

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Dental Care, Vision Care and Extended Health Care

Plan #11293

Royal & Sun Alliance Policy #32448102

Faculty Association Employees

ADMINISTERED BY:

D.A. TOWNLEY & ASSOCIATES LTD.

101 – 4190 LOUGHEED HIGHWAY, BURNABY, BC V5C 6A8

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Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of the self-insured funding subject to disclosing this information to the covered employees in writing.

Your Employer is constantly attempting to provide benefits to you in the most cost-effective manner. For some benefits such as Dental, Short Term Disability and some portions of the Extended Health Care, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through your Employer are not insured by an insurance company regulated under the Financial Institutions Act, and the employer is exempt from the regulatory requirements of the Act.

September 2009

This brochure explains, in general terms, the plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the Plan Document.

ELIGIBILITY

Employees working at least 18 hours per week will be covered immediately upon active employment for Extended Health and Vision Care, and immediately following the date you complete 3 months of continuous employment for Dental, provided a Group Insurance Enrolment Card has been completed and submitted to the Administrator.

Eligible dependents will be covered on the employee's effective date, provided dependent coverage is applied for. Newly acquired dependents must be enrolled within 31 days of becoming eligible.

Eligible Dependents are:

- Your legal spouse
- Your common-law spouse, provided you have lived together for at least one year
- Your unmarried children to age 19, who are dependent upon you
- Your unmarried children age 19 to age 25, who are in full-time attendance at a recognized college or university

Attainment of the limiting age shall not terminate the coverage for a child who is incapable of self-support as a result of mental or physical handicap and who is dependent upon you for support and maintenance.

TERMINATION

Coverage terminates on the earlier of the date your employment terminates or you retire, unless otherwise specified in the Plan Document.

Coverage for a Child (non-student) terminates at attained age 19. Coverage for a Child (student) terminates at attained age 25.

Orthodontia coverage terminates when dependents reach age 19.

Coverage will terminate on the date the benefit or Plan terminates.

DENTAL CARE

BENEFIT SUMMARY

Percentage payable:

100% Basic Services

100% Major Services

65% Dependent Orthodontia up to age 19

Maximum payable:

Basic & Major Combined - \$1,500 per calendar year

Ortho - \$3,000 lifetime

Deductible:

Single - Nil

Family - Nil

Includes Open Space Limitation**Alternate Benefits Clause****Survivor Coverage – 24 months**

Late Applicant: With respect to an Insured Person who applied for the Dental Care Benefit more than 31 days after becoming eligible for insurance, the maximum amount of benefit payable for such individual for charges incurred in the first 12 months of coverage will be \$250.

PLAN A - BASIC SERVICES

The following services are eligible for reimbursement in accordance with the percentages and maximums outlined in the BENEFIT SUMMARY. The amount paid will be the lesser of the amount charged or the Dental Association Fee Guide (General Practitioner) in the Province of treatment

Diagnostic Services

Necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:

- Oral examinations: limited to one in any 6-month period; however, complete oral examinations are limited to once every 24-month period.
- Dental x-rays: bite-wing x-rays are limited to one set in any 6-month period, full mouth x-rays are limited to one set in any 24-month period, and panoramic film is limited to one x-ray in any 24-month period.

Preventative Services

Necessary procedures to prevent the occurrence of oral disease, including:

- Cleaning (limited to once in any 6-month period), scaling and root planing (limited to 12 units per calendar year combined)
- Topical application of fluoride (limited to one application in any 6-month period)
- Pit and fissure adhesive sealant (limited to every 24 months)
- Fixed space maintainers for primary teeth (children under 18 years)

Surgical Services

Necessary procedures for extractions and other surgical procedures normally performed by a dentist.

Restorative Services

Necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations
- Replacement restorations provided 12 months has elapsed since placement
- Stainless steel crowns on primary teeth

Prosthetic Repairs

Necessary procedures required to repair or reline fixed or removable appliances.

Endodontia (Root Canals)

Necessary procedures required for pulpal therapy and root canal filling.

Periodontia

Necessary procedures for the treatment of tissues supporting the teeth.

Anesthesia

General anesthesia required in relation to oral surgery.

PLAN B—MAJOR SERVICES**Prosthetic Appliances and Crown and Bridge Procedures**

The following services are eligible for reimbursement in accordance with the percentages and maximums outlined in the BENEFIT SUMMARY. The amount paid will be the lesser of the amount charged or the Dental Association Fee Guide in effect in your Province of residence.

- Crowns, inlays or onlays and replacements, if at least 12 months has elapsed since last provided.
- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. If the open space limitation is included, such extraction(s) must have occurred after the effective date of the Covered Person's coverage. Partials may only be provided by a dentist.
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

PLAN C—ORTHODONTICS

Services are eligible for reimbursement in accordance with the percentage and maximums outlined in the BENEFIT SUMMARY.

Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced

PRE-TREATMENT ESTIMATE OF MAJOR RESTORATIVE & ORTHODONTIC CHARGES

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

EMERGENCY DENTAL CARE ANYWHERE IN THE WORLD

In an EMERGENCY, while you are traveling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed up to the amount that would have been paid had the service been rendered in your Province of residence.

COORDINATION OF BENEFITS

Benefit payments will be coordinated with any other plan or arrangement so that the total amount received from all sources will not be greater than the actual expense incurred. Where multiple choices are available, the Plan will base benefit payments on the least expensive choice.

SERVICES NOT COVERED

- Treatment of congenital malformations
- Cosmetic surgery or dentistry for purely cosmetic purposes
- Dental procedures which commenced prior to the effective date of your coverage
- Charges for broken appointments, oral hygiene or nutritional instruction, or completion of forms
- Services which are paid for by a Provincial Medical Plan, Workers' Compensation Board or any government plan
- Charges for any treatment where it is established that a third party is liable at law to make payment
- Replacement of an existing denture which, in the opinion of the attending dentist, is or can be made satisfactory
- Charges in excess of the Dental Association Fee Guide in effect in the Province of treatment
- Implants
- Other ineligible services as outlined in the Plan Document.

To MAKE A CLAIM

On your first visit to the dentist, advise the receptionist you will require a completed dental claim form. Standard dental claim forms are available from your dentist.

Submit the completed form to the Administrator within 90 days of incurring the expense, along with the dentist's bill or receipt. Please ensure that your name, address, social insurance number and Plan number are clearly shown.

If you have paid the dentist's account, the cheque will be issued payable to you. If you have not paid the account, the cheque will be payable to the dentist. You will be responsible for any differences between the dentist's charge and the amount paid by the Plan.

VISION CARE BENEFIT SCHEDULE

Benefit Maximum:	\$500 in any 24* Month Period (12* Month Period for Dependent Children under 19 years of age)
Deductible Amount:	Nil
Reimbursement Amount:	100%
Survivor Benefit:	24 months

* The 12-Month or 24-Month Period will commence on the date of purchase of the Eligible Service or Supply, provided you or your dependents were covered on the date of purchase.

ELIGIBLE CHARGES

Eligible Charges are charges incurred for frames and lenses, or contact lenses, recommended by a licensed optometrist or ophthalmologist.

In the case of non-elective contact lenses, the Maximum Amount per period is the greater of the Maximum Amount shown in the Benefits Schedule or the cost of one paid or contact lenses within the period shown.

Non-elective contact lenses means that visual acuity in the better eye is not correctible to 20/70 by the use of conventional type lenses but can be corrected to 20/70 or better by the use of contact lenses.

EXCLUSIONS

No amount is payable by The Plan for charges incurred:

1. for sunglasses, whether plain or prescription, or for any tinted gasses with a tint other than No. 1 or No. 2; or
2. in connection with special procedures such as orthoptics or visual training, or in connection with medical or surgical treatment of the eye; or
3. for visual services; or
4. for eye refractions, or for the cost or fitting of eyeglasses; or
5. for safety glasses.

To MAKE A CLAIM

Please submit your paid receipt to our office for processing. Your Employer can provide a claim form to you.

Because receipts are not returned after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit.

**EXTENDED HEALTH CARE
BENEFIT SCHEDULE**

IN-CANADA EXPENSES

Reimbursement: 80%

Overall Plan Maximum*: unlimited

Hospital: semi-private room

Convalescent Hospital: 180 days

Substance Abuse Facility: 60 day lifetime maximum

Private Duty Nursing: \$10,000 per calendar year

Paramedical Practitioners: \$500 per practitioner per calendar year

Eye Exams: \$65 every 24 months

Hearing Aids: \$400 in each 5-year period

Orthopedic Shoes: 1 pair to a maximum of \$250 per calendar year

Foot Orthotics: 1 pair to a maximum of \$300 per calendar year

Wigs: \$500 per lifetime

Surgical Brassieres: 4 per calendar year

Surgical Hose: 4 pair per calendar year

Prescription Drugs

- **Deductible Applies only to prescription drugs as follows:**
 - Single \$25 per calendar year
 - Family \$50 per calendar year
- **Reimbursement Amount:** 80%

OUT-OF-CANADA EXPENSES

Out-of-Country Emergency Travel Assistance:

- Reimbursed @ 100%
- Maximum \$5 million per individual event

*If you work past the Traditional Retirement Date:

- the annual maximum will be reduced to \$10,000 per calendar year
- you will not be eligible for Out-of-Canada coverage

FAIR PHARMACARE PROGRAM

The British Columbia Government introduced the Fair Pharmacare Program in May 2003.

Under this program the annual family deductible was changed from a flat \$1,000 to a percentage of your net family income. All BC residents are required to register for this program. Failure to do so will result not only in your deductible increasing to \$10,000 but may also prevent us from honouring your claims until you register.

If you have not already registered please do so as soon as possible to avoid any inconvenience. To register for the Fair PharmaCare Program call toll-free in BC 1-800-663-7100. If you prefer to go on-line to the Fair PharmaCare website the address is <https://pharmacare.moh.hnet.bc.ca>.

Once you have registered please contact us to provide your registration number. You can contact us in the following ways:

- **Mail** a copy of the top part of the registration letter to:
D.A. Townley & Associates Ltd.
101 – 4190 Lougheed Highway
Burnaby, BC V5C 6A8
- **Fax** the top part of the registration letter to 604.299.8136
- **E-mail** us at pharmacare@datownley.com – be sure to include your name and social insurance number, your registration number and your phone number in case there are any difficulties
- **Phone** us @ 604.299.7482 or if you are outside the Lower Mainland call toll-free @ 1-800-663-1356

If you already provided your PharmaCare Registration Number on your Group Insurance Enrolment Card there is no need to submit it again.

EXTENDED HEALTH BENEFITS

This benefit provides protection against the cost of those Medically Necessary services and supplies when there is only partial or no reimbursement from your provincial medical plan.

Eligible Charges

Charges and treatment are eligible if they are:

- not covered under your provincial medical plan,
- incurred from sickness or Accidental Bodily Injury,
- Medically Necessary, and
- given or ordered by a physician.

ELIGIBLE CHARGES INSIDE CANADA

Drugs and Medicines

Prescription-by-law charges include:

- oral contraceptives,
- fertility drugs (Lifetime Maximum of 6 months supply)
- smoking cessation drugs (Lifetime Maximum Amount: \$500)

The Deductible amount applies.

The maximum benefit amount payable for any one incurred charge for a drug or medicine is limited to the charge for a 90 day supply.

Private Duty Nursing

Charges for care provided out-of-hospital by either a Registered Nurse or a Registered Nursing Assistant (determined by the minimum level of skill needed to provide the required care) who is not related to or living in the home of the Insured.

Hospital

An institution that employs Registered Nurses who are in attendance and on duty on a 24-hour basis and is equipped for the diagnosis and treatment of sickness and injury excluding any institution which is, other than incidentally, a nursing home, a care home or a home for the aged.

Hospital – Convalescent Home or Physical Rehabilitation Facility

Room and Board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:

1. is certified as Medically necessary by a Physician,
2. occurs within 48 hours after a Hospital stay of at least 5 consecutive days, and

3. is due to the same sickness or Accidental Bodily Injury which was the reason for the Hospital stay.

Charges are limited to the difference between the Provincial Medical Allowance for Room and Board charges, and the institution's Semi-Private Charge, for up to a maximum benefit payment period of 180 days.

A new maximum benefit period of 180 days applies if the Insured Person incurs those charges as described above:

1. for a sickness or injury unrelated to the sickness or injury which was the reason for the prior stay; or
2. if at least 14 consecutive days have passed since the prior stay during which he or she was not a patient in a Hospital, Convalescent Home, or Physical Rehabilitation Facility.

Hospital – Substance Abuse Rehabilitation Facility

Room and Board charges in connection with a Substance Abuse rehabilitation programme, provided that the Insured Person's Provincial Medical Plan pays a portion of those charges and the Plan has provided the Insured Person with its prior written approval.

Charges are limited to:

1. the difference between the amount provided under the Provincial Medical Allowance for Room and Board charges and the institution's Semi-Private Charge, and
2. a cumulative lifetime maximum payment period of 60 days for each Insured Person.

Emergency Transportation

Charges made by a local licensed ambulance service, or scheduled airline, railroad, ship or boat, or air ambulance service (including the services of a medical attendant if certified as necessary by the attending physician), for transporting the covered individual for medical necessary emergency care to the nearest hospital qualified to render such care.

Accidental Dental

Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw, if:

1. those services are required as a result of a direct accidental blow to the mouth and not as a result of an object placed in the mouth;
2. the accident occurred while the Insured Person is insured under this benefit; and
3. the charges are incurred within 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90-day period.

Paramedic and Professional

The list of practitioners covered under this provision are chiropractors, podiatrists or chiropodist, osteopaths, naturopaths or homeopath, audiologists, physiotherapists, psychologists, speech therapists, acupuncturists and massage therapists.

Chiropractor, podiatrist or chiropodist, naturopath or homeopath, physiotherapist and massage therapist is limited to a maximum amount payable of \$10.00 for the first 12 visits per practitioner, in each calendar year.

However:

1. No amount is payable for any paramedical service visits payable by any Provincial Medical Allowance.
2. The Plan may require written certification from a Physician that paramedical services, such as speech therapy and massage therapy, are Medically Necessary.

Orthopedic Shoes

The cost of orthopaedic shoes, which are specifically designed and constructed for the Insured Person as instructed in writing by a podiatrist to the maximum shown in the Benefit Schedule.

Supplies and Equipment

Charges for Medically Necessary items, such as:

1. artificial limbs and eyes, casts, splints, trusses, braces, crutches, and surgical supplies;
2. oxygen and the rental of the equipment for its use;
3. foot orthotics, including foot braces, limited in each calendar year to one pair up to a maximum of \$300;
4. wigs when hair loss is due to chemotherapy treatment, up to a lifetime maximum benefit of \$500;
5. the cost of an intrauterine device (IUD) and diaphragms; and
6. contact lenses, when required as a result of cataract surgery or keratoconus; and
7. blood, blood plasma when not replaced.

Hearing Aids

Charges for the purchase, fitting and repairs of a hearing aid, but excluding routine maintenance and batteries.

Eye Exams

Charges for services performed by licensed optometrist or ophthalmologist, limited to one examination and a maximum amount of \$65.

ELIGIBLE CHARGES OUTSIDE CANADA

Referral – Charges for services and supplies that are not available in Canada if:

1. you are referred by two physicians in Canada who are specialists in the treatment of the sickness or injury involved;
2. you receive written approval of the referral from the Plan before the treatment starts;
3. your provincial medical plan pays a portion of the charges; and
4. the charges are made by a physician, anaesthetist, radiologist, laboratory or hospital.

The amount payable is reduced by the amount allowed under your provincial medical plan.

Emergency

Charges for services and supplies required as a result of a medical emergency occurring while travelling outside Canada if:

- you are or your Dependent is covered under a provincial medical plan; and
- treatment could not have been delayed until return to Canada.

Emergency Medical Insurance & Travel Assistance

While you are travelling outside your Province of residence carry the wallet card that has been provided to you.

LIMITATIONS

No amount will be paid by the Plan under this benefit for charges:

1. for the cost of fitting of contraceptive devices, except for the cost of an intrauterine device (IUD) or diaphragm;
2. for in vitro or in vivo procedures, or any other fertility procedures including drugs, unless otherwise specifically allowed in this plan;
3. made by a Physician in Canada;
4. for medical care or services which are cosmetic unless it is reconstructive surgery to restore tissue damaged by sickness or bodily injury;
5. for dental care or services, other than Hospital charges, except as described under Eligible Charges;
6. incurred for personal comfort items;
7. incurred for a change in gender;
8. for treatment which is experimental;
9. or myoelectric and electric prostheses;
10. foot orthotics/braces which have been specifically designed and made for an Insured as instructed in writing by a podiatrist;
11. for services or supplies in connection with participation in any sport or recreational activity if not required for other daily living activities;
12. that are in contravention of legislation forming a provincial medical plan;
13. charges excluded in this Plan Document.

To MAKE A CLAIM

Please submit your paid receipt to our office for processing. Your Employer can provide a claim form to you.

Because receipts are not returned after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit.

D.A. Townley & Associates Ltd. is the claims adjudicator only. Benefits are provided in accordance with the Plan Document issued to the Plan Sponsor, University of Northern British Columbia.

RESPECTING YOUR PRIVACY

At D.A. Townley & Associates Ltd. we are committed to protecting your personal information. This is a priority.

We maintain personal information about you that is required to provide the benefits and services that you or your employer request. We may also need to collect information about you from sources such as insurance companies, doctors and health care providers, the government and governmental agencies, and your employer.

This information is required to:

- *determine your eligibility for benefits,*
- *administer and adjudicate your benefits,*
- *determine the cost and financially manage these programs,*
- *meet regulatory or contractual requirements relating to the benefits and related services provided to you.*

Access to your personal information is restricted to those employees and representatives who are responsible for the administration and servicing of your contract(s) with us, or any other person whom you authorize. Your personal information will not be shared with your employer without your consent.

You are entitled to consult the information contained in our file and, if applicable, to have it corrected. To access the information that we have about you or to ask us to correct information, you can contact us at:

*D.A. Townley & Associates Ltd.
#101 – 4190 Lougheed Highway
Burnaby, BC V5C 6A8*

*Telephone: 604.299.7482 (for local calls) or
1.800.663.1356 (if you are calling from outside the Lower Mainland)
Facsimile: 604.299.8136*

To find out about our Privacy Policy, visit our website at www.datownley.com. You can also contact the Privacy Officer at the address and phone numbers listed above.