

Your Group Benefits Booklet

Labourers Atlantic Region District Council Employee Life and Health Trust

Local 615

Plan Number: 91155

Updated Effective Date: September 1, 2023

LiUNA!

Feel the Power

LABOURERS ATLANTIC REGION DISTRICT COUNCIL
EMPLOYEE LIFE AND HEALTH TRUST

MEDAVIE BLUE CROSS™

Your Plan Administrator is:

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For more information about your eligibility for coverage, self-payment options, changes to dependent information and to update your beneficiary, please contact your Plan Administrator.

Welcome to your Group Benefits Plan

Your group benefits coverage provides you with the peace of mind that you and your family are protected today and in the future, for health and medical expenses not available through the coverage provided by government.

All references to the Plan Sponsor shall mean Labourers Atlantic Region District Council Employee Life and Health Trust.

In this plan, drug, extended health, dental and short term disability benefits are self-insured by the Plan Sponsor and are administered by Medavie Inc. Travel benefit is insured by Medavie Inc. and member life, dependent life and critical illness benefits are insured by Blue Cross Life Insurance Company of Canada.

Accidental Death & Dismemberment (AD&D) is insured by AIG Insurance Company of Canada.

Medavie Inc. (also known as Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada, together will be referred to as "Blue Cross" for convenience of reference.

Blue Cross has been a trusted health services partner for individuals, Plan Sponsors and governments across Canada for over 75 years. Our core purpose is to help improve the health and well-being of people and their communities.

Our commitment to service, innovative solutions and technological expertise mean you can rest easy because at Blue Cross, we're always there for you.

About this Booklet

This booklet, together with your identification card, contains important information about your group benefits coverage. You should keep them in a safe place for future reference.

This booklet summarizes the important features of your group benefits coverage. It is prepared as information only, and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefits coverage are described in the group contract held by your Plan Sponsor. In the event of a difference of wording of the group contract, the group contract will prevail, to the extent permitted by law.

Helpful Tip

Take a tour in the Member Centre section at **www.medaviebc.ca**

Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.
- **Coverage Details:** Contains important information regarding the eligibility requirements for your group benefits coverage. This includes when your coverage begins and ends, plus other useful information to help you take advantage of the coverage available to you.
- **Rights and Responsibilities under the Plan:** Outlines your responsibilities under the group contract (such as your responsibility to notify your Plan Administrator upon change in family status) and your rights (for example your right to privacy).
- **How to Submit a Claim and Obtain More Information:** Provides additional information on how you can submit claims and obtain more information regarding your coverage.
- **Helpful Tips:** Throughout this booklet we provide useful tips to help you better understand and get the most out of your group benefits.

Medavie Mobile App

Submit a claim, access an electronic version of your ID card, check coverage, find a health professional in your area, and much more! Visit **www.medaviebc.ca/app** for more information or to download the app.

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*Eligibility is subject to the terms and conditions specified in the *Who is Eligible for Coverage* section*, found under the Coverage Details* of this booklet.

Summary of Benefits

Member Life Benefit*

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Benefit Formula	Flat amount
Benefit Maximum	$150,000
Non-Evidence Limit	$150,000
Terminal Illness Benefit	Included
Termination	
Class B	When the Member retires or as specified in the Coverage Details. Upon retirement, if the Member is eligible, coverage may continue under a retiree plan
Classes B1, B2	The end of the month the Member reaches age 70, retires or as specified in the Coverage Details. Upon retirement, if the Member is eligible, coverage may continue under a retiree plan.
Waiver of Premium	Yes

*Members under age 70 who are not eligible for member life benefit coverage as an Active, Self-pay or Retired Member, but are in good standing with the Labourers International Union of North America Local 615, shall be eligible for an amount of insurance equal to $1,000.

Member Life Benefit*

Class	B3. Retirees B4. Retirees without Dental
Benefit Formula	Flat amount
Benefit Maximum	$10,000
Non-Evidence Limit	$10,000
Terminal Illness Benefit	Not included
Termination	The end of the month the Member reaches age 70 or as specified in the Coverage Details
Waiver of Premium	No

*Members under age 70 who are not eligible for member life benefit coverage as an Active, Self-pay or Retired Member, but are in good standing with the Labourers International Union of North America Local 615, shall be eligible for an amount of insurance equal to $1,000.

Summary of Benefits

Dependent Life Benefit

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Benefit Formula	
Spouse	$25,000
Child*	$25,000/Child
Termination	
Class B	When the Member retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan.
Classes B1, B2	The end of the month the Member reaches age 70, retires, or as specified in the Coverage Details. Upon retirement, if the Member is under age 70 and eligible, coverage may continue under a retiree plan.
Waiver of Premium	Yes

*From birth or 28 weeks gestation if stillborn.

Dependent Life Benefit

Class	B3. Retirees B4. Retirees without Dental
Benefit Formula	
Spouse	$1,000
Child*	$2,500/Child
Termination	The end of the month the Member reaches age 70 or as specified in the Coverage Details
Waiver of Premium	No

*From birth or 28 weeks gestation if stillborn.

Summary of Benefits

Accidental Death & Dismemberment (AD&D)

(Underwritten by AIG Insurance Company of Canada)*

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Benefit Amount	$200,000*

*Please refer to the Accidental Death & Dismemberment (AD&D) section at the back of this booklet for all details that apply to this benefit.

Accidental Death & Dismemberment (AD&D)

(Underwritten by AIG Insurance Company of Canada)*

Class	B3. Retirees B4. Retirees without Dental
Benefit Amount	$50,000*

*Please refer to the Accidental Death & Dismemberment (AD&D) section at the back of this booklet for all details that apply to this benefit.

Summary of Benefits

Enhanced Critical Illness Benefit

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Benefit Amount	
Full Benefit Payment	
Member	$10,000
Spouse	$2,000
Child	$1,000/Child
Partial Benefit Payment	10% of the full benefit payment
Maximum Conditions Payable	Up to 2 Unrelated Covered Conditions eligible for full benefit payment/lifetime 1 per covered condition eligible for partial benefit payment/lifetime 1 covered childhood condition/lifetime
Survival Period	21 consecutive days unless otherwise specified in the defined covered conditions
Termination	The earlier of when the Participant receives 2 full payments or the end of the month the Member reaches age 70 or retires. In addition, coverage for a Child will terminate when a childhood condition payment is received.
Waiver of Premium	Yes

Summary of Benefits

Short Term Disability Benefit

Class	B. Active Members
Benefit Formula	Flat amount
Benefit Maximum	$250/week
Non-Evidence Limit	Same as the Benefit Maximum
Elimination Period:	Calculated in Calendar days
Hospital	None
Outpatient surgery covered	Yes
Accident*	None
Illness	7 days
Benefit Period	37 weeks Week 1 - Short Term Disability Benefit Weeks 2- 27 - CEIC Benefit, if eligible Weeks 28 - 37 - Short Term Disability Benefit
Taxable	Yes
Payment Basis	Calendar days
Integration with Canada Employment Insurance Commission (CEIC) Benefit	Yes When this benefit is integrated with the CEIC benefit, the Benefit Period includes the number of weeks for which benefits are payable by CEIC. Short term disability benefits are initially payable for the first week of the Benefit Period, subject to the Elimination Period. Afterward, the Member can apply for an additional 26 weeks with the CEIC. If the Member is not eligible for the CEIC benefit or remains Totally Disabled when the CEIC benefit is exhausted, they can apply for short term disability benefit payments through the Plan Sponsor. Short term disability benefits are then payable from week 28 to week 37.
Supplemental Unemployment Benefit (SUB) Coverage	No
Termination	The end of the month the Member reaches age 70 or retires

*Total Disability beginning more than 30 days after an accident will be considered an illness.

Summary of Benefits

Drug Benefit

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental	B3. Retirees B4. Retirees without Dental
Deductible	None	
Reimbursement Level	85% up to an out-of-pocket maximum of $25 per prescription; 100% thereafter	
Overall Benefit (Applicable to classes B3, B4)	$10,000/calendar year combined with Hospitalization and Extended Health Care	
Method of Payment	Pay Direct	
Days Supply	100-days maximum supply (1-month supply may apply to some drugs)	
Drug Formulary		
Specialty High Cost Drugs	Managed Formulary	
All Other Eligible Drugs	Open Formulary	
Plan Management Features		
Substitution Provision	Mandatory Generic Substitution	
Quebec Pharmacy Pricing Controls	Usual, Customary and Reasonable applies	
Additional Benefit Modules	**Benefit Maximum**	
Glucose Monitoring Systems	$4,000/calendar year	
Managing Chronic Disease	$500/calendar year	
Fertility Treatments	$15,000/lifetime	
Sexual Dysfunction Drugs	$400/calendar year	
Smoking Cessation Aids	$600/lifetime - Prescription and over-the-counter products (including natural health products)	
Vaccines	$500/calendar year	
Weight Loss Drugs	$3,200/calendar year - Prior Authorization Required	
Termination		
Class B	When the Member retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan.	
Classes B1, B2	The end of the month the Member reaches age 70, retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan.	
Classes B3, B4*	When the Participant reaches age 65 or as specified in the Coverage Details	
Survivor Coverage	24 months	

*Coverage will continue for a Spouse over age 65, until the Member reaches age 65.

Summary of Benefits

Extended Health Care

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental B3. Retirees B4. Retirees without Dental
Deductible	
Hospitalization	None
Overall Benefit (Applicable to classes B3, B4)	$10,000/calendar year combined with Extended Health Care and Drug Benefit

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	90%		Semi-private

Summary of Benefits

Extended Health Care

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental	B3. Retirees B4. Retirees without Dental
Deductible		
Vision Care	None	
All Other Extended Health Care	None	
Overall Benefit (Applicable to classes B3, B4)	$10,000/calendar year combined with Hospitalization and Drug Benefit	

	Reimbursement Level	**Benefit Maximum**
Medical Services and Supplies		
Ambulance Transportation	90%	$1,000/calendar year
Nursing Care	90%	$25,000/lifetime
Health Practitioners:		**Maximum per calendar year**
Mental Health Practitioners *(Psychologist includes Marriage and Family Therapist /Social Worker/Counselling Therapist/Psychoeducator/Psychotherapist (combined))*	90%	$1,000*
Chiropractor (including X-rays)	90%	$1,000*
Naturopath (including X-rays)	90%	$1,000*
Acupuncturist	90%	$1,000*
Osteopath (including X-rays)	90%	$1,000*
Chiropodist/Podiatrist (combined) (including X-rays)	90%	$1,000*
Speech Therapist	90%	$1,000*
*Physiotherapist***	90%	$1,000*
Massage Therapist	90%	$1,000*

*Reimbursement per visit is limited to Usual, Customary and Reasonable charges.

**When prescribed by a Physician.

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	90%	1/month for rental, 1/5 calendar years for approved purchase
Mobility Aids and Orthopedic Appliances	90%	See benefit details
Prostheses	90%	See benefit details
Diabetic Equipment	90%	$200/calendar year
Hearing Aids	90%	$2,000/24 consecutive months**
Custom Orthopedic Shoes***	90%	1 pair/24 consecutive months; 12 consecutive months for a Participant under age 19
Prefabricated Orthopedic Shoes with Permanent Modifications	90%	1 pair/24 consecutive months; 12 consecutive months for a Participant under age 19
Orthopedic Shoe Supplies/Repairs /Adjustments (combined)	90%	$200/calendar year
Custom Made Foot Orthotics***	90%	1 pair/24 consecutive months; 12 consecutive months for a Participant under age 19
Diagnostic Tests****	90%	$1,000/calendar year
Other Medical Services and Supplies	90%	See benefit details
Accidental Dental	90%	$500/tooth to a maximum of $5,000/accident - Predetermination of claim required

*Pre-authorization required.

**Unlimited, if required due to accidental injury to the ear.

***When prescribed by a Physician or Chiropodist/Podiatrist.

****Diagnostic imaging services coverage for residents of Quebec only.

Summary of Benefits

Extended Health Care

Deductible	None	
Vision Care		
Eye Examination	100%	$100/24 consecutive months/12 consecutive months for a Participant under age 19
Lenses*	100%	1 pair/24 consecutive months/12 consecutive months for a Participant under age 19
Frames/Contact Lenses (combined)	100%	$125/24 consecutive months/12 consecutive months for a Participant under age 19
Safety Glass Frames (Member only)	100%	$125/24 consecutive months
Safety Glass Lenses (Member only)*	100%	1 pair/24 consecutive months
Laser Eye Surgery	100%	$1,000/lifetime
Termination		
Class B	When the Member retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan	
Classes B1, B2	The end of the month the Member reaches age 70, retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan	
Classes B3, B4	The end of the month the Member reaches age 70 or as specified in the Coverage Details.	
Survivor Coverage	24 months	

*No time limit applies on lenses and safety glass lenses if there is a change in prescription.

Summary of Benefits

Dental Benefit

Class	B. Active Members B1. Self-pay Members B3. Retirees	
Deductible	None	
Fee Guide Schedule	Current/Province of Member's residence (Specialist fees paid at GP rate)	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	90%	$2,000/calendar year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		1/12 consecutive months
Preventive Treatment		
Polishing of teeth		1/12 consecutive months
Fluoride treatment		1/12 consecutive months
Scaling		9 Units/12 consecutive months (combined with Root Planing)
Basic Care	90%	$2,000/calendar year combined with Preventive Care and Major Restoration
Endodontic Services		Included
Periodontic Services		Included
Root Planing		9 Units/12 consecutive months (combined with Scaling)
Major Restoration	75%	$2,000/calendar year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services		See benefit details
Restorations on implants		1/tooth every 10 calendar years
Orthodontic Services	50%	$2,500/lifetime (Participants under age 19)
Lowest Cost Alternative Benefit	Inlays and crowns	
Termination		
Class B	When the Member retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan.	
Class B1	The end of the month the Member reaches age 70, retires or as specified in the Coverage Details. Upon retirement, if Member is eligible, coverage may continue under a retiree plan.	
Class B3	The end of the month the Member reaches age 70.	
Survivor Coverage	24 months	

Summary of Benefits

Travel Benefit

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Deductible	None
Reimbursement Level	100%
Coverage Duration	First 90 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$1,000,000/Participant/lifetime
Worldwide Travel Assistance	Yes
Termination	
Class B	When the Member retires or as specified in the Coverage Details.
Classes B1, B2	The end of the month the Member reaches age 70, retires or as specified in the Coverage Details.
Survivor Coverage	24 months

Summary of Benefits

Second Opinion®

Refer to the *Second Opinion® Benefit* for a detailed description.

Class	B. Active Members B1. Self-pay Members B2. Self-pay Members without Dental
Termination	
Member	Age 85 or retirement
Spouse	When the Member or Spouse reaches age 85 or when the Member retires
Child	When the Member reaches age 85 or retires

You and Your Dependents

Throughout this booklet several key terms are used to refer to you and your Dependents:

- the terms that may refer to you are: Member and Participant;
- the terms that may refer to your Dependents are: Dependent, Spouse, Child and Participant.

Member: A person who:

- resides in Canada;
- is a member as defined in the Labourers International Union of North America Local 615;
- is working for a contributing employer;
- is performing work within the jurisdiction of the Union; and
- satisfies all the conditions of eligibility described in this plan.

For the purposes of those benefits which continue beyond retirement, the term Member also means Retired Member.

Retired Member: a person who:

- resides in Canada;
- is a member in good standing and has 20 years or more of service with the Labourers International Union of North America Local 615; and
- is at least 55 years of age.

Dependent: Your Spouse or Child.

Spouse: The person who:

- is a resident of Canada; and
- meets one of the following criteria:
  - is married to the Member;
  - is in a civil union with the Member as defined by the Civil Code of Quebec; or
  - has been living with the Member in a conjugal relationship for at least 1 year; however, where required by provincial legislation, this 1 year period is waived if a child is born of such relationship.

The Spouse must be designated by the Member on their application for coverage. Only one person may be covered as a Spouse at any one time.

Child: A person who:

- is a resident of Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
  a) is under age 22;
  b) is under age 25 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

A child is considered to be mentally or physically disabled for the purposes of this definition if they are incapable of engaging in any substantially gainful activity and are financially reliant on the Member or Spouse for care, maintenance and support due to this disability. Blue Cross may require the provision of written proof of a child's disability as often as is reasonably necessary.

Participant: The Member or one of the Member's Dependents who has been approved for coverage under this plan.

Helpful Tip

You are responsible for enrolling your Dependents under the plan when they become eligible.

In addition, you are responsible for removing them when they no longer meet the definitions outlined here.

You can update your family or Dependent status by filling out and submitting a change form, available through our website.

Helpful Tip

A Member, Spouse and Child are all Participants under the plan.

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

- is violent in nature;
- arises solely from external means;
- causes bodily injury to the Participant directly and independently of all other causes; and
- is unintended by the Participant.

The resulting injury to the Participant must be certified by a physician.

Actively at Work: (Applicable to Class B only)
Members are Actively at Work if they are working for a contributing employer or available for work as determined by their name appearing on the out-of-work list of the union.

Members who are not required to report for work on a specified day due to holidays, shift variances, vacations or weekends are still considered to be Actively at Work if they could have reported for work and performed the Regular Duties of their occupation on that day.

Activities of Daily Living: The following 6 activities:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting: getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel continence: managing bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: moving in and out of a bed, chair or wheelchair; and
- Feeding: consuming food or drink that already have been prepared and made available.

Approved Provider: A provider of health care services or supplies who has been approved by Blue Cross to provide specific Eligible Expenses.

Deductible: The amount of Eligible Expenses that the Participant must pay before Blue Cross will reimburse any Eligible Expenses.

The Deductible amount applies once per calendar year or per prescription drug, as specified in the Summary of Benefits. However, Eligible Expenses incurred during the last 3 months of a calendar year that totally or partially met the Deductible for that year may be used to reduce the Deductible for the following calendar year.

Eligible Expenses: Charges incurred by the Participant for health care services and supplies that are:

- Medically Necessary;
- Usual, Customary and Reasonable;
- recommended or prescribed by a physician or Health Practitioner who:
  - does not normally reside in the Participant's home;
  - is not the Participant's Family Member; and
  - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant's home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the plan is in effect, unless otherwise specified.

Helpful Tip

Important: Blue Cross will only reimburse health expenses meeting these Eligible Expenses criteria.

Health care services and supplies that Participants prescribe, render or dispense to themselves are not Eligible Expenses.

An Eligible Expense is considered to be incurred on the date the service or supply was received by the Participant. Reimbursement for Eligible Expenses incurred outside of Canada will be limited to the amount that would have been reimbursed if the expense had been incurred in the Participant's province of residence, unless the benefit is restricted to in Canada only.

Where more than one form or an alternative form of Treatment exists, Blue Cross has the right to base its payment for Eligible Expenses on the lowest cost alternative if Blue Cross, in consultation with its health care consultants, deems the alternative Treatment to be appropriate and consistent with good health management.

Experimental or Investigative: Any treatment, procedure, facility, equipment, drug or drug usage that, in the opinion of Blue Cross after consultation with its health care consultants:

- is not Medically Necessary; or
- lacks sufficient published data to establish its medical effectiveness or safety for the purpose for which it is being provided or prescribed; or
- is not recognized as standard of care in current prescribing guidelines or practice setting protocols.

Helpful Tip

Family member refers to a Participant's:

- spouse or common law partner;
- parent and parent's spouse or common law partner;
- children and spouse's or common law partner's children;
- brothers and sisters;
- grandchildren; or
- grandparents.

Health Practitioner: A health care practitioner who is a registered member of their regulatory body (if applicable) and practices within the limits of their authority as established by law. If no occupational guild applies to a particular practitioner, the practitioner must:

- be a registered member of their association;
- provide care and treatment within the limits of their professional scope of practice; and
- be an Approved Provider.

Illness: A deterioration of health or a bodily disorder that has been diagnosed by a physician and requires regular and continuous care.

Insured Benefits: Benefits underwritten and administered by Medavie Inc. or Blue Cross Life Insurance Company of Canada, one or the other of which assumes all liability for their payment.

In this plan, travel, member life, dependent life and enhanced critical illness are Insured Benefits.

Life Event: A Member is adding a Dependent for the first time or no longer has any eligible Dependents, as a result of one of the following:

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- Dependent no longer meets eligibility criteria; or
- death of a Dependent.

Helpful Tip

Blue Cross will only pay for Eligible Expenses that are Medically Necessary.

Medically Necessary: A health care service or supply provided or prescribed by a physician or Health Practitioner to treat an injury or Illness that, in the opinion of Blue Cross after consultation with its health care consultants:

- has not been provided or prescribed primarily for convenience or cosmetic reasons;
- is the most appropriate, safe and cost effective Treatment for the diagnosed injury or Illness; and
- is generally medically recognized as acceptable Treatment for the diagnosed injury or Illness.

Quebec Participant: A Member or Dependent is considered to be a Quebec Participant if:

- the Plan Sponsor has a business office in Quebec;
- the Member resides and works in Quebec; and
- the Participant is subject to the Act Respecting Prescription Drug Insurance.

Self-Insured Benefits: Benefits that are:

- fully funded by the Plan Sponsor who assumes sole liability for their payment; and
- administered by Medavie Inc. under an administrative services only contract with the Plan Sponsor.

In this plan, drug, extended health, dental and short term disability benefits are Self-Insured Benefits.

Treatment: The management and care of a Participant to improve or cure an Illness, disorder or injury. This management and care must be:

- considered appropriate and approved by Blue Cross; and
- prescribed, provided or performed by a Health Practitioner or physician practicing in the field of medicine applicable to the Participant's disease, disorder or injury.

Usual, Customary and Reasonable: Charges incurred by the Participant that are:

- consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
- in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition.

Who is Eligible for Coverage?

Members are eligible for coverage:

- on the first day of the second calendar month following the date on which you have accumulated at least 260 hours of work in your hour bank; and
- you meet the definition of Member.

Retired Members are eligible for coverage if you meet the definition of Retired Member.

Your Dependents are also eligible for coverage if they meet the definition of Spouse or Child outlined above in the *Key Terms*.

To be eligible for coverage, you and your Dependents must be entitled to government health care coverage or similar coverage deemed satisfactory by Blue Cross.

Coverage Cost

Each month, 130 hours will be deducted from your hour bank account. The number of hours in your hour bank may never exceed 3,120 hours. If there are excess hours over this amount they will be credited to the general reserves of the Fund.

Forfeiture

If you had hours in your hour bank and you do not have reported hours within a 12-month period, you forfeit your hours in your hour bank to the general reserves of the Trust.

If you cease your membership of Local 615, you forfeit your hours in your hour bank to the general reserves of the Trust.

When Does My Coverage Begin?

Members

Your coverage takes effect on the latest of the following dates:

- the effective date of the plan; or
- the date you meet all of the eligibility requirements.

If you are not Actively at Work on the date you would have become eligible for coverage, your coverage begins on the date you resume being Actively at Work.

Dependents

Your Dependent's coverage takes effect on the latest of the following dates:

- the date you become eligible for coverage;
- the date they meet all of the eligibility requirements;
- the date Blue Cross approves their proof of health, if required; or
- the date following their discharge from hospital if they were hospitalized on the date they would have become eligible for coverage, unless:
  - they were covered under a Previous Policy, in which case their coverage begins on the effective date of the plan; or
  - they were born while this coverage is in force, in which case their coverage will be effective from their live birth, or for dependent life coverage, as specified in the dependent life Summary of Benefits (if applicable).

Helpful Tip

Previous Policy refers to a group contract that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this group contract.

What Happens to my Coverage During Periods of Absence from Work?

Illness/Accident

If you are absent from work due to illness or accident, your group benefits coverage is retained. In such circumstances, please contact your group benefits Plan Administrator to discuss the maximum period for which your coverage will be retained.

Maternity Leave/Parental Leave

During a maternity or parental leave of absence, you have the choice to either retain or discontinue all coverage for the maximum period provided under the applicable legislation.

Your decision to retain or discontinue coverage must be made before the beginning of your leave of absence and this decision cannot be changed at a later date. If you decide to retain coverage, you must continue to pay your premium contributions (if any) for the whole duration of the absence.

If you are a Quebec Participant, you must at least retain drug coverage unless you benefit from drug coverage under another group contract.

Temporary Layoff/Authorized Leave of Absence/Disciplinary Suspension/Strike or Lockout

In such circumstances, please contact your group benefits Plan Administrator to discuss the benefits you must retain during such an absence and the maximum period these benefits will be retained.

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the plan terminates;
- the last day of the month in which you have less than 130 hours in your hour bank;
- you cease to be a member of the Local 615;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- you (or your Spouse, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire, unless otherwise specified in the Summary of Benefits;
- you die;*
- you or your Dependents commit a fraudulent act against Blue Cross or the Plan Sponsor;
- the Plan Sponsor defaults in payment of premiums; or
- if, as a self-paying Member, you fail to meet the required monthly contributions of premiums.

*Exception: In the event of your death, coverage for your Dependents will continue for certain benefits, as described in the Survivor Coverage section of this booklet.

No coverage will be provided to you or your Dependents while performing duties as an active member in the armed forces of any country, unless coverage must be retained under applicable provincial legislation.

Reinstatement of Coverage

If your coverage had previously terminated because of insufficient hours in your hour bank account, your coverage will become reinstated on the first day of the second month following the accumulation of 260 hours your hour bank, provided you meet all the other eligibility requirements.

Coverage while on Self-Pay

If, at the end of any given month, you fail to meet the required monthly coverage costs, as determined by the rules of the Trust Fund, you will be notified by the Plan Administrator before your coverage is terminated and given the opportunity to contribute the necessary amount of money so that you may continue to be covered. Under this provision, self-payments may be made on the following basis:

- **Self-pay**: For up to 27 months, you may self-pay member life, dependent life, critical illness, accidental death and dismemberment (AD&D), health and dental benefits or you may self-pay member life, dependent life, critical illness, accidental death and dismemberment (AD&D) and health benefits (including travel and no dental) until age 70.
- **Disabled Member in receipt of workers' compensation board/commission or Canada Pension Plan to age 65**: You may self-pay member life and dependent life (subject to waiver of premium provision), health or health and dental benefits to age 65, or until no longer disabled. At age 65, you transfer to the Retiree class.
- **Retired Member over age 55 with 20 years of service**: If you meet the definition of Retired Member, you may self-pay member life, dependent life, accidental death and dismemberment (AD&D) and health benefits (no travel) or member life, dependent life, accidental death and dismemberment (AD&D), health (no travel) and dental benefits until age 70.

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

Upon termination of coverage for certain benefits, you and your Dependents have the right to convert your group benefits coverage to an individual insurance policy, provided certain criteria are met.

The benefit details will specify if this conversion right applies to a particular benefit.

When conversion is available, the following terms and conditions apply:

- You must, within 31 days of the date of termination of your group coverage:
  - submit the application form provided by Blue Cross for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by Blue Cross;
- the individual policy will be issued without requiring proof of health;
- the premium for the individual policy is based upon the individual policy rates in effect on the date of application and the age and sex of the Participant on that date;
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are specified in the *Right to Convert to Individual Coverage* provision of the applicable benefit.

Helpful Tip

The benefit of converting your group coverage is that you do so without having to provide proof of health.

Conversion premium rates will typically be higher than group premium rates currently paid.

Instead of converting your group coverage, you may prefer to apply for an individual plan, which will require Proof of Health.

Survivor Coverage

In the event of your death, coverage for your Dependents will continue for certain benefits, if specified in the Summary of Benefits.

Survivor Coverage for your Dependents will terminate on the earliest of the following dates:

- the group contract termination date;
- the date the maximum Survivor Coverage period has been reached, as specified in the Summary of Benefits;
- the date your Dependents obtains similar coverage under another plan; or
- the date your Dependents are no longer considered to be eligible Dependents (for reasons other than your death).

What if I Have Coverage Elsewhere?

With the exception of the travel benefits provided under the travel benefit section of this booklet, Blue Cross will co-ordinate your group benefits coverage with other health plans when similar coverage is available. The co-ordination of benefits process helps ensure you get the most out of your coverage. It means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Helpful Tip

Blue Cross will help direct you to existing **government programs** whenever possible.

Government Health Care Coverage

Blue Cross will not pay for any health care services or supplies available under government health care coverage, or administered by government funded hospitals, agencies or providers. Blue Cross will only consider Eligible Expenses in excess of those provided under government health care coverage.

Other Health Plans

Do you take advantage of coverage under the other benefit plans available to you, such as your Spouse's? If not, you may be missing out on possible reimbursement of up to 100% of Eligible Expenses.

Helpful Tip

The types of other plans that are potentially subject to co-ordination of benefits include any form of group, individual, family, creditor or saving insurance coverage that provides reimbursement for medical treatment, services or supplies.

Blue Cross applies co-ordination of benefits according to the guidelines of the Canadian Life and Health Insurance Association Inc. (CLHIA). Here are the general rules:

Expenses for Yourself:

- You must first submit expenses incurred to this plan (where you are covered as a Member). The balance that has not been paid by this plan (if any) can then be submitted to the other plan where you are covered as a dependent (for example your Spouse's plan).
- If you are covered as a member under more than one group benefit plan, the plan that has covered you the longest pays first.

Expenses for Your Spouse:

- Your Spouse must submit any expenses incurred for themselves to their own group benefit plan (if any) first. The balance that is not paid by their plan (if any) can then be submitted to this plan.

Expenses for Your Child:

- If a Child is covered as a dependent by both you and your Spouse, you should submit their claim to the plan of the parent whose birthday comes first in the year.
- In the event of divorce or separation, the plan of the parent with whom the Child resides (the plan of the parent with custody of the Child) pays first.

Helpful Tip

For more information on co-ordination of benefits (including examples), visit our website.

Purpose of Coverage

If a Member becomes Totally Disabled while their coverage is in force and before reaching age 65, the Member's premiums for certain Insured Benefits will be waived. The Summary of Benefits specifies the benefits to which this waiver of premium applies.

Proof of Total Disability must be submitted to Blue Cross within 12 months of the onset of Total Disability and while Total Disability persists.

Definition of Total Disability

The definition of Total Disability or Totally Disabled is as follows:

- a state of continuous incapacity, resulting from an Illness or Accident, which prevents the Member from performing the regular duties of any occupation for which the Member:
  - would earn 60% or more of the Salary earned by the Member immediately before the date of disability; and
  - is reasonably qualified or may so become by training, education or experience.

The loss of a professional or occupational licence or certification does not, in itself, constitute Total Disability.

The availability of work is not considered when assessing the Member's Total Disability.

Amount of Coverage Provided

The amount of coverage subject to this *Waiver of Premium* provision is the amount of coverage in force on the beginning date of Total Disability.

Date the Waiver of Premium Begins

Premiums will be waived beginning on the first day following the expiry of 179 days of Total Disability, as defined in this section of the booklet.

Date the Waiver of Premium Ends

Subject to the exceptions outlined below, the waiver of premium terminates on the earliest of the date:

- the waiver of premium period expires, if any, as specified in the Summary of Benefits;
- the Member no longer meets the definition of Total Disability;
- the Member engages in any occupation for remuneration or profit, except for a rehabilitation program pre-approved by Blue Cross;
- the Member fails to submit the required proof of Total Disability;
- the Member reaches age 65;
- the Member retires;
- coverage terminates for the class of Members to which the Member belongs;
- the benefit or plan terminates; or
- the Member dies.

If, while a Member is Totally Disabled and benefitting from waiver of premium, coverage for their class of Members or all Members under this plan terminates:

- the waiver of premium is extended beyond the termination date outlined above;
- the member life and dependent life benefit coverage will remain in force; and
- continue to be eligible for waiver of premiums until age 65.

Purpose of Coverage

If the Member dies while covered by this benefit, Blue Cross will pay the Member's beneficiary the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Advance Payment Due to Terminal Illness

An advance payment of the member life benefit may be paid to the Member if:

- the Member submits a request to Blue Cross in writing;
- Blue Cross is satisfied, on the basis of medical evidence provided by the Member's attending physician, that the Member is suffering from a condition that is expected to result in the Member's death within 12 months of the date of the request;
- the Member is eligible for waiver of premium; and
- the Member is under age 65.

An advanced payment amount cannot be more than 50% of the member life benefit amount in effect at the time of the request or $50,000, whichever is less. It will be paid in one lump sum that will be deducted from the member life benefit amount. The remainder of the member life benefit will be paid to the Member's beneficiary on death of the Member.

Members are only eligible for an advance payment once per lifetime.

Payment of Claims

Beneficiary

Member life benefits will be paid to the Member's beneficiary with the exception of an advance payment due to terminal illness that will be paid directly to the Member.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 15 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

The Member has the right to purchase an individual life policy from Blue Cross if their member life benefit coverage terminates on or before their 65th birthday due to retirement, termination of employment or termination of coverage for the group or class of Members to which the Member belongs.

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages.

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

They are also subject to the following additional terms and conditions:

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;

- the types of individual life policies available for conversion are:
    - a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);
    - a non-convertible term life policy that provides level term coverage to age 65; or
    - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage available under the individual life policy is the lesser of:
    - the amount of member life benefit coverage in effect on the termination date;
    - the amount of any scheduled reduction of the member life benefit coverage;
    - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination;
    - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec; and
- the coverage provided by the individual life policy cannot be less than:
    - the minimum amount Blue Cross will normally issue for the type of policy selected; or
    - $10,000 for residents of Quebec.

Purpose of Coverage

If a Dependent dies while covered by this benefit, Blue Cross will pay the Member the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Payment of Claims

All benefits will be paid directly to the Member.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 15 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

On or before their 65th birthday, a Spouse residing in any province or a Child who is a resident of Quebec has the right to purchase an individual life policy from Blue Cross if their dependent life coverage terminates for one of the following reasons:

- death of the Member;
- termination of the Member's life coverage for a reason that entitles the Member to convert their member life benefit to an individual policy; or
- the Spouse or Child is no longer eligible for coverage as a Dependent.

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

They are also subject to the following additional terms and conditions:

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the types of individual life policies available for conversion are:
    - a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);
    - a non-convertible term life policy that provides level term coverage to age 65; or
    - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the coverage provided by the individual life policy cannot be:
    - more than the amount of dependent life benefit coverage in effect on the termination date; or
    - less than the minimum amount Blue Cross will normally issue for the type of policy selected or $5,000 for residents of Quebec.

Purpose of Coverage

On satisfactory medical evidence that a Participant suffers from a covered condition described in this benefit, Blue Cross will pay the amount specified in the Summary of Benefits, subject to the conditions outlined below. If there is a change in critical illness coverage, the coverage in effect when the covered condition was diagnosed is the coverage that applies to all claims for that covered condition.

Helpful Tip

Enhanced Critical Illness provides a lump sum cash payment. The benefit is paid regardless of ability to work or of expenses incurred. There are no restrictions on how the money is spent.

For example, you may use the money to:

- pay for the costs of bringing home friends or family members in your time of need;
- pay off outstanding debts; or
- help with home renovations required to accommodate new physical limitations.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Specialist: A licensed medical practitioner who is certified by a specialty examining board and is trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed. In the absence of a Specialist, and as approved by Blue Cross, a condition may be diagnosed by a qualified Health Practitioner that practices in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn Specialist and internist. The Specialist must not be:

- the Participant or the Participant's Family Member; or
- the Participant's employer or co-worker.

Any tests or examinations to satisfy the condition requirements must be performed by a medical professional who is not:

- the Participant or the Participant's Family Member; or
- the Participant's employer or co-worker.

Survival Period: The continuous period of time between the date the definition of a covered condition is met and the date the benefit is payable, as long as the Participant is still living. The Survival Period is specified in the Summary of Benefits.

Unrelated Covered Conditions: Medical conditions that are deemed to have a separate and distinct cause. All critical conditions that have the same cause will be considered related events and eligible for one benefit payment.

Covered Conditions Eligible for Full Benefit Payment

A full benefit amount is paid for up to 2 Unrelated Covered Conditions. When a benefit becomes payable for a covered condition in one Category, the Participant will not be covered for any future conditions in the same Category.

Category 1: Cancer

Category 2: Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair

Category 3: Blindness, Severe Burns, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection

Category 4: Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke

All covered conditions must be the result of Illness or disease in order to be considered eligible with the exception of Severe Burns. Severe Burns are covered even if they do not result from Illness or disease.

Aortic Surgery: Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be Medically Necessary by a Specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia: Definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis: Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

The diagnosis of Bacterial Meningitis must be made by a Specialist.

Neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing or vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination or new-onset seizures undergoing treatment. Headache or fatigue is not considered a neurological deficit.

This coverage excludes viral meningitis.

Benign Brain Tumour: Definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The Participant must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The diagnosis of Benign Brain Tumour must be made by a Specialist.

Neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing or vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

No benefit is payable under this condition for pituitary adenomas less than 10 mm, vascular malformations; cholesteatomas or infectious or inflammatory tumours.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, leading directly or indirectly to a diagnosis of any benign brain tumour, regardless of when the diagnosis is made; or
- a diagnosis of any benign brain tumour.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness: Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a Specialist.

Cancer: Definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of this condition:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or
  - small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm^2, or 50 per HPF.
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

No benefit is payable under this condition for the following:

- lesions described as benign, non-invasive, pre-malignant, of low or uncertain malignant potential, borderline, carcinoma in situ or tumours classified as Tis or Ta;
- malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- gastro-intestinal stromal tumours classified as AJCC Stage 1;

- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under this plan), regardless of when the diagnosis is made; or
- a diagnosis of any cancer (covered or not covered under this plan).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for Cancer, or any critical illness caused by any cancer or its treatment.

Coma: Definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a Specialist.

This coverage excludes:

- a medically induced coma;
- a coma that result directly from alcohol or drug use; and
- a diagnosis of brain death.

Coronary Artery Bypass Surgery: Heart surgery to correct narrowing or blockage of 1 or more coronary arteries with bypass graft(s). The surgery must be determined to be Medically Necessary by a Specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness: Definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of Deafness must be made by a Specialist.

Dementia (including Alzheimer's Disease): Definite diagnosis, made by a Specialist, of dementia which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (for example, inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Participant must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

This coverage excludes affective or schizophrenic disorders or delirium.

Reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975; 12(3):189.

Heart Attack (acute myocardial infarction)**:** Definite diagnosis of death of heart muscle due to obstruction of blood flow that results in a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiographic (ECG) changes consistent with a heart attack; or
- development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography or angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

No benefit is payable under this condition for:

- ECG changes suggestive of a prior myocardial infarction;
- other acute coronary syndromes, including angina pectoris and unstable angina; or
- elevated cardiac biomarkers or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair: Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be Medically Necessary by a Specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure: Definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence: Definite diagnosis of the total inability, due to disease or injury, to independently perform at least 3 of 6 Activities of Daily Living:

- with or without the aid of assistive devices;
- with no reasonable chance of recovery; and
- for a continuous period of at least 90 days.

The diagnosis of Loss of Independent Existence must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

No additional Survival Period is required once the conditions described above are satisfied.

Loss of Limbs: Definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech: Definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

This coverage excludes all psychiatric related causes.

Major Organ Failure on Waiting List: Definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Failure on Waiting List, the Participant must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of diagnosis is the date of the Participant's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant: Definite diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, such that an organ transplant is Medically Necessary.

To qualify under Major Organ Transplant, the Participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease: Definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: Definite diagnosis of at least one of the following occurring after the effective date of coverage:

- two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- a single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of Multiple Sclerosis must be made by a Specialist.

Neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing or vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

No benefit is payable for the following:

- solitary sclerosis;
- clinically isolated syndrome;
- radiologically isolated syndrome;
- neuromyelitis optica spectrum disorders; or
- suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: No benefit will be payable under this condition if, within the first year following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis regardless of when the diagnosis is made; or
- a diagnosis of multiple sclerosis.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection: Definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Participant's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the effective date of the coverage.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to Blue Cross within 14 days of the accidental injury;
b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

No benefit is payable under this condition if:

- The Participant has elected not to take any available licensed vaccine offering protection against HIV;
- A licensed cure for HIV infection becomes available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: Definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

Parkinson's Disease: Definite diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Participant must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders: Definite diagnosis of progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusion: No benefit is payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations leading directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit is payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns: Definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits): Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage or embolism with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of Stroke must be made by a Specialist.

Neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing or vision , measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

No benefit is payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma;
- ischaemic disorders of the vestibular system;
- death of tissue of the optic nerve or retina without total loss of vision of that eye; or
- lacunar infarcts which do not meet the definition of Stroke as described above.

Covered Childhood Conditions

If a Member is enrolled in family coverage, the benefit amount specified in the Summary of Benefits for a Child is payable for up to 1 covered childhood condition per lifetime.

Coverage includes the following childhood conditions:

- **Autism:** an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the Child's third birthday.
- **Cerebral Palsy:** a definitive diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.
- **Congenital Heart Disease:** any one or more diagnosis(es) from the following lists of heart conditions:

  List A

  a) Total Anomalous Pulmonary Venous Connection;
  b) Transposition of The Great Vessels;
  c) Atresia of any heart valve;
  d) Coarctation of the Aorta;
  e) Single Ventricle;
  f) Hypoplastic Left Heart Syndrome;
  g) Double Outlet Left Ventricle;
  h) Truncus Arteriosus;
  i) Tetralogy of Fallot;
  j) Eisenmenger Syndrome;
  k) Double Inlet Ventricle;
  l) Hypoplastic Right Ventricle; or
  m) Ebstein's Anomaly.

The above conditions are covered after a 30-day Survival Period, beginning from the later of the date of diagnosis or birth. The diagnosis of any of the conditions in List A must be made by a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

a) Pulmonary Stenosis;
b) Aortic Stenosis;
c) Discrete Subvalvular Aortic Stenosis;
d) Ventricular Septal Defect; or
e) Atrial Septal Defect.

The above conditions are covered only when open heart surgery is performed for correction of the condition after a 30-day Survival Period from the later of the date of diagnosis or birth. The diagnosis of any of the conditions in this List B must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada.

- **Cystic Fibrosis:** a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.
- **Down Syndrome:** a definitive diagnosis of Down Syndrome by a qualified Specialist.
- **Muscular Dystrophy:** a definitive diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.
- **Type 1 Diabetes Mellitus:** a diagnosis of Type 1 Diabetes Mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

No benefit is payable if a Child is born within 10 months of the effective date of family coverage, and that Child is diagnosed with a childhood condition within those 10 months.

Covered Conditions Eligible for Partial Benefit Payment

A partial benefit payment up to the amount specified in the Summary of Benefits is payable for any of the following non-life threatening critical conditions:

- Coronary Angioplasty;
- Ductal Carcinoma in Situ of the Breast;
- Stage A (T1a or T1b) Prostate Cancer; or
- Stage 1A Malignant Melanoma.

Participants may be eligible for one partial benefit payment per lifetime for each covered condition eligible for partial benefit payment. A partial benefit payment does not reduce the amount of coverage available for covered conditions eligible for full benefit payment.

All covered conditions must be the result of Illness or disease in order to be considered eligible for partial benefit payment. The following conditions are covered to the partial benefit payment limits specified in the Summary of Benefits:

Coronary Angioplasty: An interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be Medically Necessary by a Specialist.

Ductal Carcinoma In Situ Of The Breast: A non-invasive cancer that must be confirmed by biopsy. The diagnosis of ductal carcinoma in situ of the breast must be made by a Specialist.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for cancer, or any critical illness caused by any cancer or its treatment.

Stage A (T1a or T1b) Prostate Cancer: The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a Specialist and confirmed by pathological examination of prostate tissue.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for cancer, or any critical illness caused by any cancer or its treatment.

Stage 1A Malignant Melanoma: A melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion. The diagnosis of state 1A malignant melanoma must be made by a Specialist.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Blue Cross within 6 months of the date of the diagnosis. If this information is not provided within this period, Blue Cross has the right to deny any claim for cancer, or any critical illness caused by any cancer or its treatment.

Payment of Claims

The benefit amount is payable after the expiration of the Survival Period specified in the Summary of Benefits, provided the Participant is still living at that time.

The benefit amount is limited to the Benefit Maximum specified in the Summary of Benefits, regardless of the number of covered conditions a Participant may experience.

A full benefit amount is payable for up to 2 Unrelated Covered Conditions eligible for full benefit payment. Once a benefit has become payable for a covered condition in one category (Category 1, 2, 3 or 4), the Participant is not covered for any future covered condition specified under the same category. However, a Participant is eligible to receive a second full benefit amount for a covered condition specified under a different category.

A partial benefit amount is payable for up to 4 covered conditions eligible for partial benefit payment. The Participant is eligible for 1 partial benefit payment per non-life threatening covered condition.

A full benefit amount is payable for 1 covered childhood condition.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date of the diagnosis.

Exclusions and Limitations

Blue Cross will not pay benefits for any condition that results, directly or indirectly, from any of the following causes:

a) an Accident, unless the covered condition is a Severe Burn;
b) attempted suicide or voluntary injury or Illness;
c) use of any poison, intoxicant or drug, unless prescribed by a Physician and used as directed;
d) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
e) any Accident or injury occurring while operating a vehicle under the influence of drugs (including marijuana) or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or
f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Right to Convert to Individual Coverage

Eligibility for Conversion

The Member has the right to purchase an individual critical illness policy from Blue Cross if their enhanced critical illness coverage terminates on or before their 65th birthday due to retirement, termination of employment or termination of coverage for the group or class of Members to which the Member belongs.

On or before their 65th birthday, a Spouse has the right to purchase an individual critical illness policy from Blue Cross if their enhanced critical illness benefit coverage terminates for any reason other than at the request of the Member.

The Member or Spouse must have critical illness benefit coverage in force for a minimum of 24 consecutive months (under this plan or a Previous Policy) before they are eligible to purchase an individual critical illness policy.

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the Right to Convert to Individual Coverage found under the Coverage Details of this policy.
They are also subject to the following additional terms and conditions:

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual critical illness policy will be 31 days after the group coverage terminates;
- the individual critical illness policy will not include any disability or other supplementary benefits;
- the maximum amount of coverage available under the individual critical illness policy is the lesser of:
  - the amount of enhanced critical illness benefit coverage in effect on the termination date;
  - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination; and
  - $100,000; and
- the coverage provided by the individual critical illness policy cannot be less than the minimum amount Blue Cross will normally issue for the type of policy selected.

Purpose of Coverage

If a Member becomes Totally Disabled following an illness or accident, Blue Cross will pay up to the maximum amount specified in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Benefit Period: The maximum number of weeks Blue Cross will pay benefits, as specified in the Summary of Benefits. The Benefit Period includes the number of weeks for which benefits are payable by the Canada Employment Insurance Commission (CEIC).

Elimination Period: The continuous period of time from the date the Member becomes Totally Disabled until the date benefits are payable. This period is specified in the Summary of Benefits.

Hospitalization: Admission to a hospital as an inpatient for a minimum period of 1 overnight stay. If so specified in the Summary of Benefits, hospitalization will include admission to a hospital as an outpatient for:

- surgery performed in a hospital or at a private surgical clinic if this surgery is or would have been covered under Government Health Care Coverage;
- chemotherapy; and
- laser treatment.

Total Disability or Totally Disabled: The complete and continuous inability of a Member to perform the regular duties of their own occupation as a result of illness or accident. Regular duties refer to those work related activities that are essential to performing your own occupation.

The Member must be under the continuous care and Treatment of a physician and must not be working, other than in a rehabilitation program pre-approved by Blue Cross.

Members who have a pending file with a workers' compensation board/commission, the Canada Employment Insurance Commission (CEIC) or the Canada Pension Plan will be adjudicated for short term disability benefits under this plan.

The loss of a professional or occupational licence or certification does not, in itself, constitute Total Disability.

Payment of Benefits

When Benefit Payments Begin

Benefit payments begin on expiry of the Elimination Period. Blue Cross will pay benefits at weekly intervals for each day a Member is Totally Disabled following the expiry of the Elimination Period.

If the Elimination Period is calculated in:

- calendar days, the benefit for each day of Total Disability will be equal to 1/7 of the weekly benefit; or
- working days, the benefit for each working day of Total Disability will be equal to 1/5 of the weekly benefit.

The calculation basis of the Elimination Period is specified in the Summary of Benefits.

Calculation of the Benefit Amount

Blue Cross applies the benefit formula specified in the Summary of Benefits to obtain a weekly benefit amount up to the benefit maximum specified in the Summary of Benefits.

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;
- the Member retires;
- the Benefit Period expires; or
- the Member dies.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 6 months of the expiry of the Elimination Period.

Recurrent Disabilities

If a Member who was Totally Disabled and receiving short term disability benefits becomes Totally Disabled again after having returned to work, Blue Cross will consider the recurrent disability to be a continuation of the initial disability if the disability results from:

- the same or related causes within the first 2 weeks of the Member being Actively at Work; or
- different and unrelated causes and the Member did not fully recover from the first disability and did not return to work for at least a full day before the start of the recurrent disability.

Helpful Tip

Proof of claim consists of 3 forms: Declaration of the Employee, Declaration of the employer and Declaration of the physician. Forms are available on our website.

When the recurrent disability is considered to be a continuation of the initial period of Total Disability:

- the Elimination Period will not be applied a second time;
- the benefit amount payable is that which was calculated for the initial period of Total Disability; and

benefits will only be paid for the balance of the initial Benefit Period.

Total Disability During Periods of Absence

If a Member becomes Totally Disabled during a period of absence from work during which disability coverage has been discontinued, no disability benefit will be payable.

If a Member becomes Totally Disabled during a period of absence from work where disability coverage has been retained and premiums have been paid:

- the Elimination Period will begin on the onset of Total Disability;
- the Benefit Period will be deemed to begin on the expiration of the Elimination Period; and
- benefit payments will begin on the later of the expiry of the Elimination Period or the date the Member was scheduled to return to work.

Rehabilitation Program

If considered appropriate by Blue Cross, Blue Cross may require a Member to participate in a rehabilitation program pre-approved by Blue Cross consisting of:

- medical care, Treatment or diagnostic measures;
- full-time work or part-time work; or
- a vocational assessment, training or re-training program for the purpose of rehabilitation.

When a Member participates in a rehabilitation program while receiving benefits, the following conditions apply:

- the Member's Total Disability will not be considered to have ended simply because they undertook a rehabilitation program;
- if the Member becomes Totally Disabled again while participating in a rehabilitation program, the terms and conditions of this benefit will apply as if the Member had remained Totally Disabled for the full duration of the rehabilitation program;
- the Benefit Period continues despite participation in the rehabilitation program; and
- during the rehabilitation program, weekly benefits will be reduced as necessary to ensure that the Member's total income from all sources does not exceed 100% of the Member's pre-disability salary.

Exclusions and Limitations

1. Benefits are not payable for any Total Disability that results from any of the following causes:
   a) participation in a criminal act;
   b) any accident or injury occurring while operating a motor vehicle under the influence of drugs (including marijuana) or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the accident occurred;
   c) any Illness that results from the use of drugs or alcohol, if the Member is not receiving continuing Treatment for the use of these substances;
   d) medical care or treatment that is performed for cosmetic purposes only, unless it is required as a result of an Illness or Accident; or
   e) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

2. Benefits are not payable during any periods in which the Member:
   a) receives compensation under a workers' compensation board/commission or any program of a similar nature;
   b) is eligible for benefits from the Canada Employment Insurance Commission (CEIC);
   c) receives maternity or parental benefits under any federal law or Quebec Parental Insurance Plan or takes maternity or parental leave in accordance with any federal law or Quebec Parental Insurance Plan or any agreement between the Member and the Plan Sponsor, subject to the following exception:
      - benefits will be payable during the health-related portion of the maternity leave when required by applicable law or legislation, provided coverage has been retained for the Member. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Blue Cross;
   d) is absent from Canada for any period during which the Canada Employment Insurance Commission (CEIC) benefits would not be payable, unless Blue Cross agrees in writing, in advance, to pay benefits during the period;
   e) is imprisoned in a correctional facility, community residence or while under house arrest by order of a criminal court;
   f) fails to:
      - provide Blue Cross with satisfactory proof of continued Total Disability;
      - submit to an independent examination requested by Blue Cross; or
      - participate in any reasonable Treatment or rehabilitation program considered appropriate by Blue Cross;
   g) engages in any occupation or employment for wage or profit, other than a rehabilitation program pre-approved by Blue Cross; or
   h) refuses to accept any reasonable offer of modified duties or alternative employment from the Plan Sponsor, provided the modified duties or alternative employment are approved by a Physician.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) in Canada;
- considered by Blue Cross to be an Essential Non-Prescription Requiring Drug or a drug that requires a prescription by law, unless specifically listed as covered under this benefit;
- prescribed by a physician or by a Health Practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Blue Cross as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may, on an ongoing basis, add, delete or amend its list of Eligible Drugs.

Essential Non-Prescription Requiring Drug: An Eligible Drug that is determined by Blue Cross to be essential and does not require a prescription by law. A prescription from a Physician or Health Practitioner is still needed for reimbursement.

Interchangeable Drug: An Eligible Drug that can be substituted for another Eligible Drug as both drugs:

- are considered pharmaceutical equivalents by Health Canada;
- contain the same active ingredients; and
- are administered in the same way.

Medication Advisory Panel: The group of health care and other industry professionals appointed by Blue Cross to review new drugs and decide which drugs Blue Cross includes on its formularies.

Patient Support Program: A program that provides assistance and services to Participants when prescribed Specialty High Cost Drugs.

Specialty High Cost Drug: An Eligible Drug that requires Prior Authorization and:

- is considered a Specialty High Cost Drug by the Medication Advisory Panel; or
- meets the following criteria:
  - costs $10,000 or more per treatment or per calendar year;
  - is used to treat complex chronic or life threatening conditions such as cardiac, rheumatoid arthritis, cancer, multiple sclerosis or hepatitis c.; and
  - is prescribed by a specialist.

What Blue Cross Will Pay

Blue Cross will pay Eligible Drugs subject to the following terms and conditions:

- payment is limited to the reimbursement level and the benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
- Prior Authorization; or
  - co-ordination with Patient Support Programs;
  - payment for a Specialty High Cost Drug may be reduced by the amount of financial assistance available under a Patient Support Program;

- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit;
- payment for biologic drugs may be limited to the cost of a biosimilar drug as determined by Blue Cross;
- payment for Eligible Drugs not dispensed by an approved retail pharmacy will be limited to a pricing schedule as determined by Blue Cross; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses listed below, provided they also meet the definition of Eligible Expenses contained under the *Key Terms* provision of this booklet:

- diabetic supplies, including test strips, lancets, needles, syringes and insulin pump supplies;
- glucose monitoring systems, including continuous glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes;
- managing chronic disease services, including initial assessment, counselling and follow up sessions, education relating to symptom management, medication usage, and development of action plans, for medical conditions deemed eligible by Blue Cross;
- viscosupplementation injections;
- contraceptives, intrauterine contraceptive device (IUD) and diaphragms;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formularies:

Helpful Tip

Visit our website for helpful information on managing chronic diseases **www.medaviebc.ca/livebetter**.

Specialty High Cost Drugs

- **Managed Formulary:** List of Eligible Drugs and Essential Non-Prescription Requiring Drugs that are subject to the decisions of the Medication Advisory Panel.

All Other Eligible Drugs

- **Open Formulary:** List of all Essential Non-Prescription Requiring Drugs and Eligible Drugs that require a prescription by law. This list is not subject to the Medication Advisory Panel decisions.

Prior Authorization

Certain Eligible Drugs require prior or ongoing authorization by Blue Cross to qualify for reimbursement. The criteria to be met for Prior Authorization are established by Blue Cross and may include requiring the Participant to participate in a Patient Support Program.

Helpful Tip

Your group benefits plan provides you with immediate access to most Eligible Drugs.

Certain Eligible Drugs require Prior Authorization before your prescription is covered.

How does the Prior Authorization process affect my claim?

The first time you present a prescription for an Eligible Drug on the Prior Authorization list your pharmacist will indicate the need for Prior Authorization.

You can request a Prior Authorization Prescription Drug Form from your pharmacy, your Plan Sponsor, the nearest Blue Cross customer information centre or from our website. You must complete the patient section of the form, have your physician complete and sign the remaining portion and mail your completed form to the nearest Blue Cross office.

Helpful Tip

To print a copy of our Prior Authorization Prescription Drug Form, visit our website.

Your request will be confidentially reviewed by a health care professional according to the payment criteria established. When all the required information is received by Blue Cross, the standard turn-around time for Prior Authorization decisions is 7 to 10 working days.

You will receive confirmation in writing regarding the decision on your Prior Authorization request. If your request is approved, this confirmation will include the effective date and duration of your approval.

Any fees associated with completing this form or obtaining additional medical information are your responsibility.

Plan Management Features

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug. In the case of biologic drugs, Blue Cross reserves the right to reimburse to a less expensive biosimilar drug.

Participants may request a higher cost Interchangeable Drug; however, they will be responsible for paying the difference in cost between the Interchangeable Drugs.

Mandatory Generic Substitution:

Regardless of whether the Participant's physician indicates the prescribed Interchangeable Drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug.

Helpful Tip

A generic drug and its brand name equivalent are considered to be Interchangeable Drugs. Health Canada imposes the same standards and tests on generic drugs as it does on brand name drugs. Generic drugs are effective and safe, while often being less expensive.

For Participants with an adverse reaction to the Interchangeable Drug dispensed, Blue Cross will consider reimbursement to another Interchangeable Drug on a case by case basis only through the Prior Authorization process.

Quebec Pharmacy Pricing Controls

If the Summary of Benefits specifies that Quebec pharmacy pricing controls apply, Participants will be responsible for paying the difference between the amount charged by the pharmacy for professional fees and the amount Blue Cross considers acceptable Usual, Customary and Reasonable charges.

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under the group contract.

Reimbursement: The Participant will pay the full cost of the prescription to the Approved Provider at the time of purchase. Blue Cross will reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Helpful Tip

If you have a Pay Direct or Deferred Payment plan, always have your drugs submitted electronically via the Approved Provider. This will ensure you don't end up paying more out-of-pocket than you should.

Pay Direct: At the time of purchase, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility. The Participant will pay the Approved Provider only the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Deferred Payment: At the time of purchase, the Approved Provider submits the Participant's claim to Blue Cross electronically to verify eligibility. The Participant pays the full amount charged by the Approved Provider and Blue Cross will reimburse the portion of the Participant's claim covered by this benefit when a specified dollar amount or a time-period threshold has been reached.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Blue Cross will reimburse only the amount that would have been reimbursed if the claim had been submitted electronically.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 15 months of the date the Eligible Expense was incurred.

Helpful Tip

If you pay up front and submit your claim for reimbursement, you may end up with surprise out-of-pocket expenses if your pharmacist charged you more than would have been permitted by the Blue Cross system.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, expenses associated with the following categories of drugs or services are not eligible for reimbursement, even when prescribed:

a) varicose vein injections;
b) injectable and oral vitamins;
c) natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;
d) hair growth stimulants;
e) services, treatment or supplies that:
   i. are not Medically Necessary;
   ii. are for cosmetic purposes only;
   iii. are elective in nature; or
   iv. have experimental or investigative indication;
f) procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
g) drugs that Blue Cross determines are intended to be administered in hospital, based on the way they are administered and the condition the drug is used to treat;
h) expenses that are covered under any government health care coverage or charges payable under a workers' compensation board/commission, any automobile insurance bureau or any other similar law or public plan;
i) services, treatment or supplies the Participant receives free of charge;
j) charges that would not have been incurred if no coverage existed;
k) drugs that are eligible under the travel benefit provided by the group contract (if applicable);
l) all forms of cannabis; or
m) pharmacy services.

Helpful Tip

Shop around for the best price for your prescription drugs.

For the same prescription, the price can vary depending on where you go, even among stores in the same chain.

Right to Convert to Individual Coverage

A Participant who is not a Quebec Participant and who is no longer eligible under this benefit may convert their group coverage to a similar individual drug plan provided by Blue Cross.

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Acute Care: Short-term Treatment that is necessary to:

- prevent deterioration of a severe injury, episode of illness or urgent medical condition;
- promote recovery from surgery; or
- provide palliative care for an individual diagnosed with a terminal illness whose life expectancy is less than 3 months.

Convalescent Care Facility: A public establishment that provides convalescent care to patients who are under the direct care of a physician at all times. The establishment must be licensed by the appropriate government body and must provide 24-hour nursing care services.

Helpful Tip

Blue Advantage® offers savings to Blue Cross members on medical, vision care and many other products and services from participating providers across Canada.

A list of participating providers and discounts is available at **www.blueadvantage.ca**.

Convalescent Care Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, drug addiction or alcohol treatment centres or facilities intended for custodial care.

Hospital: An Acute Care facility that is licensed to provide inpatient treatment. This does not include any part of such facility that is intended for long term care. The facility must:

- have facilities for diagnostic treatment and major surgery;
- qualify to participate in and be eligible to receive payments under the provisions of the provincial hospital act in the jurisdiction in which it is located;
- operate in accordance with the applicable laws of the jurisdiction in which it is located;
- provide 24 hour nursing care services; and
- require that every patient be under the direct care of a physician.

Hospitals do not include convalescent care facilities, physical or psychiatric rehabilitation facilities, maternity homes, nursing homes, rest homes, retirement residences, homes for the aged, blind, deaf, chronically or mentally ill, long-term care or assisted living facilities or drug addiction and alcohol treatment centres. It also does not include any part of a Hospital consisting of nursing care or beds that have been set aside for any of the purposes outlined in this paragraph.

Physical Rehabilitation Facility: A public establishment that provides physical rehabilitation care to patients with physical impairments or disabilities who do not require Acute Care, but who need continued medical supervision directed toward the restoration of functional ability and quality of life. The establishment must be licensed by the appropriate government body.

Physical Rehabilitation Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, facilities intended for custodial care or drug addiction and alcohol treatment centres.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Hospitalization

Hospital: Room accommodation when a Participant is admitted to a Hospital as an inpatient for Acute Care. The type of room eligible for coverage is specified in the Summary of Benefits.

Hospitalization coverage excludes administrative and incidental fees (for example, television, telephone and parking).

Medical Services and Supplies

Ambulance Transportation: Charges for emergency transportation of a stretcher patient by a licensed ambulance to and from the nearest Hospital equipped to provide the emergency care needed by the Participant. This includes air or rail transportation.

This coverage excludes inter-Hospital transfers.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse where such services are provided at the Participant's home and are not primarily for custodial care or midwifery.

Nursing care services may require pre-approval from Blue Cross to be eligible for payment in whole or in part. Benefit payment amounts for approved nursing care services are based on the provincial payment schedule established by Blue Cross.

Helpful Tip

Before receiving nursing services you should obtain pre-approval from Blue Cross by contacting the toll-free number on your Blue Cross identification card.

Charges for the services of a personal support worker in the Participant's home may also be eligible if the Participant is under the active care of a nurse or requires home care for recuperation after a discharge from Hospital. Personal support workers offer essential services related to the Activities of Daily Living.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the Activities of Daily Living.

Health Practitioners: Eligible Expenses for Treatment provided by any Health Practitioner specified in the Summary of Benefits. Coverage is limited to:

- Treatment within the scope of the Health Practitioner's practice; and
- 1 Treatment by the same Health Practitioner per day.

Unless otherwise specified in the Summary of Benefits, a physician referral is not necessary for Treatment to be eligible for coverage.

This coverage excludes:

- products provided by a Health Practitioner (unless specified as a benefit under this group benefits plan);
- comprehensive health assessments;
- charges for services obtained in Hospital; and
- group treatment sessions.

Helpful Tip

Ask your Health Practitioner if they are a Blue Cross Approved Provider before you obtain service or supplies to avoid unexpected out-of-pocket expenses.

Durable Medical Equipment: Charges for rental of the following medical equipment:

- manual or electric wheelchair, including cushions and inserts;
- manual or electric hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
- insulin pump for the Treatment of type 1 diabetes;
- compression pump, traction equipment; and
- patient lifter.

Helpful Tip

You must obtain pre-approval from Blue Cross before purchasing durable medical equipment or prostheses. This will ensure you don't end up with significant and unexpected out-of-pocket expenses.

The purchase of durable medical equipment requires pre-approval from Blue Cross; otherwise it may be ineligible for payment in whole or in part.

If there is a long-term need for equipment due to extended illness or disability, Blue Cross may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment is limited to once every 5 consecutive calendar years.

Two pieces of equipment are similar if they serve the same purpose (for example, facilitate breathing, provide mobility, deliver insulin).

This coverage excludes charges for special mattresses and air conditioning or air purifying equipment.

Mobility Aids and Orthopedic Appliances: Charges for the purchase or rental of crutches, canes and walking aids, casts, splints, trusses, braces and cervical collars.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A $10,000 maximum applies to myoelectric limbs;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 2 calendar years; and
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of $250 per lifetime.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of $300 per calendar year.

This coverage excludes:

- microprocessor knees;
- wigs when hair loss is not due to an underlying pathology or its treatment, hair replacement therapy and other procedures for physiological hair loss (for example, male pattern baldness); and
- replacement of prostheses unless required due to pathological or physiological change.

Diabetic Equipment: Charges for glucometer, pressurized insulin injector, insulin dosing systems or other equipment approved by Blue Cross that performs similar functions. The equipment must be used for the Treatment and control of diabetes.

Insulin pumps are eligible under the durable medical equipment benefit.

Diabetic supplies are eligible under the drug benefit.

Hearing Aids: Charges for the purchase and repair of hearing aids when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum for both ears.

This coverage excludes batteries and exams.

Custom Orthopedic Shoes (and Supplies) and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes, prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
  - the shoes have been prescribed by an attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;
  - the Participant provides a copy of the biomechanical or gait analysis from the prescribing Health Practitioner; and
  - the shoes are dispensed by an Approved Provider of orthopedic shoes.
- custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:
  - they have been prescribed by an attending physician, an orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist; and
  - they are dispensed by an Approved Provider of custom made foot orthotics.

Helpful Tip

For more information on which expenses qualify under your orthopedic shoes and orthotics coverage, visit our website. www.medaviebc.ca/benefit updates.

This coverage excludes the purchase and repair of pre-fabricated orthopedic shoes without permanent modifications and extra-depth shoes.

Diagnostic Tests: Charges for the following diagnostic tests when provided by a laboratory approved by Blue Cross:

- laboratory analyses; and
- for residents of Quebec, diagnostic imaging services (ultrasounds, electrocardiograms, computerized tomography (CT Scans), X-rays and magnetic resonance imagery (MRI)). Expenses must be incurred in Canada.

This coverage excludes charges for diagnostic services if they are incurred for the purpose of health screening or if the Participant's government health care coverage prohibits payment of these expenses.

Other Medical Services and Supplies: Charges for the following medical services and supplies:

- allergy testing materials to a maximum of $50 per calendar year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per calendar year;
- burn pressure garments to a maximum of $500 per calendar year;
- graduated compression garments (including stockings) to a maximum of $400 per calendar year;
- ileostomy supplies, ostomy supplies, incontinence supplies, catheters and catheterization supplies;
- oxygen;
- sleeves for lymphedema to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of 4 per calendar year;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $300 per 5 calendar years;
- visual training and remedial eye exercises performed by an ophthalmologist or optometrist to a maximum of $150 per lifetime; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of $200 per 24 consecutive months; 12 consecutive months for a Participant under age 19. The contact lenses must improve sight to at least 20/70 and this level of improvement must not be possible with eyeglass lenses.

Accidental Dental: Charges for dental Treatment when required to repair or replace a sound natural tooth. A tooth is considered sound if, before the accident:

- it was free from injury, disease or defect;
- it did not need further restorations to remain intact or hold secure; and
- it had no breakdown or loss of root structure or loss of bone.

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the Plan Sponsor;
- initiated within 12 months of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval within that period; and
- performed within 2 years of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

Coverage amounts are determined by the fee guide for dental general practitioners applicable to the dentist's province of practice in the year expenses are incurred.

This coverage excludes accidental damage to teeth that occurs while eating.

Vision Care

Eye Examination: Charges for an eye examination performed by an Approved Provider.

Lenses, Frames, Contact Lenses, Laser Eye Surgery and Safety Glasses: Charges for the following products and services are eligible when prescribed by an Approved Provider:

- corrective eyeglasses (frames and lenses) and contact lenses; and
- laser eye surgery; and
- intraocular lenses used in cataract surgery.

This coverage excludes expenses incurred for non-corrective sunglasses.

Payment of Claims

How Payments are Made

The Participant will pay the full cost of any expense to the Approved Provider at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Certain Approved Providers may offer a pay direct arrangement. In such circumstances, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility at the time of purchase and the Participant will only pay the Approved Provider the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

Step 1. Blue Cross will apply any applicable Usual, Customary and Reasonable limits. The Eligible Expense will be equal to the lesser of the actual expense and the Usual, Customary and Reasonable charges for the service or supply;
Step 2. Blue Cross will subtract the Deductible (if any);
Step 3. the Reimbursement Level percentage will be applied to the remainder of the Eligible Expense;
Step 4. the result is the amount payable by Blue Cross, subject to any Benefit Maximums applicable.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 15 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

No payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) health care covered under any government health care coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;
c) health care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies that the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) services, treatment or supplies that are:
    i. not Medically Necessary;
    ii. for cosmetic purposes only;
    iii. elective in nature; or
    iv. experimental or investigative.
g) all services relating to family planning (unless specifically listed as a covered benefit in this booklet), including artificial insemination, laboratory fees or other charges incurred in relation to infertility treatment, regardless of whether or not infertility is considered to be an illness;
h) charges that are eligible under the travel benefit provided by the group contract (if applicable);
i) services or supplies normally intended for recreation or sports;
j) extra supplies that are spares or alternates;
k) charges for missed appointments or the completion of forms;
l) medical examinations or routine general check-ups;
m) Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) speech aid equipment for persons who do not have oral communication ability;
o) mileage or delivery charges to or from a Hospital or Health Practitioner; or
p) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained.

Right to Convert to Individual Coverage

A Participant who is no longer eligible for coverage under this benefit may convert their group coverage to a similar individual extended health care plan provided by Blue Cross. Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Unit: A 15 minute interval of time or any portion of a 15 minute interval of time.

Exception: When coverage is limited by Units but fees are not described in terms of Units by either:

- the fee guide in effect where Treatment is rendered; or
- the fee guide specified by this plan;

each incident of service is considered 1 Unit, regardless of its duration.

Helpful Tip

Blue Cross limits its payments to the amount listed in the fee guide specified in the Summary of Benefits.

Before starting your Treatment, ask your dentist if they follow the provincial fee guide.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment of all Eligible Expenses is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the reimbursement level applies is the lesser of:
  - the expense actually incurred by the Member; or
  - the fee amounts specified in the dental fee guide approved by Blue Cross (the applicable guide and annual edition are specified in the Summary of Benefits);
- the Eligible Expenses for laboratory fees are limited to 60% of the amount indicated in the provider fee guide for the dental service provided;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;
  - a licensed denturist when the services are within the scope of their profession; or
  - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

Helpful Tip

You are responsible for paying any expenses in excess of the fee guide listed in the Summary of Benefits. This is important to consider, since it can directly impact your out-of-pocket expenses.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 2 calendar years;
- recall oral examination;
- emergency oral examination;
- limited or specific oral examination to a maximum of 2 per 12 consecutive months.

Helpful Tip

If a dental procedure is required as a result of an accident, it is considered as an extended health care expense rather than a dental benefit expense.

X-rays: Charges for:

- complete series to a maximum of 1 per 2 calendar years;
- panoramic to a maximum of 1 per 2 calendar years;
- intra-oral:
  - periapical;
  - occlusal to a maximum of 1 procedure per calendar year; and
  - bitewings to a maximum of 2 films per calendar year;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

- bacterial culture;
- biopsy of soft oral tissue;
- biopsy of hard oral tissue; and
- cytological examination.

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- pit and fissure sealants (limited to Participants under age 18);
- scaling; and
- space maintainers (limited to Participants under age 18).

Helpful Tip
Scaling refers to removal of plaque, calculus, and stains from teeth.

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth (replacements to a maximum of 1 per tooth per 12 consecutive months);
- retentive pins;
- pre-fabricated steel or plastic restorations; and
- pulp capping.

Helpful Tip
Restorations (fillings) refer to dental material used to restore the function and integrity of a tooth.

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy to a maximum of 2 per tooth per lifetime (re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment);
- endodontic surgery;
- bleaching (endodontically treated teeth); and
- apexification.

Helpful Tip
Endodontic Services refer to treatment of infected root canals and tissues surrounding the root of the tooth.

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- desensitization to a maximum of 3 Units per calendar year;
- periodontal curettage;
- root planing;
- occlusal adjustments to a maximum of 4 Units per calendar year;
- periodontal appliances to a maximum of 1 per 2 calendar years;
- adjustments to appliances to a maximum of 3 Units per calendar year; and
- other adjunctive periodontal services.

Helpful Tip
Periodontic Services refers to prevention, diagnosis and treatment of gum diseases.

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments;
- rebasing or relining to a maximum of 1 per 2 calendar years; and
- prophylaxis and polishing.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth;
- surgical incision, excision and drainage of tumours or cysts;
- frenectomy (surgical alteration of the frenum);
- removal, reduction or remodelling of bone or gum tissue; and
- post-surgical care.

General adjunctive services: Charges for:

- anesthesia;
- temporary dressing for the emergency relief of pain; and
- finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- inlays;
- onlays; and
- crowns: for teeth damaged due to caries or traumatic injury (does not include pre-fabricated steel restorations).

Inlays, onlays and crowns are eligible to a combined maximum of 1 per tooth per 5 calendar years.

Other Restorative Services: Charges for:

- cast post;
- prefabricated metal post;
- recementation of inlays, onlays or crowns; and
- removal of inlays, onlays or crowns.

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 60 consecutive months;
- bridgework to a maximum of 1 per tooth per 60 consecutive months; and
- restorations on implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per tooth per 10 calendar years, if specified in the Summary of Benefits.

Helpful Tip

Prosthodontic Services refers to diagnosis, treatment, rehabilitation and maintenance of oral function, comfort, appearance and health, for patients with clinical conditions associated with missing or deficient teeth.

Orthodontic Services

Charges for:

- orthodontic examinations;
- unmounted orthodontic diagnostic casts;
- removable appliances for tooth guidance;
- fixed or cemented appliances (braces);
- appliances to control harmful oral habits;
- retention appliances; and
- comprehensive treatment.

Helpful Tip

Orthodontic Services refers to treatment to correct abnormal arrangement of teeth or jaws.

Payment of Claims

How Payments are Made

At the time of purchase, the Approved Provider will either submit the Participant's claim to Blue Cross or provide a completed claim form and proof of payment to the Participant to submit to Blue Cross. The Participant will then be required to either:

- pay the portion of the claim that is not covered by this benefit and Blue Cross will reimburse the balance to the Approved Provider directly; or
- pay the total amount requested by the Approved Provider and the Participant will receive the portion of the expenses refundable by Blue Cross.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 15 months of the date the Eligible Expense was incurred.

Predetermination for Claims over $500

If the total cost of any Treatment is expected to exceed $500, the Member must submit to Blue Cross, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

Blue Cross will then notify the Member of the amount eligible for reimbursement. The Treatment must be performed by the dentist who prepared the Treatment plan; otherwise a new Treatment plan must be submitted to Blue Cross for re-assessment.

Date of Treatment

Eligible Expenses are considered to have been incurred on the date the service or supply was provided. For procedures requiring more than 1 appointment, the Eligible Expense is considered to have been incurred on the date that the entire procedure was completed or the appliance was placed.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, no payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been made if no coverage had existed;
f) anti-snoring or sleep apnea devices;
g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
h) services, treatment or supplies that are:
    i. not Medically Necessary (except for Preventive Care services);
    ii. for cosmetic purposes only; or
    iii. experimental or investigative;
i) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
j) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;
k) services that are eligible under the extended health care (if applicable);
l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
m) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) veneers;
o) implants;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Emergency: an illness or injury that requires immediate medical Treatment due or related to:

- an injury resulting from an Accident;
- a new medical condition which begins during a Trip; or
- a medical condition that existed prior to a Trip provided that it is Stable.

Stable means the Participant, in the 90 days before the departure date, has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- been prescribed a new Treatment or change in Treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established Treatment plan);
- been admitted to or treated in a hospital for the condition; or
- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

Hospital: A facility that:

- is licensed as an accredited hospital outside of the Participant's province of residence;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by Blue Cross.

Immediate Family Member: A Participant's parents, spouse, child, brother or sister.

Incident: An individual occurrence of Emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the Participant. No more than 3 persons can qualify as a Travel Companion for any given Trip.

Trip: Travel outside of the Participant's province of residence.

What Blue Cross Will Pay

Blue Cross will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and in the Summary of Benefits;
- prior approval of Blue Cross must be obtained before the Eligible Expense is incurred;
- the charges must be usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount typically charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit;
- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this plan and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan, as specified under the *Coverage Details* section of this booklet); and
- payment is subject to post-payment audit.

Emergency Hospital and Medical Travel Coverage

Blue Cross will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency;
- the Participant is covered by government health care coverage when the Emergency occurs; and
- Blue Cross is satisfied the expense is necessary to stabilize the Participant's medical condition.

Helpful Tip

Make sure to bring your Blue Cross identification card with you when you travel.

Hospitalization: Charges for Hospital room accommodation (not a suite of rooms) and for Medically Necessary inpatient and outpatient services.

Physician Fees: Fees charged for physician or surgeon services.

Medical Appliances: The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the Participant or a member of the Hospital.

This coverage excludes nursing fees for custodial care.

Diagnostic Services: Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

Drugs: The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of the Trip. The Participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the Participant;
- the date of purchase;
- the name of the medication;
- the Drug Identification Number, if available;
- the quantity and strength of the drug; and
- the total cost.

Paramedical Services: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for Treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;
b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or
c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

With respect to Treatment under categories (a) or (b):

- Treatment must begin while the Participant is covered by this benefit and end within 12 months of the accident, unless deferred Treatment is approved by Blue Cross due to the age of the Participant.

Ambulance Service: The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-Hospital transfer if the attending physician and Blue Cross determine that existing facilities are inadequate for Treatment or stabilization.

Trip Interruption or Delay: If a trip is interrupted or delayed due to an Emergency illness or injury of a Participant, coverage includes the cost of:

- one-way economy fare to repatriate each Participant to their home city in Canada or to rejoin the Trip, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the plan; and
- a round-trip economy fare for an accompanying medical attendant, if Medically Necessary.

Unless the repatriation or transfer of the Participant is not possible for medical reasons acceptable by Blue Cross, Blue Cross may require repatriation of any Participant or transfer to other medical facilities.

All rights to benefits in relation to the Incident are terminated if the Participant:

- refuses repatriation or transfer; or
- chooses to rejoin the Trip.

Coverage includes expenses incurred for meals and accommodation, subject to the overall maximum stated in the meals and accommodation benefit below.

Only expenses over and above any redeemable portion available under pre-paid travel arrangements are eligible for reimbursement.

Repatriation of a Dependent Child: The cost of repatriating, to their province of residence, a Child who is left unattended while travelling with a Participant who becomes hospitalized due to an Emergency Illness or injury.

If necessary, the cost may include a qualified attendant selected by the Participant or an Immediate Family Member to accompany the Child.

The maximum reimbursement is the cost of the transportation to the province of residence, less any redeemable portion available under pre-paid travel arrangements.

Coverage includes expenses incurred for meals and accommodation, subject to the overall maximum stated in the meals and accommodation benefit below.

Transportation to Visit the Participant: The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to the Hospital where the Participant has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. Blue Cross may waive the 7 day waiting period if Blue Cross is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to identify the body of the Participant, if deceased.

Coverage includes expenses incurred for meals and accommodation, subject to the overall maximum stated in the meals and accommodation benefit below.

Vehicle Return: The fees charged by a commercial agency to return the Participant's vehicle, whether private or rental, to the Participant's residence or to the nearest appropriate vehicle-rental agency, when the Participant is unable to drive as a result of an Emergency illness or injury. A medical certificate from the attending physician confirming the Participant's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

Return of the Deceased: The cost of preparing and transporting the remains of the deceased Participant to their province of residence to a maximum of $5,000.

This coverage excludes burial costs, such as a coffin or urn**.**

Meals and Accommodation: The cost of commercial accommodation and meals when the Participant's travel is delayed due to an Emergency illness or injury of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending physician.

Coverage includes the cost of commercial accommodation and meals if a Participant has been hospitalized due to Emergency illness or injury, is subsequently released from Hospital but in the opinion of Blue Cross is not yet able to travel.

The overall maximum reimbursement is $2,000 per Incident.

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

Blue Cross, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Participants who need medical assistance or general assistance while travelling.

Medical Assistance

If the Participant requires hospitalization or a consultation with a physician as a result of an Emergency, the travel assistance provider appointed by Blue Cross will provide the following support services:

- direct the Participant to an appropriate clinic or Hospital;
- confirm with the service provider that the Participant is covered;
- ensure a follow-up of the medical file and communicate with the Participant's family physician;
- co-ordinate the return home of a Child if the Participant is hospitalized;
- repatriation of the Participant to the province of residence if the Participant meets the eligibility requirements of this expense;
- arrange for the transportation of an Immediate Family Member to the Participant's bedside if the Participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the Participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance

In Emergency situations, the travel assistance provider appointed by Blue Cross will also provide the Participant with the following services:

- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for Emergency calls;
- referral to legal counsel in the event of a serious accident;
- settlement of formalities in the event of death;
- assistance with the loss or theft of travel documents or identity papers; and
- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

Blue Cross and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the Participant or for the availability of such care.

Payment of Claims

How Payments are Made

Blue Cross may approve payment directly to the service provider. In certain circumstances, the Participant will pay the full cost of any Eligible Expense at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage: Blue Cross must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

Blue Cross will accept claims up to 15 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts Blue Cross would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

No payment will be made (or payment may be reduced) if:

a) the Participant fails to communicate with Blue Cross in the event of medical consultation or hospitalization following an injury or illness;
b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
c) the purpose of the Trip is primarily or incidentally to seek medical advice or treatment, even if this Trip is on the recommendation of a physician;
d) expenses have already been paid or are eligible for refund from a third party; or
e) expenses are incurred as a result of:
    i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
    ii. an illness or injury that occurred while operating a vehicle under the influence of drugs (including marijuana) or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;
    iii. an injury or illness resulting from non-compliance with medical treatment or therapy that has been prescribed;
    iv. self-inflicted injury, unless medical evidence establishes the injuries are related to mental health illness; or
    v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:
   i. are not incurred as a result of an Emergency;
   ii. are not Medically Necessary;
   iii. are performed for cosmetic purposes only;
   iv. are not required for the immediate relief of acute pain and suffering;
   v. could be delayed until the Participant's return to Canada; or
b) expenses incurred due to pregnancy or pregnancy complications that occur within 4 weeks of the expected date of delivery.

Purpose of Coverage

Blue Cross will provide access to a medical second opinion for Participants with a Qualifying Medical Condition.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Second Opinion Services: An in-depth review of a Participant's medical file by the Second Opinion institution or physician, including a review of the diagnosis and treatment plan. On completion of the review, a booklet containing the Second Opinion summary and recommendations (if applicable) is sent to the Participant along with detailed information pertaining to the Qualifying Medical Condition.

Qualifying Medical Conditions:

- AIDS
- ALS
- Alzheimer's disease
- Any Amputation
- Any life threatening illness
- Benign brain tumour
- All Cancers
- Cardiovascular conditions
- Chronic pelvic pain
- Coma
- Deafness
- Embolism/Thrombophlebitis
- Emphysema
- Hip/knee replacement
- Kidney failure
- Loss of speech
- Major or severe burns
- Major organ transplant
- Major trauma
- Multiple Sclerosis
- Neuro-degenerative disease
- Paralysis
- Parkinson's disease
- Rheumatoid Arthritis
- Stroke
- Sudden blindness due to illness

The Qualifying Medical Conditions list may change without notice.

Exclusions and Limitations

Second Opinion Services are not available for population-wide exposure to poisonous gas or radioactive contamination.

Additional Information

Termination of this plan or the Second Opinion Service will not impact any Second Opinion Services that have already been initiated or that are currently in progress.

The Second Opinion Service may be accessed toll-free Monday to Friday from 8am to 8 pm EST **1-877-893-3122**.

What Are My Responsibilities Under the Plan?

Keeping Your Plan Administrator Informed

It is your responsibility to provide your Plan Administrator with a completed and signed application form, including accurate information on your family status, as well as your beneficiary designations.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your Plan Administrator. Changes that must be reported to your Plan Administrator include:

- Adding or removing a Dependent
- Status updates of a Dependent student
- Change in marital status
- Change of beneficiary
- Application for benefits previously waived

Helpful Tip

It is very important to maintain up-to-date beneficiary designations.

When insurance money is paid to the estate, it may be subject to creditor claims and estate taxes.

However, when a beneficiary is named, this person receives the entire benefit tax free, regardless of what debts may be owed by the deceased.

You can change your beneficiary by filling out a beneficiary designation form available through your Plan Sponsor or on our website.

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

Benefits payable as a result of your death will be paid to your last designated beneficiary or beneficiaries.

Subject to the provisions of the law, the beneficiary is the person you have designated on your group benefits application form. You may change your beneficiary by submitting a signed written declaration.

If you designate 2 or more beneficiaries (other than alternatively) without any specification as to how the death benefit will be divided, the benefit payable will be divided equally among the designated beneficiaries.

If your beneficiary predeceases you, you must designate a new beneficiary.

If you die and a beneficiary has not been named in writing, the death benefit will be payable to your estate.

Designations made under the Previous Policy

Any beneficiary designation made under your previous group policy has been carried forward to this group contract. You should review the existing designation to ensure it reflects your current intentions.

Helpful Tip

Your proof of claim must be submitted in either English or French. If the original proof of claim is in a language other than English or French, you are responsible for any costs associated with translating your proof of claim.

Providing Proof of Claim

You must submit your claims for Eligible Expenses within applicable time limitations. Proof of claim must be provided in writing and in a form acceptable by Blue Cross.

Blue Cross must approve your proof of claim and may require you to provide additional information and undergo a medical examination by a physician or Health Practitioner as often as deemed necessary. Blue Cross reserves the right to suspend or deny a claim until you have submitted the additional information requested to process the claim.

Costs associated with providing proof of claim are your responsibility.

Submitting Claims After Your Group contract Terminates

If this plan has terminated, proof of claim for Insured Benefits must be received by Blue Cross:

- for accidental damage to natural teeth, **within 6 months** following the termination date of this group contract; or
- **within 90 days** following the termination date of this group contract for all other Insured Benefits.

Recovering Damages From a Third Party (Subrogation)

If you have the right to file legal action against a third party (individual or corporate body) for a loss relating to any claim submitted under this group benefits plan, Blue Cross is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross.

You must sign and return the necessary documents to facilitate this process and you must do everything that is required of you to protect your rights to recover damages from the third party.

Reporting Health Insurance Fraud

Health insurance fraud is the intentional act of submitting false, deceiving or misleading information for the purpose of financial gain.

Whether committed on a small or large scale, fraud can lead to significant financial losses to the benefit plan and result in higher premiums and decreased coverage. Blue Cross is committed to protecting the integrity of our benefit programs for our Plan Sponsors and members by monitoring and resolving any abusive or fraudulent activity.

Helpful Tip

Health care fraud in Canada is estimated to cost between $2 billion and $12 billion annually.

How You Can Help

As a group contract member, you can help eliminate fraudulent abuse of your plan:

- keep your identification card, plan number, member identification number and related information confidential and secure;
- carefully review your receipts for products and services claimed to ensure:
  - you understand the charges billed; and
  - the charges reflect the services received.

If you are unclear about any of the charges on your receipt, ask your provider to explain the charges to you:

- carefully review your Explanation of Benefits claim statements (EOB) for any discrepancies in services received compared to services claimed;
- never sign a blank claim form;
- from time to time, we send member verification questionnaires to confirm treatments and other related information. If you receive one of these questionnaires, please complete it and return it promptly. These questionnaires are essential to our fraud deterrence efforts.

Helpful Tip

If you suspect health care fraud, please refer it to Blue Cross through one of the following confidential methods:

Toll free:
1-877-412-8809

StopFraud@medavie.bluecross.ca

www.medavie.bluecross.confidenceline.net

What Are My Rights Under the Plan?

Privacy

In the course of providing customers with quality life, health and travel coverage, Blue Cross acquires and stores certain personal information about its clients and their dependents.

Protecting the confidentiality of client information is fundamental to the way we do business. Our staff takes our privacy policies and procedures very seriously.

What is personal information?

Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is Your Personal Information Used?

Your personal information is necessary for Blue Cross to process your application for coverage under its life, health and travel plans. Your personal information is used to provide the services outlined in your group contract, to understand your needs so that we can recommend suitable products and services, and to manage our business.

To Whom Could This Personal Information be Disclosed?

Depending on the type of coverage you carry, release of selected personal information to the following may be necessary in order to provide the services outlined in the group contract of which you are an eligible member:

- specialized health care professionals when required to assess benefit eligibility;
- government and regulatory authorities in an emergency situation or where required by law ;
- Blue Cross Life Insurance Company of Canada and other third parties, on a confidential basis, when required to administer your benefits; or
- the plan member in any contract under which you are a participant.

Helpful Tip

For more information on our privacy protection practices, please visit our website.

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your Dependents is not released to a third party without permission unless necessary to fulfil the services Blue Cross is contracted to provide to you.

By becoming a Blue Cross customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above.

Disputing a Claim Decision

In the event Blue Cross determines that benefits are not payable, you have the right to appeal the decision by providing written notice to Blue Cross within 30 days from the date of the written denial.

The time limitation to bring an action against Blue Cross under the group contract begins on the date of the initial written denial from Blue Cross and runs until the expiry of the minimum limitation period as prescribed by the applicable provincial legislation.

Every action or proceeding against Blue Cross for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Copy of the Group contract

Where legislated, you have the right to request a copy of the contract for insured benefits, your application for benefits and any written statements or other record provided to Blue Cross as proof of your health.

The Rights of Blue Cross Under the Plan

Right to Audit

Blue Cross has the right, at any time, to inspect or audit the health and claim records of a Participant in relation to a claim for benefits.

Helpful Tip

The right to inspect or audit applies to records held by Blue Cross or Approved Providers.

Recovery of Overpaid Amounts

Blue Cross has the right to recover from a Participant:

- any amount paid in error;
- any amount paid as a result of claims made by the Participant on the basis of fraudulent pretences or misrepresentations; or
- any amount paid that has resulted in overpayment to the Participant.

If the amount of overpayment or claim paid in error relates to Self-Insured Benefits, the Plan Sponsor agrees to take reasonable steps to recover this amount.

If overpayment amounts or amounts paid in error cannot be recovered, Blue Cross has the right to reduce future Insured Benefit payments to the Participant until the amount is fully recovered.

Termination or Suspension of Benefit Payments

The rights and benefits of a Participant may be suspended or terminated without prior notice in the following circumstances:

- the discovery of a claims discrepancy or the initiation of a claim abuse investigation; or
- the filing of criminal charges or initiation of disciplinary action against the Participant by Blue Cross or the Plan Sponsor.

Payment of a claim may also be suspended or denied if it relates to services or supplies prescribed, provided or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or has been charged with an offence in relation to their conduct or practice.

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- your group benefits Plan Administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for life, short term disability or critical illness benefits can be obtained through your group benefits Plan Administrator.

How to Submit a Claim

Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

> **Helpful Tip**
> Instead of a cheque by mail, get reimbursement directly to your bank account by signing up for direct deposit. It's fast, and convenient. Visit our website to register.

- **Provider eClaims**
  For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

- **Member eClaims**
  You can quickly and easily submit your health, drug and dental claims (as applicable) through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- **Mobile App**
  Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.

  Visit www.medaviebc.ca**/app** for more information or to download the app.

- To find the Medavie Blue Cross office nearest you, visit our website at **www.medaviebc.ca/ouroffices**.

- You can also mail your completed claim form to the nearest Medavie Blue Cross office.

A claim can be submitted for **life, short term disability or critical illness benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form; or
- providing them to your group benefits Plan Administrator.

Plan Member Website

Helpful Tip

For security reasons, the plan member website is for your use only. Dependents and other family members will not have access to the site.

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- **Coverage inquiry:** Detailed information about your group benefits plan;
- **Forms:** Printable versions of Blue Cross forms;
- **Requests for new identification cards;**
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider;
- **Submit claims** electronically.

To register for the plan member website, visit **www.medaviebc.ca** and log in.

Blue Cross Contact Information

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Centre toll free at:

Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
All Other Provinces: 1-800-667-4511

Alternatively, you can email your questions to **inquiry@medavie.bluecross.ca** or visit our website at **www.medaviebc.ca**.

Helpful Tip

Have your group contract number and identification number ready when you call for questions regarding your coverage.

Connect with Blue Cross

Like us on Facebook at **facebook.com/MedavieBlueCross**

Follow us on Twitter at @**MedavieBC**

My Good Health®

My Good Health is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to **medaviebc.mygoodhealth.ca** and simply follow the instructions to register for your free account!

BLUE ADVANTAGE®

Savings are available to Blue Cross Members across Canada. To take advantage of these savings, simply present your Blue Cross identification card to any participating provider and mention the **Blue Advantage®** program. A complete list of providers and discounts is available at **www.blueadvantage.ca.**

Accidental Death & Dismemberment (AD&D)

Accident Insurance is underwritten by AIG Insurance Company of Canada.

Why You Need Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your Spouse from meeting your financial obligations. Your Employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to your beneficiary to help ease any financial burden if you suffer a Loss of Life as a result of an accident. The policy also provides you with 'living benefits' should you suffer an accident that results in any of the Losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Eligibility and Principal Sum

Your plan provides Accidental Death & Dismemberment benefits for Injuries as a result of covered accidents. You are automatically covered if you are a member of one of the following eligible classes:

Class	Description	Coverage amount
I	All active and self-pay members,	$200,000.00
II	All retired members of Locals who have chosen this option and for whom a premium is paid	$50,000.00

Special Arrangement

For the members who have not reached their hour bank requirement, the Company will provide coverage on an occupational basis (while working only, not including commuting to and from work). The Principal Sum for such occupational coverage is one-fifth (1/5) of the "24 hours" Principal Sum. When such members will reach their hour bank requirement (same as the Policyholder Basic Life Insurance), their Principal Sum will increase accordingly and their scope of the coverage will change from occupational only" to "24 hours".

Definitions

The following is an explanation of the terms used in this benefit booklet.

Activities of Daily Living means the following six activities:

1. Maintaining continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower or washing satisfactorily by other means.

Annual Earnings means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Carjacking means taking unlawful possession of a Private Passenger Type Automobile by means of force or threats against you then rightfully occupying such Private Passenger Type Automobile.

Company means AIG Insurance Company of Canada.

Dependent Child means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Dependent Parent means your parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the you for support, maintenance and care.

Employer means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

Hospital means an establishment which:
holds a licence as a hospital (if licencing is required in the jurisdiction);
operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
provides 24 hour a day nursing service by registered or graduate nurses;
has a staff of one or more licenced Physicians available at all times;
provides organized facilities for diagnosis, and major medical surgical facilities;
is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and
is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family means a person who is related to you in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury or ***Injuries*** means bodily injury which is sustained by you as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

Insured Employee means an individual who belongs to an eligible class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

Loss when used with reference to:
Quadriplegia, ***Paraplegia***, and ***Hemiplegia*** means the complete and irreversible paralysis of such limbs;
Hand or Foot means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
Arm or Leg means the complete severance through or above the elbow or knee joint;
Thumb and Index Finger means the complete severance through or above the first phalange;
Fingers means the complete severance through or above the first phalange of all four Fingers of one Hand;
Toes means the complete severance of both phalanges of all the toes of one foot;
The Entire Sight of One Eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;
The Entire Sight of Both Eyes means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing;
Hearing in One Ear means the diagnosis of permanent loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in otolaryngology must confirm the diagnosis in writing;
Hearing means the diagnosis of permanent loss of Hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in otolaryngology must confirm the diagnosis in writing;
Speech means complete and irrecoverable loss of the ability to utter intelligible sounds; and

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

Loss when used herein may also include ***Loss of Life.***

Permanent and Total Disability means Injury which prevents you from performing at least two of the six Activities of Daily

Living, without assistance from another person and you have been determined on evidence satisfactory to the Company, to be and remain, as of 12 months after the date of the Injury, incapable of performing at least two of the six Activities of Daily Living without assistance from another for the remainder of your life. The disability must be determined to be total, permanent, and irreversible and certified to be such by a Physician acceptable to the Company. Your inability to actually obtain employment is not a criteria to qualify for the Permanent and Total Disability benefit.

Physician means a medical doctor, other than you or your Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

Private Passenger Type Automobile means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Spouse means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

General Policy Provisions

Effective Date
Your coverage begins on the date you satisfy the eligibility requirements to become an Insured Employee.

Termination Date
Coverage ends on the earliest of:
the date the policy is terminated;
the premium due date if premiums are not paid when due;
the date you no longer satisfy the definition of an Insured Employee; or
the first day of the month following the date you no longer belong to an eligible class of employees as set out in the policy.

Continuance of Coverage
If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Aggregate Limit Per Accident
The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy schedule, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use
If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Table of Losses	Percentage Principal Sum Payable
Loss	
Loss of Life	100%

Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%
Loss of One Finger or Toe (per Finger/Toe)	5% per Finger/Toe up to a maximum of $25,000
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of $1 million

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

Benefit	Maximum	Benefit Description
DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant.
REHABILITATION BENEFIT	$15,000	Pays the expenses incurred for occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder.
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPTIAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you suffer an Injury for which you receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.
FAMILY TRANSPORATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometres from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
SPOUSAL EDUCATIONAL BENEFIT	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.

Benefit	Maximum	Benefit Description
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of your loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays a benefit of 10% of the Principal Sum up to the Maximum if you suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which your seatbelt was properly fastened. If the seat belt benefit is payable and you were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.
FELONIOUS ASSAULT BENEFIT	10% of Principal Sum	Pays an additional benefit of 10% of the Principal Sum if you suffer an Injury for which you receive a benefit under the policy as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.
COMA BENEFIT	Principal Sum	Pays a monthly benefit of 1% of the difference between the Principal Sum and any other amount payable under the policy in connection with the injury for up to 100 months, if you suffer an injury for which you receive a benefit under the policy, and within 90 days of the date of the covered accident are disabled by coma which lasts for at least 6 consecutive months and is then determined by a physician to be permanent.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

suicide or any attempt thereat by you while sane;
self inflicted Injury or any attempt thereat by you while sane or insane;
declared or undeclared war or any act thereof;
sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you are:
riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;
travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:

except as a passenger on a regularly scheduled commercial airline; or
being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
operating to or from off-shore landing sites; or
used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
Injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;
Injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
Injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;
the commission or attempted commission by you or Injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
natural causes.

Claims Process

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

How to Make a Claim

In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Important Notes

This booklet, as may be amended, provides only a summary of the provisions for the Group Personal Accident coverage and the Additional Benefits. The full coverage details are contained in the policy including eligibility, limitations, exclusions and termination provisions. In the event of a discrepancy between this booklet and policy, the terms of the policy shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Insurance is underwritten by AIG Insurance Company of Canada.