing medical treatment. The maximum amount payable is $500 every 2 years.
10. one pair of eyeglasses or contact lenses following non-refractive eye surgery.
11. cardiac screeners.
12. growth guidance systems.
13. seasonal affective disorder (SAD) light boxes and visors.
14. Therabite and accessories, for patients undergoing jaw rehabilitation following surgery for oral cancer.

DIAGNOSTIC SERVICES	PSA Tests (Prostate Cancer Screening Tests) performed in the person's province of residence are covered when coverage is not available under his provincial government plan. One test is covered each calendar year.

PHYSICIAN SERVICES

The plan covers charges for medical examinations for employment purposes when:

1. performed by a physician;

2. required by government statute or regulation;

3. it is not payable by the employer or union.

PARAMEDICAL SERVICES

- acupuncturists
- chiropractors
- massage therapists
- naturopaths
- physiotherapists
- podiatrists
- psychologists/social workers/counsellors

The following paramedical services are covered when provided out-of-hospital:

1. treatment by a qualified acupuncturist.
2. treatment of muscle and bone disorders, by a licensed chiropractor.
3. treatment by a qualified massage therapist.
4. treatment by a licensed naturopath.
5. treatment of movement disorders by a licensed physiotherapist.
6. treatment of foot disorders by a licensed podiatrist.
7. treatment by a registered psychologist, qualified social worker or a registered clinical counsellor.

   Treatment by a clinical counsellor is only eligible if provided in British Columbia.

   Plan members of class 10 are not eligible for treatment by social workers.

Benefit Maximum for plan members of class 10

The maximum amount payable for treatment by acupuncturists, chiropractors, naturopaths and podiatrists is $200 per person in a calendar year, to a maximum of $500 per family in a calendar year, for each practitioner.

The maximum amount payable for treatment by massage therapists is $850 in a calendar year.

There is no maximum amount payable for treatment by physiotherapists.

The maximum amount payable for all treatment combined by psychologists and clinical counsellors is $500 per family in a calendar year.

Benefit Maximum for all other plan members	The maximum amount payable for treatment by massage therapists, psychologists, clinical counsellors and social workers is $750 in a calendar year. The maximum amount payable for treatment by physiotherapists is $2,000 in a calendar year. The maximum amount payable for treatment by all other practitioners is $500 in a calendar year, for each practitioner. Treatment by psychologists, social workers and clinical counsellors is considered together in applying the calendar year maximum.
Government Coverage	Unless prohibited by law, benefits will be paid under this plan for the portion of the cost that is not payable under a government plan.

VISIONCARE

The following visioncare services and supplies are covered:

- eye examinations

1. eye examinations, including refraction, if:

   (a) they are performed by a licensed ophthalmologist or optometrist; and
   (b) coverage is not available under the person's provincial government plan.

   For a plan member of class 10, the maximum amount payable is $75 every 2 calendar years for a person over age 19 but under age 64.

   For any other plan member, the maximum amount payable is $100 every 2 calendar years for a person age 19 or older.

- glasses, contact lenses, laser eye surgery

2. the following services and supplies required to correct vision:

   (a) glasses and contact lenses when provided by a licensed ophthalmologist, optometrist, or optician; and
   (b) laser eye surgery when performed by a licensed ophthalmologist.

   The maximum amount payable is $250 every year for a dependent child, and $250 every 2 years for any other person.

Limitation

No benefits will be paid for:

1. visioncare services and supplies required by an employer as a condition of employment; and

2. safety glasses for a plan member of class 10.

DENTAL ACCIDENT TREATMENT

Customary charges for dental treatment resulting from accidental injury to natural teeth or prosthetics is covered if:

1. the accident occurs while the person is covered under this benefit provision; and
2. treatment is performed by a licensed dentist, oral surgeon, or denturist.

A natural tooth is any tooth that has not been artificially replaced.

Coverage Criteria

Coverage for diagnostic, restorative, preventive, endodontic, periodontal, surgical, and adjunctive services under this provision is based on basic coverage provisions. Frequency limits on diagnostic services are waived.

Coverage for crowns, pontics, initial dentures, and bridgework under this provision is based on major coverage provisions. Time limits on coverage of replacements are waived.

- customary charges

Customary charges are the lowest of:

1. prices shown for a general practitioner in the dental fee guide identified in the Table of Benefits. Denturist fee guides are applicable when services are provided by a denturist.
2. representative prices in the area where the treatment was provided.
3. maximum prices established by law.

Limitations

No benefits will be paid for:

1. accidental damage to dentures.
2. dental treatment completed more than 12 months after the accident.
3. orthodontic diagnostic services or treatment.

OTHER SERVICES OR SUPPLIES

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

AMOUNT PAYABLE

Benefits are payable for covered expenses:

1. that are incurred while the person is covered for them; and
2. that exceed the deductible.

For continuous positive airway pressure machines (CPAP), automatic positive airway pressure machines (APAP), graduated compression hose and growth guidance system benefits, covered expenses are the actual expenses. For all other services and supplies, covered expenses are the lesser of actual expenses and customary charges for covered services and supplies.

- interchangeable drug limitation

The covered expense for any drug may be limited to that of a lower cost interchangeable drug determined in accordance with the plan administrator's adjudication practices at the time of claim.

An interchangeable drug includes but is not limited to:

1. a generic equivalent of the brand name drug deemed to be interchangeable by law where the drug is dispensed; or
2. a subsequent entry biologic drug.

The right to limit the covered expense does not apply if medical evidence has been provided that indicates a contraindication to the interchangeable drug.

- lower cost alternative limitation	The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment. Reimbursement of in-Canada prescription drugs will be subject to provincial/territorial plans low cost alternative and reference drug programs, inclusive of provincial/territorial plans allowed markup. For in-Canada prescription drugs not eligible under a provincial/territorial plan, the ingredient cost of generic drugs and medicines and multi-source brand drugs and medicines, plus a 7% markup will be cut back to the cost of the lowest cost equivalent drug or medicine plus a 7% markup. The ingredient cost of single source brand drugs and medicines plus 7% markup is eligible.
- dispensing fee limitation	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $7.60.
- customary charges	Customary charges are the lowest of: 1. representative prices in the area where the treatment was provided, plus a markup for in-Canada prescription drugs; 2. prices shown in any applicable professional association fee guide; and 3. maximum prices established by law.
- payment of benefits	Payment is made at the reimbursement level shown in the Table of Benefits. Benefits are subject to any maximums identified for the covered services or supplies and to the lifetime maximum.
• frequency limitations	Unless otherwise specifically stated, frequency limitations or maximums expressed in years refer to 12-month periods and not calendar years.

Date of Incurral

For the purposes of all calculations made under this benefit provision, expenses for services and supplies are considered to be incurred when the person receives them.

Deductibles

The deductible amounts shown in the Table of Benefits are applied each calendar year. They are applied as expenses are incurred. No more than the individual deductible will apply to one person's expenses. No more than the family deductible will apply to expenses for a plan member and his family.

- deductible carryover

The calendar year deductible is reduced by the amount of covered expenses:

1. that were incurred in October, November, or December of the previous year; and
2. that were used to satisfy the deductible for that year.

- exception

The calendar year deductible amounts do not apply to certain coverages identified in the Table of Benefits.

Lifetime Maximum

The maximum amount payable under this benefit provision for all expenses incurred during a person's lifetime is shown in the Table of Benefits. The maximum does not apply to certain coverages which are identified in the Table of Benefits.

- reinstatement

A plan member may apply for full reinstatement of his own or a family member's maximum amount. The plan member must supply any information the plan administrator may require to assess his application. Applications for full reinstatement will be approved if they meet the plan administrator's underwriting standards.

GENERAL LIMITATIONS

No benefits will be paid for:

1. expenses that private benefit plans are not permitted to cover by law.

2. services or supplies for which a charge is made only because the person has coverage under a private benefit plan.

3. the portion of the expense for services or supplies that is payable by the government health plan in the person's home province, whether or not the person is actually covered under the government health plan.

4. any portion of services or supplies which the person is entitled to receive, or for which he is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan.

   In this limitation, government plan does not include a group plan for government plan members.

5. services or supplies that do not represent reasonable treatment.

6. services or supplies associated with:

   (a) treatment performed for cosmetic purposes only;
   (b) recreation or sports rather than with other regular daily living activities;
   (c) the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision; or
   (d) contraception, except as may be provided under the prescription drug provision.

7. services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply.

8. extra medical supplies that function as spares or alternates.

9. services or supplies received outside Canada except as provided under the out-of-country care provision.

10. services or supplies received out-of-province in Canada, unless:

    (a) the person is covered by the government health plan in his home province or the government coverage replacement plan sponsored by the employer; and
    (b) this plan would have paid benefits for the same services or supplies if they had been received in the person's home province.

11. medical evacuation services covered under the employer's global medical assistance plan.

12. expenses arising from war, insurrection, or voluntary participation in a riot.

A general limitation does not apply to coverage provided under this benefit provision that directly and specifically conflicts with that limitation. Where coverage is described only in general terms, a conflict is not considered to exist.

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

BENEFIT PROVISIONS

DENTALCARE BENEFITS FOR PLAN MEMBERS AND DEPENDENTS

ASSESSMENT STANDARD

All services and supplies covered under this benefit provision must represent reasonable treatment. Unless otherwise specified, dental treatment is both described and assessed according to the Canadian Dental Association Uniform System of Coding and List of Services.

Reasonable Treatment

Treatment is considered reasonable if it is:

1. recognized by the Canadian Dental Association;

2. proven to be effective;

3. performed by a dentist or under a dentist's supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist; and

4. of a form, frequency, and duration essential to management of the person's dental health.

BASIC COVERAGE

Basic coverage is provided for the services described below.

Diagnostic Services

The following diagnostic services are covered:

- examinations

1. one complete oral or prosthodontic examination every 3 years.
2. oral pathology, periodontal, surgical, stomatognathic dysfunctional and endodontic examinations.
3. limited oral examinations twice in a calendar year for a person under age 19, and once every 9 months for any other person, except that only one limited oral examination is covered in any year that a complete oral examination is also performed.
4. limited periodontal examinations, twice in a calendar year for a person under age 19, and once every 9 months for any other person.
5. one specific examination every 60 days.
6. emergency examinations.
7. four orthodontic examinations every 3 years.

- radiographs

8. complete series of intra-oral radiographs, once every 3 years.
9. intra-oral radiographs to a maximum of 15 films every 3 years. Services provided in the same year as a complete series are not covered.
10. a panoramic radiograph every 5 years.
11. sialography, tomography and cone beam computerized tomography.
12. temporomandibular joint radiographs.
13. extra-oral radiographs other than panoramic and sialography.
14. radiopaque dyes used to demonstrate lesions.
15. interpretation of radiographs or models from another source.

- tests and laboratory reports	16. microbiological, histological and cytological tests. 17. one pulp vitality test every 6 months. 18. laboratory reports.
- consultation with patient	19. consultation with patient, limited to 2 per day, and a maximum of 4 in a calendar year.
- diagnostic casts	20. mounted diagnostic study casts, once in a calendar year. 21. unmounted diagnostic study casts. 22. diagnostic photographs.
- limitation	No benefits will be paid for duplicate radiographs under this provision.

Preventive Services

The following preventive services are covered:

- polishing, scaling, and fluoride

1. polishing twice in a calendar year for a person under age 19, and once every 9 months for any other person.
2. scaling, limited to a maximum combined with periodontal root planing of 13 time units in a calendar year for a person under age 19, and 13 time units every 9 months for any other person.
3. topical application of fluoride twice in a calendar year for a person under age 19, and once every 9 months for any other person.

- sealants

4. pit and fissure sealants, once per tooth every 2 years.

- space maintainers

5. one space maintainer per quadrant in a calendar year. Acid etched pontic type space maintainers are covered only when provided for missing central and lateral teeth.
6. maintenance of space maintainers.

- other services

7. finishing restorations.
8. interproximal disking, once per tooth in a person's lifetime.
9. recontouring of teeth.

- time units

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

Where coverage is limited by time units but fees are not described in terms of time units by either:

1. the fee guide in effect where treatment is rendered; or
2. the fee guide specified by this plan;

each incident of service is considered 1 time unit, regardless of its duration.

- limitations

No benefits will be paid for:

1. custom fluoride appliances.
2. oral hygiene instruction.
3. nutritional counselling.

Minor Restorative Services

The following minor restorative services are covered:

1. caries and pain control, once per tooth in a person's lifetime.
2. trauma control, once per tooth every 6 months.
3. amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan.
4. retentive pins and prefabricated posts for fillings.
5. prefabricated crowns, once every 2 years.
6. inlays and onlays, once per tooth every 5 years.
7. tooth-coloured veneers.

Endodontic Services

Covered endodontic services include but are not limited to:

- root canal therapy

1. treatment of the pulp chamber.
2. root canal therapy for primary teeth, once per tooth every 5 years. Pulpectomy is covered once per tooth in a person's lifetime.
3. root canal therapy for permanent teeth, limited to 2 courses of treatment per tooth in a person's lifetime.
4. apexification, once per tooth in a person's lifetime.
5. periapical services;
   (a) apicoectomies and apical curettage are covered for permanent teeth only, once per tooth in a person's lifetime.
   (b) hemisection, retrofilling, root amputation, open and drain, each covered once per tooth in a person's lifetime.
6. apexification re-insertion is covered 3 times per tooth in a person's lifetime.

- limitations

No benefits will be paid for:

1. isolation of teeth.
2. enlargement of pulp chambers.
3. endosseous intra coronal implants.

Periodontal Services

Covered periodontal services include but are not limited to:

1. root planing, limited to a maximum combined with preventive scaling of 13 time units in a calendar year for a person under age 19, and 13 time units every 9 months for any other person.
2. periodontal surgery.
3. occlusal adjustment and equilibration, limited to a combined maximum of 4 time units a year.
4. two periodontal appliances every 5 years, including adjustments, relines, and repairs.
5. proximal wedge, once per site every 5 years.
6. removal of fixed periodontal splint extra coronal, twice in a calendar year.
7. gingival curettage, 6 times every 5 years.

- limitations

No benefits will be paid for:

1. desensitization.
2. topical application of antimicrobial agents.
3. subgingival periodontal irrigation.
4. charges for post surgical treatment.
5. periodontal re-evaluations.

Appliance Maintenance

- denture maintenance
- bridgework maintenance
- inlays, onlays, and crown maintenance

The following services are covered:

1. denture relines for dentures at least 6 months old, once every 2 years. If a separate charge is made for relines in connection with immediate dentures, the 6-month restriction is waived.
2. denture rebases for dentures at least 2 years old, once every 2 years.
3. resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 3 years.
4. denture adjustments after the 3-month post-insertion care period has elapsed, to a maximum of 4 in a calendar year.
5. denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed.
6. tissue conditioning, twice every 5 years.
7. repairs to covered bridgework, once for each tooth every 5 years.
8. removal and recementation of bridgework.
9. repairs to inlays, onlays and crowns, once for each tooth every 5 years.

Oral Surgery

Covered oral surgery includes but is not limited to:

1. removal of teeth.
2. surgical exposure of teeth.
3. the following procedures for remodelling and recontouring oral tissues:

   (a) minor alveoloplasty, in conjunction with extraction, once per sextant in a person's lifetime.
   (b) stomatoplasty.
   (c) gingivoplasty in conjunction with extraction, once per sextant every 5 years.
   (d) gingivectomy, once per sextant every 5 years.
   (e) frenectomy, 3 times per arch in a person's lifetime.

4. surgical incisions.
5. surgical excision of tumors, cysts, and granulomas. Surgical enucleation is also covered.
6. treatment of fractures, including torus treatment and related bone grafts to the jaw, once per tooth in a person's lifetime.
7. treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty.
8. residual root extractions, once per tooth in a person's lifetime.
9. soft tissue extraction and surgical exposure, once per tooth in a person's lifetime.
10. rigid osseous anchorage.
11. the following denture-related surgical services for remodelling and recontouring oral tissues are covered:

    (a) remodelling, excision, removal, reduction, or augmentation of the alveolar bone.
    (b) remodelling of the floor of the mouth.
    (c) vestibuloplasty.
    (d) reconstruction of the alveolar ridge.
    (e) extensions of mucous folds.
    (f) related surgical grafts.

    Related stents, although not listed with denture-related surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision.

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

- limitations

No benefits will be paid for:

1. implantology.
2. surgical movement of teeth.
3. services performed to remodel or recontour oral tissues, other than those listed above. Services for remodelling and recontouring oral tissues are covered under major coverage.

Adjunctive Services

The following adjunctive services are covered:

1. minor remedies for relief of dental pain when provided on an emergency basis.
2. therapeutic injections.
3. consultations with a member of the profession, limited to 3 in a calendar year.
4. house calls and emergency room visits.

- limitation

No benefits will be paid for:

1. hypnosis.
2. acupuncture.
3. general anesthesia.

MAJOR COVERAGE

Major coverage is provided for the services described below.

Crowns and Veneers

The following crowns, veneers and related items are covered:

1. metal, plastic, porcelain, and ceramic crowns. Coverage for complicated crowns is limited to the cost of standard crowns.
2. lab processed veneers, once per tooth every 5 years.
3. posts, once per tooth every 5 years.
4. cores, once every 5 years.
5. pins related to covered crowns.
6. copings related to covered crowns.
7. repairs to covered tooth-coloured materials.
8. removal of crowns.

- replacements

Replacement crowns and veneers are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

- limitations

No benefits will be paid for:

1. recontouring existing crowns.
2. staining porcelain.

Dentures and Bridgework

The following appliances are covered when required to replace one or more extracted teeth.

1. standard complete dentures.
2. standard cast or acrylic partial dentures.
3. complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics.

Replacement appliances are also covered when:

1. the existing appliance is a covered temporary appliance.
2. the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of:

   (a) the placement of an initial opposing appliance; or
   (b) the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

- alternative benefits

If implants are provided, the plan provides alternative benefits based on the equivalent cost of a single crown/abutment when the restoration of an individual tooth is rendered by placing a single crown/abutment on an implant, subject to approval by the plan administrator. If approval is granted, payment will not include any post or screws used to retain the crown to the implant. The same will apply to retainers attached to implants when the retainers act as abutments.

Appliance Maintenance

- denture maintenance
- inlays, onlays and crown maintenance

The following services are covered after the 3-month post-insertion care period has elapsed:

1. denture remakes, once every 3 years.
2. recementation to inlays, onlays, crowns and veneers, twice per tooth for each visit.

ORTHODONTIC COVERAGE

Orthodontics are covered for both children and adults. Children must be 6 years of age or over when treatment starts.

Diagnostic Services

The following diagnostic services are covered:

1. orthodontic examinations.
2. cephalometric radiographs.
3. hand and wrist radiographs.
4. orthodontic diagnostic casts.

Treatment

Fixed and removable appliances for orthodontic treatment are covered. This includes related charges for observations, adjustments, repairs, alterations, removal, retention and appliances to control harmful habits.

Benefit Maximum

The maximum amount payable for orthodontics in a person's lifetime is shown in the Table of Benefits.

Limitation

No benefits will be paid for expenses covered under another group plan's extension of benefits.

AMOUNT PAYABLE

Benefits are payable for covered expenses that are incurred while the person is covered for them.

Covered expenses are the lesser of actual expenses or customary charges for covered services and supplies.

- customary charges

Customary charges are the lowest of:

1. prices shown for a general practitioner in the dental fee guide identified in the Table of Benefits. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently. For treatment rendered in British Columbia, or outside of Canada, for a British Columbia resident, specialist fee guides are applicable when the specialist provides services within his specialty. When a specialist without a specialist fee guide provides services within his specialty, customary charges will be the prices shown for a general practitioner plus an additional 10%. For treatment rendered outside of British Columbia, specialist fee guides are applicable when a specialist provides services within his specialty.
2. representative prices in the area where the treatment was provided.
3. maximum prices established by law.

- payment of benefits

Payment is made at the reimbursement level shown in the Table of Benefits. Benefits are subject to any maximums identified for the covered services or supplies and to the orthodontic lifetime maximum and the calendar year maximum for other dental expenses.

- frequency limitations

Frequency limitations or maximums expressed in years refer to 12-month periods and not calendar years.

Date of Incurral

For the purposes of calculations made under this benefit provision, expenses other than orthodontic expenses are considered to be incurred when treatment is completed.

Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment.

Calendar Year Maximum

The maximum amount payable under this benefit provision for all dental expenses incurred for one person in a calendar year, except those incurred for orthodontics, is shown in the Table of Benefits. Orthodontic expenses are subject to a separate lifetime maximum shown in the Table of Benefits.

GENERAL LIMITATIONS

No benefits will be paid for:

1. expenses that private benefit plans are not permitted to cover by law.

2. services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a private benefit plan.

3. services or supplies that do not represent reasonable treatment.

4. services or supplies associated with:

   (a) treatment performed for cosmetic purposes only;
   (b) congenital defects or developmental malformations in people 19 years of age or over, except orthodontics;
   (c) temporomandibular joint disorders;
   (d) vertical dimension correction; or
   (e) myofacial pain.

5. expenses arising from war, insurrection, or voluntary participation in a riot.

6. services or supplies covered under this plan's healthcare benefit, unless the amount payable for the same expenses is greater under this benefit provision. If it is, benefits will be paid under this benefit provision and not under the healthcare benefit.

A general limitation does not apply to coverage provided under this benefit provision that directly and specifically conflicts with that limitation. Where coverage is described only in general terms, a conflict is not considered to exist.

PROOF OF CLAIM

Benefits under this plan will only be paid for expenses for which the plan administrator has received satisfactory proof that payment is due. For dentalcare benefits, proof must include pre-treatment radiographs and study models when required by the plan administrator.

- claimant responsibility

The claimant must provide information required to prove his entitlement to benefits and must also authorize the plan administrator to obtain information from other sources for this purpose.

- time limits

The employer will not be liable for healthcare or dentalcare expenses that are submitted more than 15 months after the services or supplies are provided.

QUEBEC TIME LIMIT FOR THE PAYMENT OF BENEFITS

Where Quebec law applies, benefits will be paid in accordance with the terms set out in this plan document within 60 days following receipt of the required proof of claim.

PRE-DETERMINATION OF DENTALCARE BENEFITS

To determine the extent of benefits provided under this plan, it is recommended that a person submit a treatment plan to the plan administrator before having dental treatment that will cost $200 or more.

On receipt of the treatment plan, the plan administrator will advise the person of the estimated amount payable under this plan. This pre-determination of benefits is only valid for 90 days.

- treatment plan

A treatment plan must contain the dental service provider's confirmation of:

1. the recommended treatment for complete correction of the person's condition;
2. the approximate date of completion; and
3. the estimated cost.

CONCURRENT DRUG UTILIZATION REVIEW

In-Canada claims for covered drugs submitted electronically to the pharmacy benefits manager appointed by the plan administrator are subject to concurrent drug utilization review at point-of-sale to determine if:

1. an adverse interaction is possible between a prescribed drug and another drug already being taken by the patient;

2. a prescribed drug may be harmful to a patient who is a child or a senior;

3. a refill prescription is being filled too early or too late;

4. a prescribed drug contains ingredients in the same therapeutic class as another drug currently being taken or that has recently been taken and the ingredients remain active in the patient's system;

5. the prescribed therapy duration falls outside the drug manufacturer's recommended minimum and maximum limits;

6. the prescribed daily dosage of a drug falls outside the age band limits established by the drug manufacturer;

7. a prescribed drug is intended solely for the use of a member of the opposite gender to that of the patient.

Based on the outcome of the review, a pharmacist may refuse to dispense the drug as prescribed.

- exceptions

Claims for covered drugs are not subject to concurrent drug utilization review if:

1. the drugs are dispensed at a pharmacy that is not properly equipped to provide the service; or
2. the drugs are extemporaneous preparations or compounds.

- disclaimer

Neither the employer, the plan administrator nor the pharmacy benefits manager makes any guarantees, representations or warranties about the accuracy or completeness of the patient information provided for the concurrent drug utilization review or about the review results nor are they liable for any decision made by a pharmacist as a result of the review process.

PAYMENT OF CLAIMS

Benefits will be issued to the plan member unless:

1. they are prescription drug benefits for drug claims submitted through the electronic claims processing system established by the pharmacy benefits manager. In this case, benefits will be issued to the pharmacy benefits manager.

2. the plan member chooses to assign benefits to the provider of service. This method of payment is valid only if assignments to the provider of service are acceptable according to the plan administrator's administrative practices at the time of claim.

OVERPAYMENT

If a person's benefits are overpaid he is responsible for repayment within 6 months, or within a longer period if agreed to by the employer. If he fails to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit the employer's right to use other legal means to recover the overpayment.

SUBROGATION AND RIGHT OF RECOVERY

If a person receives, or is entitled to receive, a benefit under this plan for a loss for which a third party is or may be liable, the plan administrator has an interest in any claim the person may have against such third party.

The person must immediately notify the plan administrator in writing when the person is pursuing a claim against a third party. Upon receiving such notification, the plan administrator will provide the person with a Third Party Claims Acknowledgement and Agreement which the person must sign and return to the plan administrator. If applicable, the person must provide the plan administrator with the name and address of any lawyer or other personal representative pursuing such claim on behalf of the person, and direct and authorize such personal representative to cooperate with the plan administrator.

In pursuing any third party claim, the person must:

1. pursue the claim against the third party in good faith and with due diligence;

2. keep the plan administrator informed as to the status of such third party claim, including but not limited to confirmation of any change in lawyer or other personal representative within 15 days of such change;

3. ensure that the claim against the third party is pursued for 100% of the loss for which the third party is liable, with no deduction to be taken for benefits that have been or may be paid under this plan;

4. provide the plan administrator in a timely manner with full details of the third party claim advanced, including but not limited to copies of all mediation briefs, actuarial reports, wage loss calculations, and such further documentation as the plan administrator may request;

5. advise the plan administrator, immediately upon becoming aware, of any scheduled settlement discussions of the third party claim;

6. provide full details of any settlement of the third party claim, including but not limited to the attribution of such settlement as between each head of damages together with supporting documentation;

7. provide a copy of any judgment rendered by any court, or decision of an arbitrator, within 15 days of receipt of same; and

8. hold in trust and pay to the plan administrator the amount repayable under this provision within 15 days of receipt of the proceeds of any third party settlement or damage award.

The person must obtain the consent of the plan administrator to any settlement of the third party claim, which consent will not be unreasonably withheld. If the person fails to obtain the plan administrator's consent to any settlement, the person will be considered to have recovered 100% of their losses from the third party.

If the person receives compensation from a third party for any past loss for which the person received a benefit under this plan, the person must repay to the plan administrator the amount of any such benefit received, up to the amount received from the third party for such loss.

If the person receives compensation from a third party for a future loss, no benefits will be payable under this plan in respect of such loss until such time as the amount of the benefits that would otherwise be payable under this plan for such loss equal the amount received from the third party for that loss.

If the person does not pursue a claim for a loss for which a third party is or may be liable and for which a benefit has been paid or may be payable under this plan, the plan administrator may pursue a claim against the third party in the name of the person. The person must cooperate with the plan administrator and provide all the assistance that the plan administrator may reasonably require to pursue a claim against the third party.

No benefits are payable under this plan unless all of the requirements of this provision are satisfied.

Any failure by the plan administrator to insist upon compliance with any requirement under this Third Party Claims provision shall in no way be construed as a waiver of such requirement or any other requirement under this Third Party Claims provision.

LEGAL ACTIONS

No legal action to recover benefits under this plan can be introduced:

1. for 60 days after notice of claim is submitted; or
2. more than 2 years after a benefit has been denied.

COORDINATION OF BENEFITS

Benefits under this plan are coordinated when other similar coverage is available.

Government Plans

When reimbursement is available under a government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other coordination provisions. It is subject to any applicable deductible, reimbursement level, and maximum under this plan.

Government plans are plans that are legislated, funded, or administered by a government. Group plans for government plan members are not included.

Group Plans

- secondary plan

The amount payable is reduced when this plan is secondary to another group plan. The reduction is the amount by which total payments under all group plans would exceed eligible expenses. An eligible expense is that portion of a customary charge for reasonable treatment for which coverage is provided under this plan.

When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum.

Group plans are plans that are available only to members of particular groups and not to the general public. Student accident plans are not considered group plans.

A secondary plan is one that determines its benefits after another plan.

- plan member coverage

A plan determines its benefits first if it covers the person as a plan member. If he is covered as a plan member under more than one plan, the plans are prioritized in the following order:

1. the plan covering him as an active, full-time plan member;
2. the plan covering him as an active, part-time plan member;
3. the plan covering him as a retired plan member.

- dependent coverage

A plan is secondary if it covers the person as a dependent. If he is covered as a dependent of more than one person, the plans are prioritized in the following order:

1. the plan covering him as a dependent spouse;
2. the plan covering him as a dependent child of the parent with the earlier birthday in the calendar year;
3. the plan covering him as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

If the parents are separated or divorced, the plans under which benefits for the child are determined are prioritized in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

- dental accidents

In the case of dental accidents, dental plans are secondary to health plans with dental accident coverage.

• benefits paid under another plan	If benefits have already been paid under another group plan, this plan is automatically secondary.
• prorated benefits	If these rules do not establish an order of benefit determination, or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before coordination.
• coordination within this plan	For any plan member except a plan member of class 10 or class 13, coordination of benefits will also take place within this plan if: 1. a person is covered as both a plan member and a dependent under this plan; or 2. a person is covered as a dependent of two plan members under this plan.
- capitation plans	If other coverage is available under a capitation plan, benefits will be coordinated according to guidelines prepared by the Canadian Life and Health Insurance Association.

Other Sources

The amount payable is also reduced when this plan is secondary to sources other than government and group plans. The reduction is the amount by which total payments from all sources would exceed covered expenses. When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum.

This plan is considered secondary only if payment has already been made by the other source.

Right to Release or Receive Information

The plan administrator may release or receive information required for coordination of benefits without specific authorization.

Limitation

For a plan member of class 10 or class 13, coordination of benefits will not apply when both the plan member and the spouse are employed by the Government of British Columbia and each is covered under the Traditional Plan.

MEDICAL AND DENTAL ASSESSMENTS

The plan administrator has the right to conduct necessary investigations relating to applications or claims, and to obtain independent medical or dental assessments if required. The plan administrator must also be given the opportunity to examine the person for whom an application or claim is made as often as it may reasonably require during the course of an investigation or assessment.

The employer will not assume the cost of assessment or investigation in connection with a late application. The employer may assume the cost of other assessments or investigations according to administrative practices in effect at the time of application or claim.

DISCLOSURE PROVISIONS

The plan document will be available through the employer for review by plan members.

APPEALS

A person has the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as he does so within 2 years after the denial. An appeal must be in writing and must include the person's reasons for believing the denial to be incorrect.

CONFORMITY TO LEGISLATION

If this plan does not conform to legislation that governs it, it is considered automatically amended to comply with the minimum requirements of that legislation.

GENDER

The words he, him and his refer to all genders.

TRANSFER PROVISIONS

Transfer of Coverage

The following provisions apply when coverage for any class of plan members takes effect under this plan during the 31 days after coverage ends for that class under another group health plan.

1. Any person who was covered in the terminating class under the other plan when coverage for that class ended will be covered on the effective date of coverage for that class under this plan, as long as he is then a qualified plan member.

2. If the person's coverage has not been interrupted from one plan to another, the period of coverage used in assessing his entitlement to benefits under this plan for hospital or nursing care or for dentures or bridgework is considered to start on the date he last became covered for the same benefit under the other plan.

   If this provision entitles the person to benefits that would not otherwise have been payable under this plan, his benefit entitlement will be assessed under each plan. The amount payable will be determined according to the plan providing the lesser benefits. No benefits will be paid under this provision if:

   (a) no benefits would have been paid under the other plan had coverage for the terminating class remained in force; or
   (b) benefits are payable under the other plan after termination of coverage.

   No benefits will be paid under this plan for that portion of a loss incurred before termination of coverage under the other plan.