

**UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees
HEALTH CARE PLAN
INFORMATION BOOKLET**

**For the Employees of the
Hilton Vancouver Metrotown**

Effective January 1, 2010

UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan

Board of Trustees

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**IMPORTANT POINTS YOU SHOULD KNOW
ABOUT THIS PLAN**

- Coverage each month you are employed with one of the UNITE HERE Local 40 hotels depends on the hours you worked in the three consecutive months before that month.
- If you are not covered in any given month, it is YOUR RESPONSIBILITY to enroll you and your family in the B. C. Medical Services Plan (MSP).
- You must complete an Application form for Maternity/Parental Leave at least 4 weeks before you wish your leave to start.
- You must notify your hotel immediately when you cannot work due to disability. The Wage Loss claim form must be returned to the hotel or the Plan Administrator as soon as possible or your benefit payments could be reduced.
- Your Identification number under this Plan is your Social Insurance Number.
- There must be at least 6 months between Dental recall exams for children and at least 12 months between Dental recall exams for adults.
- It is your responsibility to make sure the claim forms are completed properly.
- IF YOU HAVE ANY QUESTIONS CONCERNING COVERAGE OR YOUR ELIGIBILITY, call the Plan Administrator.

The Trustees reserve the right to amend the Plan at anytime, with or without notice.

This booklet is an outline only. Should there be any conflict between this booklet and the Insurance Contracts or Plan Document, the terms of the Insurance Contracts and/or Plan Document will prevail.

SUMMARY OF THE HEALTH CARE PLAN as January 1, 2010

TABLE OF BENEFITS

Benefit	Group 1	Group 2	Group 3	Group 4
Life Insurance	\$15,000	\$10,000	\$5,000	\$5,000
Dep Life Spouse	Covered	Covered	Not Covered	Not Covered
Child	\$1,000	\$500		
AD&D	\$500	\$250		
Wage Loss	\$10,000	\$7,000	\$5,000	\$5,000
	75% to \$457/ week	75% to \$457/ week	Not Covered	Not Covered
MSP of BC	Covered	Covered	Covered	Not Covered
Extended Health Prescription Drug Card	Covered	Covered	Not Covered	Not Covered
Vision Care	Covered	Covered	Not Covered	Not Covered
Dental	Covered	Covered	Not Covered	Not Covered
Routine	90%	60%		
Major	80%	Not Covered		
Ortho	50%	Not Covered		
Fee Guide	current	current		

HEALTH CARE PLAN ELIGIBILITY

- Group 1** - If you have worked at least 324 hours in the 3 consecutive calendar months immediately before the date of a claim, you will be in Group 1.
- Group 2** - If you have worked at least 240 hours (but less than 324) in the 3 consecutive calendar months before the date of a claim, you will be in Group 2.
- Group 3** - If you have worked at least 190 hours (but less than 240) in the 3 consecutive calendar months before the date of a claim, you will be in Group 3.
- Group 4** - If you have worked at least 40 hours (but less than 190) in the 3 consecutive calendar months before the date of a claim, you will be in Group 4.
- NB** – See special requirements for Dental eligibility on Page 6.

HEALTH CARE PLAN HIGHLIGHTS

	Group 1	Group 2	Group 3	Group 4
A. <u>Life Insurance</u> (for Employees)	\$15,000	\$10,000	\$5,000	\$5,000
B. <u>Accidental Death & Dismemberment</u> (AD&D)	\$10,000	\$7,000	\$5,000	\$5,000
C. <u>Dependent Life</u>				
– Spouse	\$1,000	\$500	Not Covered	Not Covered
– Each Dependent Child	\$500	\$250	Covered	Covered
D. <u>Medical Services Plan</u> (MSP)				
<i>Groups 1, 2 & 3 only</i>	Premium Paid for Employee and dependents			Not Covered
E. <u>Wage Loss Indemnity</u> (TDI)				
– Amount	75% of Weekly earnings	75% of Weekly earnings	Not Covered	Not Covered
– Maximum	75% to \$457/week			
– Benefits Payable for disability caused by:				
• Accident	From 1st day	From 1st day		
• Illness	4th day	4th day		
• (if hospitalized)	1st day	1st day		
– Benefits Payable For	15 Plan weeks then EI then 15 Plan weeks	15 Plan weeks then EI then 15 Plan weeks		

<u>F. Extended Medical Benefits</u> <i>(Groups 1 & 2 only)</i>	Groups 1 & 2	Groups 3 & 4
Co-Insurance (i.e. The Plan Pays)	100% of eligible expenses 50% of Smoking Cessation Drugs	Not Covered
Maximum – Overall In Canada and Outside Canada	\$1,000,000 lifetime	
Maximum – Specific		
Health Practitioners (see page 31)	\$300/person/calendar year for each type of practitioner	
Orthopedic Shoes	\$250/person/calendar year	Not Covered
Orthotics	\$100/person/calendar year	
Private Duty Nursing	\$10,000/family every 3 yrs	
Hearing Aids (Jan. 1, 2001)	\$750/person/5 year period	
Wigs	\$150/person/lifetime	
Smoking Cessation	\$150/person lifetime	

<u>G. Dental Care Benefits</u> Co-Insurance <i>(i.e. The Plan Pays)</i>	Group 1	Group 2	Groups 3 & 4
Basic Services	90%	60%	Not Covered
Major Services	80%	Not Covered	Not Covered
Orthodontic Services	50%	Not Covered	Not Covered
Annual Maximum Payment			
Individual	\$2,100	\$2,100	N/A
Family	\$2,400	\$2,400	N/A
Aggregate	\$4,000	\$4,000	N/A
Dental Fee Guide	current	current	N/A

Pre-Authorization recommended for:

Basic Services	over \$500	over \$500
Major Services	all work	not covered
Orthodontia	all work	

H. Vision Care Benefits (Group 1 Participants only)

Maximum:

1. Lenses (including contact lenses)

– Single Vision	\$200*	not covered
– Bifocal	\$240*	not covered
– Trifocal	\$280*	not covered

*maximum allowed every 12 months for children under 19 or every 24 months for adults

2. Contact Lenses for specific conditions

	\$500/lifetime	not covered
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HEALTH CARE PLAN ELIGIBILITY

FOR THE EMPLOYEE

In order to become a Participant and to be eligible for benefits under the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan, you must meet all of the following qualifications:

1. You must be an Hourly Paid union employee.
2. You must be a member in good standing of the UNITE HERE Local 40.
3. You must have worked the **QUALIFYING HOURS** described below.
4. You must complete the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan Enrollment Card.

QUALIFYING HOURS

1. **Initial Eligibility (following Date of Hire)**

To be considered for coverage in any of the Groups for the first time, you must have worked three (3) “full months” and a minimum of forty (40) hours in that three-month period. You will then be eligible to be covered in one of the four Groups on the first day of the fourth month.

Example: If you were hired August 10th, the three “full months” would be:

Month No.	“Full Months”
1	August 10 to September 10
2	September 11 to October 10
3	October 11 to November 10

If the total hours worked were 40 or greater, you would enter the Plan December 1st.

2. **Continuing Eligibility**

To stay in the Plan, you must maintain a minimum 40 hours over three consecutive months.

3. To have Group 1 Benefits, you must have 324 hours over each three consecutive months (after you have “come on the plan” as described in (1) above).

Example: If you had a claim in December, the hours worked in September, October and November are added together. If the total was 324 or more, the claim would be paid as a Group 1 Benefit.

4. To have Group 2 Benefits, you must have 240 (but less than 324) hours over three consecutive months.

Example: If you had a claim in December, the hours worked in September, October and November are added together. If the total was 240 but less than 324, the claim would be paid as a Group 2 Benefit.

5. To have Group 3 Benefits, you must have 190 (but less than 240) hours over three consecutive months.
6. To have Group 4 benefits, you must have 40 (but less than 190) hours over three consecutive months and be an active employee at the time of death. (ie – your employment has not been terminated)

NOTE RE DENTAL ELIGIBILITY:

To come on the Dental Plan for the first time you must first have worked at least 3 consecutive months and become a GROUP 1 OR GROUP 2 Participant as described above; then, you must remain covered AS A GROUP 1 OR GROUP 2 PARTICIPANT for an additional four (4) consecutive months. Coverage begins in the month following this qualifying period. Once you have met this 7-month qualification, you will not have to serve an additional 4-month waiting period, should your hours fall below the 240 minimum, unless you terminate employment with the named hotel and do not return to one of them within six months.

FOR THE EMPLOYEE'S DEPENDENTS

1. Dependent Spouse

– must be a legal spouse or a common-law spouse (including a person of the same gender) with whom you have lived and represented to the public as your husband or wife in a marriage-like relationship for a continuous period of at least 12 months.

2. Dependent Children

- must be natural children, stepchildren, adopted children or foster children or legal ward (proof of legal guardianship is required).
- must be under the age of 19
- if your child is 19 but less than 25 years old, attending a university or similar institute of learning on a full-time basis, and wholly dependent on you for support and maintenance, he/she will continue to be covered until his/her 25th birthday. You must be able to provide proof of full-time attendance in school each academic semester.
- if your child is over 19 years of age and cannot support himself because he/she is functionally impaired, coverage will be continued as long as this plan is in force and he/she is wholly dependent on you for support and maintenance.

The following persons may not be covered as dependents under this plan:

- (i) your – parents, grandparents, brothers, sisters, nieces, nephews
- (ii) any person not resident in Canada unless attending university in the United States
- (iii) any person on active duty in the armed forces of any country
- (iv) any person who is covered as a Participant under this Plan

Special Restrictions for Dependent Life Insurance

- (i) Dependent Life Insurance does not cover children under 14 days old or over 21 years old.

COVERAGE DURING CERTAIN ABSENCES:

1. When You are Disabled (on Wage Loss Indemnity, EI disability or Workers' Compensation)

You will continue to be credited with hours for your entire period of disability so that your coverage will continue in the same "Group" you were in when you became disabled.

This means you will be credited with hours while disabled only when you are receiving Workers' Compensation Benefits, EI disability or Wage Loss Replacement benefits from this Plan.

If you have received the full 30 weeks of Wage Loss Replacement benefits from this Plan and you do not return to work, you will change Groups until your hours over three consecutive months drop below 40, at which time all benefits will cease. You may apply for Waiver of Premium to have your Life Insurance benefits continued during your disability.

If you are in receipt of Workers' Compensation Wage Loss benefits you will be credited with the hours you would have worked throughout the period you are in receipt of WCB wage loss benefits. Your benefits coverage will be reinstated according to the hours requirements stated above.

2. When You Are Laid Off

Hours are not credited while you are on lay-off. However, your coverage will continue as long as the hours credited before your lay-off add up to 240 or more over three consecutive months. It is your responsibility to keep track of your hours. **You will not be advised when your coverage runs out, but you can check with the Plan Administrator if in doubt.**

Example: If you are laid off January 1st and have a claim that occurred on the 15th, we would count your hours for October, November and December. If you had 160 hours in each month, you would have a total of 480 hours and, therefore, still qualify for Group 1 benefits.

If you had a claim in February, we would count hours in November (160), December (160) and January (0), for a total of 320; so you would qualify for Group 2 benefits.

If you had a claim in March and were still on lay-off, we would count December (160), January (0) and February (0), for a total of 160. You would qualify for Group 3 benefits.

When you return to work after lay-off, you will come back on the Plan when your hours over three consecutive months are sufficient to have you qualify for either Group 1, 2, 3 or 4.

3. When You Are On Paid Vacation

You will continue to be credited with hours based on the three months preceding the month of your vacation for your entire period of paid vacation so that your coverage will continue in the same “Group” you were in prior to your vacation. Qualified vacation is vacation to which you are entitled under the terms of the Collective Agreement.

4. For Maternity/Parental Leave

You will continue to be credited with hours based on the three months preceding the month of your maternity leave for the entire period of this leave, as defined in the Employment Standards Act of B.C. so that your coverage will continue in the same “Group” you were in prior to your leave. You must continue to make your contributions as stated in the Collective Agreement for the entire length of the leave.

5. During Paid Union Leave

You will continue to be credited with hours based on the three months preceding the month of your leave for your entire period of paid union leave so that your coverage will continue in the same “Group” you were in prior to your leave.

6. During Leave of Absence to Attend Apprenticeship School

You will continue to be credited with hours based on the three months preceding the month of your leave for your entire period of apprenticeship leave so that your coverage will continue in the same “Group” you were in prior to your leave.

7. During Lay-Off

You will not be credited with any hours during any period of lay-off. Your coverage will run out when your hours over three consecutive months no longer total 40.

8. During a Period of Suspension

Your coverage will run out when your hours no longer total 40. You will be credited with hours you would have worked for any period of suspension for which you are “made whole”.

9. Other Non-Paid Leaves of Absence

You will not be credited with any hours during any non-paid leave of absence (unless stated otherwise in the Collective Agreement). Your coverage will end in the month your hours over three consecutive months no longer total 40.

10. When You Return To Work After Leave of Absence

You will come back on the Plan in the month you have accumulated at least 240 hours in three consecutive months.

AFTER YOU TERMINATE EMPLOYMENT

There is no coverage after you terminate employment. With the exception of the Medical Services Plan of B.C. (MSP) and certain dental procedures, all coverage ceases on your date of termination. If you have a dental or extended medical claim that occurred after you terminated, it would not be paid. Claims should be submitted within six (6) months of termination of employment to ensure payment is made.

Your Medical Services Plan of B.C. would remain in effect until the end of the month following the month in which you terminate, if you were covered before you terminated.

If you die, from accidental or natural causes, within 31 days of your date of termination, your Life Insurance benefit would be paid to your named beneficiary, providing you were covered in one of the eligible Groups when you terminated.

COST OF THIS PLAN

Under the terms of your Collective Agreement, you are required to contribute to this Plan for each hour worked (whether or not you qualify for benefits). You are also required to contribute while on maternity/parental leave of absence in order to have your coverage continued throughout your maternity/ parental leave.

TAXATION OF HEALTH CARE PLAN BENEFITS

There are presently three (3) Health Care Plan benefits that are taxable by the Canada Revenue Agency:

1. Medical Services Plan of British Columbia premiums

Effective January 1, 1973, Canada Revenue Agency declared that Provincial medical premiums paid on behalf of eligible persons from a Health Care Plan funded with employer contributions, constituted a taxable benefit to the individual.

Accordingly, within the first two month period of each calendar year, members for whom the Medical Services Plan of British Columbia coverage was purchased will receive from the Office of the Plan Administrator, a T-4A which will reflect the amount of premium paid by the Health Care Plan during the previous calendar year on behalf of eligible Plan members.

2. Accident & Sickness (Wage Loss) Benefit payments

Effective January 1, 1974, Wage Loss benefits received from a Health Care Plan funded with employer contributions, constituted a taxable benefit to the individual.

Each Plan member who has received Accident & Sickness (Wage Loss) Benefit payments from the Health Care Plan will receive a T-4A from the Office of the Plan Administrator which will reflect the amount of Wage Loss benefit paid by the Health Care Plan to the Plan member during the previous calendar year.

3. Life Insurance and Dependent Life Insurance premiums

Effective July 1, 1994, Canada Revenue Agency declared that Life Insurance and Dependent Life Insurance premiums paid on behalf of eligible persons from a Health Care Plan funded with employer contributions, constituted a taxable benefit to the individual.

Accordingly, within the first two month period of each calendar year, members for whom Life Insurance and Dependent Life Insurance premiums were paid will receive from the Office of the Plan Administrator, a T-4A which will reflect the amount of premium paid by the Health Care Plan during the previous calendar year on behalf of eligible Plan members.

Coordination of Medical and Dental Care Benefits

The purpose of the health care insurance is to help meet actual expenses and consequently this Plan contains a non-profit provision. As a result, your benefits under this Plan may be reduced so that you will not receive more in benefits from all plans covering you and your dependents than your actual expenses, "Plans" include medical and dental care benefits under a law or government program, Group Insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above high school level.

LIFE INSURANCE PLAN DETAILS

LIFE INSURANCE (for Employees)

Amount of Coverage

Group 1	Group 2	Group 3	Group 4
\$15,000	\$10,000	\$5,000	\$5,000

If you die, from any cause, while you are a participant, benefits will be paid to the beneficiary you have named on your Enrollment Card.

No benefit is paid if you die after age 70.

Participant Conversion Option

If the Participant Life Insurance terminates because the insured Participant's employment or class membership terminates or because the insured Participant no longer qualifies for coverage under the Disability Provision, then on or before the insured Participant's 65th birthday, the insured Participant may convert up to 100% of the terminated amount, less any amount of group life insurance for which the insured Participant may become eligible within 31 days of the date of the termination.

Note: The conversion option does not apply to reduction of life insurance or termination of insurance which become effective at specified ages or upon an insured Participant's retirement.

The individual policy may be:

- a permanent plan that Manulife Financial offers to the public at the time of conversion;
- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

In no event may the converted policy exceed \$200,000, nor may it include disability or other added benefits.

An insured Participant must apply in writing and pay the first premium to Manulife Financial within 31 days of the date the Participant's insurance terminates. The premium rates will be based on the age and class of risk of the Participant at the time of conversion. No medical examination or health questionnaire will be required. See your Human Resources Department for details.

Continuation of Coverage During Disability

If you become **Totally and Permanently Disabled** prior to age 60 and remain so for the next 15 weeks, you may apply to have your life insurance coverage continued for the duration of your disability (up to age 65). **Totally and Permanently Disabled** means that, solely because of an illness or injury, you are unable to work at any occupation for which you are or may become fitted by education, training or experience. It is **your responsibility** to apply for this "Waiver of Premium for Disability" benefit and provide the proof of continuing disability required from time-to-time by the Insurance Company. This should be done immediately after your Wage Loss Benefits cease or within 24 months of the date of cessation of active work when you became disabled. See your Human Resources Department for details.

Extension of Benefit

If you die within 31 days of the date your Life Insurance terminates, the amount that could have been converted will be paid to your named beneficiary as a death benefit even if you did not apply for conversion.

LIFE INSURANCE FOR YOUR DEPENDENTS

Amount of Coverage

	Group 1	Group 2	Group 3	Group 4
Spouse	\$1,000	\$500	Not	Not
Each Dependent Child	\$500	\$250	Covered	Covered

If one of your dependents dies while you qualify for Group 1 or Group 2 benefits, you will be paid the above amount of coverage.

You will be required to complete the Death Benefit Claim form and provide the required Proof of Death.

Dependent Life Insurance terminates when your Life Insurance terminates.

No benefit is payable for death of a spouse who dies after age 70.

Continuation of Coverage During Disability

If premium has been continued as described under the “Continuation of Coverage During Disability” provision in the section titled Life Insurance Plan Details, your Dependent Life Insurance will also be continued.

Dependent Conversion Option

If Dependent Life Insurance for a spouse terminates because the insured Participant’s employment or class membership terminates or because of the insured Participant’s death, on or before the spouse’s 65th birthday, the spouse may convert up to 100% of the terminated amount, less any amount of group life insurance for which the spouse may become eligible within 31 days of the date this Benefit is discontinued.

Note: The conversion option does not apply to reduction of life insurance or termination of insurance which become effective at specified ages or upon an insured Participant’s retirement.

The individual policy may be:

- a permanent plan that Manulife Financial offers to the public at the time of conversion;
- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

In no event may the converted policy exceed \$200,000, nor may it include disability or other added benefits.

The insured Participant or spouse must apply in writing and pay the first premium to Manulife Financial within 31 days of the date the spouse’s insurance terminates. The premium rates will be based on the spouse’s age and class of risk at the time of conversion. No medical examination or health questionnaire will be required.

Extension of Benefit

If your spouse dies within 31 days of the date Dependent Life Insurance terminates, the amount that could have been converted will be paid to you as a death benefit even if no application for conversion was made.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

	Group 1	Group 2	Group 3	Group 4
Amount of Coverage	\$10,000	\$7,000	\$5,000	\$5,000

If you sustain an accidental bodily injury while insured and if your loss occurs as a direct result, and within 1 year, of the accident, the amount shown in the Table of Benefits will be paid to you, if living, otherwise to the named beneficiary(ies), if living, or to your estate.

If you suffer one of the following “losses”, a portion of your AD&D Insurance benefit will be paid to you:

For Loss of:	% Paid
Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200%
Life	100%
Both hands	100%
Both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the entire sight of one eye	100%
One foot and the entire sight of one eye	100%
Both arms	100%
Both legs	100%
Speech and Hearing	100%
One arm	75%
One hand	66 ² / ₃ %
One foot	66 ² / ₃ %
Entire sight of one eye	66 ² / ₃ %
Speech, or hearing of both ears	66 ² / ₃ %
Thumb and index finger or 4 fingers of one hand	33 ¹ / ₃ %
Hearing in one ear	16 ² / ₃ %
Five toes of one foot	12 ¹ / ₂ %
 Loss or Loss of Use of:	
One arm and one leg	100%
One arm	75%
One leg	75%
One hand or foot	66 ² / ₃ %

If you suffer more than one of the above losses as a result of the same accident, not more than 100% of the amount for which you are insured will be paid.

Loss as above used with reference to:

- quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs;
- hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- arm or leg means complete severance through or above the elbow or knee joint;
- thumb or finger means complete severance through or above the first phalange;
- toes means complete severance of both phalanges of all the toes of one foot;
- eye means the irrecoverable loss of the entire sight thereof;
- speech means complete and irrecoverable loss of the ability to utter intelligible sounds; and
- hearing means complete and irrecoverable loss of hearing in both ears.

Loss of use as above used means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

Exposure and Disappearance

Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

If an insured participant disappears as a direct result of the accidental disappearance, wrecking or sinking of the conveyance in which he was an occupant; provided, there is no evidence within 1 year thereafter that the insured participant is still alive.

Repatriation Benefit

When injuries result in loss of life of an insured participant more than 200km from such participant's permanent city or town of residence and for which the death benefit is payable, payment will be made for the actual expenses incurred, but not more than \$10,000, for preparing the deceased for burial and shipment of the body to the city or town of residence.

Transportation of A Family Member

If a participant is confined in a hospital as a result of an accident for which a benefit may be payable while the participant is more than 200 km from his permanent place of residence and the attending physician recommends the personal attendance of a member of the immediate family, an amount equal to the actual expenses incurred, but not more than \$10,000, will be paid for round-trip transportation by the most direct route by a licensed common carrier for one Immediate Family Member to the participant.

Immediate Family Member means the participant's spouse (or common-law spouse), or a parent, grandparent, child over age 18, brother or sister.

Rehabilitation Benefit

If a benefit, other than a benefit for loss of life, becomes payable, an additional benefit equal to the reasonable and necessary expenses actually incurred up to a limit of \$10,000 will be paid for the participant's special training, provided:

- such training is required because of the injuries sustained in the accident and in order for the participant to be qualified to engage in an occupation in which he would not have been engaged except for such injuries;
- expenses are incurred within two years from the date of the accident; and

No payment will be made for ordinary living, travelling or clothing expenses.

Seat Belt Benefit

If a participant while insured is a passenger or driver of a private passenger type automobile and is involved in an accident for which a benefit is payable under this contract, the benefit will be increased by 10% if the participant was wearing a seat belt properly fastened. Verification of actual use of the seat belt must be part of the official report of the accident or certified by the investigating police officer.

Day Care Benefit

If the death benefit becomes payable for the accidental loss of life of an insured participant the Insurer will pay the lesser of the following amounts for each dependent child who is under age 13 and is currently enrolled or becomes enrolled in an accredited day care centre within 90 days following the participant's death:

- the actual charges made by such day care centre per year with respect to such child;
- 3% of the death benefit;
- \$5,000 per year.

Such amount will be payable annually for a maximum of four consecutive annual payments while child continues to be enrolled in an accredited day care centre and under age 13.

Home Alteration and Vehicle Modification Benefit

If a benefit, other than a benefit for loss of life, becomes payable and the participant is subsequently required to use a wheelchair to be ambulatory due to the same cause for which the benefit became payable, upon presentation of proof of payment, the Insurer will pay:

- the one-time cost of alterations to the participant's residence, to make it wheelchair accessible and habitable, if carried out by an experienced individual in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users; and
- the one-time cost of modifications necessary to a motor vehicle owned by the participant, to make the vehicle accessible or driveable for the participant, if carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities;

up to a combined maximum of \$10,000, provided these are made on the participant's behalf.

Benefits for loss of life are payable to the Beneficiary you name on your Enrollment Card. Benefits for other losses are payable to you.

This Benefit Does Not Cover: (Limitations)

No amount will be paid for a loss which results from or is contributed to by:

- war, whether declared or not;
- suicide or attempt thereat, while sane or insane;
- self-inflicted injury, while sane or insane;
- active full-time service in the armed forces of any country;
- travelling or flying in, or descending from, any kind of aircraft, as a pilot, operator or member of the crew. However, insurance will include injury sustained while the participant is riding as a passenger with no duties whatsoever, in or on, boarding or alighting from any aircraft having a current and valid air worthiness certificate, or from any transport type aircraft operated by the transport command of the Canadian Armed Forces Air Transport Command or by the similar Transport Service of any country but excluding while flying in any aircraft owned or operated by the employer.

MEDICAL SERVICES PLAN OF BC (MSP) COVERAGE

The MSP plan provides only basic medical coverage which is available to residents of British Columbia.

Eligibility (as determined by the Medical Services Plan of B.C.)

The Medical and Health Care Services Act defines a resident as a person who:

- (a) is a citizen of Canada or is lawfully admitted to Canada for permanent residence,
- (b) makes his or her home in British Columbia, and
- (c) is physically present in British Columbia at least six months in a calendar year,

and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to BC.

In order for the Plan to pay the premium required for this benefit, you must have met the “Qualifying Hours” requirements for either Group 1, Group 2 or Group 3.

Note:

- Eligibility for MSP coverage is determined by the B. C. Medical Plan. You will be required to provide proof of Canadian citizenship or up-to-date immigration documents for each of your family members. You will also be required proof on-going proof of an over-age dependent’s attendance at school.
- There will be a three month waiting period for all new residents to the province.
- This Plan will not pay MSP premiums if you are covered as an employee or dependent of another plan that pays the premium (eg. Your spouse’s employer, Social Services, etc.).

Benefits under the Plan

- Medically required services of a physician for diagnosis and treatment of illness or injury
- Services of certified specialist where referred by a family physician
- Obstetrical care or specialist with proper referral
- Administration of anaesthetics
- Diagnostic x-ray and laboratory services
- Dental surgery when performed in a hospital
- Chiropractic, osteopath, massage, naturopathic, and physiotherapy services (12 treatments maximum per year if under age 65; 15 treatments for age 65 and over)
- Diagnostic optometric services (one exam every 2 years for persons age 16 to 64)
- Podiatry including Chiropodist services which is medically necessary and orthodontic service for cleft palate.

Other Agencies Health Related Benefits

- B.C. Hospital Act - (Public Ward Accommodation)
- Fair Pharmacare - prescription drugs (annual deductible, co-insurance, reference-based pricing)
- Ambulance service provided by Emergency Health Services Commission.

Cost of the MSP Plan (if you do not qualify for the Health Care Plan)

If you do not meet the “Qualifying Hours” requirement, you can purchase individual coverage from MSP. The rates as of the date of this booklet printing are:

	Jan. 1, 2009	Jan. 1, 2010	Jan. 1, 2011	Jan. 1, 2012
Single	\$ 54.00	\$ 57.00	\$ 60.00	\$ 64.00
Couple	\$ 96.00	\$ 102.00	\$ 108.00	\$ 114.00
Family	\$ 108.00	\$ 114.00	\$ 120.00	\$ 124.00

Your Human Resources Office may have a supply, or you can telephone the MSP office at 604-683-7151.

If your total family income is less than \$30,000.00 in a year, you may be eligible for a premium reduction. Applications for this premium reduction are available in the Human Resources Office.

Special Note re MSP:

If you do not have enough hours to qualify for premium payment under this plan (ie, at least 190 hours in the three months preceding the month of coverage), you must maintain personal coverage for you and your family.

If you do not maintain coverage, not only will you and your family not have any medical insurance, MSP will not backdate coverage when you again become eligible for premium payment under this plan.

DISABILITY BENEFIT (WAGE LOSS BENEFITS)

Amount of Coverage

Groups 1 & 2

75% of weekly earnings to current maximum payable of \$457/week

Groups 3 & 4

Not Covered

When Benefits Start

If you are disabled because of an accident, benefits begin immediately (**1st day**).

If you are disabled because of illness, benefit payments begin on the **4th day**.

If you are admitted to hospital, benefits begin immediately (**1st day**).

In all cases, benefits are not paid on days that would have been your “day off”.

In all cases, you must be under the care of a physician (M.D.). The calculation of the benefit period does not begin until you have seen a doctor or completed the waiting period, whichever is later.

Wage Loss Benefit Payment Periods

1. From Health Care Plan
A maximum 15 week period at 75% of weekly earnings to current maximum payable of \$457/wk.
2. From Employment Insurance (EI).
Your maximum EI entitlement or 15 weeks, whichever is shorter, and
3. From Health Care Plan
A further maximum 15 week period payable at the rate of the initial 15 week payment period (75% of weekly earnings rounded up to the nearest dollar to a weekly maximum of \$457).

When do benefit payments end?

Benefit payments will end on the earlier of:

- the date your disability ends and you return to work
- the date you are no longer under the care of a doctor
- the date that is 45 weeks from the day you were disabled (or, in the case of sickness, from the end of the 3 day waiting period)

The 45 weeks will be reduced by any weeks or part weeks denied due to late filing of your claim.

Exclusions and Limitations

In cases of sickness or injury, wage loss benefits will not be paid to any participant:

- who does not have the qualifying hours;
- who is not under the care of a licensed physician;
- whose illness or injury is covered by workers' compensation, the Canada Pension Plan or the Quebec Pension Plan;
- whose illness or injury is intentionally self-inflicted;
- whose illness or injury results from war, participation in a riot or disorderly conduct;
- while on leave of absence or on paid vacation;
- whose illness or injury results from committing a criminal offence;
- who is disabled by drugs or alcoholism, unless you are receiving continuous treatment for that disability by a physician in an approved program;
- who is not receiving accepted standard professional treatment for the condition being treated and where appropriate, treatment by a relevant and certified specialist;
- when you are pregnant:
- for any week or period for which you are eligible, or would have been eligible if you had applied, to collect Employment Canada Maternity Benefits;
- who leaves Canada;
- who engages in **any** work for which you are paid, either in your hotel or for any other employer in which you did not engage immediately prior to the start of the disability;

- for any period of lay-off for which you received written notice prior to the date you became totally disabled. However, if, at the scheduled date of layoff, you have been receiving wage loss benefits for 2 months or more, your benefits will continue until the date of recovery or 30 weeks from the date of disability, whichever is earlier;
- for any period for which you are claiming compensation as set out in **Participant’s Obligation to Reimburse the Plan;**
- who has plastic surgery solely for cosmetic purposes, except where attributable to illness or injury;

Note - Retroactive benefits will not be paid for the period that is more than 4 weeks before the date your hotel received the claim. For example, if you are off 6 weeks and you wait until you return to work before submitting your claim, you will only be paid for 4 weeks instead of 6 weeks.

Also, if you do not return your supplementary medical evidence to your hotel within 4 weeks of its being requested, your retroactive benefits will not be paid for the period since your last payment that is more than 4 weeks before the date your hotel received the supplementary medical report.

How the Amount of Coverage is Calculated

The benefit amount is 75% of your average weekly earnings that you were paid in the three consecutive calendar months immediately preceding the month you were disabled, including bonus and overtime pay, to a maximum specified above.

If you were on paid vacation during this three month period, the calculation will include the earnings paid to you during this period.

If you are disabled for a part of a week, the daily amount of benefit is calculated at 1/5 of the weekly rate (eg. If the weekly benefit amount is \$400, the daily rate will be \$400 divided by 5 or \$80/day).

You are not paid for days off and your regular days off are not counted in the calculation of the 3 day waiting period for disability due to illness.

This amount will be reduced by income you receive from:

1. any other group disability benefits;
2. retirement benefits provided by an employer and/or the government;
3. other benefits payable under any government disability plan;
4. benefits payable under any Workers’ Compensation Act;
5. income replacement paid to you under a government plan of automobile insurance (eg. ICBC);
6. earnings recovered through a legally enforceable cause of action against some other person or corporation in accordance with provisions under Participant’s Obligation to Reimburse the Plan.

Recurrent Disabilities

A new Waiting Period and Benefit Period will start if you return to active full-time work for:

- a period of 2 weeks before you again become disabled because of the same or a related cause; or
- One full day before you again become disabled because of a different or an unrelated cause.

Examples

1. You are disabled because of a broken leg and collect 8 weeks of benefit before returning to work. You are back to work one week and have to go off again for the same reason (the leg has not healed yet):
 - you would be eligible to collect 22 more weeks of disability, if you were totally disabled for that amount of time.
2. You are disabled for pneumonia and collect 4 weeks of benefit before returning to work. You come back to work for one week and break your leg in an accident (off the job):
 - the broken leg would be considered an unrelated cause and you would be eligible for full (30 weeks) benefits again.
3. If you are disabled for pneumonia and collect 4 weeks of benefit, however before you return to work you are disabled with a broken leg, you would be eligible to receive the remaining 26 weeks of disability because you did not return to work for one full day before becoming disabled by the unrelated cause.

Participant's Obligation to Reimburse the Plan

In every case where a Participant claims in the form of monetary compensation payments made for wage loss from the Workers' Compensation Board or the Insurance Corporation of B.C. (or similar agents or legislative bodies in other provinces) or any other third party, then the Participant shall not be entitled to the payment of benefits. However, money may be advanced as a loan in an amount equal to that which would otherwise be paid as benefits. This loan is to be repaid by the Participant in the event he recovers such compensation. This loan will not include legal fees incurred by the Participant in the course of recovery of compensation from a third party.

Where the Participant makes such a claim, he shall:

- (i) **Complete and sign the Third Party Liability Reimbursement Agreement/Direction provided by the Trustees and, if applicable, the Assignment of benefits Agreement;**
- (ii) **Notify his legal counsel, if any, and the third party's insurer of the Plan's subrogation interest.**

- (iii) **As soon as he becomes aware that there is a settlement for monetary compensation, provide to the Trustees full particulars of the settlement and co-operate with and assist the Trustees to obtain any and all information and documents with respect to the settlement which they may require;**
- (iv) **Promptly pay to the Trustees the lesser of the amount or amounts loaned to him under the Plan or the full amount recovered by the Participant in settlement of the third party claim.**

It shall be the duty and obligation of a Participant whose disability or loss is caused by or attributable to any act or omission by the Workers' Compensation Board or I.C.B.C. or any other third party to do everything necessary to make a claim to effect a settlement.

If, after a request by the Trustees that he do so, such Participant shall decline or refuse to do anything which, in the opinion of the Trustees, is necessary to make a claim to effect a settlement and the Trustees are advised by legal counsel that such Participant has a valid claim, then the Trustees shall be entitled to do any such thing in the name of the Participant to make a claim to effect a settlement.

BRITISH COLUMBIA FAIR PHARMACARE PROGRAM – Effective May 1, 2003

Residents of British Columbia are required to register with the BC Fair PharmaCare Program and complete a “consent form” which will permit Fair PharmaCare to verify with Canada Revenue Agency (CRA) the information necessary to calculate the income-based annual Family Deductible and Family Maximum.

The annual Fair PharmaCare “Family Deductible” and the “Family Maximum” calculations are based on a percentage of net annual family income. After the annual “Family Maximum” has been reached, 100% of eligible drug costs are paid by Fair PharmaCare.

Registration with the BC Fair PharmaCare Program can be accomplished through one of the following means:

- 1. Telephone 604-683-7151, or
- 2. Complete a Fair PharmaCare Program Registration Form which can be obtained at the Office of the Plan Administrator or your Human Resources Department, or
- 3. Go on-line: www.healthservices.gov.bc.ca/pharme/

Health Care Plan participants are required to register with BC Fair PharmaCare only once after which confirmation of their BC Fair PharmaCare Financial Assistance Level (Year of Coverage, Family Deductible, PharmaCare Portion and Family Maximum) will be mailed to them upon request for each subsequent calendar year.

Confirmation of your annual BC Fair PharmaCare Financial Assistance Level should then be forwarded to the Health Care Plan Administrator.

The BC Fair PharmaCare Program will no longer retroactively assign an “Annual Deductible” or “Annual Family Maximum” to persons who have failed to register with Fair PharmaCare.

Fair PharmaCare will assign an annual deductible of \$10,000 to persons for calendar years prior to the calendar year of registration with the BC Fair PharmaCare Program.

Prescription drug expenses incurred prior to the calendar year of registration with Fair PharmaCare are not eligible UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan expenses.

After the annual “Family deductible” which is 100% paid by the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan, the BC Fair PharmaCare Program will pay 70% (or 75% for BC seniors who are 65 years or older) of the cost of eligible prescription drugs. The UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan will pay the remaining 30% up to the annual “Family Maximum” of \$2,000.

Eligible prescription drugs may include the lowest cost alternative to the drug prescribed by your doctor. Your pharmacist will advise you of the low cost alternative and you will have the choice of the low cost alternative or the higher cost brand name drug.

If you select the higher cost drug, Fair PharmaCare and the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan will only pay for the lower cost drug unless your physician has applied for and been approved for a “Special Authority” which permits payment of the higher cost drug.

(i)	Annual Fair PharmaCare Deductible (per Family)	Income based
(ii)	Co-insurance paid by Fair PharmaCare	70%
(iii)	Co-insurance paid by UNITE HERE Local 40 Health Care Plan to an annual maximum of \$2,000	30%

Example

If you had \$1,000 in prescription drug expenses and your annual Fair PharmaCare deductible was \$300:

1.	The UNITE HERE Local 40 Health Care Plan would pay		
	(i)	100% of \$300	= \$300
	(ii)	plus 100% of the 30% not paid by Pharmacare	= <u>\$210</u>
			\$510
2.	B.C. Pharmacare would pay		
		\$1,000	
		<u>-\$300</u>	
		\$700* x 70%	= \$490

*assuming all expenses met Pharmacare’s reference-based, low cost alternative price list. If it did not, the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Plan would pick up more. NB: The BC Pharmacare plan also has a cap on the dispensing fee.

Effective September 1, 1995, all BC Pharmacists were required to be “on-line” to the Pharmanet system. This will enable BC Pharmacare to adjudicate claims automatically so that once you have reached the

deductible, you will be charged only the amount not paid by Pharmcare. Pharmacare Claims will be processed electronically so that you will not have to send your receipts to them each year. You will have to submit original receipts to this plan in order to claim benefits. These receipts will no longer be returned by the insurance company. You will be able to use your Explanation of Benefits for income tax purposes if required.

EXTENDED MEDICAL BENEFITS (Groups 1 & 2 only)

Amount Paid by Plan	100% of covered expenses
Overall Maximum	In Canada and Out of Province – \$1,000,000 per person per lifetime

* Certain expenses described below have annual maximums - Refer to Summary of the Plan for details.

Covered Expenses

The Plan will pay **one hundred percent (100%)** of the charges for the following eligible services (if ordered by a physician) for Group 1 and Group 2 Participants only if approved by the BC Fair PharmaCare Program to an annual family maximum of \$2,000. Individual maximums may apply to certain benefits as determined from time to time by the Trustees.

- (a) charges for drugs, including oral contraceptives but excluding fertility drugs, prescribed by a licensed doctor (MD) or licensed dentist and dispensed by a registered pharmacist that, regardless of their legal status are not normally obtainable except by a prescription from a licensed doctor (MD) or licensed dentist (limited to a 3-month supply at any one time);

Viagra lifetime maximum is \$1,000

Prescription drugs for Smoking cessation products are paid at 50% to a lifetime maximum payment of \$150 per covered person.

- (b) intra-uterine devices and diaphragms prescribed by a medical doctor(MD);
- (c) charges for room and board in a hospital in Canada, including regular daily services and supplies furnished by the hospital on a semi-private room basis. If the hospital does not have semi-private rooms, the charge will be limited to 80% of the lowest daily rate for a private room in that hospital;
- (d) licensed ground ambulance when used to transport the Participant or his/her Insured Dependent;
- from the place where the Participant or his eligible Dependent suffers bodily injury, illness or disease to the nearest hospital where adequate treatment is available, or
 - from one hospital to another hospital, for specialized medical treatment not available at the first hospital, or from a hospital to a convalescent hospital, or
 - from a hospital to the Participant's residence;

- (e) private duty professional nursing services by a registered graduate nurse, licensed practical nurse, registered nursing assistant where ordered by a doctor as medically necessary for a disability that requires the specialized training of an RN, LPN or RNA other than someone living in the same house as the patient and is not a member of your family. (See Summary of the Plan for maximum payable);
- (f) the following orthopedic supplies prescribed by a medical doctor up to the maximums specified on Page 3 of this Booklet:
 - (i) arch supports, Dennis Browne Splints, lifts and wedges, or custom made orthotic devices required for everyday use (but not for sports) when recommended by a licensed doctor (MD);
 - (ii) Orthopedic shoes custom made for the covered person or orthopedic shoes that have been custom adjusted for the covered person and purchased through a orthopedic shoe supplier upon the recommendation of a medical doctor. (Off-the-shelf orthopedic shoes are not covered)
- (g) services of the following health care practitioners up to the maximums specified;
 - (i) \$24 first visit, \$16 for the next 11 visits and reasonable and customary charges for any further visits up to the maximum of \$300 per type of practitioner:
 - Chiropractor, Physiotherapist, Masseur* or Massage Therapist*, Naturopath or Podiatrist
 - (ii) \$300 per type of practitioner:
 - Psychologist*, Osteopath, Chiropodist, Speech Therapist*, Acupuncturist* or Dietician,

*These services require a referral by a medical doctor.

In all cases, the medical practitioner cannot be a close relative or reside in the same house as the patient.

NB: No amount will be paid for any visits for which any amount is payable under the Medical Services Plan nor will any amount be paid for the user fee.

- (h) the following other services and supplies:
 - (i) diagnostic x-ray and laboratory examinations;
 - (ii) surgical dressings;
 - (iii) blood and blood plasma;
 - (iv) artificial limbs, larynx and eyes;
 - (v) plaster casts, splints, trusses, braces and crutches;
 - (vi) rental or, at the option of the Trustees on the advice of the Claims Adjudicator, purchase of wheelchair, hospital bed or iron lung;
 - (vii) treatment by x-ray, radium or other radioactive substances;

- (viii) oxygen and rental of equipment for its administration, except where charges for these items are included in any hospital charge;
 - (ix) diabetic and colostomy supplies;
 - (x) support hose prescribed by a physician for treatment of a medical condition to a maximum of 2 pair per calendar year;
 - (xi) wigs for cancer patients undergoing chemotherapy, up to a lifetime maximum of \$150 per person;
 - (xii) hearing aids (excluding batteries), when recommended by an otolaryngologist or licensed audiologist, up to a benefit maximum of \$750 per 5 year period, effective January 1, 2001.
- (i) vaccinations and immunizations for the preventive treatment of communicable diseases;
 - (j) **Out-of-Province but within Canada**

Emergency Care

Charges incurred while travelling or vacationing outside the covered person's home Province for periods of not more than **2 months**, provided part of the charge is payable under the covered person's Provincial Health Plan, that are:

- hospital charges, but not beyond the Hospital Maximum Stay shown in the Schedule for:
- room and board in excess of the ward rate under the covered person's Provincial Health Plan up to the Hospital Room and Board Limit shown in the Schedule excluding user fees; and
- other inpatient and outpatient medical services; and
- reasonable and customary charges for the area in which they are incurred, that are in excess of the amount payable under the covered person's Provincial Health Plan for:
- a licensed doctor (M.D.);
- professional licensed ambulance service, including air or rail ambulance service, to transport the covered person back to a hospital within such person's home Province, provided prior approval is obtained from the Insurer; and
- blood, blood products and their transfusion.

(k) Expenses Incurred While Out-of-Canada

Charges for the following items incurred while out of Canada for periods not exceeding 2 months will be paid provided the expense is prescribed by a doctor and a portion is paid by the BC Medical Services Plan:

- (i) Services for emergency treatment of a bodily injury or disease which occurred while the Participant or his Dependent was travelling outside Canada which require:
 - public ward accommodation and auxiliary hospital services in a hospital, and
 - services of a doctor; and
 - drugs which may only be dispensed upon the prescription of a doctor or a dentist.

The eligible expenses will be equivalent to the charge made in the area where the expenses are incurred less any charge covered by any government plan subject to the lifetime maximum.

VISION CARE BENEFITS

The following Vision Care benefits apply only to Group 1 Participants and their Dependents, if prescribed by a licensed ophthalmologist or optometrist. The Vision Care prescription must be included with all claims submitted to the Plan Administrator.

Vision Care (Group 1 only)

- (a) One set of new lenses, including contact lenses selected in place of spectacle lenses, not more frequently than once in 24 months, or in 12 months in the case of individuals under 19 years of age, to the following limits:
- | | |
|---|---------|
| single vision lenses or laser eye surgery | – \$200 |
| bifocal lenses | – \$240 |
| trifocal lenses | – \$280 |
- (b) Up to \$500 during the lifetime of the Participant and their qualified Dependents for one set of contact lenses or laser eye surgery prescribed by an Ophthalmologist or Optometrist for:
- (i) correction of corneal astigmatism, severe corneal scarring keratoconus, conical cornea or aphakia, and
- (ii) when visual acuity in the better eye cannot be improved to at least the 20/40 level by glasses.

No benefits will be paid for frames or the replacement of lost, stolen or broken lenses or frames, duplicate or spare eyeglasses, nor for safety or sunglasses nor tinted glasses with a tint other than Number 1, nor for eye examinations required as a condition of employment.

Definitions With Respect to These Extended Medical and Vision Care Benefits:

- (a) “Close Relative” means brother, sister, parent or child or such in-law of a Participant or of his Spouse.
- (b) “Hospital” is a place that:
- chiefly provides inpatient medical care of the injured, sick or chronically ill;
 - has a staff of licensed doctors (M.D.) and 24-hour nursing care by registered nurses (R.N.); and
 - is approved as a hospital for payment of the ward rate under the Provincial Health Plan.

No Benefits Will be Paid in Connection With:

- (a) charges for:
- (i) remedying a condition by means of cosmetic surgery, unless such condition is the result of accidental injuries sustained while the person is eligible for benefits,

- (ii) illness due to war, whether declared or undeclared, including resistance to armed aggression, or
 - (iii) telephone consultations made by a physician with respect to a person's sickness or injury;
- (b) charges incurred for examinations to determine the need for, or the proper adjustment of, hearing aids
- (c) **no benefit will be paid in respect of any charge for a service or supply:**
- (i) furnished by or on behalf of any government, unless payment of the charge is legally required,
 - (ii) to the extent to which any benefit is provided by any law, governmental program, or regulation of Canada or of any of its Provinces, under which the individual is eligible to be covered,
 - (iii) to any extent that group insurance benefits are prohibited in connection with such charge,
 - (iv) not reasonably necessary for the medical care of the patient's sickness, injury, or condition,
 - (v) for check-ups (including screening, routine physical examinations, and research studies) not reasonably necessary to the treatment of a sickness or injury,
 - (vi) or in excess of the reasonable and customary charge for the Area in which the charge was incurred. Provided, however, that where a charge is prescribed under the Medical Services Plan of British Columbia, such charge shall be deemed conclusively to be the reasonable and customary charge for such service or supply,
 - (vii) **covered expenses incurred outside Canada, unless required for EMERGENCY treatment.** Benefits will be limited to the reasonable and customary charges for the area in which they are incurred, decreased by the amount that is paid or would have been paid by the Medical Services Plan of British Columbia,
 - (viii) for physicians' services or x-ray examinations in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue, UNLESS the charges are in connection with the treatment or removal of malignant tumours which, except for this clause, would be covered under the coverage,
 - (ix) for physicians' services in connection with eye refraction or any other examination to determine the need for or the proper adjustment of eyeglasses,
 - (x) for the user fee amount charged by certain practitioners and not paid by the B.C. Medical Services Plan.
 - (xi) for physicians' services in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion, UNLESS the charges are for an open cutting operation, which, except for this clause, would be covered under the coverage,

- (xii) for physicians' services in connection with corns, calluses, or toenails, UNLESS the charges are for the following service, which, except for this clause, would be covered under the coverage: the partial or complete removal of nail roots, or services reasonably necessary for the treatment of a metabolic or peripheral-vascular disease,

DENTAL CARE BENEFITS (Groups 1 & 2 only)

NOTE:

It is advisable that you and your dependents show your dentist(s) this booklet at the time of your first visit to ensure there is no misunderstanding regarding your coverage.

Eligibility

You and your dependents do not qualify for these benefits until you have been eligible for coverage in the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan for 7 consecutive months as a Group 1 or Group 2 Participant.

	Group 1	Group 2
Co-Insurance (Amount paid by Plan)		
– Routine Services	90%	60%
– Major Services	80%	not covered
– Orthodontics (Jan. 1, 2001)	50%	not covered
 Annual Max Pmt		
Individual	\$2,100	\$2,100
Family	\$2,400	\$2,400
Aggregate	\$4,000	\$4,000
Dental Fee Guide	current	current
 Pre-Authorization Recommended		
– Routine Services	over \$500	over \$500
– Major Services	ALL work	not covered
– Orthodontia	ALL work	

Benefit Year

The benefit year is January 1 to December 31.

Dental Expenses Covered by the Plan:

1. ROUTINE SERVICES (Plan A)
(Paid at 90% for Group 1 and 60% for Group 2)

Diagnostic Services

- Clinical Exams;
- Standard oral examination of a new patient (once every three years);
- Recall Examinations (not exceeding 2 per year for dependent children under age 19; or one per calendar year for all other participants);
- Emergency Oral Examination or Specific Oral Examination.

- X-Rays
 - bitewing, not more than once every 6 months (one to four films)
 - Panoramic film (not more than once every 3 years)
- Laboratory Examinations

Preventive Services

- Dental Prophylaxis (Scaling & Polishing limited to once every 6 months)
- Topical Fluoride Treatment (limited to two treatments per year for children under age 19 and one treatment per year for Participants and Dependents age 19 or over)
- Pit and fissure adhesive sealants (limited to dependent children up to 19th birthday only and to one treatment every two years in same tooth)
- Space maintainers and prefabricated full coverage restoration for primary teeth for children under 19 years only, including stainless steel crowns for baby teeth that have several cavities which would otherwise require filling or which are non-restorable using normal restorative dental material

Restorative Services

- Amalgam Restorations
- Acrylic, Composite and Silicate Restorations when done without etch and bond technique.

Endodontics

- Endodontic Treatment including root canal therapy
- Periodontics
- Periodontal scaling and root planing (limited to 10 units per year for all procedures combined, however children under 13 years of age are limited to 1 unit every 6 months for all procedures combined);
- Periodontic treatment for disease of the bones and gums of the mouth, including tissue grafts and occlusal guards, in connection with 1 periodontal treatment or bruxism but not athletic guards;
- Occlusal equilibration (limited to 8 units per calendar year).

Removable Prosthetics

- Denture Repairs, Relining and Rebasing
- Repair, resurfacing or recementing of crowns, inlays, onlays or Bridges

Oral Surgery

- Oral Surgery, including excision of impacted wisdom teeth;

Other Services

- Anaesthesia (used in conjunction with oral surgery, periodontal surgery and fractures and dislocations) but not the facilities fees associated with the provision of anaesthesia.
- Conscious Sedation – the use of systemic drugs to produce a calm, relaxed and comfortable patient without the loss of consciousness.
- Adjunctive General Services
- Professional Consultation

2. MAJOR SERVICES (Plan B)

(Paid at 80% Group 1 only. Not Covered for Group 2, 3 & 4 Participants.)

Crowns and Bridgework

- inlays, onlays, gold fillings and crowns
- first installation of fixed bridgework, including crowns to form abutments, to replace 1 or more natural teeth extracted while a member of this plan
- replacement of existing bridgework, but only if it was installed at least 5 years before and cannot be made serviceable
- addition of teeth to an existing bridgework, if required to replace 1 or more natural teeth extracted while a member of this plan

Dentures

- first installation, including adjustments, of partial permanent or full temporary or permanent removable dentures or the additional teeth to an existing denture to replace 1 or more natural teeth extracted while a member of this plan;
- denture adjustments that occur more than 3 months after installation;
- replacement of an existing partial or full removable denture, if it:
 - was installed at least 5 years before and cannot be made serviceable; or
 - is a temporary full denture which replaces 1 or more natural teeth extracted while a plan member and for which replacement by a permanent denture is required and takes place within 1 year from the date the temporary denture was installed; and
 - addition of teeth to an existing partial denture, if required to replace 1 or more natural teeth extracted while the person is covered.

The replacement of an existing appliance by another of its kind (fixed bridge-work, removable partial or complete dentures) only under one of the circumstances set out below:

- (i) if necessitated by the extraction of additional natural teeth while insured under this Plan;
- (ii) if the existing appliance is at least five years old and cannot be made serviceable;
- (iii) if the existing appliance is temporary and is replaced with a permanent bridge or denture and takes place within 12 months of when the temporary appliance was installed.

3. ORTHODONTIC SERVICES (Effective January 1, 2001)

Payments in respect of Orthodontic dental services are applicable only for **(i) diagnostic procedures, including models, (ii) therapy and appliances, and (iii) correction of malocclusion** for eligible members and dependents **under** 19 years of age at the time of treatment approval and are then subject to a co-insurance level of 50% to a lifetime maximum payment of \$1,500.

OTHER DENTAL PRACTITIONERS

Dental care, services or supplies must be rendered and dispensed by a licensed dentist, except that:

- scaling and cleaning of teeth may be done by a licensed dental hygienist; and
- installation, adjustment, repair, relining or rebasing of full dentures, may be done by a denturist, denture therapist, technician or mechanic, who is registered and practicing within the scope of his/her license.

ALTERNATIVE SERVICES

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

PRE-DETERMINATION OF BENEFITS

If charges for a planned course of treatment by a licensed dentist would exceed \$500, proposed details and x-rays should be submitted to the Claims Adjudicator for approval. Dental x-rays will be promptly returned to the dentist.

Course of treatment means one or more services rendered by one or more dentists for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered.

NB: You must have enough hours to qualify for coverage on the date the service is performed, even if a pre-determination approval has been done earlier.

DENTAL EXPENSES THAT ARE NOT COVERED

The Plan will not pay charges for:

- (a) the replacement of teeth that were missing prior to the claimant's eligibility for this dental care benefit unless additional natural teeth are extracted while insured under this Plan;
- (b) anything not furnished by a dentist, licensed, dental hygienist or dental mechanic except x-rays ordered by a dentist; anything not necessary or not customarily provided for dental care;
- (c) services (i) furnished by or for any government unless payment is legally required; or (ii) to the extent provided under any government program or law under which the individual is, or could be, covered;

- (d) services due to an accident related to employment or disease covered under workers' compensation or similar law;
- (e) any portion of a charge for a service in excess of the Fee Schedule of the Association of Dental Surgeons of British Columbia approved by the Board of Trustees;
- (f) cosmetic surgery or treatment unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident which occurred while covered; facings on molar crowns or pontics are always considered cosmetic;
- (g) the replacement of an existing appliance (fixed bridgework, removable partial or complete dentures) which has been lost, mislaid, or stolen;
- (h) replacement of dentures within 5 years of last receiving the service;
- (i) oral hygiene instructions or nutritional counselling;
- (j) self-inflicted injuries or illness;
- (k) examinations required for use of a third party;
- (l) charges levied by a physician or dentist for his time spent travelling, broken appointments, completion of claim forms, his transportation costs or for advice given by him by telephone or other means of telecommunication;
- (m) injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or a riot except when individual is performing his normal duties;
- (n) an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
- (o) appliances or restoration for the purpose of splinting, or to increase vertical dimension or restore occlusion;
- (p) dental injuries incurred while working for another Employer or on a freelance basis;
- (q) dental care of a congenital or developmental malformation.
- (r) the additional cost of porcelain (white) fillings on molar teeth. Such expenses will be reimbursed only up to the cost of an amalgam restoration.
- (s) replacement of a lost or stolen prosthesis;
- (t) dental care which is cosmetic;

- (u) which, in the absence of this coverage, there would be no charge;
- (v) prefabricated full coverage restorations for permanent teeth;
- (w) protective athletic appliances;
- (x) a full-mouth reconstruction, a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- (y) prostheses, including crowns and bridgework and the fitting thereof which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this Benefit is discontinued or more than 31 days after termination of coverage for any other reason;

EXTENSION OF DENTAL BENEFITS

If your coverage or your dependents' coverage terminates, the Plan will pay charges for the following dental care received within 30 days following the date of termination, provided such charges would have been paid had you remained a participant in this Health Care Plan:

- (a) an appliance, or modification of one, for which an impression was taken before termination;
- (b) a crown, bridge or gold restoration for which the tooth was prepared before termination;
- (c) root canal therapy, provided the pulp chamber was opened before termination.

HOW TO CLAIM AND OTHER PROCEDURES

NOTICE OF PROOF OF CLAIM

Notice of Life Insurance, AD&D and Dependent Life Insurance claims must be submitted to your hotel within 90 days of the date of death (or dismemberment).

Wage Loss Benefits must be claimed within 30 days of the date of disability. **Retroactive benefits will not be paid for a period of disability occurring more than 4 weeks before the claim was received by the Plan Administrator.**

Dental and Extended Medical Benefit claims should be submitted within 90 days of incurring the expense.

TIME LIMIT FOR FILING CLAIMS

No benefits will be paid for claims exceeding the following time limits:

- Dental Claims – 12 months following the date the expense was incurred.
- Extended Medical – 18 months following the date the expense was incurred.
- When you terminate employment – 6 months from the date of termination of employment, for both Dental Care & Extended Medical benefit claims.

24 months after the date you cease active work for Total and Permanent Disability under the Disability Provision for Life Insurance Benefits.

PROCEDURE FOR FILING CLAIMS

Life, Accidental Death & Dismemberment and Dependent Life

Claim Forms for these three benefits can be obtained from the Human Resources Department. These must be completed by the attending physician before being returned to the Human Resources Department. In the case of death, a Provincial Death Certificate or an Attending Physician's Statement will be required.

Disability Benefits (Wage Loss Claims)

1. Visit your Human Resources Department to collect the "Accident and Sickness Benefit Short Term Disability" claim form;
2. Request that your Human Resources Department complete in full the area entitled "**Section 2 – Employer's Statement**";
3. Fully complete the area entitled "**Section 1 – Claimant's Statement**" and in **Section 4 – "Medical Release Authorization"**;
4. Take the Accident and Sickness Benefit Short Term Disability Claim Form to your Doctor and request that your Doctor fully complete the areas marked "**Section 4 – to be completed by Attending Physician**";
5. Forward your Wage Loss claim form to the Plan Administrator.

You may, from time to time, be required to have your doctor complete the "Supplementary Disability Statement". The Plan Administrator will stop paying claims until this form is received. The "4-week retroactive" clause will be applied to your claim if the Supplementary Disability Statement is not returned within 4 weeks after it was requested.

If you are disabled by an accident in which there could be a third party who has liability, you will be required to sign a “Reimbursement Agreement” and an assignment of benefits allowing ICBC or another third party to reimburse the Plan directly. As wage loss funds are benefits loaned to you for wage loss, in the case of third party liability, these forms must be signed before you receive your first cheque. Please make sure these forms are with your claim form. You are required to reimburse the Plan in full. **Legal fees are not paid by this Plan.**

Claim cheques will be sent to your home address.

Dental Benefits

1. Obtain a Standard Dental Claim Form from your Dental Office to be completed by your Dentist.
2. The Dentist completes only Part 1 (the information concerning the type of treatment.)
3. You must complete Part 2 in full. (The information concerning you and your dependents. **MAKE SURE YOUR ADDRESS AND THE NAME OF YOUR HOTEL IS ON THE FORM AND IS CORRECT!**)
4. The claim form can be sent to the Plan Administrator by you or by your dentist.

Please note, the claim form must be signed by you or your spouse on the same form as the dental services and charges. This plan does not accept electronic dental claim processing or a form stating “signature attached”. You should check the services listed before signing to ensure these are the services you had received.

Extended Medical Benefits (exclusive of prescription drugs) and Vision Care claims

1. Save your receipts! (You must pay for services first - then collect from the Plan).
2. When you wish to claim, obtain a Claim form and pre-addressed envelope from your Human Resources Department.
3. Complete all the information requested on the form with the exception of the shaded areas. You must list each receipt, giving the details asked for on the form. **If your claim is for Vision Care, be sure the receipt or Prescription indicates whether the glasses are Single vision, Bi-focal or Tri-focal.**
4. Attach all receipts to the back of the claim form.
5. Send the completed claim, with receipts attached to the Plan Administrator in the envelope provided.

Please note, claims cannot be processed if they do not contain:

- Your Name
- Your full address (including Postal Code)
- Your Certificate or Social Insurance Number
- The Name of your Hotel.

COORDINATION OF DENTAL AND EXTENDED MEDICAL BENEFITS

If you have coverage for Dental and Extended Medical Benefits through another plan (i.e. your spouse has a plan through his/her employer), benefits will be reduced so that no more than 100% of any covered expense is paid out. The method of coordination is as set out by the Canadian Life & Health Insurance Association (CLHIA).

If you qualify as an employee under another plan, benefits will be co-ordinated so that each carrier pays their fair share. If both plans provide 100% coverage, each carrier will pay the applicable amount of eligible expenses.

OTHER PROCEDURES

ENROLLMENT

When you are hired you will be asked to complete the following:

1. UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan Enrollment Card.
2. Medical Services Plan - Group Application.

You will also be asked to provide copies of your immigration papers or proof of Canadian citizenship for the Medical Services Plan of B.C., including those for each of your dependents if you are applying for dependent coverage.

WHAT IF I HAVE A QUESTION?

This booklet has been designed to answer most of your questions.

If your Dentist has questions concerning the Dental Plan, show him/her the booklet. Your dentist may also contact the Administrator.

Questions regarding claims already submitted:

- Contact the Plan Administrator who will contact the insurance company on your behalf.

Questions regarding Qualifying Hours or your current Eligibility:

- It is a good idea to keep track of your hours worked so you know whether or not you are eligible each month. If you have not done this, you may contact the Plan Administrator.

Should there be disagreement as between the wording in this booklet and the Plan Document and Group Insurance Contracts, the Plan Document and Group Insurance Contracts will prevail.

**UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees
HEALTH CARE PLAN**

Benefit Increases - Collective Bargaining 2007

Effective from February 1, 2008

An employee will be eligible for the Group 1 Health Care Plan if the employee has worked at least 324 hours in the three consecutive calendar months immediately before the date of a claim.

Effective from February 1, 2008

The Vision Care Plan will provide as follows; one set of new lenses, including contact lenses selected in place of spectacle lenses, not more frequently than once in 24 months, or in 12 months in the case of individuals under 19 years of age, to the following limits:

Single vision lenses or laser eye surgery	\$200.00
Bifocal lenses	\$240.00
Trifocal lenses	\$280.00
Contact lenses or laser eye surgery	\$500.00 lifetime

Effective from February 1, 2008

An employee and the employee's dependants will qualify for Dental Care benefits once the employees has been eligible for coverage in the UNITE HERE Local 40 Camp, Culinary & Non-aligned Employees Health Care Plan for seven consecutive months as a Group 1 or Group 2 Participant.

Effective with ratification, MSP coverage continues for employees on long term illness.

The Health Care Plan will be amended to include a Prescription Drug Card.

PRESCRIPTION DRUG CARD

DRUG CLAIM REIMBURSEMENT

How much does your group plan cover?

Your group benefit plan provides sound drug coverage. With that coverage, you can show your pharmacist your benefits card to have your drug claim processed right at the counter so you instantly know the amount covered by your plan and the amount you need to pay.

With every prescription, the coverage provided is based on three things: wholesale ingredient drug cost, mark-up and the dispensing fee.

THINGS YOUR PHARMACY FACTORS INTO THEIR PRICING...

- 1. Wholesale ingredient drug cost**
The amount your pharmacist pays to purchase a drug.
- 2. Mark-up**
An additional charge your pharmacist may place on a drug, over and above the actual drug cost. Like any other business, your pharmacist uses this mark-up to cover the costs of running the pharmacy.
- 3. Dispensing fee**
The professional fee your pharmacist charges to provide the medication prescribed by your physician

What does Manulife Financial cover? Reasonable and customary limits

Manulife Financial reimburses claims based on ‘reasonable and customary’ amounts associated with ingredient cost, mark-up and dispensing fees. Just like provincial drug plans, we apply these limits at point-of-sale for each and every pay direct drug claim. By doing this, we:

- protect plan sponsors from unusually high prices and overcharging that eventually cause increased insurance rates, and
- manage health care claims costs and promote fair treatment of claimants, plan sponsors and health care providers.

How do we decide?

To determine limits for our pay direct drug plans; we work closely with ESI Canada, our Pharmacy Benefit Manager (PBM) to review what pharmacists typically charge their customers. We review drug and other costs. From there, we decide on a range of claims reimbursement that’s representative of the market and reasonable for the province you live in (limits vary by province). And to ensure these limits are always up-to-date, we review them regularly.

Reasonable and customary

Insurance companies analyze all the charges for a particular service or treatment submitted by health care providers from a defined geographic area. **The most common price for the service or treatment becomes the “reasonable and customary” charge for providers in that area.** The insurance company then uses the reasonable and customary charge to set limits to use as a guideline when they review claims that have been submitted.

- 1. Wholesale ingredient drug cost**
When you fill a prescription, the wholesale drug ingredient cost submitted by your pharmacist is automatically checked by our on-line drug adjudication system against the wholesale drug ingredient cost price lists we maintain for the dispensing pharmacy’s province.

- If the drug cost submitted by your pharmacist is with the amount shown on the price list, Manulife Financial uses this cost as the allowable in claim adjudication
- If it's higher than the amount allowed, we limit the claim adjudication to the amount indicated on the price list.

2. Mark-up

Allowable mark-ups vary by province (they're determined by comparing a range of mark-up charges, including those allowed by provincial drug plans).

- If the pharmacist's mark-up is within the allowable maximum within the province, Manulife Financial uses this cost as the allowable amount when we review your claim.
- If it's higher than the amount allowed, we limit the claim to the allowable amount.

3. Dispensing Fee

Dispensing fees charged by a pharmacist are measured against limits set for both regular and compound drugs. These limits, which vary by province, are determined by comparing a range of dispensing fee charges, including those allowed by provincial drug plans.

- If the pharmacist's dispensing fees are within the allowable maximum within the province, Manulife Financial uses this cost as the allowable amount in claim adjudication
- If they're higher than the amount allowed, we limit the claim to the allowable amount

We offer a reference document on our website showing up-to-date limits on mark-ups and dispensing fees by province. Find it at www.manulife.ca/groupbenefits/manuscriptlimits.html

Province

Alberta

BC

Lowest generic price source (lowest unit price for each interchangeable drug category)

Alberta Health and Wellness Drug Benefit List

Alberta Human Resources and Employment Drug Benefit Supplement

BC Pharmacare

Formulary drugs pricing source

Alberta Health and Wellness Drug Benefit List

Alberta Human Resources and Employment Drug Benefit Supplement

BC Pharmacare

Non formulary drugs and non-interchangeable pricing source

Mckesson Alberta

Mckesson British Columbia

Regular vs. compound fees

A regular dispensing fee is what the pharmacist charges for services provided with each prescription. These services include dispensing the drug and providing instructions on when and how to take it. Regular fees apply to all non-compound prescriptions.

A compound dispensing fee is what the pharmacist charges for services provided with each prescription plus an additional amount for time spent and materials used to prepare a drug that has to be mixed in the pharmacy. These drugs are known as extemporaneous compounds.

A little information about Provincial drug plans and private plans

Some provinces offer drug plans to residents to help with the cost of prescription drugs. Residents may have to meet qualifying conditions to participate in the Provincial drug plans (e.g., over age 65, welfare recipients). Provincial drug plans regulate the mark-up and dispensing fees charges that will reimburse to a pharmacist for claims processed under the Provincial plan. Similar regulations do not extend to private drugs plans, such as your Manulife group benefit plan. Because there are no limits on what pharmacists can charge private drug plans, insurance companies need to carefully consider the amount of claims reimbursement they provide. This amount varies, depending on the company.

Q: Are drug prices regulated in Canada? Isn't there a standard price that everyone has to pay?

A: It depends on where a pharmacy buys its drugs.

- The Patented Medicines Prices Review Board (PMPRB) regulates the price that drug companies can charge for a patented brand drug in Canada (typically, drug companies sell their drugs to hospitals, drug wholesalers, large pharmacy chains and other smaller pharmacies). Some drug companies do not sell directly to pharmacies.
- The price of generic drugs is not regulated at all.
- Retail Pharmacies (i.e., where private drug plan members shop) can buy their drugs from either a drug company or a drug wholesaler.
- If a pharmacy buys directly from a drug company, the drug prices are regulated by the PMPRB.
- If a pharmacy buys directly from a drug wholesaler, there are no regulations on what the wholesaler can charge. Depending on how much the pharmacy purchases and how many middlemen are involved, different pharmacies may pay a wide price range for exactly the same drug.

Q: Can insurance companies negotiate directly with drug companies for better drug prices?

A: No. In Canada, plan members must buy their drugs directly from a pharmacy. As a result, we can't negotiate prices directly with drug companies – we must reimburse pharmacies on behalf of our plan members, based on what the pharmacy had to pay to acquire the drugs.

Q: How do you determine the wholesale ingredient cost for each drug?

A: ESI Canada uses a variety of sources to validate wholesale ingredient costs, including wholesaler, pharmaceutical manufacturers and all Canadian Provincial Health Ministries (see the accompanying chart). ESI maintains their Drug Identification Number* (DIN) files daily and audits all price changes for accuracy.

*Health Canada assigns Drug Identification Numbers (DIN) for each different drug. For instance, if the drug Losec has a 10mg, a 20mg tablet and a 40mg capsule, each strength and dosage form of Losec will have a different DIN. The files used as pricing references are sorted by DIN.

**What happens when a prescription is filled:
The electronic drug claims process**

STEP 1 - At the Pharmacy

The pharmacist begins by entering information into the system under three categories: patient, prescription and adjudication.

Here's what it might look like:

Patient Information:

Surname:	Jones
First Name:	Elizabeth
Date of Birth:	1945/10/23
Gender:	F
Relationship Code:	Cardholder(or spouse/under-age/over-age/disabled dependent)
Allergies:	None

Prescription Information:

Prescription Number:	222333
Drug:	Tylenol #3 with codeine
DIN:	02163925
Quantity:	30
Days Supply:	10
Professional Fee:	\$8.49
Compounding Fee:	\$0.00
Date Filled:	February 3, 2007

Adjudication Information:

Third Party:	ESI Canada
Carrier ID:	02 (for Manulife Financial)
Group Number:	56789
Client ID:	1234567890

While each pharmacy may use a different computer system, all data entered must include certain Canadian Pharmacists' Association (CPhA) codes that are required in order to transmit the claim correctly. For example, an intervention code" is used to identify things such as a "co-ordination of benefits" claim (this happens with both patient and spouse have group benefits coverage). "Product selection" codes are used to indicate that the physician requested "No Substitution," or a "Drug Utilization Review" override.

Once this information and coding has been entered into the pharmacists' computer system, he'll identify the claim as an ESI Canada pay-direct card claim (ESI Canada is Manulife Financial's Pharmacy Benefit Manager.) The drug claim is then sent electronically from the pharmacy, to ESI Canada, using a network provided by National Data Corporation. At ESI, the claim is merged with the plan member's eligibility and pharmacy history data, as outlined in steps 2, 3 and 4.

STEP 2 - The First Series of Checks

Via the computer network, the claim is checked to make sure:

- The data has been entered in standard CPhA format. (The system verifies that all of the data is in the correct location.)
- The pharmacy is valid and active
- The plan member is eligible. (The system looks up a plan member's eligibility information to determine whether she is still active within the group plan and verifies the effective dates of her coverage.)

STEP 3 - The Second Series of Checks

If all of the elements in "Step 2" have been satisfied, the system asks:

- Is the group plan valid and active?
- Who pays first? (The system checks the "co-ordination of benefits" indicator on the eligibility file to determine whether a government plan, or another insurer pays first.)
- Is the Drug Identification Number Valid? (The pharmacist must enter a valid, 8-digit DIN number.)
- Is the drug covered by the benefits plan?

Should any of the "checks" fail, the pharmacist receives a response code identifying why the claim has been adjusted or rejected. In most cases, the pharmacist can fix a data entry problem by correcting the information or speaking with the plan member. The pharmacist can also get help by calling the ESI Canada help desk. Usually, this means the claim can be paid right away.

STEP 4 - Adjudication by ESI Canada

When all of the pre-screening "edit checks" pass, the claim is adjudicated.

- Plan limits are applied.
- Drug pricing is verified including provincial mark-ups.
- Plan details are applied. (Fee caps, deductibles, co-pays, maximums, co-insurance.)
- The net payable amount is determined.
- A Drug Utilization Review (DUR) is performed to identify potentially dangerous drug interactions, early refills (two-thirds of the previous prescription has not been used yet), duplicate

drug or therapy. DUR messages may provide information to the pharmacist (soft edit) or cause a claim to be rejected (hard edit). For instance, a claim would be rejected if the DUR detected a potentially fatal drug-to-drug interaction.

ESI sends a response to the pharmacy indicating the dollar amount paid for each claim, along with up to five messages. These messages, may explain the plan design details that have been applied, indicate that a maximum benefit has been met, that the professional fee has been adjusted, or that the ingredient cost has been adjusted.

It all happens in less than thirty seconds!

**Here is a sample response the pharmacist receives from
ESI Canada:**

Ref. #	Pharmacy Charges	Plan Pays	Plan Member Pays	Explanation
1 Professional Fee	8.49			
2 Professional Fee reasonable and customary		7.00	1.49	Plan member pays 0% coinsurance (plan pays 100%) of eligible professional fees. (\$8.49-\$1.49=\$7.00) \$7.00x0%=\$0.00
Ingredient Cost	11.60			\$11.60 initially charged by pharmacy.
3 Ingredient cost reasonable and customary (R&C)		11.26 eligible	0.34	Ingredient cost reduced to \$11.26 due to R&C cutback. Plan member pays \$0.34.
4 Ingredient cost coinsurance (plan pays 100%)		11.26	0.00	Plan member pays 0% eligible ingredient cost. \$11.26 x 0%=\$0.00
Total amount	20.09	18.26	1.83	

Coordinating with a patient’s secondary benefits plan

If the patient is covered by another drug plan, the amount she’s required to pay can then be submitted to the second carrier for “co-ordination of benefits.” The claim can be submitted electronically (if the carrier and pharmacy software can support it) or it may be necessary to submit the claim manually.

In the case of a husband and wife with coverage under two separate pay-direct drug cards, ESI Canada supports on-line co-ordination of benefits for both primary and secondary claims. The pharmacist can submit the second claim electronically to ESI, even if the primary claim is not with ESI Canada.

STEP 5 - Receipt

The pharmacist provides the patient with her medication and a detailed official prescription receipt.

**Total paid by plan member
(amount not paid for by drug plan)**

OFFICIAL PRESCRIPTION RECEIPT

Rx# 222333 **Refills:** 00 **▶ Patient Pays:** \$1.83
Elizabeth Jones
Date: 2001/02/03
Tylenol #3 with Codeine
DIN: 02163925 **Tx#** 1234567
Drug Cost Charged: \$11.26
Professional Fee: \$ 8.49
Total: \$20.09

Pharmacist's Signature:

ABC Pharmacy 123 Main Street Anywhere, ON L5L 5L5
(555) 555-5555

Summary

A patient takes a prescription to the pharmacist. The pharmacist processes the prescription, transmitting pertinent information to ESI Canada. ESI Canada transmits a record of the claim to Manulife Financial, and checks the data associated with the claim against plan design, limits and other information supplied by MLI. ESI sends appropriate messages to the pharmacist, who provides the patient with a receipt at the end of the transaction.

Important Notice on Confidentiality

At no time can the pharmacy browse or view the ESI Canada eligibility files or the DIN files. Some people have the false impression that pharmacies can view or browse these files. In reality, the pharmacy enters the patient's profile and ESI Canada specific codes/numbers and transmits the claim. ESI Canada adjudicates the claim and sends a CPhA response code back to the pharmacy. Also, ESI Canada is restricted in terms of how it responds to claims transmissions by the CPhA standard.