

Your Group Benefits Booklet

ERCO Worldwide LP

Buckingham Union Hourly Local 169

Group Policy Number:
99117

Updated Effective Date:
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MEDAVIE BLUE CROSS™

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.

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

Medavie Blue Cross insures all health benefits. All other benefits are insured by Blue Cross Life Insurance Company of Canada.

Blue Cross has been a trusted health services partner for individuals, employers 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 means 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 policy held by your employer. In the event of a difference of wording of the group policy, the group policy 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 Policy:** Outlines your responsibilities under the group policy (such as your responsibility to notify your employer upon change in 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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Basic Accident Insurance Program
Policy No. 9907-47-49 underwritten by Chubb Insurance Company of Canada

Summary of Benefits

Member Life Benefit

Benefit Formula	Flat amount
Benefit Maximum	$50,000
Non-Evidence Limit	$50,000
Terminal Illness Benefit	Not applicable
Benefit Reduction	Not applicable
Termination	Age 65 or retirement
Waiver of Premium	Yes

Summary of Benefits

Optional Life Benefit

Benefit Formula	Units of $10,000
Benefit Maximum	$500,000
Non-Evidence Limit	$50,000*
Termination	Age 65 or retirement
Waiver of Premium	Yes

*Proof of health is required for any amount of coverage if the application is received by Blue Cross more than 60 days after the date the Member became eligible for coverage, or 31 days after the date the Member experiences a qualifying Life Event.

Summary of Benefits

Salary Continuance Disability Plan (Provided by the Policyholder)

Refer to the provisions of this booklet or to the collective bargaining agreement for a detailed description.

Long Term Disability Benefit

Benefit Formula	60% of monthly Pre-Disability Salary not exceeding the All Source Maximum
Benefit Maximum	$4,300/month*
Non-Evidence Limit	$3,800
Elimination Period	41 weeks or the end of the salary continuance disability benefit payments (if applicable), whichever is later
Benefit Period	To age 65
Taxable	Yes
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Salary
Duration of Own Occupation	2 years
Cost-of-Living Adjustment	None
Effective Date of Adjustment	Not applicable
Survivor Benefit	Equal to 3 times the Member's net monthly long term disability benefit. The benefit is payable to the Member's estate.
Termination	Age 65 less the Elimination Period or at retirement
Waiver of Premium	Yes

*Effective

- December 1, 2018: $4,000
- December 1, 2019: $4,100
- December 1, 2020: $4,200
- December 1, 2021: $4,300
- December 1, 2022: $4,400

Summary of Benefits

Drug Benefit

Deductible	$25 per Participant or per family, per calendar year, combined with Extended Health Care
Reimbursement Level*	Interchangeable brand name drugs: 80% Other drugs: 100%
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
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
Opioid Management Strategy	Included
Additional Benefit Modules	**Benefit Maximum**
Fertility Drugs	$2,500/calendar year
Smoking Cessation Aids	$600/calendar year Prescription and over-the-counter products (including natural health products)
Injectable Vitamins	Included
Termination	When the Member reaches age 65 or retires
Survivor Coverage	None

*For Quebec Participants, reimbursement for pharmacy services and the out-of-pocket maximum meet the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

Summary of Benefits

Extended Health Care

Deductible	
Hospitalization	None
Insulin Pump	None
Glucometer	None
Vision Care	None
All Other Extended Health Care	$25 per Participant or per family, per calendar year, combined with Drug Benefit
Overall Benefit Maximum (excluding Hospitalization)	$25,000 per Participant, per calendar year

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Chronic Care	100%	$20/day	
Medical Services and Supplies			
Ambulance Transportation	100%	$1,000/calendar year	
Nursing Care	100%	720 hours/calendar year	
Health Practitioners:		**Maximum per calendar year**	
Psychologist	100%	$225*	
Chiropractor/Acupuncturist/Occupational Therapist/Physiotherapist/Massage Therapist (combined)	100%	$1,100*	
Naturopath	100%	$225*	
Dietitian	100%	$225*	
Osteopath	100%	$225*	
*Chiropodist/Podiatrist (combined)***	100%	$225*	
*Surgery performed by a Chiropodist or Podiatrist (combined)***	100%	$100*	
Speech Therapist	100%	$225*	
X-rays (Chiropractor, Osteopath)	100%	$25/practitioner	

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

**Podiatrist expenses are covered only after provincial health care program coverage is exhausted.

Summary of Benefits

Extended Health Care

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 calendar years for approved purchase
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	
Glucometer		1/5 calendar years
Other Diabetic Equipment		$200/calendar year
Custom Orthopedic Shoes	100%	See benefit details
Custom Made Foot Orthotics	50%	2 pairs/calendar year
Diagnostic Tests**	100%	See benefit details
Other Medical Services and Supplies	100%	See benefit details
Accidental Dental	100%	Predetermination of claim required
Vision Care		
Eye Examination	100%	$80/2 calendar years; $80/calendar year for a Participant under age 18
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	100%	$375/2 calendar years; $375/calendar year for a Participant under age 18
Termination	When the Member reaches age 65 or retires	
Survivor Coverage	None	

*Pre-authorization required.

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

Summary of Benefits

Dental Benefit

Deductible	None		
Fee Guide Schedule	Current year/Province of Provider (Specialist fees paid at general practitioner rate)		
	Reimbursement Level		**Benefit Maximum**
Preventive Care	100%		See benefit details
Oral Exam and Diagnosis			
Recall oral exams			1/9 consecutive months
Preventive Treatment			
Polishing of teeth			1/9 consecutive months
Fluoride treatment			1/9 consecutive months
Scaling			Included
Basic Care	100%		See benefit details
Endodontic Services			Included
Periodontic Services			Included
Root Planing			Included
Major Restoration	50%		$1,500/calendar year
Restorative and Prosthodontic Services			See benefit details
Restorations on implants			1/tooth every 10 calendar years
Orthodontic Services	50%		$1,750/lifetime (Children only)
Lowest Cost Alternative Benefit	Inlays and crowns Bridgework		
Termination	When the Member reaches age 65 or retires		
Survivor Coverage	None		

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

Employee: A person who:

- resides in Canada; and
- works for the employer.

Member: An Employee who is eligible and approved for coverage under this policy.

Dependent: Your Spouse or Child.

Spouse: A person who:

- is a resident of Canada; and
- meets one of the following criteria:
  - is legally 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 21;
  b) is under age 26 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 policy.

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 policy.

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: Employees are Actively at Work on a specified day if they report for work at their usual place of employment and are able to perform the Regular Duties of their occupation, according to their regular work schedules.

Employees 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.

Helpful Tip

One of the eligibility requirements for coverage is that you be Actively at Work.

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 policy 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.

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.

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.

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.

Life Event: A situation resulting from one of the following that permits a Member to change their coverage:

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- the Member's or Dependent's other coverage terminates for reasons outside of their control; or
- death of a Dependent.

Helpful Tip

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

Proof of health is required if the request is received more than 31 days after the Life Event date.

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 policyholder 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.

Salary: A Member's regular earnings paid by the employer. It does not include overtime and any additional remuneration or incentives that are received by the Member on a regular basis, irregular dividends or any other irregular gains, such as bonuses and gratuities.

For commission-based Members, Salary is the Member's average earnings over the last 2 years of employment as indicated on their Canada Revenue Agency (CRA) taxation form. If the Member has been employed for less than 2 years, Salary will be prorated.

In determining benefits, Salary will be the lesser of:

- the Salary amount defined above; or
- the Salary last reported to Blue Cross and used in the calculation of the premium payable.

Helpful Tip

If specified in the Summary of Benefits, your Salary may be used in calculating your life, accidental death and dismemberment or disability benefits. (if applicable)

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?

You are eligible for coverage if you:

- meet the definition of Employee and are Actively at Work; and
- have completed the **3-month** waiting period.

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.

You must continue to work the minimum number of hours per week (if applicable) to maintain eligibility under the policy.

Helpful Tip

Waiting Period refers to the continuous period of time during which you must be Actively at Work before being eligible for coverage.

Do I Need to Supply Proof of Health to Obtain Coverage?

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted if the coverage for yourself or your Dependents exceeds the non-evidence limit specified in the Summary of Benefits.

Helpful Tip

Proof of health refers to statements or medical evidence about your health or the health of your Dependents.

Non-evidence limit refers to the amount of coverage for which you or your Dependents are eligible, without having to submit satisfactory proof of health.

The non-evidence limits for each benefit (if any) are specified in the Summary of Benefits.

How do I Enrol for Coverage?

Application

To obtain coverage, you must submit a completed and signed application, and submit proof of health, if required for one of the reasons listed above.

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the policy. In addition, when you enrol for coverage you must also enrol all of your eligible Dependents, subject to the exceptions noted below:

- it is your choice whether or not to obtain coverage for optional benefits; and
- you are allowed to waive the health benefits coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. In this case, you or your Dependents will again be eligible for health benefits if you experience a Life Event, subject to proof of health if required.

Helpful Tip

Health benefits may include: drug benefits, extended health care, dental benefits and travel benefits.

When Does My Coverage Begin?

Employees

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

- the effective date of the policy;
- the date you meet all of the eligibility requirements; or
- the date Blue Cross approves your proof of health, if required.

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 policy; 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 insurance policy that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this group policy.

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 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 plan.

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

In such circumstances, please contact your group benefits 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 policy terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your Spouse no longer meets the definition of Spouse;
- your Child no longer meets the definition of Child;
- your employment is terminated;
- you or your Dependents reach 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 policyholder defaults in payment of premiums.

Coverage for your Dependents will also terminate on the date your coverage terminates.

If premiums for optional life benefit are not paid within 31 days of their due date, the benefit will be terminated without further notice from the date premiums were due.

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.

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.

What if I Have Coverage Elsewhere?

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.

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.

Helpful Tip

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

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.

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:

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.

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.

Helpful Tip

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

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.

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 benefits will be waived. The Summary of Benefits specifies the benefits to which this waiver of premium applies.

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, proof of Total Disability must be submitted to Blue Cross within 15 months of the onset of Total Disability and while Total Disability persists.

Definition of Total Disability

For the purpose of this provision, the definition of Total Disability or Totally Disabled is that found under the *Additional Definitions* provision in the *Long Term Disability Benefit* provisions of this booklet.

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, 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 due will be waived beginning on the first day following the end of the Elimination Period of the long term disability benefit if the Member meets the definition of Total Disability found under the *Additional Definitions* provision in the *Long Term Disability Benefit* provisions of this booklet.

However, if the policy does not include long term disability benefit, or the Member belongs to a class of Employees not covered under this benefit, premiums will be waived beginning on the first day following the expiry of 6 consecutive months 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;
- the Member's employment terminates;
- coverage terminates for the class of Employees to which the Member belongs;
- the benefit or policy terminates; or
- the Member dies.

If, while a Member is Totally Disabled and benefitting from waiver of premium:

- the Member's employment terminates; or
- coverage for their class of Employees or all Employees under this policy terminates;

the waiver of premium is extended beyond the termination date outlined above in accordance with the following:

- member life and member optional life benefit coverage will remain in force and continue to be eligible for waiver of premiums until age 65; and
- long term disability benefit coverage will remain in force and continue to be eligible for waiver of premium as long as the Member remains in receipt of long term disability benefit payments. This waiver of premium will not extend beyond the maximum benefit period of the long term disability benefit specified in the Summary of Benefits.

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.

Payment of Claims

Beneficiary

Member life benefits will be paid to the Member's beneficiary.

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 Employees 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) 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);
  b) a non-convertible term life policy that provides level term coverage to age 65; or
  c) 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

This benefit provides additional amounts of life insurance to those available through the member life benefit.

If a Member dies while covered by this benefit, Blue Cross will pay the amount of the optional life benefit in effect at the time of death, subject to the conditions outlined below.

Amount of Coverage

The benefit is equal to the amount of optional life benefit selected by the Member, up to the maximum amount specified in the Summary of Benefits.

The Member must submit proof of health deemed satisfactory by Blue Cross to be eligible for any amount of coverage in excess of the non-evidence limit specified in the Summary of Benefits.

A Member may request a change in the amount of their coverage under this benefit at any time, provided the Member is Actively at Work. However, requests to increase coverage in excess of the non-evidence limit or more than 31 days after a Life Event will not be granted without submission of proof of health deemed satisfactory by Blue Cross.

Payment of Claims

Beneficiary

In the case of the Member's death, benefits will be paid directly to the Member's beneficiary.

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.

Exclusions and Limitations

If the Member's death is a result of suicide while an amount of optional life benefit has been in effect for less than 24 consecutive months, the payment for this amount of optional life benefit will be limited to the return of premiums.

Right to Convert to Individual Coverage

Eligibility for Conversion

A Member has the right to purchase an individual life policy from Blue Cross if their optional 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 Employees to which the Member belongs.

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) a 1 year term life policy that may be exchanged, prior to its expiry date, for 1 of the following 2 life policy options (b) or (c);
  b) a non-convertible term life policy that provides level term coverage to age 65; or
  c) a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;

- the maximum amount of coverage provided by the Member's individual life policy is the lesser of:
  - the amount of member life benefit coverage plus optional life coverage in effect on the date of termination of the optional life benefit; and
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec; and
- the amount of coverage provided by the Member's 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

The Policyholder has the sole legal and financial liability for salary continuance disability plan. Blue Cross is responsible for providing salary continuance services on behalf of the Policyholder.

If a Member becomes Totally Disabled following an illness or accident, they must contact their group benefits administrator.

Submit a Claim

The Member must inform their manager on the first day they are absent from work.

If the absence is prolonged to 2 days, Blue Cross must receive proof of claim.

Blue Cross will inform the Member whether they meet the requirements of the Plan.

For more information, the Member must contact the group benefits administrator.

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.

Purpose of Coverage

If the 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 duration for which Blue Cross will pay benefits. This maximum is specified in the Summary of Benefits.

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.

If Total Disability is not continuous, the days the Member is Totally Disabled may be accumulated to satisfy the Elimination Period, provided that:

- coverage remains in force during the entirety of the accumulated Elimination Period;
- there is no interruption in Total Disability that is longer than 30 days;
- successive disabilities are due to the same or related causes; and
- the Elimination Period is completed within a 1 year period.

Net Salary: The Member's Salary less income taxes and contributions to the Canada Pension Plan, Quebec Pension Plan, the Canada Employment Insurance Commission (CEIC) and the Quebec Parental Insurance Plan, if applicable.

Pre-Disability Salary: The Member's Salary immediately before the date of Total Disability.

Total Disability or Totally Disabled: During the Elimination Period and for the Own Occupation Duration specified in the Summary of Benefits, a Member is Totally Disabled for the purposes of this benefit if the Member is completely and continuously unable to perform the regular duties of their own occupation as a result of illness or accident.

Afterward, a Member is Totally Disabled if the Member is completely and continuously unable to perform the regular duties of any occupation for which the Member:

- would earn 60% or more of the Member's Pre-disability Salary; and
- is reasonably qualified or may so become by training, education or experience.

Helpful Tip

If you are performing modified work duties for at least 6 months before applying for long term disability benefits, these modified work duties constitute your own occupation for purposes of assessing Total Disability.

Regular duties refer to those work related activities that are essential to performing a particular occupation.

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 disability.

Payment of Benefits

When Benefit Payments Begin

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

The benefit for each day of Total Disability will be equal to 1/30 of the monthly amount.

Calculation of the Benefit Amount

Blue Cross calculates the monthly benefit amount in accordance with the following 3 step process:

Step 1. Blue Cross applies the benefit formula specified in the Summary of Benefits to obtain a monthly benefit amount (to the benefit maximum specified in the Summary of Benefits);

Step 2. Blue Cross subtracts from this monthly benefit amount any income amounts that are payable to the Member as a result of the current or a subsequent disability under any one or more of the following:

a) the Quebec Pension Plan or the Canada Pension Plan;
b) any workers' compensation board/commission;
c) any automobile insurance bureau, if applicable;
d) the Canada Employment Insurance Commission (CEIC); or
e) any federal or provincial law or legislation;

Step 3. If the amount of long term disability benefit calculated in Step 2 and all the applicable Additional Sources of Income listed below exceed the All Source Maximum specified in the Summary of Benefits, then the long term disability benefit will be further reduced to ensure total benefits received from all sources does not exceed this percentage.

Helpful Tip

The long term disability benefit you receive, when added to any other disability income to which you are entitled, cannot exceed the All Source Maximum listed in the Summary of Benefits.

Additional Sources of Income means:

a) any of the following income amounts payable to the Member, as a result of their current or subsequent disability, under one of the following:
   i. any wage or remuneration payable from any employer;
   ii. any plan under which the Member is covered as a member of an association; or
   iii. any disability payments from any of the plans specified in Step 2; and
b) any income amounts payable to the Member under any retirement or pension plan funded in whole or in part by the employer. This includes the Quebec Pension Plan or Canada Pension Plan if the application for retirement benefits is made following the date of Total Disability.

With respect to the income amounts calculated in Step 2 and Step 3:

- income amounts received for children are not included;
- if it appears to Blue Cross that there are income amounts to which the Member is or may be eligible, Blue Cross may include these amounts in its calculations. Blue Cross may estimate income amounts if the Member fails to apply for or exercise their right to claim these income amounts;
- Blue Cross will perform its calculations without including subsequent increases to these income amounts by way of cost-of-living adjustments; and
- if an income amount is paid by lump sum rather than monthly instalments, Blue Cross will include in its calculations the amount obtained by dividing this lump sum by:
  - the number of monthly instalments the lump sum represents, if known to Blue Cross; or
  - 60, if Blue Cross does not know the number of months represented.

Cost-of-Living Adjustment

If the Summary of Benefits specifies a cost-of-living adjustment, it will be applied on the effective date of the adjustment as specified in the Summary of Benefits.

Survivor Benefit

If the Summary of Benefits specifies a Survivor Benefit, Blue Cross will pay the Member's estate the lump sum amount specified in the Summary of Benefits in the event that the Member dies while receiving long term disability benefits.

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;
- the Member 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;
- the Benefit Period expires;
- the Member engages in any occupation, employment or volunteer work other than a rehabilitation program pre-approved by Blue Cross;
- the Member refuses to accept any reasonable offer of modified duties or alternative employment from the employer; or
- the Member dies.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 90 days of the expiry of the Elimination Period.

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.

Recurrent Disabilities

If a Member who was Totally Disabled and receiving long 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 6 consecutive months 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.

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 where disability coverage has been discontinued, no disability benefit will be payable.

If a Member becomes Totally Disabled during a period of absence from work during which 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 expiry 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, part-time work or volunteer work whether or not wages or remuneration are received for such 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, monthly benefits will be reduced by 50% of the remuneration received by the Member from such a program and will further 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, directly or indirectly, from any of the following causes:
    a) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
    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 a Member is not receiving continuing Treatment for the use of these substances;
    d) medical care or treatment that is not Medically Necessary or that is performed for cosmetic purposes only; 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 maternity or parental benefits under any provincial or federal law or takes maternity or parental leave in accordance with any provincial or federal law or any agreement between the Member and the employer, 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 continued 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;
    b) is absent from Canada for any reason, unless Blue Cross agrees in writing, in advance, to pay benefits during the period; or
    c) is imprisoned in a correctional facility or community residence or while under house arrest by order of a criminal court.

Pre-Existing Conditions

A Pre-Existing Condition is any diagnosed or undiagnosed illness or injury for which, during the 3 months immediately before the Member's effective date of coverage (under this policy or a Previous Policy), the Member has:

- had a medical consultation;
- been prescribed or taken medication; or
- received treatment, including diagnostic measures.

Long term disability benefits are not payable if Total Disability results from a Pre-Existing Condition unless Total Disability begins after the Member has been covered for long term disability benefits (under this policy or a Previous Policy) for at least 12 consecutive months.

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;
- viscosupplementation injections;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formularies:

  Specialty High Cost Drugs:

  - **Managed Formulary:** List of Eligible Drugs that are subject to the decisions of the Medication Advisory Panel.

  All Other Eligible Drugs:

  - **Open Formulary:** List of all Eligible Drugs. 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 employer, 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.

Opioid Management Strategy

If the Summary of Benefits specifies that opioid management strategy applies, certain Eligible Drugs will not be eligible for reimbursement, and other Eligible Drugs may require Prior Authorization. Opioid management strategy ensures Participants are reimbursed for drugs with the best clinical evidence for pain management while managing the potential for overuse or misuse.

Payment of Claims

How Payments are Made

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

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.

Helpful Tip

If you have a Pay Direct 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.

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

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) smoking cessation aids;
c) vaccines;
d) injectable and oral vitamins;
e) treatments for weight loss, including drugs, proteins and food or dietary supplements;
f) natural health products including homeopathic products, herbal medicines, traditional medicines, nutritional and dietary supplements, unless specifically listed as covered under this benefit;

g) fertility drugs;
h) sexual dysfunction drugs;
i) hair growth stimulants;
j) 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;
k) procedures related to drugs injected by a Health Practitioner or Physician in a private clinic;
l) 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;
m) 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;
n) services, treatment or supplies the Participant receives free of charge;
o) charges that would not have been incurred if no coverage existed;
p) drugs that are eligible under the travel benefit provided by the group policy (if applicable);
q) all forms of cannabis; or
r) 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.

Quebec Participants who are no longer eligible for drug benefit coverage cannot convert their group drug coverage to an individual plan. If they are not eligible under another group plan, they must contact the Régie de l'assurance maladie du Québec (RAMQ) to obtain coverage from the RAMQ's public drug plan.

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

The group policy must be administered in accordance with the *Act Respecting Prescription Drug Insurance* ("the Act") for Quebec Participants, including the Act's provisions about maximum coinsurance, out-of-pocket maximums, eligible drugs, exception drugs and eligible pharmacy services.

Under no circumstances will the *Exclusions and Limitations* provision of this benefit render drug benefit coverage for Quebec Participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Calendar Year

If, in any calendar year, a Member spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses on the RAMQ list for themselves or their Dependent Children, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the reimbursement level or co-payment, if applicable.

If, in any calendar year, a Spouse spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses on the RAMQ list for themselves, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the reimbursement level or co-payment, if applicable.

Participants Age 65 Years and Over

At age 65, a Quebec Participant is automatically registered as a beneficiary of the RAMQ public drug plan. Therefore, on reaching age 65, a Quebec Participant must decide whether to:

- cancel their automatic registration with the RAMQ drug plan in order to continue their coverage under this benefit; or
- accept coverage under the RAMQ public drug plan.

The decision to accept coverage under the RAMQ public drug plan is irrevocable.

Quebec Participants who decide to accept coverage under the RAMQ public drug plan are no longer eligible for coverage under this benefit.

Exception: If the Summary of Benefits specifies this benefit is supplemental to the RAMQ public drug plan coverage, the following expenses are eligible, subject to the Deductible and Reimbursement Level specified in the Summary of Benefits:

- the Deductible and coinsurance paid by the Quebec Participant under the RAMQ public drug plan; and
- reimbursement for any Eligible Drug that is not included in the RAMQ public drug plan but is covered under this benefit.

If the Member decides to join the RAMQ public drug plan, the Member's Dependents must also register with the RAMQ public drug plan.

If a Quebec Participant decides to maintain coverage under this benefit, Blue Cross reserves the right to modify the premium rates applicable to this benefit for any Quebec Participant age 65 and over.

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.

Chronic Care: Care for patients with long term conditions for which medical care is required.

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**.

Such care must be provided in a public establishment that provides Chronic 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.

Chronic Care facilities do not include rest homes, nursing homes, retirement homes, drug addiction or alcohol treatment centres.

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.

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.

Chronic Care: Room accommodation when a Participant is admitted to a Chronic Care facility on the recommendation and written approval of a physician.

Coverage under this category is limited to room and board only.

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.

This coverage excludes expenses for the services of a personal support worker, 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.

* Eligible Expenses for the electric hospital bed are limited to the cost of a manual hospital bed.

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. Eligible Expenses for myoelectric limbs are limited to the cost of a standard artificial limb;
- 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 $1,500 per calendar year.

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.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes or 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; and
  - electrocardiograms, computerized tomography (CT Scans), X-rays and magnetic resonance imagery (MRI) to a maximum of $1,000 per calendar year.

*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 $200 per calendar year;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of 3 per calendar year;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $300 per 5 calendar years; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of 1 lense per eye per lifetime. The contact lenses must improve sight to at least 20/40 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 employer;
- 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 12 months 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.

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

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.

Vision Care

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

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

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

This coverage excludes expenses incurred for non-corrective sunglasses and safety glasses.

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 workers' compensation board/commission, 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 policy (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) mileage or delivery charges to or from a Hospital or Health Practitioner; or
o) 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.

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.

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

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.

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.

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.

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.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a combined maximum of 1 per 36 consecutive months;
- recall oral examination;

- emergency oral examination; and
- limited or specific oral examination to a combined maximum of 1 per calendar year.

X-rays: Charges for:

- complete series and panoramic to a combined maximum of 1 per 36 consecutive months;
- intra-oral:
  - periapical;
  - occlusal to a maximum of 1 procedure per calendar year; and
  - bitewings to a maximum of 1 procedure per 9 consecutive months;
- 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;
- oral hygiene instruction to a maximum of 1 Unit per 9 consecutive months;
- 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;
- 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;
- 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 8 Units per 12 consecutive months;
- 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 combined 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;
- 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; and
- initial construction and insertion of an initial permanent denture or bridgework if necessary due to the extraction of at least 1 natural tooth while covered under this benefit.

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 $600

If the total cost of any Treatment is expected to exceed $600, 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 and related services;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

What Are My Responsibilities Under the Policy?

Keeping Your Employer Informed

It is your responsibility to provide your employer with a completed and signed application form, including accurate information on your family status, as well as your beneficiary designations. You must complete the group benefits application form within 31 days from the date you become eligible for coverage.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Changes that must be reported to your employer 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 employer 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. You may change your beneficiary by submitting a signed declaration to Blue Cross.

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, the death benefit will be payable to your estate.

Providing Proof of Claim

You must submit your claims for Eligible Expenses within applicable time limitations. Proof of claim must be provided 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.

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.

Submitting Claims After Your Group Policy Terminates

If the group policy has terminated, you must submit proof of claim to Blue Cross:

- for Long Term Disability Benefit, **within 6 months** of the onset of disability or the time limit specified by applicable provincial legislation, whichever period is longer;
- for accidental damage to natural teeth, **within 6 months** following the termination date of this group policy; or
- **within 90 days** following the termination date of this group policy for all other 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 policyholders 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 plan member, you can help eliminate fraudulent abuse of your plan:

- keep your identification card, policy 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 Policy?

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 policy, 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 policy of which you are an eligible member:

- other Canadian Blue Cross organizations to administer your benefit plan if you reside outside the Atlantic Provinces, Quebec or Ontario;
- 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 policy 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 policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Copy of the Group Policy

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 Policy

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.

Blue Cross has the right to reduce future benefit payments to the Participant until the excess amount is fully recovered.

Termination or Suspension of Benefit Payments

Blue Cross may, without prior notice, suspend or terminate the rights and benefits of a Participant 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.

Blue Cross also has the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or who has been charged with an offence in relation to the provider's 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);
- one of our Quick Pay® locations;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for life or disability benefits can be obtained through your group benefits administrator.

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.

How to Submit a Claim

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

- **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.

- **Quick Pay®**
  Quick Pay is a unique service of Blue Cross. Through Quick Pay, you may submit all your dental, drug and extended health care claims and receive immediate adjudication.

  Quick Pay provides you with an opportunity to discuss how the claim was adjudicated, Co-ordination of Benefits, subrogation or other details of your benefit program. You meet face-to-face with a customer service representative equipped to answer your questions.

  To find the Blue Cross office or Quick Pay location nearest you, visit our website at **www.medaviebc.ca/ouroffices**.

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

You can submit your claims for **life or disability benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.

Plan Member Website

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.

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.

Helpful Tip

Please record your password in a secure site for future reference.

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:

Atlantic Provinces: 1-800-667-4511
Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
From Anywhere in Canada: 1-888-873-9200

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

Helpful Tip

Have your group policy 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.**

CHUBB®

BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

SCOPE OF INSURANCE

The Chubb Insurance Company of Canada Basic Accidental Death and Dismemberment Plan provides accident insurance 24 hours a day, anywhere in the world.

ELIGIBILITY

All Buckingham union hourly (local 169) employees under the age of 65 of ERCO are automatically covered upon completion of 3 months of continuous employment.

YOUR BENEFITS

You are automatically covered for a principal sum of $50,000.

The following benefits are provided if the loss occurs as a result of an accident within one year from the date of the accident:

- **Accidental Death & Dismemberment, Loss of Use and Paralysis**

For Accidental Loss of:	**Percent of Principal Sum**
Life	100%
Both Arms or Both Legs	200%*
Speech and Hearing	100%
Both Hands, Both Feet or Sight of Both Eyes or a combination of any two of a Hand, a Foot or Sight of One Eye	100%
One Arm or One Leg	80%
One Hand, One Foot or Sight of One Eye	75%
Speech or Hearing	75%
Thumb and Index Finger of Same Hand	33%
Hearing in One Ear	33%
All Toes of One Foot	25%
For Accidental Loss of Use of:	
Both Arms or Both Legs or a Combination of An Arm and a Leg	200%*
Both Hands or Both Feet or a Combination of A Hand and a Foot	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Thumb and Index Finger of Same Hand	33%
Paralysis	
Quadriplegia	200%*
Paraplegia	200%*
Hemiplegia	200%*

* to a maximum of $1,500,000

- **Brain Damage**

  This benefit will pay 100% of the principal sum for brain damage, if an accidental bodily injury results in brain damage to you. The benefit amount for brain damage will be paid if:

  1) brain damage begins, and is diagnosed by a physician, within 30 days after the accident;
  2) you are in a hospital or other licensed facility, to receive medically necessary treatment for brain damage, prescribed and supervised by a physician, within the first 30 days following the accident;
  3) brain damage continues for 12 consecutive month; and
  4) a physician determines brain damage is permanent, complete and irreversible at the end of the 12 consecutive months.

  If you die within 365 days after the accident, then the benefit will pay a lump sum equal to your principal sum, less any benefit amount for brain damage already paid.

- **Coma**

  This benefit will pay 1% of the principal sum if accidental bodily injury causes you to:

  1) lapse into a coma within 30 days after the accident;
  2) remain in a coma for 30 consecutive days; and
  3) be confined to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician, within the first 30 days following the accident.

  The benefit amount for coma is payable monthly up to 100% of the principal sum.

  Brief lapses from a coma will not be considered an interruption of the consecutive 30 day period, or cause a discontinuance in payment, if the lapses and subsequent coma recurrences are due to the same accident.

  The coma monthly payment will be made until the earliest of the date:

  1) you die;
  2) you are no longer in a coma; or
  3) total payments equal 100% of the principal sum.

  If you die within 365 days after the accident, then the benefit will pay a lump sum equal to your principal sum, less any benefit amount for coma already paid.

- **Permanent Total Disability**

  If an accidental bodily injury causes you to have a permanent total disability, we will pay 100% of the principal sum. The permanent total disability benefit is subject to a 365 day elimination period.

  Permanent total disability coverage does not apply to insured persons age 70 or older.

  Permanent total disability means total disability that:

  1) continues without interruption during, and subsequent to, the elimination period; and
  2) is reasonably expected, in the opinion of a physician approved by us, to continue without interruption and without exception of full or partial recovery for the rest of your life.

Total disability means that accidental bodily injury solely and directly:

1) prevents you from performing all the substantial and material duties of any gainful occupation for which you are qualified, or could be qualified, by reason of education, training, experience, or skill;
2) causes a condition which is medically determined by a physician, approved by Us, to be of continuous and indefinite duration; and
3) requires the continuous care of a physician, unless you have reached his or her maximum point of recovery.

Maximum Payment for Multiple Losses and Multiple Benefits

If you are entitled to receive payment of multiple benefit amounts as a result of one (1) covered accident, then the maximum we will pay for all benefits shall not exceed the principal sum with the exception of Loss of Both Arms or Both Legs, Loss of Use of Both Arms or Both Legs or a Combination of an Arm and a Leg, Quadriplegia, Paraplegia or Hemiplegia. In no event will the maximum amount payable exceed 200% of the principal sum.

TERMS AND CONDITIONS

Definitions:

"Loss" with reference to speech means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices; with reference to hearing means the permanent, irrecoverable and total deafness, with an auditory threshold of more than 90 decibels in each ear which cannot be corrected by any aid or device; and with reference to sight means the permanent loss of vision, remaining vision must be no better than 20/200 using a corrective aid or device.

"Loss" with reference to hand or foot means complete severance through or above the metacarpal phalangeal joint of at least four fingers or three fingers and a thumb or the ankle joint; with reference to arm or leg means complete severance through or above the elbow or knee joint; with reference to thumb and index finger means complete severance through the metacarpal phalangeal joints of the thumb and index finger of the same hand; and with reference to toes means complete severance of all toes on a foot. We will consider such severance a loss even if the specified body part is later reattached. If the reattachment fails and amputation becomes necessary, then we will not pay an additional amount for such amputation.

"Paralysis" means complete and irreversible loss of all motion and all practical use of an arm or leg provided the loss is continuous for 365 days.

"Loss of Use" means the permanent and total inability of the specified body part to function.

Exposure & Disappearance

If you have not been found within one (1) year of the disappearance, stranding, sinking, or wrecking of any conveyance in which you were an occupant at the time of the accident, then it will be assumed, subject to all other terms and conditions of the policy, that you have suffered Loss of Life insured under the policy.

Accident includes unavoidable exposure to elements.

Beneficiary Designation

You have the right to designate a beneficiary. All beneficiary designations must be:

1) in writing;
2) filed with the administrator; and
3) provided to the insurance company at the time of claim or at such other time as they may require.

You, and no one else, unless there is an irrevocable assignment, have the right to change the beneficiary except as set forth above. You do not need the consent of anyone to do so. All beneficiary changes must be:

1) in writing;
2) filed with the administrator; and
3) provided to the insurance company at the time of claim or at such other time as they may require.

The benefit amount for covered loss of life will be paid to the beneficiary designated by you.

If you have not chosen a beneficiary or if there is no beneficiary alive when you die, then the insurance company will pay the benefit amount for loss of life to the first surviving party in the following order:

1) your spouse;
2) in equal shares to your surviving children;
3) in equal shares to your surviving parents;
4) in equal shares to your surviving brothers and sisters;
5) your estate.

ADDITIONAL BENEFITS

- **Burn Benefit**

  This benefit will pay up to 10% of the principal sum for burns if an accidental bodily injury causes you to be burned. The benefit amount for Burn is determined by multiplying the percentage of the body surface actually burned by the maximum benefit amount for burn. The attending physician will determine the percentage applicable to each burn.

- **Child Care Expense**

  This benefit will reimburse child care expenses up to $5,000 annually for each eligible dependent child if accidental bodily injury causes your covered loss of life. This insurance applies only if you have a dependent child under the age of 13 years for whom child care expenses are incurred within 365 days of your covered loss of life.

  This benefit will reimburse child care expenses for each eligible dependent child. However, the total payment will not exceed $25,000 regardless of the number of dependent children for whom payment is made.

  Child care expenses shall be paid to the natural person who incurs such expenses for the dependent child.

- **Education Expense**

  This benefit will reimburse education expense up to $7,500 annually for each eligible dependent child if accidental bodily injury causes your covered loss of life. This insurance applies only if you have a dependent child at the time of a covered loss of life who:

  1) is enrolled as a full-time student at an institution of higher learning on the date of your covered loss of life; or
  2) subsequently enrols as a full-time student at an institution of higher learning within 2 years following the date of your covered loss of life; and
  3) incurs education expense.

  This benefit will reimburse education expenses for each eligible dependent child. However, the total annual payment for each dependent child will not exceed $7,500. The education expense payment is limited to 4 consecutive years for each dependent child. In no event will the total payment exceed $50,000.

  The benefit amount for education expense shall be paid to the natural person who incurs the expense.

- **Family Travel Expense**

  This benefit will reimburse expenses up to $15,000 for the actual costs incurred by an immediate family member for temporary lodging, transportation and meals while travelling to and from visits with you, if within one (1) year of an accidental bodily injury which causes you to suffer a covered loss:

  1) you are confined in a hospital not less than fifty (50 km) kilometres from your city of permanent residence; and
  2) the attending physician recommends the personal attendance of an immediate family member.

  The benefit amount for family travel expense will be paid to the natural person who incurs the expense.

- **Funeral Expense**

  This benefit will reimburse funeral expense up to $5,000 if accidental bodily injury causes your covered loss of life.

  The benefit amount for funeral expense will be paid to the natural person who incurs the expense.

- **Home Alteration or Vehicle Modification**

  This benefit will reimburse charges up to $15,000 for home alteration and up to $15,000 for vehicle modification if a covered loss due to an accidental bodily injury requires you to incur expenses for home alteration or vehicle modification. The expenses for home alteration or vehicle modification must be incurred within 3 years after the accidental bodily injury.

  The benefit amount for home alteration or vehicle modification is payable if:

  1) a physician certifies that the home alteration or vehicle modification is needed to accommodate your physical disability;
  2) the home alteration or vehicle modification is made by people experienced in such home alteration or vehicle modification;

3) the home alteration or vehicle modification is in compliance with any applicable laws or requirements for approval by the appropriate governmental authority in the jurisdiction where the services are rendered; and
4) the home alteration or vehicle modification expenses do not exceed the usual level of charges for similar alterations and modifications in the jurisdiction where the expenses are incurred.

The benefit amount for home alteration and vehicle modification is payable to the natural person who incurs the expense. In no event will the total payments for home alteration and vehicle modification exceed $15,000.

- **Home Health Care**

  This benefit will reimburse charges up to $5,000 if a covered loss due to an accidental bodily injury causes your confinement to home after a hospital stay of 15 days. The expenses that are the subject of the benefit amount for home health care must be incurred within 18 months after the accidental bodily injury. The benefit amount for home health care is payable on an excess basis. The insurance company will determine the charges for home health care. It will then reduce that amount by amounts already paid or payable by any other plan and it will pay the resulting benefit amount. In no event will the insurance company pay more than $5,000.

  No benefit amount for home health care shall be paid if:

  1) treatment is educational, experimental or investigational or does not constitute accepted medical practice; or
  2) services are provided by a person who is an immediate family member.

- **Identification Expense**

  This benefit will reimburse expenses up to $15,000 for the reasonable transportation and accommodations costs incurred by an immediate family member, if accidental bodily injury causes your covered loss of life within one (1) year of an accidental bodily injury and:

  1) the presence of an immediate family member is requested by the police or a similar governmental authority; and
  2) the loss of life occurs not less than one hundred and fifty (150 km) kilometres from your city of permanent residence.

  The benefit amount for identification expense will be paid to the natural person who incurs the expense.

- **In-Hospital**

  This benefit will pay $100 after an elimination period of 3 days for each day you are in-hospital, if an accidental bodily injury causes you to suffer a covered loss which results in you being in-hospital. The in-hospital benefit amount will not be paid for more than 30 days.

  The in-hospital benefit amount will be paid until the earliest of the date:

  1) you die;
  2) you are no longer in-hospital; or
  3) 30 days has elapsed.

If you are discharged from the hospital and the same accident causes you to be in-hospital again within 3 days after discharge, then any time in the hospital will count to satisfy the elimination period. However, in no event will total payment of the in-hospital benefit amount exceed 30 days.

- **Parent Care**

  This benefit will pay $5,000 in equal shares to each of your dependent parents who is receiving support and care provided by you (as evidenced by income tax returns showing such parent as a dependent), to a maximum of $20,000, if you suffer an accidental bodily injury resulting in a covered loss of life.

- **Psychological Therapy Expense**

  This benefit will reimburse the reasonable and customary expenses up to $5,000 for medically necessary counselling for a mental or nervous disorder by a physician, whether on an out-patient basis, in a hospital or any other medical facility licensed to provide such treatment if an accidental bodily injury causes you to suffer a covered loss resulting in a physician's determination that psychological therapy is required for:

  1) you; or
  2) your dependent.

  The benefit amount for psychological therapy expense is s payable on an excess basis. The insurance company will determine the charge for the psychological therapy expense and will then reduce that amount by amounts already paid or payable by any other plan. The insurance company will pay the resulting benefit amount, but in no event will it pay more than $5,000.

  The benefit amount for psychological therapy expense will be paid to the natural person who incurs the expense.

  The benefit amount for psychological therapy expense will be paid until the earlier of the date on which:

  1) $5,000 has been paid; or
  2) 2 years have elapsed from the date of a covered loss.

- **Rehabilitation Expense**

  If an accidental bodily injury causes you to suffer a covered loss which:

  1) prevents you from performing all the duties of your regular occupation; and
  2) requires you to obtain Rehabilitation, as determined by a physician

  then this benefit will reimburse the reasonable and customary charges up to $15,000 for treatment, other than psychological therapy, intended to prepare you for work in any gainful occupation, including your regular occupation that is:

  1) provided by a therapist licensed, registered, or certified to perform such treatment; or
  2) provided in a hospital or other facility, which is licensed to provide such treatment.

  The rehabilitation must take place under the direction of a physician.

  The benefit amount for rehabilitation expense is payable on an excess basis. The insurance company will determine the charge for the rehabilitation expense and will then reduce that amount by amounts already paid or payable by any other plan. The insurance company will pay the resulting benefit amount, but in no event will it pay more than $15,000.

The benefit amount for rehabilitation expense will be paid to the natural person who incurs the expense.

The benefit amount for rehabilitation expense will be paid until the earlier of the date on which:

1) $15,000 has been paid; or
2) 3 years have elapsed from the date of the accidental bodily injury.

- **Repatriation**

  This benefit will reimburse expenses up to $15,000 for the actual costs for preparation of the body for burial or cremation and shipment of the body to your city of permanent residence, if within one (1) year of an accidental bodily injury you suffer a covered loss of life not less than fifty (50 km) kilometres away from your city of permanent residence.

  The benefit amount for repatriation expense will be paid to the natural person who incurs the expense.

- **Seat Belt & Occupant Protection Device**

  This benefit will pay 10% of the principal sum if you suffer an accidental bodily injury resulting in a covered loss of life while you are operating or riding in a private passenger automobile, and using a seat belt. The seat belt must have been properly secured and used in accordance with the recommendations of its manufacturer.

  This benefit will also pay 10% of the principal sum if you suffer an accidental bodily injury as set forth above and you are positioned in a seat protected by a properly deployed occupant protection device. Occupant protection device means either an air bag, which inflates for added protection to the head and chest areas, or any other personal safety restraint system other than a seat belt. The benefit amount for an occupant protection device will only be paid if a benefit amount for seat belt is paid.

  Verification of the actual use of the seat belt and proper operation of the occupant protection device at the time of the accident must be part of an official report of such accident or be certified, in writing, by an investigating police officer.

  In no event will a benefit amount for seat belt be paid if you are operating or riding as a passenger in any vehicle used for a race or contest of any type. In no event will the total payments for seat belt and occupant protection device exceed 20% of the principal sum.

- **Spouse Employment Training Expense**

  If an accidental bodily injury causes your covered loss of life then this benefit will reimburse the actual costs incurred by your spouse for tuition, fees, room and board, required books and course supplies billed by an institution of higher learning that are incurred for the purpose of your spouse obtaining or refreshing skills needed for employment.

  This insurance applies only if your surviving spouse incurs employment training expense within three (3) years following the date of your covered loss of life. In no event will the total payment for this benefit exceed $15,000.

  The benefit amount for spouse employment training expense will be paid to the natural person who incurs the expense.

- **Vocational Training Expense**

  If you suffer a covered loss due to an accidental bodily injury then this benefit will reimburse the actual costs incurred for tuition, fees, room and board, required books and course supplies, billed by an institution of higher learning for training that is intended to prepare you for work in any gainful occupation.

  The benefit amount for vocational training expense will be paid to the natural person who incurs the expense.

  The benefit amount for vocational training expense will be paid until the earlier of the date on which:

  1) $15,000 has been paid; or
  2) three (3) years have elapsed from the date of the accidental bodily injury.

- **Workplace Modifications/Accommodations**

  This benefit will reimburse charges up to $5,000 for workplace modification/accommodation if a covered loss due to an accidental bodily injury requires you to incur expenses workplace modification/accommodation. The expenses for workplace modification/accommodation must be incurred within 3 years after the accidental bodily injury. The benefit amount for workplace modification/accommodation is payable if:

  1) a physician certifies that the workplace modification/accommodation is needed to accommodate your physical disability;
  2) the workplace modification/accommodation is made by people experienced in such home workplace modification/accommodation;
  3) the home workplace modification/accommodation is in compliance with any applicable laws or requirements for approval by the appropriate governmental authority in the jurisdiction where the services are rendered; and
  4) the workplace modification/accommodation expenses do not exceed the usual level of charges for similar alterations and modifications in the jurisdiction where the expenses are incurred.

  The benefit amount for workplace modification/accommodation is payable to the natural person who incurs the expense. In no event will the total payments for workplace modification/ accommodation $5,000.

TERMINATION OF INSURANCE

Your insurance automatically terminates on the earliest of:

1) the termination date of the policy;
2) the expiration of the period for which required premium has been paid for such you;
3) the date on which you no longer meets the eligibility criteria.

With respect to active employees, upon termination, your insurance may continue, subject to your employer's employment policy, as follows:

1) if you are on temporary lay-off, then insurance may continue for the full period of such lay-off but not for more than three hundred and sixty-five (365) days after the date on which such lay off begins;

2) if you are on a leave of absence, then the insurance may continue for the full period of the leave of absence but not for more than three hundred and sixty-five (365) days after the date on which such leave begins;
3) if you are absent from work due to an authorized family or medical leave, then insurance may continue for the full period of the leave but not for more than three hundred and sixty-five (365) days after the date on which such leave begins unless a longer period is agreed to.

Continuation of insurance is subject to the payment of premium.

Conversion Privilege

In the event your insurance under the policy ceases for any reason other than termination of the policy, you are eligible to purchase an individual accident insurance policy.

In order to convert this insurance to an individual accident insurance policy, you must submit to us or our authorized representative:

1) a completed, written application; and
2) the required premium

for the individual accident insurance policy within thirty-one (31) days after your insurance ended.

The individual accident insurance policy will:

1) be issued without evidence of insurability;
2) provide insurance only for loss of life and dismemberment that is most similar to, but not greater than, the terminated insurance;
3) not pay for the same loss for which benefits have already been paid under the policy;
4) provide a benefit amount which will be equal to your benefit amount under the policy, subject to a maximum benefit amount of $250,000; and
5) be subject to individual policy terms and conditions.

Premium Waiver

We will waive your premium due and continue insurance under this policy if you are approved for premium waiver under the life insurance policy. The waiver of premium ends at the earliest of (a) the date you cease to be approved for premium waiver under the life insurance policy or (b) the date the policy ends or (c) the day you die.

EXCLUSIONS

There are certain situations we do not cover in our policy. These include:

Owned or Leased Aircraft

- Loss caused by or resulting from, directly or indirectly, you being in, entering, or exiting any aircraft owned, leased or operated by your employer or on your employer's behalf; or operated by an employee of your employer on your employer's behalf.

Pilot or Crew

- Loss caused by or resulting from, directly or indirectly, you riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member.

Disease or Illness

- Loss caused by or resulting from, directly or indirectly, your emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to bacterial infection caused by an accident or accidental consumption of a substance contaminated by bacteria.

Incarceration

- Loss caused by or resulting from, directly or indirectly any occurrence while you are incarcerated after conviction.

Service in the Armed Forces

- Loss caused by or resulting from, directly or indirectly, you participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to the first sixty (60) consecutive days of active military service with the armed forces of any country or established international authority.

Suicide or Intentional Injury

- Loss caused by or resulting from, directly or indirectly, your suicide, attempted suicide or intentionally self-inflicted injury.

Trade Sanctions

- Loss when the Government of Canada has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss; or there is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

War

- Loss caused by or resulting from, directly or indirectly, a declared or undeclared war. Declared or undeclared war does not include acts of terrorism.

This description is a summary of the principal features of the Plan, which is governed by the terms of the insurance contract with Chubb Insurance Company of Canada under policy 9907-47-49.