Blue Cross Health™

A PLAN THAT'S RIGHT FOR YOU

Complete Health Policy

FLEXIBLE. PERSONAL. AFFORDABLE.

Welcome to Blue Cross®

Your Blue Cross *Personal Health Plan* 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 a government health plan.

Québec Blue Cross® has been a trusted health services partner for over 80 years.

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

This *policy*, together with your *application*, and any following amendments forms your Blue Cross *Personal Health Plan policy*. Refer to this document to learn which benefits are covered under your *policy*, including maximums and coverage limitations and keep it in a safe place for future reference.

Usage of *italics* indicates terms that are defined in the Definitions section.

Your new ID card

Your Blue Cross ID card includes your *policy* and identification numbers. If *your policy* provides coverage for Drug Benefits, you should present your card to your pharmacy so they can update your records and coverage. Your card can also be used by your dentist and other participating providers to submit claims directly to Blue Cross. Your card also allows you to access exclusive discounts through our *Blue Advantage*® program and, if covered for Travel Benefits, lists the toll-free Blue Cross Travel Assistance phone number required for medical emergencies while travelling. You should keep your ID card with you for easy access.

Member Services Site

Once you have your new ID card, click Login on the Member Services Site. Follow the prompts to register for our secure Member Services Site, which offers a number of features to help you manage and keep track of your benefits including:

- Review your *policy* details, coverage and who is included under your *policy*
- View claims history
- View and print statements
- Submit claims electronically

For security reasons, Member Services is for use by the primary *policy member* only. *Dependents* and other *family members* will not have access to the site. Please ensure you make note of your user ID and password for future reference.

Mobile app

To access your coverage details on the go, download our free Mobile app. You can:

- Access *your* electronic ID card to present to health care providers
- Submit a claim by uploading a picture of your receipt
- Check your coverage
- Find a health professional who will submit your claims directly to us

Submitting a Claim

We offer a variety of options for submitting your claims:

- ePay (Provider Online Claims) – If your provider is registered for online billing, they can submit your claim for you. This is the easiest way to submit claims.
- eClaims – Scan a copy of receipt(s) and submit claims electronically through our secure Member Services Site. Visit the Member Services Site and log in under Plan Member or download the Mobile member app to get started. Travel claims require original receipts.
- Mail claims – You can find and print our claim forms.

Direct Deposit

Skip waiting for the mail and a trip to your bank. Your reimbursements will be deposited directly into your bank account. You can change your bank account for direct deposit by signing into our secure Member Services Site, by using our Mobile app or by using the deposit form available on the website.

Make Smart Choices and Stay Well

As a Québec Blue Cross *member* you have access to a number of resources to help you be and stay well, along with tools to help you make wise health care choices.

MY GOOD HEALTH™ | *medaviebc.mygoodhealth.ca*

By creating your own personal profile, My Good Health offers advice, information and tips on how to be and stay healthy. It also includes an interactive health risk assessment tool to assess your current health, set and track personal goals and learn what lifestyle changes you can make to live a longer and healthier life.

BLUE ADVANTAGE | *blueadvantage.ca*

As a Blue Cross *member*, you enjoy exclusive discounts on the total cost of products and services from participating providers across Canada, regardless of whether the item is covered under your benefit plan. Present your Blue Cross ID card and mention the *Blue Advantage*® program to the participating provider to receive your special savings.

Policy Information

This *policy* is offered by Canassurance Insurance Company, doing business as Québec Blue Cross. The administrative functions relating to this plan are carried out by Medavie Inc., doing business as Medavie Blue Cross.

Canassurance Insurance Company provides coverage for all hospital, hospital cash, Assured Access, dental, health, drug and travel benefits. Blue Cross Life Insurance Company of Canada provides coverage for accidental death and dismemberment and critical illness benefits.

In this *policy*, for convenience of reference, Canassurance Insurance Company (Québec Blue Cross), Medavie Inc. (Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada (Blue Cross Life) are referred to collectively as "Blue Cross".

Blue Cross agrees to provide the benefits specified in this *policy* to *members* and their *dependents*, subject to the terms contained on this and the following pages and to the payment of premiums by the *member*.

This *policy*, together with *your application* and any subsequent amendments, constitutes your Blue Cross *policy*. Please read it carefully and keep these documents in a safe place. A copy of the *application* is available upon request.

Sylvain Charbonneau
President and Chief Executive Officer
Québec Blue Cross

Coverage Selected

This *policy* contains a description of the benefits available with your Blue Cross *Personal Health Plan*. However, *you* may not have purchased all benefits available.

To identify *your* specific coverage, please refer to the marked boxes below that indicate the benefits *you* purchased. The Wellness Program is included in *your Personal Health Plan*. Health Benefit coverage is mandatory and must be maintained.

Wellness Program - inConfidence®

(Included in your plan)

Program Description

A confidential assistance program offering counselling and support by phone, in person and online 24 hours a day, 7 days a week.

inConfidence® provides comprehensive and personalized wellbeing support from a diverse network of care providers. *You* and *your dependents* will have access to valuable resources such as therapy counselling and work and life support specialists, to help you navigate life's challenges and achieve your personal goals.

Your plan offers 5 hours of individual counselling and 5 hours of couples counselling with a qualified professional per year. You get to choose the counsellor best suited to your needs and preferences based on clinical fit and therapy approach.

inConfidence also provides counselling by registered nurses, dieticians, life/health coaches and trained experts to help support you with different aspects of your life such as work, health and nutrition, life transitions, financial and legal issues.

How does it work?

Register online by visiting www.myinconfidence.ca.

Or call toll free: **1-855-933-0103** (available 24/7)

Service Provider

Blue Cross's inConfidence service provider is Inkblot.

Inkblot abides by all provincial and federal laws. These laws may require Inkblot to limit service or to report information to authorities regarding child abuse, elder care or threat of harm to yourself or others.

Limitation of Liability

The inConfidence program does not replace disciplines requiring provincial and federal licensure such as the practice of law or medicine. An independent lawyer, doctor or other applicable licensed professional will be involved when activities constitute the practice of law, medicine or other licensed discipline.

When the inConfidence program's service provider provides information on third party services and programs, they will provide information on licensed, certified or registered services if such services are subject to legal regulation. Where recognized existing community services are legally exempt from regulation or where regulation is not in effect, *insured persons* may be provided with information on such services but will be advised that such services are not required to be licensed, certified or registered.

In all cases, whether regulated or not, it is the *insured person's* responsibility to ascertain the quality, capability and suitability for the *insured person's* needs of services provided by third parties. The inConfidence program's service provider or Blue Cross are not responsible or liable for the actions, inaction, information or advice of third party service providers, nor does the inConfidence program's service provider or Blue Cross provide insurance for any such actions, inaction, information or advice.

Blue Cross reserves the right to change, modify or substitute without notice, the service provider or any services offered through the inConfidence program.

Health Benefit Summary

ENTRY

Reimbursement level 100%	Maximum per *Insured Person*
Diagnostic Services	
Laboratory tests	$500 per *calendar year*. Prescription required.
Magnetic resonance imaging	$675 per *calendar year*. Prescription required.
Polysomnography	$500 per 2 *calendar years*. Prescription required.
CT Scan Computer Tomography	$250 per *calendar year*. Prescription required.
Ultrasound	$100 per *calendar year*. Prescription required.
***Reimbursement level* 60%**	**Maximum per *Insured Person***
Accidental Dental*	$7,000 per lifetime. Result of a direct accidental blow to the mouth.
Custom Foot Orthotics and Custom Orthopedic Shoes	$150 per *calendar year* combined. Prescription required. Must be custom made.
Health Practitioners	
Audiologist	$40 per visit up to a maximum of $250 per *calendar year*.
Chiropodist/Podiatrist	$40 per visit up to a maximum of $250 per *calendar year*.
Chiropractor	$40 per visit up to a maximum of $250 per *calendar year*.
Dietitian	$40 per visit up to a maximum of $250 per *calendar year*.
Occupational Therapist	$40 per visit up to a maximum of $250 per *calendar year*.
Osteopath	$40 per visit up to a maximum of $250 per *calendar year*.
Physiotherapist/Physiotherapy Technologist/ Athletic Therapist	$40 per visit up to a maximum of $250 per *calendar year*.
Psychologist/Social Worker/Clinical Counsellor/Psychotherapists	$55 per visit up to a maximum of $250 per *calendar year*.
Speech Therapist	$40 per visit up to a maximum of $250 per *calendar year*.
Health Coaching and Chronic Disease Management	$250 per *calendar year*. Visit www.medaviebc.ca/livebetter to find a provider
Mobility Aids and Orthopedic Appliances	Splints and cervical collars – 1 per *calendar year*. Prescription required. Braces – 1 per limb per lifetime. Prescription required.
Vision Care	$100 per 2 *calendar years* combined. 6 month *waiting period*.

See the Health Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

*Pre-authorization is required

Health Benefit Summary

ESSENTIAL

Reimbursement level 100%	Maximum per *Insured Person*
Diagnostic Services	
Laboratory tests	$500 per *calendar year*. Prescription required.
Magnetic resonance imaging	$675 per *calendar year*. Prescription required.
Polysomnography	$500 per 2 *calendar years*. Prescription required.
CT Scan Computer Tomography	$250 per *calendar year*. Prescription required.
Ultrasound	$100 per *calendar year*. Prescription required.
***Reimbursement level* 70%**	**Maximum per *Insured Person***
Accidental Dental*	$7,000 per lifetime. Result of a direct accidental blow to the mouth.
Ambulance Transportation	$420 per *calendar year* for emergency transportation.
Custom Foot Orthotics and Custom Orthopedic Shoes	$150 per *calendar year* combined. Prescription required. Must be custom made.
Diabetic Supplies and Equipment	Prescription with diagnosis required.
Health Practitioners	
Acupuncturist	$55 per visit up to a maximum of $400 per *calendar year*.
Audiologist	$55 per visit up to a maximum of $400 per *calendar year*.
Chiropodist/Podiatrist	$55 per visit up to a maximum of $400 per *calendar year*.
Chiropractor	$55 per visit up to a maximum of $400 per *calendar year*.
Dietitian	$55 per visit up to a maximum of $400 per *calendar year*.
Massage Therapist (requires a *physician's* written referral each year.)	$55 per visit up to a maximum of $400 per *calendar year*.
Naturopath	$55 per visit up to a maximum of $400 per *calendar year*.
Occupational Therapist	$55 per visit up to a maximum of $400 per *calendar year*.
Osteopath	$55 per visit up to a maximum of $400 per *calendar year*.
Physiotherapist/Physiotherapy Technologist/ Athletic Therapist	$55 per visit up to a maximum of $400 per *calendar year*.
Psychologist/Social Worker/Clinical Counsellor/Psychotherapists	$80 per visit up to a maximum of $400 per *calendar year*.
Speech Therapist	$55 per visit up to a maximum of $400 per *calendar year*.
Hearing Aids/Repairs	$400 per 5 *calendar years*. 6 month *waiting period*. Prescription required.
Health Coaching and Chronic Disease Management	$400 per *calendar year*. Visit www.medaviebc.ca/livebetter to find a provider
Medical Equipment*	Once per 5 *calendar years*. Prescription required.
Medical Services and Supplies	Includes ostomy supplies and oxygen. Prescription required.
Mobility Aids and Orthopedic Appliances	Splints and cervical collars – 1 per *calendar year*. Prescription required. Braces – 1 per limb per lifetime. Prescription required.
Nursing Care*	$3,500 per 2 *calendar years*. Prescription required.
Prostheses	Lifetime / frequency maximums apply. Prescription required.
Vision Care	$150 per 2 *calendar years* combined. 6 month *waiting period*.
***Reimbursement level* 50 to 100%**	**Maximum per *Insured Person***
Accidental Death and Dismemberment (AD&D)	$15,000 for *member* or *spouse* (Principal Sum). $5,000 for each dependent *child* (Principal Sum).

See the Health Benefit Provisions related to this summary and the Accidental Death and Dismemberment provisions. See General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*. *Pre-authorization is required.

Health Benefit Summary

ENHANCED

Reimbursement level 100%	Maximum per *Insured Person*
Diagnostic Services	
Laboratory tests	$500 per *calendar year*. Prescription required.
Magnetic resonance imaging	$675 per *calendar year*. Prescription required.
Polysomnography	$500 per 2 *calendar years*. Prescription required.
CT Scan Computer Tomography	$250 per *calendar year*. Prescription required.
Ultrasound	$100 per *calendar year*. Prescription required.
***Reimbursement level* 80%**	**Maximum per *Insured Person***
Accidental Dental*	$7,000 per lifetime. Result of a direct accidental blow to the mouth.
Ambulance Transportation	$420 per *calendar year* for emergency transportation.
Custom Foot Orthotics and Custom Orthopedic Shoes	$225 per *calendar year* combined. Prescription required. Must be custom made.
Diabetic Supplies and Equipment	Prescription with diagnosis required.
Health Practitioners	
Acupuncturist	$70 per visit up to a maximum of $500 per *calendar year*.
Audiologist	$70 per visit up to a maximum of $500 per *calendar year*.
Chiropodist/Podiatrist	$70 per visit up to a maximum of $500 per *calendar year*.
Chiropractor	$70 per visit up to a maximum of $500 per *calendar year*.
Dietitian	$70 per visit up to a maximum of $500 per *calendar year*.
Massage Therapist (requires a *physician's* written referral each year.)	$70 per visit up to a maximum of $500 per *calendar year*.
Naturopath	$70 per visit up to a maximum of $500 per *calendar year*.
Occupational Therapist	$70 per visit up to a maximum of $500 per *calendar year*.
Osteopath	$70 per visit up to a maximum of $500 per *calendar year*.
Physiotherapist/Physiotherapy Technologist/ Athletic Therapist	$70 per visit up to a maximum of $500 per *calendar year*.
Psychologist/Social Worker/Clinical Counsellor/Psychotherapists	$95 per visit up to a maximum of $500 per *calendar year*.
Speech Therapist	$70 per visit up to a maximum of $500 per *calendar year*.
Hearing Aids/Repairs	$500 per 5 *calendar years*. 6 month *waiting period*. Prescription required.
Health Coaching and Chronic Disease Management	$500 per *calendar year*. Visit www.medaviebc.ca/livebetter to find a provider
Medical Equipment*	Once per 5 *calendar years*. Prescription required.
Medical Services and Supplies	Includes ostomy supplies and oxygen. Prescription required.
Mobility Aids and Orthopedic Appliances	Splints and cervical collars – 1 per *calendar year*. Prescription required. Braces – 1 per limb per lifetime. Prescription required.
Nursing Care*	$5,600 per 2 *calendar years*. Prescription required.
Prostheses	Lifetime / frequency maximums apply. Prescription required.
Semi-Private Hospital Room	100% up to 90 day maximum. $30 per day if semi-private room is not available. 8 month *waiting period* for pregnancy claims.
Vision Care	$300 per 2 *calendar years* combined. 6 month *waiting period*.
***Reimbursement level* 50 to 100%**	**Maximum per *Insured Person***
Accidental Death and Dismemberment (AD&D)	$20,000 for *member* or *spouse* (Principal Sum). $5,000 for each dependent *child* (Principal Sum).

See the Health Benefit Provisions related to this summary and the Accidental Death and Dismemberment provisions. See General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*. *Pre-authorization is required.

Travel Benefit Summary *(Optional from age 65)*

(Included only if you purchased Health Benefits - Enhanced)

Reimbursement level 100%	Maximum per *Insured Person*
Coverage Duration	30 days per *trip* outside province of residence
Maximum Coverage	Limited to $5 million per *insured person* per 30 day *trip*
Stability Requirement	Blue Cross will not pay any benefit or accept any liability for claims relating to a medical condition, *illness* or injury or *related medical condition, illness or injury* that has deteriorated or for which an *insured person* has been diagnosed, required medical consultation (other than a routine checkup), hospitalization or has had a *change in medication* at any time within the: a) 3 month period immediately prior to the date of departure from the *insured person's* province of residence, if the *insured person* is under age 65. b) 6 month period immediately prior to the date of departure from the *insured person's* province of residence, if the *insured person* is age 65 or older.
Blue Cross Travel Assistance	In the event of an *accident* or sudden *illness* requiring *treatment*, *insured persons* are required to contact our Blue Cross Travel Assistance immediately. We reserve the right to direct *insured persons* to *hospitals* and *physicians* that have been selected to provide health care services.
Government Health Care Coverage	*Insured persons* must be covered by *government health care coverage*.

IMPORTANT REMINDER

When hospitalization is necessary, Blue Cross Travel Assistance must be contacted prior to admission.

Call from the United States or Canada – **1-800-361-6068**

From elsewhere in the world, have the operator place a "Collect Call to Canada" – **514-286-8411**

If travelling in a country that cannot place a collect call, submit a receipt for reimbursement to this secure website canassistance.com/en/policyholder/depot

See the Travel Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Drug Benefit Summary

Supplemental coverage only (optional)

ESSENTIAL

This benefit provides supplemental coverage only. *Insured persons* must be covered under the List of Medications administered by Régie de l'assurance maladie du Québec (RAMQ) or by equivalent coverage under a group plan.

Reimbursement level	Reimbursement at 70% for the deductible and the coinsurance payable under the basic prescription drug insurance plan provided for in the Act respecting prescription drug insurance and administered by the Régie de l'assurance maladie du Québec (RAMQ) or under an equivalent group insurance coverage. Reimbursement at 70% for the cost of prescription drugs not listed on the RAMQ List of Medications provided they meet the definition of *eligible drugs* under the *policy* and appear on the managed drug formulary.
Method of Payment	Pay direct. Simply present *your* ID card at participating pharmacy.
***Eligible Drug* Lists**	List of Medications administered by RAMQ Managed formulary - Enhanced
Benefit Maximum	Benefit maximum $100,000 per *insured person* per *calendar year*. However, certain drugs on the *eligible drug* lists may be subject to quantity maximums, deductibles, co-*payments* or other maximums.
Substitution Provision	Mandatory generic substitution
Days Supply	100 day maximum supply (1 month supply may apply to some drugs).
Maximum for the following drugs does not apply if the drugs are indicated as covered under the List of Medications administered by RAMQ or under an equivalent group plan.	
Smoking Cessation Drugs	$800 per 5 *calendar years*

See the Drug Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible drug* under the Drug Benefit Provisions and meet the definition of *eligible expenses* under the Definitions provision of this *policy*. *Special authorization* may be required.

Drug Benefit Summary

ENHANCED

Supplemental coverage only (optional)

This benefit provides supplemental coverage only. *Insured persons* must be covered under the List of Medications administered by Régie de l'assurance maladie du Québec (RAMQ) or by equivalent coverage under a group plan.

Reimbursement level	Reimbursement at 80% for the deductible and the coinsurance payable under the basic prescription drug insurance plan provided for in the Act respecting prescription drug insurance and administered by the Régie de l'assurance maladie du Québec (RAMQ) or under an equivalent group insurance coverage. Reimbursement at 80% for the cost of prescription drugs not listed on the RAMQ list of medications provided they meet the definition of *eligible drugs* under the *policy* and appear on the managed drug formulary.
Method of Payment	Pay direct. Simply present *your* ID card at participating pharmacy.
***Eligible Drug* Lists**	List of Medications administered by RAMQ Managed formulary - Enhanced
Substitution Provision	Mandatory generic substitution.
Days Supply	100 day maximum supply (1 month supply may apply to some drugs).
Benefit Maximum	Benefit maximum $300,000 per *insured person* per *calendar year*. However, certain drugs on the *eligible drug* lists may be subject to quantity maximums, deductibles, co-*payments* or other maximums.
Maximums for the following drugs do not apply if the drugs are indicated as covered under the List of Medications administered by RAMQ or under an equivalent group plan.	
Smoking Cessation Drugs	$800 per 5 *calendar years*
Allergy Serums	$500 per *calendar year*
Fertility Drugs	$1,500 per *calendar year* to a lifetime maximum of $3,000.
Erectile Dysfunction Drugs	$250 per *calendar year*
Vaccines	$250 per *calendar year*

See the Drug Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible drug* under the Drug Benefit Provisions and meet the definition of *eligible expenses* under the Definitions provision of this *policy*. *Special authorization* may be required.

Dental Benefit Summary

(optional)

ENTRY

Fee Guide	Current year fee guide in effect for the provider of service. (Specialist fees will be paid at general practitioner rates)
Waiting Periods	**Basic and Preventive** - 3 consecutive months
Reimbursement Level 60%	**Benefit Maximum $500 per *calendar year***
Basic and Preventive Care:	
Recall oral exam (dental exam)	1 per *calendar year*
Complete oral exam	1 per 3 *calendar years*
Panoramic X-rays	1 per 3 *calendar years*
Bitewing X-rays	4 films per *calendar year*
Fluoride treatment (age 18 and under)	1 per *calendar year*
Polishing of teeth	1 unit per *calendar year*
Scaling (removal of plaque/tartar)	2 units per *calendar year*
Denture prophylaxis (cleaning)	2 units per *calendar year*
Denture reline or rebase	1 upper and 1 lower per 2 *calendar years*
Fillings (white or amalgam)	

***Note:* A unit equals 15 minutes of time**

Oral Surgery, Root Canals, Periodontal Services, Major Dental and Orthodontics are not covered under this benefit. See the Dental Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Dental Benefit Summary

(optional)

ESSENTIAL

Fee Guide	Current year fee guide in effect for the provider of service. (Specialist fees will be paid at general practitioner rates)
Waiting Periods	**Basic and Preventive, Oral Surgery and Root Canals** - 6 consecutive months
***Reimbursement level* 70%**	**No Overall Benefit Maximum**
Basic and Preventive Care:	
Recall oral exam (dental exam)	1 per *calendar year*
Complete oral exam	1 per 3 *calendar years*
Panoramic X-rays	1 per 3 *calendar years*
Bitewing X-rays	4 films per *calendar year*
Fluoride treatment (age 18 and under)	1 per *calendar year*
Polishing of teeth	1 unit per *calendar year*
Scaling (removal of plaque/tartar)	2 units per *calendar year*
Denture prophylaxis (cleaning)	2 units per *calendar year*
Denture reline or rebase	1 upper and 1 lower per 2 *calendar years*
Fillings (white or amalgam)	
***Reimbursement level* 70%**	**No Overall Benefit Maximum**
Oral Surgery and Root Canals:	
Extractions (removal of teeth)	
Endodontic Services – Root Canals	

***Note*: A unit equals 15 minutes of time**

Periodontal Services, Major Dental and Orthodontics are not covered under this Dental Benefit. See the Dental Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Dental Benefit Summary
(optional)

ENHANCED

Fee Guide	Current year fee guide in effect for the provider of service. (Specialist fees will be paid at general practitioner rates)
Waiting Periods	**Basic and Preventive, Oral Surgery and Root Canals** - 6 consecutive months **Periodontal and Major Dental Care and Orthodontic Services** - 24 consecutive months
***Reimbursement level* 80%**	**No Overall Benefit Maximum**
Basic and Preventive Care:	
Recall oral exam (dental exam)	1 per *calendar year*
Complete oral exam	1 per 3 *calendar years*
Panoramic X-rays	1 per 3 *calendar years*
Bitewing X-rays	4 films per *calendar year*
Fluoride treatment (age 18 and under)	1 per *calendar year*
Polishing of teeth	1 unit per *calendar year*
Scaling (removal of plaque/tartar)	2 units per *calendar year*
Denture prophylaxis (cleaning)	2 units per *calendar year*
Denture reline or rebase	1 upper and 1 lower per 2 *calendar years*
Fillings (white or amalgam)	
***Reimbursement level* 80%**	**No Overall Benefit Maximum**
Oral Surgery and Root Canals:	
Extractions (removal of teeth)	
Endodontic Services – Root Canals	
***Reimbursement level* 60%**	**Benefit Maximum $1,200 per *calendar year***
Periodontal – Additional Services:	
Occlusal adjustments	2 units per *calendar year*
Periodontal Appliances	1 upper and 1 lower per 2 *calendar years*
Scaling (removal of plaque/tartar)	6 additional units of scaling per *calendar year*
Root planing	8 units per *calendar year*
Surgical services	
***Reimbursement level* 60%**	**Benefit Maximum $500 per *calendar year***
Major Dental Restoration Services:	
Inlays/Onlays/Crowns	1 per tooth per 5 *calendar years*
Complete and Partial Dentures	1 upper and 1 lower per 5 *calendar years*
Bridgework	1 per tooth per 5 *calendar years*
Implant and Related Services	1 per missing tooth per 10 *calendar years*
***Reimbursement level* 60%**	**Benefit Maximum $1,500 in a lifetime**
Orthodontics: (age 18 and under)	$125 per month up to $1,500 in a lifetime

See the Dental Benefit Provisions related to this summary and the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Critical Illness Benefit Summary *(optional)*

Benefit Maximum	$25,000 for *member* or *spouse* $10,000 for each *dependent child*
Maximum Number of Conditions	1 *covered condition* for each *insured person* per lifetime
Waiting Period	*Insured person* must be covered under this *policy* for 90 days before being eligible for this benefit.
Elimination Period	The *insured person* must survive the onset of the *covered condition* for a period of 30 days, unless otherwise specified in the defined *covered conditions*, before the benefit will be paid.
Adding Dependents	All *dependents* require *medical underwriting* to be added to this benefit. However, a *newborn child* can be added without *medical underwriting* but will not be insured until 15 days of age.
Includes Accidental Death and Dismemberment Benefit (AD&D)	
Benefit Maximum	$25,000 for *member* or *spouse* (Principal Sum) $10,000 for each *dependent child* (Principal Sum)
Termination	Month prior to age 65. See provisions for further details.

See the Critical Illness Benefit Provisions and the Accidental Death and Dismemberment Benefit Provisions as well as the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Hospital Cash Benefit *(optional)*

Benefit Description	If an *insured person* is confined to a *hospital* in Canada on an inpatient basis undergoing active *treatment* while insured under this *policy*, Blue Cross will pay: Under age 65 - $100 per day up to 100 consecutive days of hospitalization per *calendar year* Age 65 and over - $100 per day up to 30 consecutive days of hospitalization per *calendar year*
Elimination Period	Benefit payment begins on the: 1st day of hospitalization due to an *accident* 4th day of hospitalization due to sickness 8th day of hospitalization due to maternity Day of admission will be counted as 1 day but day of discharge will not be counted unless it is also the day of admission.
Adding Dependents	*Dependents* require *medical underwriting* to be added to this benefit. A *newborn child* can be added without *medical underwriting*, however, this benefit will not apply to the *newborn child* until released from the *hospital* following birth.
Recurrent Hospitalization	Successive periods of hospitalization due to the same or related causes that start within 60 days of the previous release from *hospital* will be considered part of the same period of hospitalization when calculating benefit payment amount.
Termination	*Spouse* and *dependent child* - Coverage ends when they no longer meet the *policy* definition of *dependent* or on termination of the entire *policy*. Coverage also ends for a *dependent child* when neither the *member* or *member's spouse* is covered for this benefit under the *policy*.
General Exclusions	The following are exclusions under this benefit: • Intentional self-inflicted injury • War or acts of war, declared or undeclared • Injury sustained while committing or attempting to commit a criminal act • Treatment of mental or emotional disorders • Rehabilitation or treatment of alcoholism or drug addiction • Service in the armed forces of any nation

See the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Assured Access Benefit *(optional)*

Benefit Description	The Assured Access Benefit provides the opportunity for the *member* and eligible *dependents* to put a *personal health plan* on hold when *group health benefits* are acquired. It also provides return access to the *personal health plan* without additional *medical underwriting* on the *loss of group health benefits*. The *personal health plan* may be put on hold or reactivated as often as there is a qualifying loss or gain of *group health benefits*.
Eligibility	To be eligible to purchase the Assured Access Benefit, *insured persons* must be age 64 or under on the effective date of coverage and must have purchased Health and Drug Benefits under this *policy*. Assured Access may also be purchased when *group health benefits* are acquired provided *insured persons* qualify with additional *medical underwriting*.
Putting *Personal Health Plan* on Hold	Call toll free at 1-855-906-8993 within 60 days of acquiring *group health benefits* to have *your personal health plan* put on hold.
Activation of *Personal Health Plan*	Call toll free at 1-855-906-8993 within 60 days of losing *group health benefits* to have *your personal health plan* activated. Proof of *loss of group health benefits* will be required.
Coverage	Assured Access *insured persons* have return access to the previously selected Health and Drug Benefits and the Assured Access Benefit when activating the *personal health plan* without additional *medical underwriting*. The Dental Benefit can be added at any time without additional *medical underwriting*. *Waiting periods* may apply. The Critical Illness Benefit and the Hospital Cash Benefit require additional *medical underwriting* each time they are added or activated.
Underwriting Requirements	Any conditions or benefits excluded during the initial *medical underwriting* on *application* for coverage will continue to be excluded each time the plan is reactivated. *Insured persons* who received *substandard rates* under their *personal health plan* will continue to receive *substandard rates* under Assured Access and the *personal health plan*.
Member Premiums	Premiums must be paid for Assured Access whether *your personal health plan* is active or on hold. The regular rate for Assured Access applies when your *personal health plan* is on hold, and a reduced rate applies when it is active. When activating *your personal health plan you* will pay the premium rates in effect at the time of activation and will be subject to any changes made to benefits during the time the plan was on hold.

See the General Provisions, Statutory Conditions, General Exclusions and Limitations and Definitions for all conditions and restrictions. Benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*. Refer to the Assured Access policy for further details.

Health Benefit Provisions

The descriptions of the products and services outlined below provide a more detailed explanation of the benefit information included in the Health Benefit Summaries.

Each benefit is only eligible if it is listed in the Health Benefit Summary for the coverage *you* have purchased. For example, if *you* purchased Health Benefit - Entry, *you* would not have coverage for ambulance services.

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*, maximums and details specified below and in the Health Benefit Summary for the benefit *you* purchased;
- payment is limited in accordance with the General Exclusions and Limitations provision of this *policy*; and
- benefits must meet the definition of *eligible expenses* under the Definitions provision of this *policy*.

Benefit Description:

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 bone or root structure.

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 after the *policy* effective date;
- initiated within 180 days of the *accident* or dislocation or a detailed *treatment* plan satisfactory to Blue Cross must be submitted for approval within that period;
- performed within 2 years of the date of the *accident* or dislocation, unless the *insured person* has been approved by Blue Cross for deferred *treatment* due to the *insured person's* age; and
- provided at a time when coverage under this *policy* is still in effect.

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

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

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 *insured person*. This includes air or rail transportation. This coverage excludes inter- *hospital* transfers. Charges for travel expenses of an accompanying registered nurse (who is not a relative) when *medically necessary* and approved by Blue Cross are covered up to $280 per *calendar year*.

Diabetic Supplies and Equipment:

Diabetic Supplies: Charges for test strips, lancets, needles, syringes and insulin pump supplies. Continuous blood glucose monitoring sensors are also covered up to $2,280 per *calendar year*.

Equipment: Charges for glucometer, continuous blood glucose monitoring transmitters and pressurized insulin injector are covered up to $200 per 5 *calendar years*.

Diabetic Supplies and Equipment must be used for the *treatment* and control of diabetes and a prescription is required. Insulin Pumps are eligible under the Medical Equipment benefit.

Diagnostic Services:

Laboratory tests: Charges for tests carried out in a laboratory, required for the diagnosis or *treatment* of an *illness* or injury, such as, blood tests, urine tests, throat culture, cytology. A prescription from the attending *physician* is required.

Magnetic resonance imaging: Expenses for magnetic resonance imaging required for the diagnosis or *treatment* of an *illness* or injury, when prescribed by the attending *physician*.

Polysomnography: Expenses for polysomnography required for the diagnosis, when prescribed by the attending *physician*.

Scanner: Expenses for scans required for the diagnosis or *treatment* of an *illness* or injury, when prescribed by the attending *physician*.

Ultrasound: Expenses for ultrasound scans required for the diagnosis or *treatment* of an *illness* or injury, when prescribed by the attending *physician*.

Ask your health practitioner if they are a Blue Cross approved provider before you obtain a service or supplies to avoid unexpected out-of-pocket expenses.

Foot Orthotics and Custom Orthopedic Shoes: 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 podiatrist;
    - the *insured person* provides a copy of the biomechanical or gait analysis from the prescribing *health practitioner*; and
    - the orthopedic 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 provided that:
    - they have been prescribed by the attending *physician*, orthopedic surgeon, physiatrist, rheumatologist or podiatrist; and
    - the custom made foot orthotics are dispensed by an *approved provider* of custom made foot orthotics.

This coverage excludes the purchase and repair of:

- pre-fabricated orthopedic shoes without permanent modifications; and
- extra-depth shoes.

Health Practitioners: *Eligible expenses* for *treatment* provided by any *health practitioner* specified in the Health Benefit Summary. Coverage is limited to:

- *treatment* within the scope of the *health practitioner's* practice; and
- 1 *treatment* by the same *health practitioner* per day.

A *physician* referral is necessary each year for massage therapy *treatment* to be eligible. Orthotherapists and Kinesitherapist can be considered in combination with the Massage Therapist benefit. This coverage excludes:

- products;
- comprehensive health assessments;
- charges for services obtained in *hospital*; and
- group *treatment* sessions.

Visit the website for helpful information on managing chronic diseases and health coaching.

www.medaviebc.ca/livebetter

Hearing Aids/Repairs: Charges for the purchase or repair of hearing aids when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum amount for both ears. This coverage is limited to once per 5 *calendar years* and excludes batteries and exams.

Coverage must be active 6 months before benefit becomes eligible.

Health Coaching and Chronic Disease Management: Charges for the services rendered by an *approved provider* who is a certified specialist in health coaching and managing chronic disease. Services must be delivered by the *approved provider* for medical conditions considered eligible by Blue Cross. Please visit our site to find a provider www.medaviebc.ca/livebetter

Coverage includes:

- Initial assessment, counselling and follow-up sessions;
- Education relating to symptom management, medication usage; and
- Development of action plans.

Pre-approval from Blue Cross is required before purchasing Medical Equipment or prostheses. This will ensure you don't end up with significant and unexpected out-of-pocket expenses.

Medical Equipment: Charges for rental or purchase of the following medical equipment:

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

The purchase of 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 per 5 *calendar years*.

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

This coverage excludes charges for special mattresses, air conditioning, air purifying equipment or any equipment that is not considered durable.

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 1 artificial larynx up to a maximum of $1,200 per lifetime;
- repair of artificial larynx to a maximum of $300 per *calendar year*;
- surgical brassieres to a maximum of $150 per bra, limited to 2 per *calendar year*;
- intrauterine contraceptive device (IUD) to a maximum of $75 per 2 *calendar years*;
- ostomy supplies and catheters and catheterization supplies when prescribed by a *physician*. Appliance covers and deodorants are not eligible benefits;
- oxygen, but excludes liquid oxygen;
- sleeves for lymphedema that can be inflated with compressed air to a maximum of 2 per *calendar year*;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $300 per 5 *calendar years*.

Before receiving nursing services you must obtain pre-approval from Blue Cross.

Mobility Aids and Orthopedic Appliances: Charges for the purchase or rental of crutches and canes (2 per lifetime), walking aids (1 per 5 *calendar years*), casts and splints, trusses (1 per 5 *calendar years*), braces (1 per lifetime) and cervical collars (1 per *calendar year*) as indicated in the benefit summary. Replacement of braces is not a benefit unless replacement is required due to pathological change. Repairs and adjustments limited to a maximum of $105 per item in a *calendar year*.

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

Nursing care services must be pre-approved by 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.

Charges for the services of a personal support worker in the *insured person's* home may also be eligible up to 4 hours per day if the *insured person* is under the active care of a nurse or requires home care for recuperation after discharge from *hospital*. Personal support workers offer essential services related to the 5 *activities of daily living*.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the *activities of daily living*.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A $10,000 maximum per lifetime applies to myoelectric limbs;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 2 *calendar years*; and
- wigs when hair loss is due to an underlying pathology or its *treatment* to a maximum of $300 per lifetime.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of $300 per *calendar year*. This coverage excludes:

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

Semi-Private *Hospital Room*:

Charges for the difference in cost between standard ward and semi-private room accommodation in a licensed general *hospital* in Canada when the *insured person* is admitted as an inpatient for *acute care* up to a maximum of 90 days per *insured person* per *calendar year*. Semi-Private *Hospital Room* coverage excludes administrative and incidental fees (for example, television, telephone and parking). Present *your* identification card to a *hospital* and the *hospital* will bill Blue Cross directly.

When the *hospital* is unable to provide the semi-private or preferred accommodations, Blue Cross agrees to pay the *member* $30 per day for each day hospitalized for active *treatment*. Appropriate claim form required. Claims related to pregnancy are eligible only after 8 months of continuous coverage.

Vision Care:

Eye Examination, Lenses, Frames, Contact Lenses and Laser Eye Surgery: Combined benefit per 2 *calendar years*. Charges must be prescribed or performed by an ophthalmologist or optometrist.

Contact Lenses Due to Disease: $210 per 2 *calendar years* for charges for contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea. The contact lenses must improve sight to at least the 20/40 level and this level of improvement must not be possible with eyeglass lenses.

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

Coverage must be active 6 months before benefit becomes eligible.

Payment of Claims

How Payments are Made

The *insured person* will pay the full cost of any expense to the *approved provider* at the time of purchase. Blue Cross will then reimburse any *eligible expense* on receipt of proof of payment from the *insured person*.

Certain *approved providers* may offer a pay direct arrangement. If they do, the *approved provider* will submit the *insured person's* claim to Blue Cross electronically to verify eligibility at the time of purchase and Blue Cross will reimburse the claim directly to the *approved provider*. The *insured person* will pay the *approved provider* only the portion of the claim that is not covered by this benefit.

Accidental Death and Dismemberment Benefit Provisions

The benefits listed in this provision provide further explanation of the Accidental Death and Dismemberment benefit. Payment is limited to the *reimbursement level*, maximums and details specified below and in the Benefit Summaries for Health Benefit – Essential or Enhanced and the Critical Illness Benefit.

This benefit is only included in *your* coverage if you purchased Health Benefits – Essential or Enhanced or the Critical Illness Benefit.

Coverage

If an *insured person*, while covered under this benefit, suffers an accidental death or an accidental *loss* as defined in this benefit, Blue Cross will pay the amount of insurance shown in the Benefit Summary subject to the conditions outlined below.

To be covered under this benefit, a *loss* must:

- result from an *accident* that occurs while the *insured person* is covered under this benefit;
- occur within 365 days after the date of this *accident*; and
- result directly or independently of all other causes, from bodily injuries suffered by accidental external and violent means.

Death caused by accidental drowning shall also be covered.

When does my Coverage Begin?

Coverage begins on the effective date of the Health Benefit – Essential or Enhanced or the effective date of the Critical Illness Benefit.

Table of Benefits

What Blue Cross will Pay

The amount payable (listed to the right) shall be the percentage of the principal sum of Accidental Death and Dismemberment Insurance for which the *insured person* is covered on the date of the injury.

Coverage	Benefit Amount
Loss of life	100% of the principal sum
Loss of, or loss of use of, both hands or both feet	100% of the principal sum
Loss of, or loss of use of, 1 hand and 1 foot	100% of the principal sum
Loss of entire sight in both eyes	100% of the principal sum
Loss of, or loss of use of, 1 hand or 1 foot	50% of the principal sum

Principal sum is listed in Benefit Summary

Additional Benefit

Exposure and Disappearance

If an *insured person* is unavoidably exposed to the elements and suffers a *loss* as a result of and within 365 days of this exposure, the *loss* will be considered to be the result of an *accident*. An *insured person* will be determined to have suffered *loss* of life as a result of an *accident* if the *insured person* disappears due to the accidental wrecking, sinking or disappearance of a vehicle and their body is not found within 365 days (unless there is contrary evidence to suggest that the *insured person* is still alive).

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the Definitions provision of this *policy*.

Loss: Any *loss* specified in the Table of Benefits.

Loss of hand or foot: Severance at or above the wrist or ankle joint. Severance is defined as the permanent and complete detachment of the affected area.

Loss of entire sight: Total and irrecoverable *loss* of sight, certified by a *physician*. *Loss* of entire sight is also considered to have occurred if sight cannot be restored to better than 20/200 vision by surgical or other means (i.e. spectacles) within 12 months following the date of the *accident* and the *loss* is determined to be permanent by Blue Cross.

Loss of use: Total and irrecoverable *loss* of use for 12 consecutive months that is determined to be permanent by Blue Cross.

Payment of Claims

Beneficiary

In the case of *loss* of life of an *insured person*, Blue Cross will pay benefits directly to the *insured person's* estate. For any other *loss*, benefits will be paid to the *insured person*, unless otherwise stated.

Maximum Amount Payable

The total amount payable for 1 or more *losses* that result from the same *accident* will not exceed 100% of the benefit amount specified in the Benefit Summaries for Health Benefit – Essential or Enhanced and the Critical Illness Benefit.

Proof of Claim

All *losses* must be certified by a *physician*. Blue Cross may:

- require that the *insured person* undergo a medical examination; or
- if the *insured person* is deceased, request an autopsy report in accordance with applicable laws.

Exclusions and Limitations

Blue Cross will not pay any benefits for a *loss* that results directly or indirectly from the following causes:

a. any medical or surgical treatment, *illness* or disease of any kind, other than septic infection caused through a wound sustained as a result of an *accident*;
b. voluntary injury or *illness*, suicide or attempted suicide, whatever the state of mind of the *insured person*;
c. voluntary ingestion of poison or drugs;
d. inhalation of fumes, unless an occupational health and safety board has determined such inhalation to be an *accident*;
e. any *accident* or injury occurring while the *insured person* is participating in a criminal act or attempting to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
f. insurrection, war (declared or not), the hostile action of the armed forces of any country or the *insured person's* participation in any riot or civil commotion;
g. injuries sustained while the *insured person* is flying or attempting to fly an airplane or other type of *aircraft* if the *insured person* is part of the crew or is performing any other flight duties; or
h. any *accident* or injury that occurs while the *insured person* is operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the *accident* occurred.

When Coverage Ends

Coverage for the *member* will terminate at the end of the month prior to the month in which the *member* turns 65 years of age or upon termination of the *policy*.

Coverage for the *spouse* will terminate at the end of the month prior to the month in which the *spouse* turns 65 years of age, when the *spouse* no longer meets the definition of *spouse* under the *policy* or upon termination of the *policy*.

Coverage for *dependents* will terminate when neither the *member* or *member's spouse*, if applicable, is covered for this benefit under this *policy*, when the *dependent* no longer meets the definition of *dependent* under the *policy* or upon termination of the *policy*.

Travel Benefit Provisions

The benefits listed in this provision provide further explanation of the Travel Benefit Summary. Payment is limited to the *reimbursement level*, benefit maximums and coverage duration specified below and in the Benefit Summary.

This benefit is only included in *your* coverage if *you* purchased Health Benefit – Enhanced and becomes optional at age 65.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the Definitions provision of this policy.

Change in Medication: Any increase or decrease in dose, strength or frequency of medication, as well as the addition or discontinuation of any medication.

Emergency: An *illness* or injury that requires immediate medical *treatment* due or related to:

- an injury resulting from an *accident*;
- a new medical condition that begins during the *trip*;
- a medical condition that existed prior to the *trip* provided that it is stable.

Immediate Family: An immediate family means *your spouse* or cohabitant, parent, step-parent, grandparent, grandchild, in-law, natural or adopted child, stepchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew or legal guardian.

Related Medical Condition, Illness or Injury: Any medical condition, *illness* or injury precipitated or caused by, resulting or arising from or directly or indirectly attributed to another medical condition, *illness* or injury.

Trip: Travel outside of the *insured person's* province of residence.

What Blue Cross Will Pay

Blue Cross will pay e*ligible expenses* in excess of the amount paid by *your government health care coverage* listed in this section if:

- the *eligible expense* required immediate medical *treatment* as a result of an *accident* or an unexpected sudden *illness*;
- they are incurred as a result of an *emergency*;
- the *emergency* occurs during the first 30 days of a *trip* outside the *insured person's* province of residence;
- the *insured person* is covered by *government health care coverage* when the *emergency* occurs;
- Blue Cross is satisfied the expense is necessary to stabilize the *insured person's* medical condition; and
- the *eligible expenses* do not fall within the Exclusion and Limitations provisions of this benefit or the *policy*.

In the event of an *accident* or sudden *illness* requiring *treatment*, *insured persons* are required to contact Blue Cross Travel Assistance immediately prior to admission. Blue Cross Travel Assistance reserves the right to direct *insured persons* requiring medical *treatment* to *hospitals* and *physicians* that have been selected to provide health care services. To contact Blue Cross Travel Assistance call toll free 1-800-361-6068 from Canada or the United States. Elsewhere in the world (call collect) 514-286-8411.

When does Coverage Begin?

Coverage is effective once the *insured person* leaves their province of residence or, if travelling by air, at the time the airplane takes off. Coverage for the *trip* terminates once the *insured person* returns to their province of residence, the 30 day *trip* limit expires, or the termination of this *policy*, whichever comes first.

There is no limit to the number of 30 day *trips* that can be taken while covered under this *policy*. For coverage over 30 consecutive days, please contact *your* authorized Blue Cross representative.

Benefit Description

Hospitalization: Charges for active *treatment* in a *hospital* room accommodation (not a suite of rooms) and for *medically necessary* inpatient and outpatient services.

Physician Fees: Fees charged for *physician* or surgeon services in excess of the amount paid by the *insured person's government health care coverage*.

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

Nursing Care: Fees for private duty nursing performed by a professional nurse when prescribed by the attending *physician*. The nurse providing the service must not be a *family member* of the *insured person* or an employee of the *hospital*. This coverage excludes nursing fees for custodial care.

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

Drugs: The cost of drugs prescribed by a *physician* and supplied by a licensed pharmacist, but only in a quantity sufficient to treat the condition for the duration of the *trip*. Vitamins, patent, proprietary products and drugs available without a prescription are excluded. The *insured person* must provide satisfactory proof of purchase of this medication that includes:

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

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

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for *treatment* of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth.

The maximum reimbursement per *insured person* per *accident* is $2,000. A *physician* or dentist must be seen immediately following the *accident*. *Treatment* must begin while the *insured person* is covered by this benefit and end within 90 days of the *accident*. This *treatment* may be completed in the *insured person's* province of residence. An *accident* report is required from the *physician* or dentist.

Blue Cross will cover *treatment* to natural teeth for the *emergency* relief of dental pain, excluding root canals, to a maximum of $200. *Treatment* must be performed at a location not less than 200 kilometres outside the boundary of the province of residence.

Ambulance Services: Charges for ambulance services from the place of *illness* or *accident* to the nearest qualified medical facility capable of providing appropriate *treatment*.

Air Ambulance Services: The cost of air evacuation between *hospitals* or for *hospital* admission in the *insured person's* province of residence, at the discretion of Blue Cross, when ordered by the attending *physician*.

Repatriation to the Province of Residence: Unless not possible for medical reasons acceptable to Blue Cross, Blue Cross may require the repatriation of the *insured person* to their province of residence.

Blue Cross will reimburse the extra cost of one-way economy airfare plus the additional economy airfare, if required, to accommodate a stretcher, to return the *insured person* by the most direct route to the air terminal nearest the departure point from the *insured person's* province of residence.

This coverage also includes:

- economy airfare for any *spouse* or *dependent children* of the *insured person* covered by this *policy* who are travelling with the *insured person* at the time of *illness* or injury; and
- if the attending *physician* or commercial airline confirms in writing that the *insured person* must be accompanied by a qualified medical attendant (not a relative), the usual, customary and reasonable fee charged by a medical attendant registered in the jurisdiction in which *treatment* is provided, including round-trip economy airfare, and overnight hotel and meal expenses, if required.

This benefit assumes the *insured person* is not holding valid, open or unrestricted airline tickets. If the repatriation benefit is used, the unused portion of the *insured person's* airline ticket must be surrendered to Blue Cross.

If the *insured person* refuses repatriation or transfer, all rights to travel benefits will be terminated for the remainder of the period the *insured person* is out of their province of residence and the expense for these services will not be covered by this *policy*.

Transportation to Visit the Insured Person: The cost of 1 round-trip economy fare (by airline, bus or train) by the most direct route, for an *immediate family* member or friend to the *hospital* where the *insured person* has been confined for 3 or more days outside their province of residence. The attending *physician* must provide written acknowledgement that this attendance is required and that the situation was serious enough to have required this visit.

The cost of 1 round-trip economy fare (by airline, bus or train) for an *immediate family* member or friend to identify the deceased *insured person* prior to the release of the body, where necessary.

Vehicle Return: Up to $1,000 toward the cost of having 1 person drive the *insured person's* vehicle, either private or rental, by the most direct route, to the *insured person's* province of residence or the nearest appropriate vehicle rental agency when the *insured person* is unable to do so due to an unexpected *illness* or physical injury and their travelling companion is unable to do so. Medical certification is required, as well as receipts for costs incurred (i.e. fuel, accommodation, meals and airfare).

Return of the Deceased: Reimbursements will be paid toward the cost of preparation, including cremation, and homeward transportation to the province of residence of a deceased person covered under this *policy* up to $5,000. Up to $2,500 will be reimbursed toward the cost of cremation and preparation for burial in the event the deceased person covered under this *policy* is not returned to Canada. These benefits exclude the cost of an urn or coffin.

Meals and Accommodations: Reimbursement up to $1,500 per *calendar year*, to a maximum of $150 per day, for the extra costs of commercial accommodation and meals incurred by an *insured person* and a travelling companion covered under this *policy* when return to the province of residence is delayed beyond the planned termination date of the *trip* due to *illness* or injury of the *insured person* or their travelling companion covered under this *policy*. This must be verified by the attending *physician* and supported with detailed receipts from commercial organizations.

Automatic Extension of Coverage: Coverage under this *policy* will automatically be extended, free of charge, to *insured persons* and any accompanying *family members* covered under this *policy*, up to 72 hours following the:

- date of discharge from *hospital*, if admitted to *hospital* prior to the expiry date of this *policy*;
- expiry date of this *policy* when return to province of residence is delayed, by order of the attending *physician*, due to a covered *illness* or accidental injury;
- expiry date of this *policy* when return to the province of residence is delayed due to the delay of a common carrier (airplane, bus, taxi, train) on which the *insured person* is a passenger or when delay is caused by a traffic *accident* or mechanical failure of a private automobile en route to the departure point. Claims must be supported by documentary proof.

Blue Cross Travel Assistance

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

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

Medical Assistance Services:

- Emergency response in any major language;
- Referral to an appropriate *physician*, clinic or *hospital*;
- Confirmation of coverage with the *hospital* or *physician*;
- Arrangement of payment to the *hospital* or *physician*;
- Assistance in contacting *family members*, business partners or family *physician*;
- Supervision of medical *treatment*;
- Keeping *family members* informed;
- Arrangement of transportation of an *immediate family* member to the patient's bedside;
- Arrangement for transportation to identify the deceased; and
- Arrangement for transportation home of the patient, if medically permissible.

Non-Medical Assistance Services:

- Arrangement for local care of *dependent children*;
- Coordination of the return home travel for *dependent children* if *you* are hospitalized;
- Transmission of urgent messages to *family members* or business partners;
- Assistance in the event of loss of passports or airline tickets;
- Referral to legal counsel in the event of a serious *accident*;
- Coordination of claims processing and negotiation of health care provider discounts; and
- Provision of pre-departure information concerning visas and vaccines.

Blue Cross and the travel assistance provider are not responsible for the availability, quality or results of any medical *treatment* or transportation or *your* failure to obtain medical *treatment*.

Payment of Claims

Blue Cross may approve payment directly to the service provider. In certain circumstances, the *insured person* may have to pay the full cost of any *eligible expense* at the time of purchase. For claims where the travel assistance provider is not used, please forward original detailed paid-in-full receipts to Blue Cross to permit coordination of eligible benefits with *government health care coverage*. Blue Cross will then reimburse any *eligible expenses* on receipt of proof of payment from the *insured person* subject to the following:

- charges must be usual, customary and reasonable, meaning that:
    - the amount charged is consistent with the amount generally charged by *health practitioners* for similar products or services in the geographical area in which the service or supply is being purchased; and
    - the frequency and quantity in which services or supplies are purchased by the *insured person* are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the *insured person's* condition;
- *insured persons* are required to provide proof of their departure and return dates and evidence that their claim occurred within 30 days of departing their province of residence.
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit and the *policy*;
- payment is subject to post-payment audit in accordance with the Right to Audit provision under the General Provisions of this *policy*;
- submission of certification by the attending *physician* that services were for *emergency treatment* defined as *treatment* of an immediate nature required as a result of an unforeseen *accident* or *illness*;
- Blue Cross has the authority to obtain *your* pertinent records or information from any *physician*, dentist, *hospital* or clinic;
- all amounts indicated in this benefit are in Canadian funds unless otherwise stated;
- payment will be made in Canadian funds and based on the rate of exchange in effect at the time the service was rendered, as determined by any Canadian chartered bank; and
- claim payments under this benefit will not carry interest.

Travel Exclusions and Limitations

Blue Cross will not pay any benefit or accept any liability for claims relating to the following:

- a medical condition, *illness* or injury or *related medical condition*, *illness or injury* that has deteriorated or for which an *insured person* has been diagnosed or hospitalized, required medical consultation (other than a routine checkup), or had a *change in medication* at any time within the:
    a. 3 month period immediately prior to the date of departure from the *insured person's* province of residence, if the *insured person* is under age 65;
    b. 6 month period immediately prior to the date of departure from the *insured person's* province of residence, if the *insured person* is age 65 or older;
- if the *insured person* fails to communicate with *Blue Cross Travel Assistance* prior to admission to *hospital* or receiving *treatment* or medical consultation;
- expenses incurred after 30 days of departure from the *insured person's* province of residence;
- expenses in excess of $5 million per *insured person*, per *trip* outside the province of residence;
- expenses incurred outside the province of residence when the *insured person* could have been returned to their province of residence without endangering life or health, even if the *treatment* available in the province of residence is of lesser quality than that available outside their province of residence.
- *trips* for which the purpose is primarily or incidentally to seek medical advice or *treatment*, even if the *trip* is on the recommendation of a *physician*;
- any hospitalization or services rendered in connection with general health examinations for "check-up" purposes;
- rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse;
- a rest cure or travel for health or cosmetic purposes;
- services in a chronic care *hospital*, chronic care unit of a public *hospital*, nursing home or health spa;
- *trips* taken or continued contrary to medical advice;
- expenses, whether before or after an *illness* or injury, regarding which the *insured person* has willfully concealed or misrepresented any material fact or circumstance concerning this coverage;
- expenses already paid by or eligible for refund from a third party;
- expenses incurred while travelling in a country (or specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued;
- expenses incurred directly or indirectly as a result of:
    i. participation in a criminal act or attempt to commit a criminal act under legislation in the jurisdiction in which the offence is committed, regardless of whether charges are laid or conviction is obtained;
    ii. an *illness* or injury that occurred while operating a vehicle under the influence of any intoxicant or drug or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the *accident* occurred or an alcohol level of more than 80 milligrams in 100 millilitres of blood;
    iii. any *treatment* relating to the use or abuse of drugs, toxic substances, alcohol or medications;
    iv. an injury or *illness* resulting from intentional non-compliance with medical *treatment* or therapy that has been prescribed;
    v. suicide, attempted suicide or voluntary injury or *illness*, whatever the state of mind of the *insured person*;
    vi. insurrection, war or warlike operations (declared or not), civil war, chemical, biological or bacteriological warfare, invasion, acts of foreign enemies, rebellion, revolution, insurrection, hostilities, the hostile action of the armed forces of any country or participation in any riot or civil commotion;
    vii. any act of terrorism. For the purpose of this benefit an act of terrorism means an act, including but not limited to, hijacking, the use of force or violence, chemical, biological or bacteriological force or the threat thereof, by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government or to put the public or any section of the public in fear, that has been determined by the appropriate federal authority to have been an act of terrorism; or
    viii. any action taken in controlling, preventing, suppressing or in any way relating to vi) or vii);

- expenses for any care, *treatment*, surgery, products or services that:
    i. are not incurred as a result of an *emergency*;
    ii. are not *medically necessary*;
    iii. are performed for cosmetic purposes only;
    iv. are not required for the immediate relief of acute pain and suffering;
    v. could be delayed until the *insured person's* return to Canada; or
    vi. relate to a terminal condition.
- expenses incurred due to pregnancy, miscarriage, childbirth or any pregnancy complications that occur within 9 weeks before or after the expected date of birth;
- expenses incurred due to an *emergency* that occurs while participating in:
    i. a sport for remuneration;
    ii. a motor vehicle or speed contest of any kind;
    iii. any extreme sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts; or
    iv. a flight *accident* unless the *insured person* is riding as a fare-paying passenger on a commercial airline or charter *aircraft* with a seating capacity of 6 people or more;
- claims that are not submitted in a format acceptable to Blue Cross;
- claims that are not submitted within 4 months of the date of service;
- the unavailability or poor quality of any medical *treatment* or transportation;
- the *insured person's* failure to obtain medical treatment; or
- the deterioration of the *insured person's* medical condition during or after the repatriation back to their province of residence.

Other Coverage and Excess Coverage Provision

Other coverage and excess coverage provisions are detailed in the General Provisions.

Drug Benefit Provisions
Supplemental coverage only

Coverage

Blue Cross covers *eligible drugs* described in this benefit, subject to the conditions outlined below. The *reimbursement level* depends on the drug coverage selected in the Drug Benefit Summary.

Additional Definitions

Certain eligible drugs may require Special Authorization by Blue Cross before your prescription is covered.

To print a copy of our Special Authorization prescription drug form, visit our website.

The following definitions apply to this benefit, in addition to those found under the Definitions provision of this *policy*.

Eligible Drug: A drug that is:

- approved by Blue Cross as an *eligible expense*;
- approved by Health Canada;
- assigned a Drug Identification Number or a Natural Health Product number in Canada;
- considered by Blue Cross to be a *life-sustaining drug* or a drug that requires a prescription by law;
- prescribed by a *physician* or by a *health practitioner* who is licensed to prescribe under applicable provincial legislation; and
- dispensed by an *approved provider* that is a licensed retail pharmacy or another Blue Cross *approved provider*.

Blue Cross may, on an ongoing basis, add, delete or amend its list of *eligible drugs* (Managed formulary only).

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.

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
- have the same route of administration.

Life-Sustaining Drug: An *eligible drug* that does not require a prescription by law but which Blue Cross is satisfied is necessary for the survival of the *insured person*. A prescription from a *physician* or *health practitioner* is still needed for reimbursement.

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 *insured persons* when prescribed *specialty high cost drugs*.

Special Authorization (Managed formulary): *Eligible drugs* that are identified by Blue Cross as requiring prior or ongoing authorization by Blue Cross to qualify for reimbursement. The criteria to be met for *Special Authorization* are established by Blue Cross and may include requiring the *insured person* to participate in a patient support program. Any fees associated with completing this form or obtaining additional medical information are the *insured person's* responsibility.

Specialty High Cost Drug: An *eligible drug* that requires *special 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 expenses* subject to the following terms and conditions:

- payment is limited to the *reimbursement level* and the benefits maximum specified in the Drug Benefit Summary;
- Blue Cross may determine that certain *eligible drugs* are subject to:
    - dollar, quantity or frequency maximums;
    - *special authorization*; or
    - coordination with the *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 by the Substitution Provision of this benefit; and
- payment is limited by the Exclusions and Limitations provision of this benefit and *policy*.

This benefit covers the expenses listed below, provided they also meet the definition of *eligible expenses* under the Definitions provision of this *policy*:

- preparations and compounds if their main ingredient is an *eligible drug*; and
- prescribed *eligible drugs* that appear on the managed drug formulary which contains an extensive list of *eligible drugs* and *life-sustaining drugs* and is updated as new drugs are reviewed and approved by the *Medication Advisory Panel*.
- prescribed *eligible drugs* covered under the List of Medications administered by RAMQ or by equivalent coverage under a group plan.

Substitution Provision

If an *interchangeable drug* has been prescribed, Blue Cross will reimburse to the lowest ingredient cost *interchangeable drug*. This applies even if the *insured person's physician* indicates the prescribed *interchangeable drug* cannot be substituted.

An *insured person* who requests a higher cost *interchangeable drug* is responsible for paying the difference in cost between the 2 *interchangeable drugs*.

For *insured persons* with an adverse reaction to the *interchangeable drug* dispensed, Blue Cross will consider reimbursement of another *interchangeable drug* on a case-by-case basis through the *Special Authorization* process.

Payment of Claims

Pay Direct: At the time of purchase, the *approved provider* will submit the *insured person's* claim to Blue Cross electronically to verify eligibility. The *insured person* 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 directly to the *approved provider*.

If the *insured person* submits to Blue Cross a paid-in-full prescription drug receipt, Blue Cross will only reimburse the amount that would have been paid to the *approved provider* if the claim had been submitted electronically.

Exclusions and Limitations

DRUG SERVICES NOT INCLUDED - Unless otherwise specified in the Drug Benefit Summary, expenses associated with the following categories of drugs are not eligible for reimbursement:

Exclusions a. to j. do not apply if drugs are covered under the List of Medications administered by RAMQ or under an equivalent group plan.

a. varicose vein injections;
b. antihistamines and allergy sera;
c. smoking cessation aids (i.e. gum, patches);
d. vaccines (vaccines are covered under Drug Benefit - Enhanced);
e. vitamins;
f. weight loss treatments;
g. Natural Health Products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
h. fertility drugs and treatments (fertility drugs are covered under Drug Benefit – Enhanced);
i. erectile dysfunction treatments (erectile dysfunction drugs are covered under Drug Benefit – Enhanced);
j. hair growth stimulants;
k. services, treatments or supplies that:
    i. are not *medically necessary*;
    ii. are for cosmetic purposes only;
    iii. are elective in nature; or
    iv. are *experimental or investigative*;
l. procedures related to drugs injected by a health care professional in a private clinic;
m. drugs Blue Cross determines are intended to be *administered* in *hospital* based on the route of administration and the condition the drug is used to treat;
n. 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;
o. services, treatments or supplies the *insured person* receives free of charge;
p. charges that would not have been incurred if no coverage existed;
q. drugs that are eligible under the Travel Benefit provided by this *policy* (if applicable); or
r. drugs defined by a *pre-existing condition exclusion* of this *policy*.

Dental Benefit Provisions

The descriptions of the benefits outlined below provide a more detailed explanation of the benefit information that may be included in the Dental Benefit Summaries.

Each benefit is only eligible for coverage if it is listed in the Dental Benefit Summary for the coverage *you* have purchased. For example, if *you* purchased Dental Benefit - Entry, *you* would not have coverage for Oral Surgery and Root Canals.

What Blue Cross Will Pay

Blue Cross will pay *eligible expenses* subject to the following terms and conditions:

- the benefit must be listed in the Benefit Summary that *you* purchased;
- payment is limited to the *reimbursement level*, benefit maximums and frequency limits specified below or in the Benefit Summary;
- the maximum amount considered before the *reimbursement level* is applied is the lesser of:
  - the expense actually incurred; or
  - the current year fee guide in effect for the provider of service (note: specialists fees will be paid at general practitioner rates);
- *eligible expenses* for laboratory fees are limited to 60% of the provider fee suggested in the fee guide;
- if one or more forms of alternative *treatment* exist, payment is limited to the cost of the least expensive *treatment* that will meet the *insured person's* basic dental needs;
- *eligible expenses* 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 by the Exclusions and Limitations provisions of this benefit and *policy*.

All procedures have been assigned a 5-digit numeric procedure code and a corresponding cost depending on the province of the provider of service. Cost is based on the provincial fee guide.

A unit equals 15 minutes of time.

Basic and Preventive Care

Oral Examinations and Diagnosis: Charges for:

- recall oral examination (dental exam) (1 exam per *calendar year*);
- complete oral examination (1 exam per 3 *calendar years*);
- emergency oral examination;
- specific oral examination.

X-rays: Charges for:

- complete series films (1 film per 3 *calendar years*);
- panoramic film (1 film per 3 *calendar years*);
- intra-oral films:
  - periapical (10 films per *calendar year*);
  - occlusal (4 films per *calendar year*);
  - bitewings (4 films per *calendar year*).

Laboratory Tests and Examinations:

Charges for:

- bacterial culture;
- biopsy of soft and hard oral tissue;
- pulp vitality tests;
- caries susceptibility tests;
- histological tests;
- cytological tests;
- diagnostic casts;
- diagnostic photographs;
- interpretation of models.

Contact your dental provider for procedure codes for your planned treatment and call us to confirm coverage.

Preventive Treatment: Charges for:

- polishing of teeth (1 unit per *calendar year*);
- fluoride *treatment* (1 per *calendar year*, limited to *insured persons* 18 years of age and under);
- pit and fissure sealants (limited to *insured persons* 18 years of age and under);
- scaling (2 units per *calendar year*).

Scaling refers to removal of plaque and tartar from teeth.

Removable Denture Adjustments and Repairs: Charges for:

- repairs;
- adjustments;
- prophylaxis and polishing (cleaning of dentures) (2 units per *calendar year*);
- rebasing or relining (1 upper and 1 lower per 2 *calendar years*);
- tissue conditioning.

Restorations (fillings): Charges for:

- caries, trauma and pain control;
- amalgam or tooth coloured (white) restorations;
- retentive pins;
- pre-fabricated steel or plastic restorations;
- pulp capping.

Oral Surgery and Root Canals

Only available with Dental – Essential and Enhanced

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy;
- endodontic surgery;
- bleaching (endodontically treated teeth);
- apexification;
- apicoectomy;
- retrofilling.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth;
- frenectomy (surgical alteration of the frenum);
- alveoloplasty – in conjunction with extraction;
- hemorrhage control;
- post-surgical care.

Adjunctive services (Conscious Sedation for Oral Surgery): Charges for:

- inhalation technique;
- nitrous oxide with oral sedation;
- intravenous sedation;
- intramuscular injection of sedative drug;
- combine inhalation and intravenous;
- oral sedation.

Periodontal Services

Only available with Dental – Enhanced

Periodontal Services: Charges for:

- periodontal surgery;
- provisional splinting or ligation;
- management of acute oral infections;
- desensitization to a maximum of 3 units per *calendar year*;
- periodontal curettage;
- scaling (6 additional units per *calendar year*);
- root planing (8 units per *calendar year*);
- occlusal adjustments to a maximum of (2 units per *calendar year*);

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

- periodontal appliances (1 upper and 1 lower per 2 *calendar years*);
- adjustments to periodontal appliances to a maximum of 2 units per *calendar year*;
- post-surgical dressing change;
- periodontal re-evaluation.

Major Dental Restoration

Only available with Dental – Enhanced

Extensive Restorations: Charges for:

- inlays;
- onlays;
- crowns: charges for single restorations only (other than pre-fabricated steel or plastic restorations), for teeth damaged due to caries or traumatic injury;

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 an inlay, onlay or crown;
- removal of an inlay, onlay or crown.

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 *calendar years*;
- bridgework to a maximum of 1 per tooth per 5 *calendar years*.
- Implant surgical placement to a maximum of 1 per missing tooth per 10 *calendar years*;
- Restorations over implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per missing tooth per 10 *calendar years*;

- Implant related services
  - tomography radiograph (excludes cone beam computerized tomography);
  - surgical guide or template;
  - periodontal surgery around an implant;
  - removal, repair and recementation of an implant retained crown or bridge;
  - repairs and adjustments to an implant retained denture;
  - rebasing and relining an implant retained denture (one upper and one lower per 2 *calendar years*);
  - tissue conditioning for an implant retained denture.

Orthodontic Services

Only available with Dental – Enhanced

Orthodontic services are limited to *insured persons* age 18 years and under.

Charges for:

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

Pre-approval of Benefits

The *insured person* must submit to Blue Cross, before *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 *insured person* 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.

Reimbursement for Orthodontic Services

Blue Cross will pay *eligible expenses* for services related to orthodontic *treatments*.

The reimbursement will be paid monthly and is limited to the *reimbursement level*, monthly maximum and lifetime maximum amounts specified in the Dental Benefit summary – Enhanced.

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.

Payment of Claims

How Payments are Made

At the time of purchase, the *approved provider* will either submit the *insured person's* claim to Blue Cross or provide a completed claim form and proof of payment to the *insured person* to submit to Blue Cross. The *insured person* 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 *insured person* will receive the refundable portion of the expenses from Blue Cross.

Dental Exclusions and Limitations

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

a) 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;

b) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;

c) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction; or

d) veneers and related services and anti-snoring or sleep apnea devices.

Critical Illness Benefit Provisions

The descriptions of the benefits outlined below provide a more detailed explanation of the benefit information included in the Critical Illness Benefit Summary.

Coverage

While coverage is in force, if an *insured person* becomes afflicted with a critical illness defined in the *covered conditions* and survives the 30 day *elimination period*, Blue Cross will pay one of the following applicable amounts:

Member	$25,000
Spouse	$25,000
Dependent Child	$10,000

These maximum benefit amounts are payable once per lifetime for each person insured under this *policy*, provided this coverage remains in force.

The Critical Illness Benefit provides a lump sum cash payment. The benefit is paid regardless of expenses incurred and there is no restriction on how the money is spent.

To be eligible for payment, the *insured person's* medical condition must still meet the definition of the *covered condition* at the end of the *elimination period*. Medical certification satisfactory to Blue Cross must be provided within 365 days following the expiration of the 30 day *elimination period*.

Additional Definitions

Pre-existing Conditions

No benefit shall be paid for a *covered condition* if symptoms or sickness:

- commenced within the *insured person's* first 90 days of continuous coverage or within 90 continuous days of the date of the last reinstatement, whichever is later, and
- result in medical treatment, consultation, care or service (including diagnostic measures) leading to the diagnosis of a *covered condition*.

In addition, no benefit shall be paid for a *covered condition* for which, before the effective date of this benefit or before the effective date of the last reinstatement, the *insured person* has:

- had a medical consultation;
- been prescribed or taken medication; or
- received *treatment*, including diagnostic measures for any symptom or medical problem that leads to a diagnosis of or *treatment* for a *covered condition*.

Activities of Daily Living

Activities of daily living include eating, dressing, bathing, ambulation and toileting and are detailed in the Definitions provision.

Elimination Period

The *insured person* must survive the onset of the *covered condition* for a period of 30 days before the benefit will be paid. At the end of the 30 day period, the *insured person's* medical condition must still meet the definition of the *covered condition*.

Covered Conditions

All *covered conditions* must be the result of *illness* or disease in order to be eligible for coverage with the exception of burns.

Alzheimer's Disease: Definitive diagnosis, by a certified neurologist or gerontologist approved by Blue Cross, of a progressive degenerative disease of the brain. This degeneration must involve a significant reduction in mental and social functioning as shown by:

- a loss of intellectual capacity and cognitive impairment;
- impaired memory and sense of judgment; and
- the need for continuous adult supervision for health and safety, whether medicated or not.

Blindness: Definitive diagnosis, by a certified ophthalmologist approved by Blue Cross, of the permanent loss of sight in both eyes where:

- visual acuity cannot be corrected beyond 20/200 in both eyes; or
- the field of vision is less than 20 degrees in both eyes.

Burns: Third degree burns that result from a single event and cover at least 20% of the body.

Coma: State of unconsciousness with no reaction to external stimuli or response to internal needs that persists for a continuous period of at least 30 days.

Deafness: Definitive diagnosis, by a certified otorhinolaryngologist approved by Blue Cross, of the permanent loss of hearing in both ears. The loss of hearing in each ear must be such that sounds of 90 decibels or less cannot be distinguished.

Life Threatening Cancer: Definitive diagnosis, as evidenced on a pathology report, of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue with distant metastasis, subject to the following exclusions:

- benign tumours or polyps;
- pre-malignant lesions;
- stage T1 prostate cancer;
- carcinoma in situ (cancer that has not spread outside the tissue in which it developed);
- melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without stage IV or V invasion; and
- basal cell and squamous cell carcinoma of the skin.

The following malignant tumours (with or without metastasis) are covered:

- oral cavity
- liver
- pharynx (including larynx)
- pancreas
- esophagus
- gall bladder and bile ducts
- stomach
- lungs and respiratory tract
- stage IV melanoma

Loss of Speech: Total and irreversible loss of speech as a result of physical disease, as diagnosed by a *health practitioner* approved by Blue Cross.

Major Organ Failure: Advanced or rapidly progressing incurable terminal kidney, liver, lung or heart failure, where the *insured person* is not a candidate for organ transplant, as determined by a *health practitioner* approved by Blue Cross.

Major Organ Failure Requiring Transplant: Irreversible failure of the kidneys, liver, lungs or heart requiring a transplant of that organ. The *insured person* must be accepted in a transplant program approved by Blue Cross. The 30 day e*limination period* begins from the date of the *insured person's* enrolment into such program.

Motor Neuron Disease: Definitive diagnosis, by a certified neurologist approved by Blue Cross, of motor neuron disease that has resulted in the *insured person's* inability to perform at least 2 of the 5 *activities of daily living* without assistance, as determined by an occupational therapist approved by Blue Cross.

Multiple Sclerosis: Definitive diagnosis, by a certified neurologist approved by Blue Cross, of having had at least 2 episodes of well-defined neurological deficit with persisting neurological abnormalities that resulted in the *insured person's* inability to perform at least 2 of the 5 *activities of daily living* without assistance, as determined by an occupational therapist approved by Blue Cross.

Paralysis: Definitive diagnosis, by a *health practitioner* approved by Blue Cross, of the complete and permanent loss of use of 2 or more limbs as a result of a neurological deficit with measurable objective impairment that cannot be surgically or otherwise corrected.

Parkinson's Disease: Definitive diagnosis, by a certified neurologist approved by Blue Cross, of Primary Idiopathic Parkinson's Disease resulting in:

- neurological impairment to a degree that requires continuous supervision for health and safety, whether medicated or not; or
- an inability to perform at least 2 of the 5 *activities of daily living* without assistance, as determined by an occupational therapist approved by Blue Cross.

Senile Dementia: Definitive clinical diagnosis, by a certified neurologist or gerontologist approved by Blue Cross, of a progressive degenerative disease of the brain that has resulted in a significant reduction in mental and social functioning as demonstrated by:

- a loss of intellectual capacity and cognitive impairment;
- impaired memory and sense of judgment; and
- the need for continuous adult supervision for health and safety, whether medicated or not.

Severe Heart Attack: A heart attack, based on symptoms and diagnostic investigations, resulting in a permanent Functional Classification of at least a Canadian Cardiovascular Society (CCS) Class IV* as demonstrated by:

- a reduced ejection fraction (<40%) on echocardiogram or nuclear study with a large or multiple wall motion defects and reduced function as evidenced by stress testing as indicated above;
- severe left ventricular dysfunction or left ventricular aneurysm, reduced ejection fraction (<40%), and left main or three vessel disease (>70% narrowing) as seen on the coronary angiogram.

* Functional Classification CCS Class IV: Patients with cardiac disease resulting in the inability to perform any physical activity without discomfort. Symptoms of heart failure or anginal syndrome may be present even at rest. Discomfort is increased by any physical activity.

Severe Stroke: Cerebrovascular event caused by intracranial thrombosis, hemorrhage or embolism from an extra-cranial source that produces definite evidence of neurological sequelae that lasts more than 30 days and causes the *insured person* to:

- require continuous supervision for health and safety, whether medicated or not; or
- be unable to perform at least 2 of the 5 *activities of daily living* without assistance, as determined by an occupational therapist approved by Blue Cross.

Payment of Claims

The benefit amount is payable to the *member* after the expiration of the 30 day *elimination period* provided the *insured person* is still living at that time.

The benefit amount is payable once per lifetime per *insured person*.

Newborn Limitation

Dependent children are not insured until 15 days of age.

Exclusions and Limitations

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

a. a *pre-existing condition*;
b. an *accident*, unless the covered condition is a burn;
c. attempted suicide or voluntary injury or *illness*, whatever the state of mind of the *insured person*;
d. participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
e. any *accident* or injury occurring while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the *accident* occurs; or
f. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

When Coverage Ends

Coverage for the *member* will terminate at the end of the month prior to the month in which the *member* turns 65 years of age or upon termination of the *policy*.

Coverage for the *spouse* will terminate at the end of the month prior to the month in which the *spouse* turns 65 years of age, when the *spouse* no longer meets the definition of *spouse* under the *policy* or upon termination of the *policy*.

Coverage for *dependents* will terminate when neither the *member* or *member's spouse*, if applicable, is covered for this benefit under this *policy*, when the *dependent* no longer meets the definition of *dependent* under the *policy* or upon termination of the *policy*.

General Provisions

Eligibility Requirements

Only permanent residents of Quebec who are covered by *government health care coverage* (RAMQ) are eligible under this *policy*.

Insured persons must meet the definition of *member*, *spouse* or *child* and must complete applicable *waiting periods*.

You are responsible for enrolling your dependents under the plan when they become eligible and removing them when they no longer meet the definitions of spouse or child.

Proof of Health

Proof of health is needed for all *applications* to be approved for coverage. Any expense incurred by the *applicant* to supply *proof of health* is the responsibility of the *applicant*.

All statements provided by an *insured person* on a *proof of health* form with respect to any *application* for coverage or increase in coverage, other than fraudulent statements and omissions, will be incontestable by Blue Cross after the coverage or increase in coverage or the date of the last reinstatement has been in force for 2 consecutive years during the lifetime of the *insured person*.

Pre-existing conditions are not covered unless they have been declared on the *application* and have not been excluded or limited by an amendment. This provision applies to the *application* for reinstatement of the *policy* as well as to the original *application* for coverage.

Enrolment

To obtain coverage, an *applicant* must complete and submit their *application* form, in a format agreed upon by Blue Cross, and submit *proof of health*.

An *applicant* who applies for coverage must also apply for the same coverage for all eligible *dependents*. Individual selection of benefits is not permitted among *insured persons* under this *policy* unless approved through *medical underwriting*. *Insured persons* may be excluded for coverage, may receive a *substandard rate* or be declined for coverage due to health.

When Coverage Begins

Member and Dependents

Coverage for a *member* and *dependents* takes effect on the latest of the following dates:

- the effective date of the *policy*;
- the date the *member* or *dependent* meets all of the eligibility requirements;
- the date Blue Cross approves the *insured person's proof of health*; or
- the date of the live birth of a *child* born while this coverage is in force, with the exception of Critical Illness Benefits where the *child* must attain the age of 15 days.

Increase Coverage

To increase coverage, all *insured persons* require *medical underwriting*. However, existing Health or Drug Benefit coverage can be increased without *medical underwriting* if requested within 60 days of:

- adding a *child* or *spouse* to the *policy*;
- removing a *child* or *spouse* from the *policy*.

If the *insured person* does not already have coverage, *medical underwriting* will be required.

For example: if the *insured person* does not already have Drug Benefits, *medical underwriting* will be required to add Drug Benefits.

The Dental Benefit coverage can be increased without *medical underwriting*. Blue Cross may determine that the *waiting period* will begin on the first day the coverage increase takes effect.

The *member* must provide at least 1 calendar month's prior notice in writing.

Decrease Coverage

Members may decrease coverage at any time without *medical underwriting* by providing at least 1 calendar month's prior notice in writing.

Revisions

Blue Cross reserves the right to modify or reduce the benefits of *your policy* at any time. Any modification must be done so in writing and signed by an officer of Blue Cross. If a modification reduces benefits, Blue Cross must give the *applicant* at least one month's prior notice.

When Coverage Ends

Either the *member* or Blue Cross may terminate this *policy*, any benefit of the *policy* or any *dependent's* coverage at the end of any *policy* month by providing at least 1 calendar month's prior notice in writing. The written notice will be sent to the last address Blue Cross has recorded for *you* in our records.

If Blue Cross determines, at any time, that an *insured person* failed to fully disclose all pertinent medical information when applying for coverage under this *policy*, the *policy* becomes null and void from the date it was originally issued. Any claims paid by Blue Cross to the *member*, minus premiums paid for this *policy*, will be repaid by the *member* to Blue Cross.

Failure of the *member* to pay any premiums within 31 days of their due date results in termination of the *policy* without further notice from the date the premiums were due. Blue Cross may, at its discretion, agree to reinstate the *policy* if payment is made after the 31 day period.

Coverage also ends on the earliest of the date:

- this *policy* terminates;
- the *insured person* no longer meets one or more of the eligibility requirements, including the definition of *spouse* or *child*;
- the *insured person* reaches the termination age of specific benefits;
- the *insured person* dies; or
- the *insured person* commits a fraudulent act against Blue Cross.

Renewal

Unless Blue Cross provides prior notice to the contrary, this *policy* is renewed automatically on November 1st of each year, based on the provisions in effect on that date.

Policy Continuation for Dependents

A *child* or *spouse* who is no longer eligible under this *policy* may apply to enrol in their own *policy*. The *application* must be made within 60 days from the date they are no longer eligible. Any *pre-existing condition exclusions* or *substandard rates* that applied to the *dependent's policy* will continue on the new *policy*.

Proof of Claim

Proof of claim must be provided in writing and in a form acceptable to Blue Cross.

Before reimbursing a claim, Blue Cross has the right to:

- obtain any information needed to administer the claim;
- require that the *insured person* provide additional proof or information in support of their claim; and
- require that the *insured person* undergo a medical examination by a *physician* or *health practitioner* chosen by Blue Cross as often as considered necessary.

Blue Cross has the right to suspend or deny payment of a claim until any additional proof or information requested by Blue Cross has been submitted by the *insured person*.

The *insured person* is responsible for any costs associated with providing proof of claim.

Right to Audit

Blue Cross has the right, at any time, to inspect or audit the health and claim records of the *insured person* in relation to a claim for benefits. This right to inspect or audit applies to records held by Blue Cross or in the files of *approved providers* and may be exercised by Blue Cross or by a third party on its behalf.

Recovery of Overpaid Amounts

Blue Cross has the right to recover from an *insured person*:

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

If the excess amounts cannot be recovered, Blue Cross has the right to reduce future benefit payments to the *insured person* 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 an *insured person* 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 *insured person* 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 regards to the provider's conduct or practice.

Other Coverage and Excess Coverage Provision

This *policy* is classified as a supplemental benefit plan and covers expenses that are not covered under any other benefit or insurance plan, collectible or otherwise. Benefits under this *policy* are payable in excess of all other benefits.

The types of other plans that are subject to *coordination of benefits* include any form of group, individual, family, credit card, creditor, saving insurance, *government health care coverage*, workers' compensation, or private or auto insurance coverage that provides reimbursement for medical *treatment*, services or supplies.

In the event a court determines that this *policy* and any other individual or group policies provide primary coverage, the benefits payable under this *policy* will be coordinated with the other plan in accordance with the *CLHIA* guidelines. *Coordination of benefits* will be calculated to ensure the reimbursement from all sources does not exceed 100% of the cost incurred by the *insured person*.

Supplemental to Government Health Care Coverage

Unless otherwise agreed by Blue Cross, no payment will be made for any health care services or supplies payable or available under *government health care coverage* or *administered* by government funded *hospitals*, agencies or providers.

Blue Cross will pay *eligible expenses* in excess of *government health care coverage* allowances only where permitted by provincial legislation.

Duplicate Coverage

An *insured person* may not be covered under more than one Blue Cross *Personal Health Plan*. If an *insured person* is covered under more than one Blue Cross *Personal Health Plan* the maximums and limitations provided in the *policy* will apply as if they were only covered under one *policy* and that which provides the greater amount of coverage.

Subrogation

If an *insured person* is injured as a result of the actions of a third party:

- Blue Cross will:
  - pay all Health Benefits to which the *insured person* is entitled under this *policy*; and
  - be subrogated to the *insured person's* rights of recovery with respect to such benefits, including the right to sue the third party in the name of the *insured person*; and
- the *insured person* will:
  - sign any documentation that is required to give effect to the subrogation rights of Blue Cross; and
  - not release the third party from liability without the prior written consent of Blue Cross or take any other action that might jeopardize the rights of subrogation of Blue Cross. Any release signed by an *insured person* without the prior written consent of Blue Cross does not bind Blue Cross.

If the amount recovered by the *insured person* or Blue Cross from the third party is not sufficient to fully indemnify the *insured person*, the amount recovered, after deduction of the cost of recovery, is divided between Blue Cross and the *insured person* in proportion to which the loss was borne by them.

If funds have been advanced to any *insured person* by Blue Cross Travel Assistance, the *insured person* must reimburse these funds if payment is received from another carrier or *government health care coverage*, or if the services are considered ineligible at the time of the assessment.

Blue Cross may require an *insured person* to sign an acknowledgement that they are bound by this provision.

Limitation of Liability

As part of the benefits provided by this *policy*, Blue Cross may from time to time provide *insured persons* with information, recommendations or discounts with respect to *health practitioners*, *hospitals*, *approved providers* or other third party services or service providers. In all such cases, it is the *insured person's* responsibility to ascertain the quality of such services or service providers as well as their suitability for the *insured person's* needs. All *insured persons* agree that neither Blue Cross, nor its affiliates, representatives, employees, officers, directors or contracting parties, will be held responsible or liable for the actions, inaction, information, advice, products or services provided by third party service providers. All *insured persons* further agree that Blue Cross does not provide any insurance with respect to such third party actions, inaction, information, advice, products or services.

Member Premiums

The premiums payable by the *member* will be established from time to time by Blue Cross. Notification of any change in the amount of premiums will be made 1 month before the effective date of the change. All premiums must be paid in advance of the benefit period.

Reinstatement

The *policy* may be reinstated within 2 years of the date of lapse upon written *application*, submission of *proof of health* satisfactory to Blue Cross and payment of all overdue premiums. The *application* for reinstatement and any statements or agreements contained therein will constitute part of the *policy*.

Misstatement of Age

Premiums are based on the age of the oldest *insured person* and benefits are based on the age of the *insured person* at the time of the event resulting in a claim. If Blue Cross discovers the age used is inaccurate, premiums and benefits will be adjusted to correspond to the amounts that would have been provided if the age had not been misstated.

If the *insured person* is not eligible for coverage due to age, the coverage will be voided and a fair adjustment of premiums between Blue Cross and the *member* will be made for the time the coverage based on the misstated age was in force.

Beneficiary

All benefits are payable to the *member*. If a *member* dies, any death benefit will be payable to the *member's* estate.

Assignment

An *insured person* or beneficiary is not allowed to assign any interest in the coverage or benefits provided under this *policy*. However, in certain circumstances, Blue Cross may permit assignment to an *approved provider*.

Legal Currency

All payments and benefit amounts referred to in this *policy* are payable in Canadian currency, unless otherwise stated.

Conformity with Existing Laws

Any provision of this *policy* that is in conflict with any applicable provincial or federal law of the *member's* province of residence is considered automatically amended to conform to the minimum requirements of that law.

Reporting Health Insurance Fraud

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

As a *member*, *you* can help us eliminate fraudulent abuse of *your* plan by keeping *your* ID card and related information confidential and secure. If *you* are unclear about any of the charges on *your* receipt, ask *your* provider to explain the charges to *you* and carefully review *your* claim statements for any discrepancies in services received compared to services claimed.

Protecting *Your* Personal Information

CONSENT

Extent of Consent

By purchasing a Blue Cross *Personal Health Plan*, *you* consent to the collection, use, retention, and disclosure of *your* personal information and the personal information of *your* dependents, if any, by the *insurer* in accordance with the terms of this *policy* and our privacy policy as amended from time to time and available on our website at the addresses listed below (hereinafter our "**Privacy Policy**") or otherwise in accordance with applicable privacy laws. For greater clarity, "**personal information**" for the purposes of this *policy* means any information about the insured that can directly or indirectly identify the *insured person*.

Withdrawal of Consent

You may withdraw *your* consent at any time, subject to any legal restrictions. However, if *you* withdraw this consent, *you* understand that we will be unable to provide you with coverage for your *Personal Health Plan policy*. We therefore reserve the right to terminate this *policy* immediately.

Privacy Policy

Our Privacy Policy is constantly evolving and will apply to the various interactions we may have with *you* during the term of this *policy*, such as when *you* interact with us on our website, send us new personal information via web or paper forms or over the phone, deposit documents on our secure deposit sites, or by any other means.

We regularly update our Privacy Policy, which is written in a simple, clear, and transparent manner. We want to help *you* better understand our privacy practices. We invite *you* to review the policy and come back to us with any questions *you* may have about it. A link to our Privacy Policy and our contact information are listed below.

CONFIDENTIALITY OF *YOUR* PERSONAL INFORMATION

Protecting the privacy of our policyholders is important to us. Our teams place great importance to our security and privacy policies and procedures. We have excellent privacy training and awareness programs that are mandatory for all our employees. We are committed to enforcing our Privacy Policy at all times in a manner consistent with applicable privacy and confidentiality laws.

COLLECTION OF *YOUR* PERSONAL INFORMATION

At the time of *your application* for coverage under this health plan and at any time thereafter when collection of *your* personal information is required, we may collect and retain *your* personal information to determine *your* eligibility, administer *your* insurance *policy*, recommend products and services to you, and for any other purpose specified in our Privacy Policy.

We may collect personal information about you, such as:

- Identification information (e.g., name, mailing address, telephone number, date of birth, email address, etc.);
- Authentication information (e.g., username, IP address, password, etc.);
- Financial information (e.g., employment, bank name, bank account number, transaction amount, etc.);
- Medical information (e.g., *your* medical records, medical history, health checkup information, lifestyle information, information about a medical procedure *you* may have undergone, etc.);
- Information about *your* products and services (e.g., insurance policy number, names and contact information of beneficiaries, claim information, etc.);
- Information about communications arising from *your* relationship with us;
- Any other information necessary to provide products and services.

We may collect *your* personal information directly from *you* or through our representatives. We may also collect such personal information from other sources, including but not limited to any *physician*, healthcare professional, *hospital*, clinic, pharmacy, other medical or related facility, or insurance company, the government, regulatory authorities, or other body, institution, or person with records or information about *you* or *your* health. In all cases, we undertake to obtain your consent prior to the collection of *your* personal information, whether it is collected by us directly or through a third party (except to the extent that collection from a third party is permitted by law).

USE OF *YOUR* PERSONAL INFORMATION

In order for us to administer *your* insurance *policy*, depending on *your* type of coverage and the various interactions we may have with *you* during the term of this *policy*, personal information that *you* provide to us or that is collected from a third party may be used, for example, for the following purposes:

- Verify *your* identity;
- Assess *your* eligibility for the products and services requested;
- Provide the products and services described in the *policy* for which *you* are eligible;
- Administer *your* products and services;
- Process a transaction for the purchase of a service or product;
- Process and pay *your* claims and settlements or any other request;
- Provide *you* with our medical and travel assistance services;
- Provide *you* with personalized promotional offers and special discounts;
- Communicate with *you*;
- Fulfill internal administrative purposes;
- Detect and prevent security breaches and fraud and conduct investigations where required; and
- As permitted or required by law.

DISCLOSURE OF *YOUR* PERSONAL INFORMATION

For these purposes, we may disclose *your* personal information to our representatives and to certain third parties to whom it is necessary to disclose it for the purposes for which it is collected, including but not limited to our employees, officers, directors, representatives, consultants, and subsidiaries, other Canadian Blue Cross organizations, our reinsurers, partners, subcontractors, and service providers, or any third party authorized by law or regulation.

Third parties may include other insurance companies, the government, regulatory agencies, and financial institutions. Medical information may also be disclosed to *your physician* or other specialized healthcare provider, if applicable, in accordance with applicable laws.

We limit the information we provide to authorized individuals to only that information that is necessary for them to perform their duties.

Also note that *your* personal information may be saved and disclosed outside *your* province of residence. For example, *your* personal information may be stored on cloud-based solutions, which may require the transfer of data outside *your* province of residence or even Canada.

RETENTION OF *YOUR* PERSONAL INFORMATION

In general, our goal is to retain *your* personal information only for as long as necessary to fulfill the purpose for which we obtained it. However, *you* should understand that in order for us to comply with legal or regulatory requirements, we may be required to retain *your* personal information for longer periods. To this end, we have established a data retention schedule based on these legal or regulatory requirements that is available to all our employees. The retention schedule helps our team better manage *your* personal information and ensure it is retained in accordance with legislation and regulations applicable to Blue Cross.

At the end of the retention period as set out in our data retention schedule, *your* personal information is securely destroyed and/or anonymized in accordance with applicable laws, industry best practices, and security practices adopted by Blue Cross from time to time.

YOUR PRIVACY RIGHTS

Access to *Your* Personal Information

Upon receipt of a written request from *you*, we will provide *you* with access to *your* personal information to verify its accuracy or completeness and, if necessary, *you* may request that *your* personal information be updated and/or corrected.

You may also request a copy of *your* personal information in our possession. A reasonable fee may be charged to cover reproduction and handling costs. *You* will be informed of the costs before the documents are reproduced.

Correction of *Your* Personal Information

If *you* believe that the personal information we have about *you* is inaccurate or incomplete, *you* may make a written request to correct that personal information. We will make the necessary changes.

HOW TO CONTACT US

For any additional information about the handling or management of *your* personal information, *you* can review our Privacy Policy on our website or write to us at:

Canassurance Insurance Company
c/o **Chief Privacy Officer**
1981, McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6

By email:

privacyofficer@qc.bluecross.ca

Privacy Policy Website:

Privacy Protection Practices| Blue Cross Health

Statutory Conditions

The Policy

The *application*, this *policy*, any document attached to this *policy* when issued, and any amendment to the *policy* agreed upon in writing after the *policy* is issued, constitute the entire *policy*, and no representative has authority to change the *policy* or waive any of its provisions.

Waiver

The insurer shall be deemed not to have waived any condition of this *policy*, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

Copy of Application

The insurer shall, upon request, furnish to the insured or to a claimant under the *policy* a copy of the *application*.

Material Facts

No statement made by the *member* or *insured person* at the time of *application* for this *policy* shall be used in defense of a claim under or to avoid this *policy* unless it is contained in the *application* or any other written statements or answers furnished as evidence of insurability.

Notice and Proof of Claim (for Accidental Death and Dismemberment and Critical Illness coverage)

The *member* or an *insured person*, or a beneficiary entitled to make a claim, or the *representative* of any of them, shall:

a) give written notice of claim to the insurer
   (i) by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the province, or
   (ii) by delivery thereof to an authorized representative of the insurer in the province, not later than 30 days from the date a claim arises under the *policy* on account of an *accident* or sickness;
b) within 90 days from the date a claim arises under the *policy* on account of an *accident* or sickness, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening of the *accident* or the commencement of the sickness and the loss occasioned thereby, the right of the claimant to receive payment, their age, and the age of the beneficiary if relevant; and
c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the *accident* or sickness for which claim may be made under the *policy*.

For all other benefits, please see the following.

Failure to Give Notice or Proof (for Accidental Death and Dismemberment and Critical illness coverage)

Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the *accident* or the date a claim arises under the *policy* on account of sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms for Proof of Claim

The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit their proof of claim in the form of a written statement of the cause or nature of the *accident* or sickness giving rise to the claim and of the extent of the loss.

Notice and Proof of Claim and Failure to Give Notice or Proof for all Benefits Other than Accidental Death and Dismemberment and Critical Illness.

Notice and proof of claim shall be given to Blue Cross within 4 months of the date of service. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it is not reasonably possible, in the discretion of Blue Cross, to furnish the proof within such time, provided such proof is given within 12 months of the date of service.

If the *policy* terminates and proof of claim is not given to Blue Cross within 4 months of the date of the *policy* termination, then the claim shall be invalid.

Rights of Examination

As a condition precedent to recovery of insurance moneys under this *policy*,

a) the claimant shall afford to the insurer an opportunity to examine the *insured person* when and so often as it reasonably requires while the claim hereunder is pending; and
b) in the case of death of the *insured person*, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

When Money is Payable

All moneys payable under this *policy* shall be paid by the insurer within 60 days after it has received proof of claim.

General Exclusions and Limitations

Regardless of the benefit provisions of this *policy*, the obligation of Blue Cross to provide all benefits under the *policy* is limited in accordance with the provisions below.

Pre-existing conditions are not covered unless they have been declared on the *application* and have not been excluded or limited by amendment. This applies to the *application* for reinstatement of the *policy* as well as to the original *application* for coverage.

No payment will be made for charges:

a. that do not meet the definition of *eligible expenses*;
b. covered under any *government health care coverage*, or that were covered by such coverage when this benefit was issued but have since been modified, suspended or discontinued;
c. payable under any occupational health and safety board, workers' compensation board, automobile insurance bureau or other similar law or public plan;
d. for services received free of charge or which are normally available without cost, or at nominal cost, under any government statute in force on the effective date of this *policy*.
e. that would not have been incurred if no coverage existed;
f. that are not *medically necessary*, for cosmetic purposes only, elective in nature, or *experimental or investigative*;
g. related to family planning (except for intrauterine contraceptive devices (IUDs)), 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. normally intended for recreation or sports;
i. for spares or alternates;
j. for missed appointments or the completion of forms or medical certificates;
k. for medical examinations or routine general checkups (with the exception of dental);
l. for mileage or delivery charges to or from a *hospital* or *health practitioner*;
m. resulting from:
    i. attempted suicide or voluntary injury or *illness*, whatever the state of mind of the *insured person*;
    ii. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    iii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or conviction is obtained;
n. for health care services (with the exception of Travel benefits) obtained by an *insured person* outside Canada;
o. required for the treatment of addictions;
p. not listed as a benefit in this *policy*;
q. necessitated by an *illness* or an *accident* occurring before this *policy* was in force;
r. incurred before the effective date of this *policy*; or
s. incurred after the termination date of the *insured person's* coverage, even if a detailed *treatment* plan was submitted and accepted by Blue Cross before this date.

Definitions

The following definitions apply to all benefits in this *policy* when written in *italics*.

Accident: A sudden, fortuitous and unforeseeable event that:
- is violent in nature;
- arises solely from external means;
- causes bodily injury to the *insured person* directly and independently of all other causes; and
- is unintended by the *insured person*.

The resulting injury to the *insured person* must be certified by a *physician*.

Activities of Daily Living: The following 5 activities:
- Eating: The ability to manipulate prepared food or liquid into the mouth;
- Dressing: The ability to put on and remove necessary articles of clothing that are normally worn, including leg braces;
- Bathing: The ability to cleanse the entire body using soap and water, including turning on faucets and shower mechanisms, getting into and out of the bath or shower and drying oneself;
- Ambulation: The ability to move independently from place to place with or without the use of mobility aids; and
- Toileting (including continence, which is the ability to control bowel and bladder function): The ability to use a toilet, bedside commode or urinal.

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.

Administered: To have managed or supervised the use of, dispensed or furnished a benefit.

Aircraft: A certified passenger *aircraft* provided by a regularly scheduled airline on any regularly scheduled flight.

Applicant or Member: The person named on the *application* for coverage under this *policy* and whose *application* has been accepted by Blue Cross.

Application: The original and any subsequent *application* forms completed and signed by the individual seeking coverage, as well as any other forms providing medical evidence.

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

Calendar Year: The period of time commencing the first (1st) day of January in a given year and ending the 31st day of December the same year. Where benefit maximums or limitations refer to a period of multiple years, that period refers to consecutive *calendar years*.

Child: A person who:
- is a resident of Quebec;
- is covered by *government health care coverage*;
- is a natural or adopted *child* of the *member* or *spouse*, or a *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 if they are incapable of engaging in any substantially gainful activity and are financially reliant on the *member* 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.

Note: A *child* may be added to a *policy* without satisfying medical requirements if *application* is made within 60 days of birth or adoption, unless otherwise stated.

Blue Cross must be notified of any *dependents* 21 years of age and over (up to their 26th birthday) who are full-time students at an accredited school, university or college. The *member* is responsible for notifying Blue Cross when *dependents* no longer meet the definitions outlined here.

CLHIA: Canadian Life and Health Insurance Association

Coordination of Benefits: If a *member* or their *spouse* has coverage under additional benefit plans, they may be able to enjoy reimbursement for up to 100% of eligible claims through *Coordination of Benefits* (COB) outlined by the *CLHIA*.

Co-payment: The percentage or dollar amount of *eligible expense* that must be paid by the *member* prior to benefits becoming payable by Blue Cross.

Covered Condition(s): *Covered conditions* as defined in the Critical Illness Benefit Provision.

Dependent: The *spouse* or *child* of a *member*. *Dependents* must be named in the *application* for enrolment or in any subsequent *application* accepted by Blue Cross.

Eligible Expenses: Charges incurred by the *insured person* for health care services and supplies that are:

- *medically necessary*;
- usual, customary and reasonable, meaning that:
  - the amount charged is 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
  - the frequency and quantity in which services or supplies are purchased by the *insured person* are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the *insured person*'s condition;
- recommended or prescribed by a *physician* or *health practitioner* who:
  - does not normally reside in the *insured person's* home;
  - is not the *insured person's family member*;
- rendered or dispensed by an *approved provider* who:
  - does not normally reside in the *insured person's* home; and
  - is not the *insured person's family member*; and
- rendered or dispensed after the effective date and while this *policy* is in effect, unless otherwise specified.

Health care services and supplies that *insured persons* 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 *insured person*. Reimbursement for *eligible expenses* incurred outside the *insured person's* province of residence will be limited to the amount that would have been reimbursed if the expense had been incurred in the *insured person's* province of residence, unless stated otherwise. Benefits are restricted to in Canada only, with the exception of Travel Benefits.

Where more than one form or an alternative form of *treatment* exists, Blue Cross has the right to base 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.

Eligible expenses are subject to post-payment audit in accordance with the Right to Audit provision found in the General Provisions of this *policy*.

Experimental or Investigative: Any *treatment*, procedure, facility, equipment, drug, drug usage or vitamin therapy 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.

Family Member: A *member*'s:

- *spouse*;
- father or mother, or their spouse or common-law partner;
- *children*, or the *children* of the *insured person*'s spouse or common-law partner;
- brothers and sisters;
- grandchildren; or
- grandparents.

Government Health Care Coverage: Any plan, program or arrangement under the administrative or regulatory control of any government in Canada that is universally available to all residents of a particular province or territory and provides coverage, in whole or in part, for comprehensive health care benefits, services or supplies.

Group Health Benefit Plan (Group Health Benefits): An employer-sponsored health benefit plan consisting of 3 or more employees.

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*.

Hospital: A licensed *acute care* facility. 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.

In reference to travel, a *hospital* means a facility that:

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

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

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

Insured person: The *member* or *dependent* who has been approved for coverage under this *policy*.

Loss of Group Health Benefits: In reference to the Assured Access Benefit, when the *insured person* has lost *group health benefits* through termination of employment, employer termination of the *group health benefit plan*, retirement or when the *insured person* no longer qualifies as a *dependent* under the *group health benefit plan*.

An *insured person* making a decision to opt out of their *group health benefit plan* does not qualify as a *loss of group health benefits* under this *policy*. If an *insured person* decides to opt out of their *group health benefit plan*, the *insured person's* coverage under this *policy* will terminate immediately.

Medical Underwriting: A process undertaken by Blue Cross to determine acceptance of an *applicant's* request for Health benefits based on medical evidence.

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*.

Member or Applicant: The person named on the *application* for coverage under this *policy* and whose *application* has been accepted by Blue Cross.

Newborn Child: A *child* 31 days of age or under.

Personal Health Plan: Plan offered and approved by Blue Cross that provides insured medical expense benefits in return for monthly *member* premiums.

Physician: A doctor of medicine who is licensed in the jurisdiction in which the services are provided to prescribe and administer medical *treatment* and drugs within the scope of their licence.

Policy: This *policy*, letter, *application* and any subsequent amendments.

Pre-existing Condition: An injury, sickness, disease, medication or *treatment* that first presented itself on or before the date of the *application* for this *policy*, the effective date of the *policy* or the date of the last reinstatement.

Pre-existing Condition Exclusion: An amendment to this *policy* that defines *treatment* of a *pre-existing condition* as being excluded as an eligible benefit upon acceptance of this *policy*.

Proof of Health: Statements or medical evidence about an *insured person's* health as requested by Blue Cross at any time. *Proof of health* must be submitted on forms approved by Blue Cross for that purpose.

Reimbursement level: The percentage Blue Cross will pay for approved *eligible expenses*.

Spouse: The person who:

- is a resident of Quebec;
- is covered by *government health care coverage*; and
- meets one of the following criteria:
  - is married to the *member*;
  - has been living with the *member* in a conjugal relationship for at least 1 year; or
  - resides at the same address as the *member*, does not qualify as a *dependent child* under the *policy* and is named in an *application* by the *member*.

A *spouse* may be added to a *policy* without satisfying medical requirements if *application* is made within 60 days of marriage, unless otherwise specified. 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.

Substandard Rates: The basis on which a *policy* is issued subsequent to the *medical underwriting* process. This may include charging a rate that is higher than the standard rate or applying exclusions for benefits under the *personal health plan* for pre-existing medical conditions.

Treatment: Management and care of an *insured person* to improve or cure an *illness*, disorder or injury. This management and care must:

- be considered appropriate and approved by Blue Cross;
- be prescribed, provided or performed by a *health practitioner* or *physician* practicing in the field of medicine applicable to the *insured person's* disease, disorder or injury; and
- result in charges that are usual, customary and reasonable, meaning:
  - the amount charged is consistent with the amount generally charged by *health practitioners* for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the *insured person* are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the *insured person's* condition.

Waiting Period: The continuous period of time during which an *insured person* must be covered before being eligible for a claim reimbursement. Blue Cross may determine the waiting period begins on the first day of the benefit's effective date or the first day the coverage increase takes effect. Waiting periods are specified in the Benefit Summary.

You or Your - refers to the *insured persons* covered by this *policy*.

NOTES

NOTES

WE MAKE IT EASY

Flexible, personal, and affordable options.

WE'RE HAPPY TO HELP

Expert advice from our friendly, knowledgeable staff.