

<b>Group Name and Number</b>
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**Telecommunication Workers Pension Plan**

**Retirees**

**Group Number 909889**

**Reissue Date: February 1, 2009**

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## Introduction

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) is referred to as “we”, “us”, or “our” in this booklet. We will refer to you, the retiree/member, as “you” or “your” in this booklet.

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

**Pacific Blue Cross**  
Dental Care

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

## **Privacy Policy**

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: [www.pac.bluecross.ca](http://www.pac.bluecross.ca). By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

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## **Schedule of Benefits**

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

<b>Dental Care</b>		
<i>Deductible</i>	No Deductible	
<i>Reimbursement</i>	<b>Plan A</b>	<b>Plan B</b>
	Basic Services	Major Restorative Services
	80%	50%
<i>Frequency Plan Limits</i>	<b>Each Calendar Year</b>	<b>Each Calendar Year</b>
<i>Financial Limit Per Dependent Child</i>	\$1,000 combined with Plan B	\$1,000 combined with Plan A
<i>Financial Limit Per Member or Spouse</i>	\$1,000 combined with Plan B	\$1,000 combined with Plan A
<i>Financial Limit for Late Applicants</i>	\$250 per person for all dental services for first 12 months of coverage	
<i>Dependent Children</i>	See definition of Dependent.	

## **Definitions**

### **Allowable enrolment period**

means within 4 months from the coverage effective date.

### **Coverage effective date**

means the day after your coverage terminates under your Employer's Plan for active employees, provided you apply for Benefits within the Allowable enrolment periods.

### **Deductible**

means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

### **Dentist**

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, or denturist.

### **Dependent**

means any of the following persons for whom coverage is provided under this Plan:

- 1) one Spouse, and
- 2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and

- 3) any age if the unmarried child is also in full-time attendance at a recognized educational institute, and
- 4) any unmarried handicapped child of any age who is living with you or your Spouse, is financially dependent and is incapable of self-sustaining employment.

**Duplicate coverage**

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

**Fee guide**

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

**Fee schedule**

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

**Spouse**

means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

## **Integration with Government Plans**

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

## **Effective Date of Coverage and Enrolment**

If you are eligible for coverage, you must complete an application card within the Allowable enrolment period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):

- 1) on the same date you apply for your own coverage, or
- 2) within the Allowable enrolment period if you have a new Dependent.

If we do not receive your application card within the required time limits, please refer to the Late Application section.

Coverage begins on the coverage effective date shown on your identification (ID) card(s), provided you and your Plan Administrator have complied with our enrolment rules.

Should you require additional information about when your coverage starts, please contact your Plan Administrator.

## **Late Applicants**

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

## **Identification (ID) Cards**

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

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

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

## Claims

- 1) All claims must be submitted to us in English.
- 2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
- 3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.
- 4) The necessary claim forms are available from your Plan Administrator
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

## Duplicate Coverage

If you and your Spouse are eligible for member coverage through the same employer, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental care benefits.

If you and your Spouse have coverage through different employers and you are both enrolled for similar benefits, Duplicate coverage is allowed.

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

Your Plan Administrator will advise you if you are eligible to waive certain benefits under this group plan.

## **Coordination of Benefits**

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

- 1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
- 2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
- 3) In situations of separation or divorce, the following order applies:
  - a) the plan of the parent with custody of the child
  - b) the plan of the Spouse of the parent with custody of the child
  - c) the plan of the parent not having custody of the child
  - d) the plan of the Spouse of the parent in c) above.
- 4) Total reimbursement shall never exceed 100% of the Eligible expenses.

## **General Exclusions**

- 1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
  - a) under any other group or individual benefit plan or insurance policy, or
  - b) due to the legal liability of any other party.

- 2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
- a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
  - b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
  - c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
  - d) false pretences or fraudulent misrepresentation
  - e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

## **Termination of Coverage**

Generally, your coverage (and any Dependent coverage) terminates if you cease to be covered under the government plan (ie. Medical Services Plan of BC), or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract.

## **Conversion to an Individual Plan**

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have

had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

**Pre-existing condition**

means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

## **Individual Travel Benefits**

Individual coverage is also available from us. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

## **CARESnet**

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our website:

<http://www.pac.bluecross.ca/caresnet/>

## **Payment of Benefits**

- 1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule.
- 2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
  - a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee schedule
  - b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
  - c) for services performed outside Canada if your province of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
- 3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

## **Plan A – Basic Preventive & Restorative Services**

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

- 1) Diagnostic services
  - a) examinations:
    - i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months – 1 per 3 year period
    - ii) recall – 2 per calendar year
    - iii) specific – 2 per calendar year
    - iv) consultations (as a separate appointment)
  - b) x-rays
    - i) diagnostic
    - ii) panoramic – 1 per 2 year period
    - iii) complete mouth series – 1 per 3 year periodAll x-rays combined shall not exceed the dollar limit for a complete mouth series.
  - c) diagnostic models – 1 set per calendar year.
- 2) Preventive services
  - a) scaling
  - b) polishing – 2 per calendar year
  - c) topical application of fluoride – 2 per calendar year
  - d) fixed space maintainers
  - e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.
- 3) Restorative services
  - a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
    - i) amalgam (silver coloured) fillings
    - ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth onlyOn permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
  - b) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.
  - c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

- 4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.
- 5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
  - a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
  - b) root planing
  - c) gingival curettage – 1 per sextant in a 5 year period
  - d) osseous surgery – 1 per sextant in a 5 year period
- 6) Prosthetic repairs
  - a) removal, repairs, and recementation of fixed appliances
  - b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
  - c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
  - d) gold foil – only when used to repair existing gold restorations.
- 7) Surgical services
  - a) extractions
  - b) other routine oral surgical procedures
  - c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

## **Plan B – Major Restorative Services**

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

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

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

- 1) Prosthodontic Services
  - a) removable
    - i) complete upper and lower dentures
    - ii) partial upper and lower dentures
  - b) fixed bridges.
- 2) Restorative Services
  - a) inlays or onlays involved in bridgework
  - b) veneers
  - c) crowns and related services.
- 3) Periodontal Appliances  
bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

#### Limitations

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

## **Emergency Treatment Outside Your Province of Residence**

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule.

## Exclusions

The following are not Eligible expenses under your dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
- 2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
- 3) procedures performed for congenital malformations or for purely cosmetic reasons
- 4) charges for drugs, pantographic tracings, and grafts
- 5) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
- 6) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 7) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
- 8) incomplete or temporary procedures
- 9) recent duplication of services by the same or different Dentist
- 10) any extra procedure which would normally be included in the basic service performed
- 11) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
- 12) any item not specifically included as a benefit
- 13) travel expenses incurred to obtain dental treatment.

## Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you

in the event that you wish to proceed with the treatment recommended by your Dentist.

- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **1 year** from the date the service is performed.
- 3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
  - a) name of the Dentist
  - b) name and birthdate of the person receiving the dental care
  - c) your group, ID, and Dependent(s) numbers (this information is on your ID card)
  - d) your home mailing address
  - e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
- 4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
  - a) We will pay the Dentist directly for services provided under this dental plan when we receive a claim form signed by the Dentist, certifying these services were performed and the fee charged.
  - b) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your Dentist. We will send you a cheque when the claim is processed.

