

*Your
Benefits*



**University
of Victoria**

University of Victoria

Dental

Plan Design 1



Group Name and Policy Number

University of Victoria

Plan Design I

Policy Number 40704

Reissue Date: September 1, 2025

Introduction

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

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

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

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

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

Coverage is provided through:

Pacific Blue Cross
Dental Care

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

Privacy Policy

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

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

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Schedule of Benefits

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

Dental Care			
<i>Deductible</i>	No Deductible		
<i>Reimbursement</i>	Plan A Basic Services	Plan B Major Restorative Services	Plan C Ortho— dontics
	80%	50%	50%
<i>Frequency Plan Limits</i>	Each Calendar Year	Each Calendar Year	Lifetime
<i>Financial Limit Per Dependent Child</i>	Not Applicable	Not Applicable	\$2,000
<i>Financial Limit Per Member or Spouse</i>	Not Applicable	Not Applicable	\$2,000
<i>Financial Limit for Late Applicants</i>	\$250 per person for all dental services for first 12 months of coverage		
<i>Termination</i>	December 31 st of the year the Member attains age 71 or earlier retirement.		
<i>Dependent Children</i>	See definition of Dependent.		

Definitions

Benefit amount

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

Benefit review

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

Coverage effective date

means the date coverage becomes effective based on

- 1) your date of hire, and
- 2) the average number of hours you work each week or each year, and,
- 3) the waiting period selected by your employer, your employee group and type, and
- 4) the Enrolment grace period.

Customary

means usual or traditional and well-established as determined by us.

This refers to:

- 1) the charges for products, services or supplies; and/or
- 2) the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is

incurred for a medical condition comparable in nature and severity to that being treated. The term “area” means a region large enough to obtain a representative cross section of similar Providers.

Deductible

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

Dentist

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

Dependent

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

- 1) one Spouse of the Member
- 2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
- 3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
- 4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

Children under age 21 are not covered if working more than 30 hours per week, unless full-time students. If no longer a student, coverage will cease at the end of the month finishing school or university.

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

Duplicate coverage

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

Eligible drug

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

Eligible expense

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

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

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

Enrolment grace period

means within 18 months from the coverage effective date.

Fee guide

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule

means Schedule 3 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Government plan

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

Hospital

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

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

Late applicant

means an employee or Dependent whose application for coverage was received by us after the Enrolment grace period.

Life event

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

Member

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

Physician

means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a

Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner

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

Provider

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

Spouse

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

Vendor

means an organization we have retained as an external Provider.

Member Information/Access to Records

- 1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.
- 2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
- 3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
- 4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
- 5) Upon request, and at no charge to the Member, we will provide the Member with 1 copy of:
 - a) the Member's application for coverage
 - b) the current Contract/Policy
 - c) any written statement or other record provided to us as evidence of insurability of the Member.
- 6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
- 7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

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

Effective Date of Coverage and Enrolment

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

You should apply for Dependent coverage (when applicable):

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

Limitations:

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

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

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

Late Applicants

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

Beneficiary

This plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits. Any Benefit amount owing will be paid to your estate or to you for a deceased Dependent.

Identification (ID) Cards

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

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

Claims

- 1) All claims must be submitted to us in English.
- 2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.

- 3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.
- 4) The necessary claim forms are available on our website at www.pac.bluecross.ca/member
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Coordination of Benefits

When coordinating benefits between plans, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

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

General Exclusions

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

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

Legal Action

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

Termination of Coverage

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

Right of Recovery

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

Conversion to an Individual Plan

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

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

If you qualify for 1 of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition

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

Call our Individual Products Department at 604 419-2000 for an application form.

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

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2000 or 1 877 PAC-BLUE (722-2583) outside the Lower Mainland for information.

Member Profile

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

Payment of Benefits

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

Plan A – Basic Preventive & Restorative Services

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

- 1) Diagnostic services
 - a) examinations:
 - i) complete – 1 per lifetime by a general Practitioner and 1 per lifetime by a specialist
 - ii) new patient and recall – combined limit of 2 per calendar year
 - iii) specific – 2 per calendar year
 - iv) consultations (as a separate appointment)
 - b) x-rays
 - i) diagnostic
 - ii) panoramic – 1 per 12 month period
 - iii) complete mouth series – 1 per 36 month periodAll x-rays combined shall not exceed the dollar limit for a complete mouth series.
 - c) diagnostic models – 1 set per calendar year.
- 2) Preventive services
 - a) scaling, root planning and gingival curettage to a combined maximum of the contract percentage of 13 units of scaling per calendar year
 - b) polishing – 2 per calendar year
 - c) topical application of fluoride – 2 per calendar year
 - d) fixed space maintainers on missing primary teeth and habit breaking appliances
 - e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.
- 3) Restorative services
 - a) fillings
 - i) amalgam (silver coloured) fillings
 - ii) composite (tooth coloured) fillings on all teeth
 - b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 5 year period.
 - c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

- 4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals. Fee guide financial limits do apply. Treatment frequency limits do not apply.
- 5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
 - a) occlusal adjustment and recontouring
 - b) root planing
 - c) gingival curettage
 - d) osseous surgery
 - e) bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).
- 6) Prosthetic repairs
 - a) removal, repairs, and recementation of fixed appliances
 - b) rebase and relining of removable appliances
 - c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
 - d) gold foil – only when used to repair existing gold restorations.
- 7) Surgical services
 - a) extractions
 - b) other routine oral surgical procedures
 - c) anesthesia in conjunction with surgery to a combined calendar year maximum of one unit.
- 8) House calls, Hospital calls only if work is not being performed, emergency visits, consultation with the Physician or Hospital staff, and office visits after regular office hours.

Plan B – Major Restorative Services

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

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

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

- 1) Prosthodontic Services
 - a) removable
 - i) complete upper and lower dentures
 - ii) partial upper and lower dentures
 - b) fixed bridges.
- 2) Restorative Services
 - a) inlays or onlays involved in bridgework
 - b) veneers
 - c) crowns and related services.

Limitations

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

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

- 1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
- 2) No benefit is payable for the replacement of appliances which are lost or stolen.
- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- 4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. You will be reimbursed according to the Fee guide. This will not apply to the services of a dental hygienist.

Exclusions

The following are not Eligible expenses under your dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
- 2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
- 3) procedures performed for congenital malformations or for purely cosmetic reasons
- 4) charges for drugs, pantographic tracings, and grafts
- 5) charges for implants and/or services performed in conjunction with implants
- 6) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 7) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
- 8) incomplete, unsuccessful or temporary procedures
- 9) recent duplication of services by the same or different Dentist

- 10) any extra procedure which would normally be included in the basic service performed
- 11) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
- 12) any item not specifically included as a benefit
- 13) travel expenses incurred to obtain dental treatment.

Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, we must receive your claim or adjustment by **December 31st** of the calendar year following the year in which the dental services were performed. If not, your claim will not be paid under any circumstances.
Example: We must receive your claim for services performed in 2025 before December 31, 2026.
- 3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
 - a) name of the Dentist
 - b) name and birthdate of the person receiving the dental care
 - c) your policy and ID numbers (this information is on your ID card)
 - d) your home mailing address

- e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by 2 plans, your Dentist must complete 2 separate dental claim forms (1 for each plan). Incomplete claims will be returned for clarification.
- 4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of 2 ways:
 - a) If you have paid your Dentist directly, we will reimburse you the Benefit amount when we receive:
 - i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
 - ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
 - b) For pay direct claims, we will pay the Benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
 - i) a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
 - ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
- 5) Orthodontic Claims Procedures
 - a) Receipts
Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.
 - b) Claiming deadlines
 - i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).

- ii) Reimbursement is made if the complete and correct claims information is received by **December 31st** of the calendar year following the year in which the expense being claimed was due. If not received by this date, your claim will not be paid under any circumstances.
- c) Treatment plan
 - i) Have your orthodontist complete the “Certified Specialist in Orthodontics Standard Information Form” (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
 - ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
 - iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
 - your initial fee/down payment
 - your monthly/quarterly fees
 - 1 time appliance fees
 - iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.
- d) Monthly or quarterly fees
 - i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are received past the claiming deadline will not be reimbursed.
 - ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
 - iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Notes

[illegible]



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

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Burnaby, BC V5G 4W6

Fast, Easy, Claims.



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Online



Mobile app

pac.bluecross.ca/fasteasyclaims

