Your Benefits

CUPE 774 – City of Abbotsford

79361

PACIFIC BLUE CROSS®

Group Name and Policy Number

CUPE 774 - City of Abbotsford

CUPE 774

Policy Number 79361

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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 Policy.

The Group Policy contains a provision removing or restricting the right of the Member to designate persons to whom or for whose benefit insurance money is to be payable.

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits.

Defined terms are capitalized (e.g. Dependent). Blue Cross Life Insurance Company of Canada (Blue Cross Life) is referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/Member, as "you" or "your" in this booklet.

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

Coverage is provided through:

Blue Cross Life
Long Term Disability (LTD)

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

Privacy Policy

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

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

Table of Contents

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.

Long Term Disability (LTD)	
Benefit Amount	60% of monthly basic earnings rounded to the next higher $1, if not already a multiple of $1, to a maximum of $3,500
Non Evidence Limit	$3,500
Elimination Period	120 Days
Maximum Benefit Period	Age 65 or earlier retirement
Termination	Age 65 less the Elimination period or earlier retirement

Definitions

Benefit amount
means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review
means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Coverage effective date
means the date coverage becomes effective based on
1) your date of hire, and
2) the average number of hours you work each week or each year, and,
3) the waiting period selected by your employer, and
4) the Enrolment grace period.

Dependent
means any of the following persons for whom coverage is provided under this Plan:
1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and

4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

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

Duplicate coverage
means that you (and your Dependents) are eligible to claim certain benefits under more than 1 plan.

Eligible drug
means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

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

1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and
3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and
4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by us.

It does not include any payment to a pharmacy or a Practitioner, demanded or received by balanced billing, extra billing, or extra charging, which represents an amount in excess of the schedule of costs prescribed by the Government plan or in any PBC Provider agreement. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Enrolment grace period
means within 90 days from the coverage effective date.

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.

Fee schedule
means 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.

Government plan
means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital
means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

Life event
means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

Member
means an employee or other person who has coverage under the Contract.

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

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner
means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider
means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. This excludes a Provider related to or residing with you or your Dependent. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse
means 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.

Vendor
means an organization we have retained as an external Provider.

Member Information/Access to Records

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.

2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with 1 copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy
   c) any written statement or other record provided to us as evidence of insurability of the Member.
6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

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

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card within the Enrolment grace 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 Enrolment grace period if you have a new Dependent.

Limitations:
1) If you are not actively at work on your coverage effective date, your coverage effective date will be delayed until you return to active full-time employment.
2) If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

Provided you and your Plan Administrator have complied with our enrolment rules, your coverage effective date is shown on our website at www.pac.bluecross.ca/member or from your Plan Administrator.

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

Late Applicants

If you did not apply during the Enrolment grace 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 – evidence of insurability or retroactive premium payment. In some instances, coverage may be denied.

Beneficiary

1) To the extent permitted by law, you have the right to name a personal representative or beneficiary for Life and Accidental Death and Dismemberment benefits or change this personal representative or beneficiary, by written request in a form satisfactory to us. If your designated personal representative or beneficiary does not survive you, any Benefit amount due will be payable to your estate.
2) For all other benefits this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits.

Identification (ID) Cards

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

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, or if any Group Contract/Policy exclusion applies.

4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/member

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) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
   e) false pretences or fraudulent misrepresentation
   f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

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

Termination of Coverage

Generally, your coverage terminates if you cease to be eligible due to change of class, age limitation, retirement, if you terminate your employment, or of the group plan terminates etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Policy.

Right of Recovery

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your employer's benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

Conversion to an Individual Plan

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

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for 1 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 604 419-2000 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 604 419-2000 or 1 877 PAC-BLUE (722-2583) outside the Lower Mainland for information.

Member Profile

Your Pacific Blue Cross Member Profile is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in you will be able to make and track online claims, get information on benefit coverage and downloadable claim forms. To login, visit: **www.pac.bluecross.ca/member/**

Definitions

Disability
means that during the Elimination period and the subsequent 24 months of Disability you are prevented, by injury or sickness, from performing each of the essential duties of your own occupation. After that you are prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

Eligible survivor
means your Spouse, if living, otherwise your children under age 25. If there are no Eligible survivors, payment will be made to your estate.

Elimination period
means a period of time, when you are continuously disabled, which must be completed before your claim will be considered. It will be calculated from the date Disability begins.

Indexed pre–disability earnings
means your basic earnings adjusted (on each anniversary of the LTD benefit payments) by the lesser of 10% or the current annual percentage increase in the all item Consumer Price Index (CPI) Canada.

Partial disability
means that within 31 days of the end of a period when you received an LTD benefit payment under the Disability definition above, and as a result of the same injury or sickness, you are incapacitated to the extent that, although unable to perform all the essential duties of your own occupation on a full-time basis, you are currently:

1) participating in a rehabilitation program, or
2) performing at least 1 of the essential duties of your own or any occupation on a part-time or full-time basis, and
3) earning at least 20% less per month than your Indexed pre-disability earnings, due to that same injury or sickness.

Availability of work is not considered when assessing Disability.

Recurrent disability
means a Disability that is related to or due to the same cause(s) as a prior Disability for which you received benefit payments.

Benefit

We will pay long term disability (LTD) benefits when Disability, as defined below, begins while you are insured for the LTD benefit.

Benefits commence on the day after the Elimination period expires and will be paid only during periods when you are receiving, from your Physician, regular care which is appropriate for the condition causing your Disability and following the treatment prescribed. We may require consultation and/or treatment by a Physician who specializes in the treatment of your condition.

The monthly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Rehabilitation Program

While you are disabled, we may suggest a rehabilitation program to help you return to the work force. This program requires the agreement of your Physician and pre-approval by us. It may include, but is not

limited to, a return to work on a part-time or full-time basis, therapy, vocational evaluation, or job preparation. Income you receive under this program will be integrated with your monthly benefit.

Recurrent Disability

A Recurrent disability will be considered part of the prior Disability if, after receiving LTD benefits, you returned to any occupation on a full-time basis and were able to perform all the essential duties of this occupation for less than 6 months. If you return to any occupation on a full-time basis for 6 months or more, a recurrence of Disability will be treated as a new period of Disability and you must complete another Elimination period.

Extended Benefit

If you are disabled when your insurance terminates, your LTD benefit will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

Survivor Benefit

If you die after being disabled for 180 or more consecutive days and while receiving a monthly Benefit amount, a payment equal to 3 times your gross monthly Benefit amount will be made to your Eligible survivor.

Coordination with other Income Sources

Your monthly LTD benefit may be reduced by any amount of Disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of:

1) your monthly basic earnings, if benefits are taxable

2) your take-home pay, if benefits are nontaxable.
For details of other income sources and how your monthly benefit is calculated, contact your Plan Administrator.

Waiver of Premium

The premiums for your LTD benefit will be waived while you are receiving monthly benefits.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable if your employer contributes to the cost of your LTD Plan. Benefits are nontaxable if you pay the entire cost.

Pre-existing Conditions Limitation

Increased amount of insurance
means an increased amount of insurance due to a change in either the non evidence limit or the maximum Benefit amount.

Pre-existing condition
means a sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures), or consumed prescribed drugs within 3 months:
1) prior to the date you became insured under this benefit, or
2) prior to the date of any Increased amount of insurance.

This exclusion will not apply if you become disabled more than 12 months:

1) after you became insured under this benefit, or
2) after you became eligible for any Increased amount of insurance.

Termination of Benefit

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer Disabled
2) you are no longer receiving regular medical care and treatment from your Physician
3) you fail to submit satisfactory proof of continuing Disability as required by us
4) you refuse a medical examination by a Physician chosen by us
5) you are no longer following the treatment recommended for your Disability
6) you refuse to participate in a rehabilitation program
7) your current earnings exceed 80% of your Indexed pre-disability earnings
8) you reach age 65
9) the end of the maximum benefit period indicated in the Schedule of Benefits
10) you retire
11) you die.

Exclusions

Benefits are not payable for any period of Disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances

b) participation in an assault or criminal offense, or an act incident thereto
c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
d) a pregnancy related sickness
    i) during any period of formal maternity leave and/or parental leave
    ii) during any period in which Employment Insurance (EI) benefits are being paid
e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are confined in a public general Hospital or you are satisfactorily participating in a withdrawal program approved by us
f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness

2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
    a) in a jail or penitentiary
    b) on leave of absence
    c) involved in a strike or lockout, if the Disability commenced 3 months after notice of strike or lockout was given
    d) receiving sick pay, vacation pay, or any other salary or wage from your normal or any occupation (except as provided under the rehabilitation program).

Claims

1) We must receive written notice of claim within **30 days** of the date Disability begins. On receipt of written notice of claim, we will provide you with a claim form.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.

5) Forward the claim form (satisfactory proof of claim) to us within **90 days** following the end of the Elimination period.
6) We may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

Note: Incomplete claim forms will cause a delay in the payment of your benefits.

Notes

PACIFIC BLUE CROSS®

Local	**604 419-2000**
Toll-free	**1 877 PAC-BLUE**
Website	**pac.bluecross.ca**

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC V5G 4W6

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pac.bluecross.ca/fasteasyclaims

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