

Your Group Benefits Booklet

PLATO Testing

All Employees

Plan Number:
91024

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MEDAVIE BLUE CROSS™

PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and travel coverage, Medavie Blue Cross collects, uses and stores certain personal information about its members and their dependents. Protecting personal information is not new to us. Ensuring the privacy of client information has always been fundamental to the way we do business.

The purpose of our **privacy statement** is to keep you informed about privacy protection practices at Medavie Blue Cross. In addition to this privacy statement, we have an **online privacy statement** that describes our practices for protecting your personal information when you use our websites and mobile applications and a **Medavie Blue Cross mobile app privacy policy** that applies to your use of our mobile app.

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

ABOUT THIS BOOKLET

Medavie Blue Cross underwrites the following benefits:
- Hospital Benefit
- Worldwide Travel Benefit
- Referrals for Services Outside Canada
- Extended Health Benefit
- Vision Benefit
- Drug Benefit
- Dental Benefit

Medavie Blue Cross provides the following benefits:
- inConfidence - Employee & Family Assistance Program (EFAP)
- Second Opinion®

Blue Cross Life Insurance Company of Canada underwrites the following benefits:
- Group Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment
- Long Term Disability

The information contained in this booklet summarizes the important features of your group program; is prepared as information only; and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefit program are described in the group policy held by your employer.

Where legislated, you have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to the Company as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross.

Every action or proceeding against an insurer (i.e. Medavie Blue Cross) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

This booklet replaces any previously issued booklet.

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HOSPITAL BENEFIT

If you (or your dependents, if applicable) incur charges in Canada for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Co-insurance: 100%

HOSPITAL ROOM
The difference between standard ward accommodation and semi-private room accommodation.

TERMINATION
Hospital benefit ceases at the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Hospital Benefit is paid directly to the hospital. Your identification card should be shown at the hospital who will arrange to bill Medavie Blue Cross directly.

To make a claim, complete the claim form that is available from the hospital.

Claims must be submitted within four (4) months and no later than 24 months of receiving services or supplies or the end of your Hospital benefit.

EXTENDED HEALTH BENEFIT

If you (or your dependents, if applicable) incur charges in Canada for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below, less the amount allowed under any government health program. Benefit maximums are applied on a per person basis.

Co-insurance: 100%

DIAGNOSTIC AND X-RAY SERVICES
Charges for laboratory service and X-ray examinations.

OXYGEN
Charges for oxygen.

PHYSICIAN SERVICES
Charges outside the covered person's province of residence in excess of the allowance under a government health plan.

PRIVATE DUTY NURSING
Maximum: $10,000 in a calendar year

Charges for medically necessary home nursing care performed by a registered nurse, registered nursing assistant or certified nursing assistant at your residence (other than a convalescent or nursing home) on the written authorization of the attending physician.

All nursing services must be pre-approved by Medavie Blue Cross in order to be considered for reimbursement.

PROFESSIONAL AMBULANCE
Maximum: $1,000 in a calendar year

Professional ambulance to and from the nearest facility able to provide essential care. Air transportation, on the written authorization of the attending physician, for a stretcher patient, up to six economy seats on a regularly scheduled flight.

SPECIAL AMBULANCE ATTENDANT
Maximum: $500 in a calendar year

Travel expenses of a Registered Nurse (not a relative) when medically necessary and approved by Medavie Blue Cross.

EXTENDED HEALTH BENEFIT

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below, less the amount allowed under any government health program. Benefit maximums are applied on a per person basis.

Co-insurance: 100%

ACCIDENTAL DENTAL
Dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered or approved for payment by Medavie Blue Cross within 180 days of the accident. Benefits will be paid up to the usual and customary fee of the current Dental Association Fee Guide for general practitioners in your province of residence at the time of treatment.

DIABETIC EQUIPMENT
Maximum: $200 in a calendar year

Charges for the following equipment used for treatment and control of diabetes: preci-jet, glucometer, or equipment approved by Medavie Blue Cross that performs similar functions.

DIABETIC SUPPLIES
Charges for needles, syringes, swabs, test tapes, and lancets prescribed by a physician.

GLUCOSE MONITORING SYSTEMS
Including continuous glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes, to a maximum of $4,000 per Calendar Year

HEALTH COACHING AND CHRONIC DISEASE MANAGEMENT
Charges include the following services for medical conditions deemed eligible by Medavie Blue Cross: initial assessment, counselling and follow up sessions, education relating to symptom management, medication usage, and development of action plans. The overall maximum Eligible Expense is $500 per Calendar Year.

HEARING AIDS
Maximum: $700 in three consecutive calendar years. Dependent children less than 21 years of age, requiring a hearing aid for each ear, are eligible for two hearing aids (one for each ear) to a maximum eligible expense of $700 for each hearing aid in three (3) consecutive calendar years.

Charges for hearing aids (excluding batteries and exams) when prescribed by an otolaryngologist, otologist and/or registered audiologist.

INTRAUTERINE CONTRACEPTIVE DEVICES
Maximum: $75 in 24 consecutive calendar months

Purchase of an intrauterine contraceptive device (IUD).

MEDICAL COMPRESSION GARMENTS
Charges for the purchase of medical compression garments when prescribed by a Physician up to a maximum of $200 in a Calendar Year.

MEDICAL SUPPLIES AND EQUIPMENT
Charges for the purchase of burn pressure garments to a maximum eligible expense of $500 per calendar year and charges for rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair, hospital-type bed, equipment for the administration of oxygen and transcutaneous electrical nerve stimulator (TENS machine) on the written authorization of a physician. The TENS machine is limited to a maximum eligible expense of $300 in five (5) consecutive calendar years.

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every five consecutive calendar years.

ORTHOPEDIC SHOES & SUPPLIES
Maximum: Orthopedic Shoes: $200 in a calendar year
Orthopedic Supplies: $300 in a calendar year

Charges for orthopedic shoes when customized with special features to accommodate, relieve or remedy some mechanical foot defect or abnormality, when prescribed by an orthopedic surgeon, physiatrist, rheumatologist or the attending physician. Also, charges for shoe modification, adjustments supplies, and/or molded arch supports when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

OSTOMY SUPPLIES
Charges for essential ostomy supplies.

MENTAL HEALTH PRACTITIONERS

Co-insurance: 80%

Maximum: $1,500 in a calendar year

Charges for treatment, except when performed in a hospital, by a licensed clinical psychologist, social worker, psychotherapist, clinical counsellor or psychoeducator.

OTHER PRACTITIONERS

Co-insurance: 80%

Maximum:	$750 per practitioner in a calendar year
	$50 for X-rays in a calendar year per practitioner
Overall maximum:	$1,500 in a calendar year

Charges for treatment, except when performed in a hospital, by a licensed speech therapist, massage therapist/kinotherapist/ orthotherapist, chiropractor, osteopath, chiropodist/podiatrist/foot care nurse, physiotherapist/athletic therapist/physiotherapy technologist, acupuncturist, naturopath, homeopath, dietitian, occupational therapist and audiologist.

PROSTHETIC APPLIANCES

Remedial appliances or supplies including artificial limbs, breasts, eyes, crutches, a cane, splints, casts, trusses and braces. Replacement must be due to pathological or physiological change. Repairs and/or adjustments are provided to a maximum eligible expense of $300 in a calendar year.

Hair prosthetics (wigs), when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $300 per lifetime. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

SPEECH AIDS

Maximum: $500 in a lifetime

Speech aid equipment, (approved by a qualified speech therapist and the attending physician), for persons who do not have normal oral communication ability.

TERMINATION

Extended Health Benefit ceases at the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM

Extended Health Benefit is reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt. You may obtain claim forms from your employer or provider of service as appropriate.

To make a claim, complete the claim form that is available.

Claims must be submitted within four (4) months and no later than 24 months of receiving services or supplies or the end of your Extended Health Benefit.

VISION BENEFIT

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Co-insurance: 100%

CONTACT LENSES DUE TO DISEASE
Maximum: $200 every two consecutive calendar years

Charges for contact lenses when medically necessary on the written authorization of the attending physician for; ulcerated keratitis, severe corneal scarring, keratoconus or aphakia, provided sight can be improved to at least the 20/40 level.

EYE EXAMINATIONS
Maximum: one eye examination every 24 consecutive months for adults and every 12 consecutive months for dependent children less than 21 years of age

Charges of a licensed optometrist or ophthalmologist for eye examinations.

LENSES, FRAMES AND CONTACT LENSES
Maximum: $150 every 24 consecutive months for adults and every 12 consecutive months for dependent children less than 21 years of age

Charges for corrective eyeglasses, including lenses, frames and contact lenses, but excluding safety glasses or glasses/contacts for cosmetic purposes.

VISUAL TRAINING
Maximum: $150 in a lifetime

Charges of a registered, licensed optometrist or ophthalmologist for visual training and remedial eye exercises.

TERMINATION
Vision benefit ceases at the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Vision benefit is reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt.

Claims must be submitted within 24 months of receiving services or supplies or within four months of the contract termination date.

DRUG BENEFIT

If you (or your dependents, if applicable) incur charges for drugs legally requiring a prescription in order to be dispensed, the eligible drug may be subject to quantity maximums and dollar maximums. All eligible expenses are considered less the amount allowed under any government health program or as approved by Medavie Blue Cross. Benefit maximums are applied on a per person basis.

Co-payment:	**20% for each eligible drug on the prescription**
Co-insurance:	**100% of the remaining eligible expense**
Method of payment:	**paid directly to the pharmacy**

Includes prescription drug items approved by Medavie Blue Cross and certain over-the-counter items that are considered life-saving in nature and that are approved by Medavie Blue Cross.

Drug Formulary

- Open Formulary

Additional Benefit Modules

- fertility drugs to a lifetime maximum of $5,000
- weight management drugs (Prior authorization required)

Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums, dollar maximums, deductibles, co-payments or other maximums as approved by Medavie Blue Cross.

Eligible drug expenses include medically necessary items that, by law, can only be obtained with a prescription of a physician or dentist, that are authorized as benefits by Medavie Blue Cross, and are dispensed by an approved provider.

EXCLUSION

If you (or your dependents, if applicable) are eligible for drug benefits under the Non-Insured Health Benefits (NIHB) Program of Health Canada's First Nations and Inuit Health Branch, no benefits will be paid for drugs listed in the NIHB drug benefit list or which are covered under the NIHB Program on an exception or limited use basis.

TERMINATION

Drug Benefit ceases at the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM

Drug benefits are paid directly to the pharmacy.

The Medavie Blue Cross Identification Card should be shown and the provider will arrange to bill Medavie Blue Cross directly.

WORLDWIDE TRAVEL BENEFIT

The Group Travel plan covers a wide range of benefits that may be available following an accident or unexpected illness incurred outside the covered person's province of residence while this plan is in effect. Payment is subject to the maximum amounts and co-insurance amount indicated below, less the amount allowed under any government health program. Benefit maximums are noted in Canadian currency.

Medavie Blue Cross will pay the usual, customary and reasonable charges for the following eligible expenses. These benefits are subject to any deductible, co-insurance or maximum amounts specified below.

Co-insurance: 100%
Coverage Duration: limited to the first 180 days of a trip if under age 65, limited to the first 60 days of a trip if over age 75
Trip Cancellation and Interruption: $5,000 per trip
Baggage Coverage $500 per trip

ACCIDENTAL DENTAL
Maximum: $1,000

Charges as a result of an accidental injury (direct accidental blow to the mouth) where natural teeth have been damaged, or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by Medavie Blue Cross within 180 days of the accident and be supported by details of the accident.

AMBULANCE
Normal charges for ambulance service, including air ambulance and evacuation to and from the nearest qualified medical facility.

COMING HOME
Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the covered person must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, the benefit covers:

- two economy seats by most direct route to the patient's home city in Canada, one for the covered person and one round trip fare for a medical attendant;
- the number of economy seats required to accommodate the covered person if on a stretcher and one round trip fare for a medical attendant.

DIAGNOSTIC SERVICES
Charges for laboratory services for diagnostics and X-rays when ordered by the attending physician.

DRUG BENEFITS
Charges for drug benefits in a quantity sufficient for the period of travel. Payment of eligible drugs will be made only when proof of purchase is supplied in the form of an account from a Medavie Blue Cross approved provider located outside the covered person’s province of residence and showing the name of the preparation, date of purchase, quantity, strength and total cost.

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EMERGENCY AND PAYMENT ASSISTANCE

The services of a 24-hour emergency hotline are available to covered persons who need assistance while travelling. By telephoning the appropriate number on your Medavie Blue Cross identification card when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or coordinated on behalf of the covered person. In addition, the following services are offered.

Medical Assistance - the covered person may call for a list of hospitals or medical facilities and arrangements will be made for:

- advice from a qualified physician,
- medical follow-up of the covered person's condition and communication with the employee and family,
- return home or transfer of covered person if medically permissible,
- transport a family member to the covered person's bedside or to identify the deceased.

Non Medical Assistance - the covered person may call to obtain:

- an emergency response in any major language,
- emergency assistance in contacting the family or business,
- referral to legal counsel.

HOSPITAL ACCOMMODATION

The cost of a public general hospital, less the amount allowed under the provincial government health plan, for (a) room accommodation (not a suite) and (b) medically necessary inpatient and outpatient services.

MEALS AND ACCOMMODATION

Maximum: $1,200 ($150 per day for eight days) per trip

Charges for extra costs of commercial accommodation and meals incurred by a covered person, remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

MEDICAL APPLIANCES

The cost of casts, canes, crutches, slings, splints, trusses, braces and/or temporary rental of a wheelchair when required due to an accident or sudden illness that occurs outside the province of residence and when ordered by a physician.

NURSE

Charges for private duty nursing (not a relative of the patient or an employee of the hospital) when ordered by an attending physician.

PARAMEDICAL SERVICES
Charges made by a licensed chiropractor, osteopath, chiropodist/podiatrist or physiotherapist (not a relative), in excess of payment by the provincial government health plan, excluding charges for X-rays.

PHYSICIANS AND SURGEONS
Customary charges by physicians and surgeons for services rendered, less the amount allowed under the provincial government health plan.

RETURN OF DECEASED
Maximum: $3,000

Charges for the cost of preparation and homeward transportation of the deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

TRANSPORTATION TO VISIT THE COVERED PERSON
Charges for one return economy fare by the most direct route for transportation costs (air, bus, train) when the covered person has been confined to hospital or has died, and the attending physician has advised of the necessity of the attendance of a family member or close friend of the covered person.

VEHICLE RETURN
Maximum: $500

Charges for the cost of driving the covered person's vehicle, either private or rental, by commercial agency to the covered person's residence or nearest appropriate vehicle rental agency when the covered person is unable to return it due to sickness or accident.

EXCLUSIONS

1. No benefits are available under the plan for the covered person travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.

2. No benefits are available under the plan for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the covered person has returned to Canada or (c) which the covered person elects to have rendered or performed outside of Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.

3. Benefits under the plan will not be paid if the covered person receives the same from a third party.

4. No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol, suicide or attempted suicide, criminal acts, war or other hostilities.

5. Medavie Blue Cross, in consultation with the attending physician, reserves the right to return the patient to Canada. If any covered person, based on medical evidence is able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition that requires continuing medical services, treatment or surgery, and the patient elects to have such treatment or services rendered, or surgery performed, outside Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan. Medavie Blue Cross accepts no responsibility in the event of deterioration of the covered person's medical condition during or after the transfer back to Canada.

6. Coverage is limited to expenses incurred as a result of a sudden illness or accident which occurs outside the participant's province of residence. Pre-existing conditions will be covered as a benefit, provided the condition is stable prior to travel, and when medical attention is not anticipated during the travel period.

   A pre-existing condition is considered stable if you, in the 90 days before the departure date, have not:

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

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

***EXCLUSIONS* (*Cont'd*)**

7. This policy excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:

   a) expenses incurred while travelling in a country (or a 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; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

8. Coverage is limited to amounts that are in excess of coverage provided by any other plan. Where a court determines that the policy and any other plan(s) provide primary coverage, the benefit will be co-ordinated with the other plan, as described in the Co-ordination of Benefits section.

9. Expenses in excess of $2 million Canadian per covered person, per incidence outside the province of residence.

   All claims and required government forms must be submitted within four (4) months of the date of service.

TRIP CANCELLATION BENEFIT

The amount of benefits of the Trip Cancellation Benefit is limited to expenses that cannot be reimbursed at the time of the event causing the cancellation, subject to a maximum of $5,000 per participant per event giving rise to claim.

NOTIFICATION

Upon the occurrence, prior to the departure date, of an event listed amongst the eligible risks, the participant must contact the travel agent or carrier, as the case may be, within 48 hours of the event in order to cancel the trip. Medavie Blue Cross must also be notified within the same time limit.

TRIP CANCELLATION BENEFIT COVERAGE

Coverage applies when the participant must cancel his departure, interrupt or extend his trip after it has begun following:

a) Sickness, bodily injury or death of the participant or a covered member of the participant's immediate family, business partners, key employee, travelling companion or caregiver.

b) Sickness, bodily injury or death of the participant's travelling companion's immediate family, business partners, key employee or caregiver.

c) The death or hospitalization of the participant's host at destination.

d) Complications of the participant's or participant's spouse's pregnancy following the booking of travel arrangements, if the departure from the place of origin is scheduled to occur within the eight (8) week period before or after the expected delivery date.

e) The legal adoptions, in Canada, of a child by the participant or the travelling companion if the adoption date is scheduled during the scheduled travel period.

f) A transfer by the participant's, the participant's spouse's or travelling companion's employer requiring the participant or the travelling companion to move permanent residences.

g) The cancellation of a business meeting required by the participant's employer or professional association. Such cancellation must be prior to departure and beyond the control of either the participant or their employer.

h) The participant, participant's spouse or travelling companion's involuntary loss of permanent employment without just cause.

i) A missed flight, missed connection or interruption of the participants travel arrangements due to delay of carrier (airline, bus, train, ferry, cruise ship or helicopter) resulting from weather conditions; mechanical failure; an accident substantiated by a police report; an emergency police directed road closure substantiated by a police report; or delay of an emergency police directed road closure substantiated by a police report.

   Note: This is subject to the connecting carrier (airline, bus, train, ferry or cruise ship) or automobile (limousine, taxi, or private automobile) being scheduled to arrive at the departure point no less than two (2) hours prior to the time scheduled for flight departure, or four (4) hours prior to the time scheduled for sailing or the helicopter is 12 hours prior to the scheduled departure.

j) Delay of scheduled carrier due to weather conditions, for a period of at least 30 percent of the total number of days of the covered trip, if the participant elects not to proceed with the trip.

TRIP CANCELLATION BENEFIT COVERAGE (Cont'd)

k) A disaster which renders the participant or the participant's travelling companion's primary residence uninhabitable or business inoperative.

l) Quarantine or summons for jury duty, subpoenaed as a witness (excluding law enforcement officers) or being required to appear as a defendant in a civil suit in a case being heard during the scheduled travel period.

m) The participant or travelling companion being summoned to service in the case of reservists, active military, police and fire personnel.

n) Other than late application or an application refusal, the cancellation of the trip as a result of the participant's or travelling companion's visa application not being issued for circumstances outside the participant's or travelling companion's control.

o) An event in the country of destination that incites the Government of Canada to issue a general recommendation to its citizens urging them to avoid travelling within that country during a period that include the scheduled trip. Travel arrangements must have been made before the recommendation was disclosed.

ELIGIBLE EXPENSES

In the event of trip cancellation, the plan guarantees reimbursement of the following expenses:

TRANSPORTATION TO DESTINATION

The extra cost of economy airfare to destination (applicable to item j only).

RETURN AIRFARE

Medavie Blue Cross will cover the extra cost of a one-way economy airfare by the most direct route back to the place of origin by a regularly scheduled flight. If the participant's return is delayed more than ten (10) days beyond the scheduled return date, this benefit shall be payable only upon submission of proof that the sick or injured person was admitted and confined to hospital as an inpatient for more than 24 hours.

REJOINING A TOUR OR A GROUP

The extra cost of economy class scheduled carrier transportation by the most direct route to join or rejoin a tour group in the event that the participant missed a portion of the trip due, after departure, to one of the events listed as a reason for delay.

UNUSED TRAVEL ARRANGEMENTS

a) The cost of the participant's prepaid non-refundable, unused travel arrangements (not applicable to items i or j).

b) The cost of the participant's prepaid non-refundable unused travel arrangements that are a direct result of a trip delay or schedule change when the participant proceeds to the next scheduled destination(s) (applicable to item i only).

c) If the participant elects not to proceed with the trip, the cost of the prepaid non-refundable unused travel arrangements if the scheduled carrier is delayed by weather conditions for a period of at least 30 percent of the total number of days of the covered trip (applicable to item j only).

NEXT OCCUPANCY CHARGE

If a travelling companion or a member of the participant's immediate family who is scheduled to accompany the participant is booked to share the same accommodation and must cancel due to one (1) of the reasons listed (a through o) and the participant elects to proceed, benefits will be reimbursed for the extra cost of the next occupancy charge.

EXCLUSIONS AND LIMITATIONS FOR TRIP CANCELLATION BENEFIT

1. Losses caused directly or indirectly, wholly or in part by one of the following:

    a) Intentional self inflicted injury, suicide or attempted suicide

    b) Committing or attempting to commit a criminal offence or provoking an assault.

    c) Intentional non-compliance with the medical treatment of therapy that has been prescribed.

    d) No benefits will be paid for expenses incurred as the result of abuse of medications; suicide or attempted suicide; criminal acts, or injuries suffered as a result of operating a motor vehicle while alcohol levels are in excess of the legal limit in the jurisdiction where the accident occurred.

    e) Participant in professional sports for remuneration, any kind of motor vehicle or speed contest, parachuting or skydiving, gliding, bungee jumping, rappelling, mountaineering (rock climbing), or a flight accident unless the participant is riding as a fare paying passenger on a commercial airline or charter aircraft with a seating capacity of six (6) people or more.

2. Losses due to the failure of any travel supplier through which a contract for services was made if such supplier be at the time in bankruptcy, insolvency or receivership.

3. Losses due to the default of the travel supplier in which the participant has controlling interest.

4. Losses due to the insolvency, receivership or bankruptcy of any airline broker whose primary function is the sale or resale of air transportation.

5. Losses due to the failure of any travel agent, agency or broker.

EXCLUSIONS AND LIMITATIONS FOR TRIP CANCELLATION BENEFIT

6. Losses due to the insolvency, receivership or bankruptcy of any U.S. air carrier protected under Chapter 11 of the U.S. bankruptcy code or with respect to airlines not holding a valid license from a Canadian Transportation Agency.

7. No trip cancellation benefits are available where the purpose of travel is to attend to or visit a person who is receiving medical care or treatment and where sickness or ensuing death is the cause of cancellation, curtailment or delayed return.

8. Loss due to a labour dispute.

9. Coverage is limited to expenses incurred as a result of a sudden illness or accident which occurs outside the participant's province of residence. Pre-existing conditions will be covered as a benefit, provided the condition is stabilized prior to travel, and medical attention is not anticipated during the travel period.

   A pre-existing condition is considered stable if you, in the 90 days before the departure date (or 90 days before the booking date for Trip Cancellation coverage), have not:

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

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

10. Loss due to inability to obtain the desired accommodation, financial difficulties, fear of flying or aversion to the trip.

BAGGAGE LOSS BENEFIT

The Baggage Loss Benefit covers the loss or damage to the baggage owned by the participant during a trip in or outside the province of residence, within the period of coverage, subject to a combined maximum of $500.

In the event checked baggage is delayed by the carrier for 12 hours or more while en route and before returning to the point of departure, Medavie Blue Cross will reimburse a maximum of $250, for the purchase of necessary toiletries and clothing. Proof of delay of checked baggage from the carrier along with receipts of purchases must accompany the claim upon presentation to Medavie Blue Cross when returning from the trip.

This benefit covers expenses to replace passport, driver's license, birth certificate or travel visa in case these documents are lost or stolen, up to a maximum of $50.

CONDITIONS PARTICULAR TO THIS COVERAGE

1. Where loss is due to theft, burglary, vandalism or disappearance, the participant must notify the police upon discovery of the loss. Failure to report the said loss to the authorities invalidates any claim under this benefit for such loss.
2. In the event of loss, the participant must notify Medavie Blue Cross as promptly as possible and take all reasonable precautions to protect, safeguard or recover his property and must also promptly notify the police and obtain from them written confirmation regarding such loss. The participant must obtain written confirmation from the hotel manager, tour guide or transportation authorities. He must furnish proof of loss or damage and value with a sworn statement within 90 days of the date of loss. Failure to comply with these conditions invalidates claims under this benefit.
3. If the covered property is checked with a public carrier and delivery is delayed until after expiry of the coverage, coverage will continue until such property is delivered by the public carrier.
4. Medavie Blue Cross is not liable beyond the actual cash value of the property at the time any loss or damage occurs and may elect to repair or replace any damaged or lost property with other of like quality or value.
5. Upon the occurrence of any loss for which a claim is made, the amount of the applicable limit of liability is reduced by the amount equivalent to such loss.
6. This coverage may not profit, directly or indirectly, any carrier or guarantor.

EXCLUSIONS AND LIMITATION FOR BAGGAGE LOSS BENEFIT

The benefits are reduced or not payable in the event of or with regard to:

1. Loss or damage to automobiles or automobile equipment, motorcycles, bicycles (unless registered with the carrier), boats, motors or other conveyances to their accessories, household furnishings or accessories, false teeth, artificial limbs, glasses, contact lenses, cash notes, securities, tickets and documents, professional equipment or property, goods brought with the intent of trading them, antiques and collectors items, perishable articles, cosmetics, personal effects, animals or any item that is not part of the usual baggage.
2. Breakage of fragile or brittle articles unless caused by fire or theft.

EXCLUSIONS AND LIMITATION FOR BAGGAGE LOSS BENEFIT (Cont'd)

3. Loss or damage due to confiscation or damage by order of any government or public authority, or to illegal transportation or trade, war demonstration or insurrection or hostilities between nations (whether or not war is declared).

4. Loss or damage caused by wear and tear, gradual deterioration, moths or vermin or while the article is actually being worked upon or processed.

5. Theft from an unattended automobile, trailer or other vehicle, unless such vehicle was securely locked or was equipped with a closed compartment which was securely locked and the theft occurred as a result of forcible entry (of which there must be visible marks).

6. The maximum amount payable for loss or damage for each item comprising the participant's baggage is $125.

   For the purpose of calculating the maximum, the following items are grouped in categories, and each category is considered, pursuant to the policy, as a single article:

   a) Jewellery: jewellery, watches, silver, gold or platinum items,
   b) Furs: fur or fur-trimmed articles,
   c) Photography equipment: cameras and photography equipment, video cameras and video or audio equipment.

7. In addition, the maximum amount payable for loss or damage of the total of the three (3) categories mentioned above is $250.

8. In the event of the loss of an article which is part of a set, the measure of loss will be in reasonable and fair proportion to the total value of the set, giving consideration to the importance of such article and with the understanding that such loss cannot be construed to mean a total loss of the set.

9. Loss or damage caused by any imprudent action or omission by the participant. When an article or personal property in question cannot be located and the circumstances of its disappearance cannot be explained or do not lend themselves to a reasonable conclusion that a theft occurred.

10. Loss or damage to any article specifically covered under any other insurance contract at the time this benefit is in effect.

TERMINATION

The Travel Benefit coverage ends at your retirement, the termination of employment, upon death or when you reach age 75, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first. Coverage for any participant ceases when he is no longer covered under the government health program in his province of residence.

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WHEN AND HOW TO MAKE A CLAIM

Please call the toll free number of the back of your Medavie Blue Cross identification card for assistance when an unexpected illness or injury happens while travelling outside your province of residence. Every effort will be made by Medavie Blue Cross to direct you towards the appropriate medical treatment and assist you in making payment to the providers of service and coordinate with your provincial government plan.

However, under certain circumstances, Medavie Blue Cross will require you to obtain and directly send original, detailed receipts for all expenses incurred outside your province of residence to your provincial government health plan for their consideration and payment. Please ensure you retain a copy of these receipts as you will then need to submit them along with the provincial government health plan proof of payment statement directly to Medavie Blue Cross. This procedure should be followed when purchasing drugs, incurring medical services not pre-approved by Medavie Blue Cross (some exceptions may apply) and when incurring medical services within Canada (that will be covered by your provincial health plan).

Please provide your Medavie Blue Cross Identification Number when submitting a claim to Medavie Blue Cross.

Claims for services outside of Canada are paid by Medavie Blue Cross in Canadian currency based on the rate of exchange in effect at the conclusion of the services.

REFERRAL FOR SERVICES OUTSIDE CANADA

When covered persons are referred outside Canada by the attending physician for medical services not available in Canada, Medavie Blue Cross will pay for the following eligible benefits. Payment will be made at the usual, customary and reasonable amount for charges in excess of provincial government health care allowances up to a lifetime maximum of $500,000.

Co-insurance: 100%

AMBULANCE
Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to a maximum of up to three economy seats on a regularly scheduled flight.

AMBULANCE ATTENDANT
Charges for travel expenses of an accompanying Registered Nurse or qualified medical attendant (not a relative) when medically necessary and approved by Medavie Blue Cross.

HOSPITAL
All hospital charges for medically necessary services, less the amount allowed under the provincial government health care plan, such as:

- hospital room accommodation
- intensive care rooms
- nursing services
- operating and recovery rooms
- diagnostic and laboratory services including X-ray
- oxygen and blood
- prescription drugs including intravenous solutions
- physiotherapy

PHYSICIANS AND SURGEONS
Customary charges of physicians and surgeons for services rendered, less the amount allowed under the provincial government health care plan.

REFERRAL FOR SERVICES OUTSIDE CANADA

LIMITATIONS AND EXCLUSIONS

1. The referral outside Canada must be medically necessary and must not be for services available in Canada, as determined by Medavie Blue Cross.

2. The claim must have prior approval for payment from Medavie Blue Cross.

3. Payment will be made for the reasonable and customary charges of the provider of the services or supplies in the area in which the services are rendered.

4. Payment will only be made for services and supplies rendered while the patient was under the active treatment of a licensed physician.

5. Payment will not be made for treatment of any illness commencing within 12 months after the covered person's effective date of group coverage for which the covered person has received medical treatment or has been prescribed drugs 12 months prior to the effective date of this coverage.

6. The services to be provided outside Canada must not be experimental or investigative in nature.

7. Referrals outside of Canada exclude, but are not limited to, services not available due to waiting lists and/or treatment which has been refused by a physician in Canada.

TERMINATION

Referral for services outside Canada benefit ceases at the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM

Obtain detailed receipts in duplicate for any expenses incurred outside your province of residence. Upon your return, send one of the receipts to your provincial government health plan for their consideration and payment. When a reply has been received from them, send proof of their payment together with appropriate receipts to Medavie Blue Cross - Claims Department for payment of the remaining eligible benefits. A letter from the referring physician is required as well as a description of the treatment rendered from the attending physician. Always provide your Medavie Blue Cross Identification Number when submitting a claim to Medavie Blue Cross.

Claims for services outside of Canada are paid by Medavie Blue Cross in Canadian currency based on the rate of exchange in effect at the conclusion of the services.

DENTAL BENEFIT

Your dental program covers you and your dependents for a wide range of dental services including the following benefits. Dental benefits are based on the usual and customary charges up to the current Dental Fee Guide for general practitioners in effect in the covered person's province of residence.

BASIC BENEFITS
Co-insurance: 80%

Maximum: $1,500 in a calendar year

Diagnostics
- complete examinations once every 36 consecutive months
- recall examinations once every six (6) consecutive months
- bitewing four films every five (5) consecutive months
- full series or panoramic x-rays once every 12 consecutive months
- tests/analysis/laboratory procedures

Preventive Services
- polishing once, up to one (1) unit of time* every six (6) consecutive months
- fluoride treatment one (1) every six (6) consecutive months
- scaling
- pit and fissure sealants and space maintainers
- protective appliance (mouth guard) one (1) appliance every 12 consecutive months
- periodontal, TMJ or Myofascial appliances once every 24 consecutive months
- periodontal, TMJ or Myofascial appliance adjustments, maintenance and repair, limited to one upper and one lower once every 24 consecutive months
- occlusal equilibration

Restorative Services
- amalgam (silver) and tooth coloured (white) fillings
- full coverage pre-fabricated restorations
- retentive pins

Endodontic Services
- root canal therapy

Periodontic Services
- periodontal scaling and root planing
- periodontal surgery (grafts)

Surgical Services (Basic)
- extraction of teeth and roots

* one unit of time is equal to 15 minutes

BASIC BENEFITS (Cont'd)

Prosthodontic Services
- denture adjustments and repairs (after 3 months of initial insertion)
- denture reline or rebase once every 24 consecutive months (using existing framework for complete or partial dentures)
- tissue conditioning

General Services
- general anaesthesia and intravenous sedation in conjunction with oral surgery

DENTAL EXCLUSIONS AND LIMITATIONS
The dental plan does not cover the following expenses:
1. Splinting for periodontal reasons, where cast, crowns or inlays are used for this purpose, with or without onlays.
2. Veneers for cosmetic purposes.
3. Accidental dental services do not form part of the Dental Benefits being offered.
4. Services rendered by a dental hygienist but not administered under the supervision of a dentist.
5. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

BENEFITS FOR LATE APPLICANTS
If application for dental benefits is made more than 31 days after the date on which the employee and/or dependent first becomes eligible, the maximum benefit will be limited to $250 per covered person during the first 12 months of coverage. This provision does not apply to dental services required as a result of natural teeth being damaged by a direct accidental blow to the mouth after the effective date of the late applicant's coverage.

TERMINATION
Dental Benefit ceases at the earlier of retirement, termination of employment or age 70.

WHEN AND HOW TO MAKE A CLAIM
Dental benefits are reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and submit to Medavie Blue Cross for processing. Some services may require a completed claim form to accompany the receipt.

To make a claim, complete the claim form that is available.

Claims must be submitted within four (4) months and no later than 24 months of receiving services or supplies or the end of your Dental benefit.

INCONFIDENCE® – EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

inConfidence® is a confidential, comprehensive Employee and Family Assistance Program (EFAP) offering counselling and access to advisory services to employees and their families.

SERVICE PROVIDER

The company, individual or other legal entity retained by Medavie Blue Cross to provide access to services described in this booklet. The Service Provider, including its employees and agents are bound by all applicable privacy legislation. Medavie Blue Cross has the right, at its sole discretion, to replace or substitute the Service Provider at any time with an alternate Service Provider capable of providing a similar level of service.

SERVICES PROVIDED

Scope of Coverage

Maximum Counselling/Participant	5 hours of individual counselling/calendar year 5 hours of couples/family counselling/calendar year
Maximum Advisory Services/Participant	Unlimited access to legal and financial advisory services 5 hours of each of the following/calendar year: - health and physical wellness coaching; - life stages and transition coaching; and - career counselling.
Crisis Support	Unlimited access - 24 hours a day, 7 days a week

inConfidence® provides unlimited access to crisis support (24 hours a day; 7 days a week) as well as the following types of counselling up to the maximum hours per calendar year specified above:

- individual; and
- couples/family counselling.

inConfidence® provides the following types of advisory services up to the maximum hours per calendar year specified above:

- health and physical wellness coaching (such as information and counselling on adaptive and preventative health and personal well-being, nutritional advice, smoking cessation, illness and disease management and weight management);
- career counselling (such as career management, career transition or retirement transition);
- life stages and transition coaching (such as marriage, divorce or separation, family planning, parenting skills, childcare, eldercare, support for teens, moving away from home and adjusting to the workplace);
- legal advisory services (such as information and clarification on real estate, divorce, custody and child support, wills and estate planning, family matters, consumer concerns, legal rights and criminal matters; and
- financial advisory services (such as credit management, budgeting, mortgages, financial management, overextension, investing, retirement planning, insurance and taxes).

Unused counselling or advisory service hours are not carried forward into the next calendar year.

Wellness Hub

The Service Provider's website and mobile app feature a Wellness Hub, where participants can access articles and videos on the following topics:

- mind;
- body;
- relationships; and
- work.

How it Works

The participant must first create an account on the Service Provider's website accessed from the Medavie Blue Cross web page **myinConfidence.ca**. They can then access EFAP services on the Service Provider's website or mobile app.

Mobile app: Inkblot Therapy

Toll-free crisis support line: 1-855-933-0103

The relationship between the Service Provider and the participant will be strictly confidential. The Service Provider will have the right to communicate directly and privately with participants as necessary to carry out its obligations to the participant.

ADDITIONAL SERVICES

Additional Counselling

After reaching the covered maximum number of hours specified above, participants can elect to continue counselling with the same therapist, for an additional fee set by the Service Provider. These charges may be eligible for reimbursement if the participant has health benefits coverage with Medavie Blue Cross or elsewhere, in accordance with the Canadian Life and Health Insurance Association Inc. (CLHIA) guidelines for co-ordination of benefits.

TERMINATION OF BENEFIT

inConfidence ends at your retirement or termination of employment, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

SECOND OPINION®

Second Opinion® Services provides an in-depth review of a participant's medical file by the Second Opinion institution or physician, including a review of the diagnosis and treatment plan. On completion of the review, a booklet containing the Second Opinion summary and recommendations (if applicable) is sent to the participant along with detailed information pertaining to the qualifying medical condition.

QUALIFYING MEDICAL CONDITIONS:

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

The list of Qualifying Medical Conditions may change without notice.

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

HOW TO ACCESS

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

TERMINATION

The Second Opinion benefit ends at your retirement, termination of employment or age 75, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

HEALTH AND DENTAL EXCLUSIONS AND LIMITATIONS

Medavie Blue Cross does not cover the following expenses:

1. Medical examinations or routine general checkups required for use by a third party.
2. Elective services obtained outside the covered person's province of residence.
3. Charges which normally would not be made if the covered person were not covered under the plan.
4. Any item or service not listed as a benefit in this plan.
5. Medications restricted under federal or provincial legislation.
6. Registration charges or non-resident surcharges in any hospital.
7. Services performed by an unqualified practitioner.
8. Charges for missed appointments or the completion of forms.
9. Services that are normally paid for directly or indirectly by the employer.
10. Charges for health care planning assessments.
11. Any health care services and supplies that are not provided by a Medavie Blue Cross approved provider.
12. Convalescent, custodial or rehabilitation services.
13. Conditions not detrimental to health.
14. Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice.
15. Services or supplies normally provided by the covered person's government health plan.
16. Benefits the covered person receives or is entitled to receive from Workers' Compensation.
17. Mileage or delivery charges.
18. Services as a result of self-inflicted injuries or any suicide attempt, whether the covered person is sane or not.
19. Any injury or illness resulting from the covered person's active participation in or related civil unrest, riot, insurrection, or war.
20. Participation in the commission of a criminal offense.
21. A service or supply that is experimental or investigative in nature.
22. A service or supply that is not medically necessary or proven effective.
23. Services for which the government prohibits the payment of benefit.
24. Services provided without charge or paid for by the employer.
25. Services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement.

TERMINATION OF BENEFITS

Coverage for you and your dependents will cease on the earliest of:

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation, change in classification, etc.

CO-ORDINATION OF BENEFITS

In the event that benefits may be claimed under more than one section of the health care plan, the claim will be assessed in a manner that provides the greatest benefit to the employee.

With the exception of Worldwide Travel Benefit provided under the policy, if you are eligible for similar benefits under another group benefit plan the amount payable through this plan shall be co-ordinated with all benefit plans and will not exceed 100% of the eligible expense. Where both spouses of a family have coverage through their own employer benefit plans, the first payer of each spouse's claim is their own employer's plan. Any amount not paid by the first payer can then be submitted for consideration to the other spouse's benefit plan (the second-payer).

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earlier birth month in the calendar year, and then to the other spouse's benefit plan. When submitting a claim to a second payer, be sure to include payment details provided by the first payer.

Benefit payments will be co-ordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines.

Payment for Worldwide Travel Benefit provided under this policy is limited to amounts that are in excess of coverage provided by any other plan(s), as specified in the Worldwide Travel Benefit Exclusions.

CONVERSION PRIVILEGE

If you should terminate employment, you may convert to an Individual Health and Dental plan currently issued by Blue Cross provided that application is made within 31 days following your date of termination. This conversion privilege is also available to the surviving spouse and/or dependents after the termination of the Survivor Benefit.

SURVIVOR BENEFIT

In the event of the employee's death, eligible dependents will continue to be covered for Health and Dental Benefits on a non-premium basis, however, coverage will end on the earliest of the following dates:

- the contract termination date;
- twenty-four (24) months after the employee's death;
- the effective date of any similar coverage with another insurer;
- whenever they cease to be eligible dependents.

GROUP LIFE INSURANCE

AMOUNT OF INSURANCE

Benefit Formula:	Flat amount
Benefit Maximum:	$100,000
Non-evidence Limit:	$100,000
Benefit Reduction:	Reduces 50% at age 65

Benefit ceases at the earlier of retirement, termination of employment or age 70.

DEATH BENEFIT

The death benefit provides for payment to your designated beneficiary for the amount of Group Life Insurance in force on the date of death.

TERMINAL ILLNESS

A special advance payment may be provided if you are suffering from a condition that is expected to result in death within 12 months of your request. A medical certificate will be required. The payment must be requested in writing and will be the lesser of $50,000 or 50% of your Group Life Insurance. This payment will be deducted from the Group Life Insurance otherwise payable upon your death.

WAIVER OF PREMIUM

If you become totally disabled prior to your 65th birthday, and remain disabled for a period of six (6) consecutive months, insurance coverage is continued without payment of premium from the first of the month following the date of disability, provided that proof of total and continuous disability is submitted as required. Total Disability means a state of incapacity due to accidental injury or illness that prevents you from engaging in any occupation for which you are reasonably qualified by education, training or experience and you are unable to perform work for remuneration or profit. However, if you are entitled to receive any Long Term Disability benefits under this plan, you will be considered to be totally disabled for the waiver of premium benefit.

In the event you recover from a total disability and become disabled again due to the same or related cause, the second period of disability will be considered a continuation of the first disability, unless the periods of disability are separated by an interval of at least six (6) months during which you returned to work on a permanent basis.

If a period of total disability is considered to be a continuation of a previous total disability, then premiums will be waived without the application of another six (6) months of total disability.

EXTENSION OF COVERAGE

In the event of your death within 31 days following termination of employment, the Group Life Insurance benefit will be paid to your designated beneficiary provided that any individual plan issued under the conversion privilege is surrendered.

CONVERSION PRIVILEGE

If your Group Life Insurance coverage ceases on or before attaining 65 years of age because of retirement, termination of employment or termination of membership in the class of employees eligible for insurance under this plan, then the employee may purchase an individual plan of the type then being offered by Blue Cross Life in an amount not to exceed $200,000.

If you terminate employment prior to your 65th birthday, you may convert to an individual plan issued by the insurer, without evidence of insurability. Written application must be made and the required premium submitted during the 31-day period immediately following the date of termination.

This option does not apply to scheduled reductions or termination of coverage that become effective at specific ages.

Limited conversion rights are available on termination of the group contract in accordance with the Superintendents of Insurance Guidelines. If the Group Life Insurance contract is not being replaced, all employees who had been insured for at least five (5) continuous years may convert their group life coverage in the same manner as terminating employees.

TERMINATION OF COVERAGE

All Group Life insurance will terminate on the earliest of:

- the date you cease to be eligible for Group Life insurance,
- the date of termination of this coverage,
- the day on which you attain the age limitation for this plan,
- the end of the grace period for which any premium has not been paid in full.

WHEN AND HOW TO MAKE A CLAIM

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

DEPENDENT LIFE INSURANCE

AMOUNT OF INSURANCE
Spouse: $10,000
Children: $ 5,000

Benefit ceases at the earlier of retirement, termination of employment or age 70.

DEATH BENEFIT
The Dependent Life Insurance benefit will be paid to you upon the death of your insured dependent.

ELIGIBLE DEPENDENTS
An eligible dependent is as defined under Additional Benefit Information.

COMMENCEMENT OF COVERAGE
Insurance on your dependent begins on the later of the date the application for dependent insurance was completed or the date you acquired the dependent, provided the dependent is not confined to a hospital. In this instance, coverage for the dependent will commence on the date the dependent ceases to be confined to a hospital. In the case of a child born while this coverage is in force, the dependent coverage on that child will become effective from 28 weeks gestation, even if confined to a hospital.

EXCEPTIONS AND LIMITATIONS
Dependents excluded from the plan:

- a spouse residing outside of Canada or the United States of America, or
- a person for whom evidence of insurability, if required, is not approved by the insurer.

WAIVER OF PREMIUM
If a claim is approved under Group Life Insurance for total disability, the Dependent Life benefit will continue for the same period without further payment of premium.

CONVERSION PRIVILEGE
Upon termination of employment you may purchase insurance on the life of your spouse in the same manner as under the Group Life benefit in an amount not to exceed the amount of insurance that terminated. The conversion privilege is available to your spouse only, and is not available to dependent children.

EXTENSION OF COVERAGE
If your spouse should die within 31 days of your termination of employment, the death benefit of your spouse will be paid, provided that any individual plan issued under the conversion privilege is surrendered.

WHEN AND HOW TO MAKE A CLAIM
Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

AMOUNT OF INSURANCE
The principal amount is equal to the amount of Group Life Insurance
Benefit Reduction: Reduces 50% at age 65

Benefit ceases at the earlier of retirement, termination of employment or age 70.

In the event of loss, occurring within 365 days after the date of injury, the amount payable will be the following percentage of the principal amount for which you are insured on the date of the injury. The maximum amount payable for all losses sustained as a result of the same accident will not exceed 100% of the amount of insurance, with the exception of Quadriplegia, Paraplegia and Hemiplegia which will be paid at 200%. Only one amount, the largest applicable, will be payable for injuries to the same limb resulting from any one accident:

Loss of life	100%
Loss of or loss of use of both hands or both feet	100%
Loss of or loss of use of one hand and one foot	100%
Loss of the entire sight of both eyes	100%
Loss of one hand and the entire sight of one eye	100%
Loss of one foot and the entire sight of one eye	100%
Loss of or loss of use of both arms or both legs	100%
Loss of or loss of use of one arm and one leg	100%
Loss of speech and hearing	100%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of or loss of use of one arm or one leg	75%
Loss of or loss of use of one hand or one foot	66 2/3%
Loss of the entire sight of one eye	66 2/3%
Loss of speech or hearing	50%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four fingers on the same hand	33 1/3%
Loss of hearing in one ear	16 2/3%
Loss of all toes on one foot	12 1/2%

Exposure - a loss caused by unavoidable exposure to the elements is covered.

Disappearance - caused by accidental wrecking, sinking or disappearance of a conveyance is considered to be loss of life if the body is not found within 365 days.

Coma Benefit - 1% of the principal amount payable monthly, following 31 consecutive days of complete and total unconsciousness caused by accidental injury.

Repatriation - $7,500 maximum reimbursement of burial expenses when death occurs more than 150 kilometers from the deceased's residence.

Rehabilitation - $5,000 maximum reimbursement of special training expenses.

Occupational Training for Spouse - $5,000 maximum reimbursement for a formal training program within three years of your date of death.

Education Benefit - the lessor of 5% of your principal sum, or $5,000 for each year of post-secondary education for your eligible dependent children to a maximum of five years or until the age of 25 inclusive, whichever occurs first.

Family Travel - $1,500 maximum reimbursement for family members to attend the hospital of your confinement if confinement is of at least four days and such confinement occurs more than 150 kilometres from your normal place of residence.

EXCLUSIONS AND LIMITATIONS

No benefit is payable if a disability, illness, injury or accident occurs while participating in or engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.

No benefit will be payable in respect of any loss caused directly or indirectly, wholly or in part by one or more of the following:

1. Intentionally self-inflicting injuries, committing suicide, or attempting suicide, while sane or insane.

2. Insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion.

3. Any accident or injury occurring while operating a motor vehicle with a blood alcohol in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes, but is not restricted to, an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.)

4. Illness or disease of any kind, or medical or surgical treatment thereof, other than septic infection caused through a wound accidentally sustained.

5. Travel or flight in, or descent from, any kind of aircraft if you:

   - are a member of the aircraft crew, or
   - have any duties relating to the operation, maintenance, testing, or control of the aircraft, or
   - are on the aircraft for the purpose of instruction or training.

REDUCTION SCHEDULE
The reduction schedule coincides with that of the Group Life Insurance plan.

AGGREGATE BENEFIT
Benefits for the following are limited in the aggregate should you also be insured under a voluntary or Optional Accidental Death and Dismemberment provision of the plan:

- Repatriation
- Rehabilitation
- Occupational Training for Spouse
- Education Benefit
- Family Travel

TERMINATION OF COVERAGE
Basic Accidental Death and Dismemberment insurance will terminate on the earlier of:

- the date you cease to be eligible for Group Life insurance, or
- the date of termination of this provision, or
- the earlier of retirement or the day on which you attain the termination age, or
- the date you cease to pay the premium for this benefit.

WAIVER OF PREMIUM
If a claim is approved under the Basic Group Life Insurance plan for total disability, the Accidental Death and Dismemberment benefit will continue for the same period without further payment of premium. Termination of the master contract, however, will also cause the waiver of premium to be terminated.

CONVERSION OPTION
If your Basic Accidental Death and Dismemberment insurance coverage ceases on or before attaining 65 years of age because of retirement, termination of employment or termination of membership in the class of employees eligible for insurance under this plan, then you may purchase an individual Accidental Death and Dismemberment plan of the type then being offered by Blue Cross Life in an amount not to exceed $200,000.

WHEN AND HOW TO MAKE A CLAIM
If you suffer a loss other than death, a claim must be received by Blue Cross Life within one (1) year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

LONG TERM DISABILITY BENEFIT

AMOUNT OF INSURANCE

Benefit Formula:	66.67% of the first $3,000 of monthly earnings plus 50% of the remainder
Benefit Maximum:	$5,000 per month
Non-evidence Limit:	$5,000
Elimination Period:	119 days
Benefit Period	To age 65

Claim payments received are non-taxable benefits.

Benefit ceases at the earlier of retirement, termination of employment or age 65.
Your coverage ceases at age 65 less the elimination period.

Long Term Disability (LTD) plans are designed to provide a monthly income to you if you are confronted with loss of income during a lengthy or permanent disability.

DISABILITY (two year own occupation - 60%/60%)

To be eligible for this benefit, you must be under the continuous care of a physician. You are not considered totally disabled during the first 24 months following the elimination period if you are deemed able, by Blue Cross Life, to do the substantial (60%) portion of the regular duties of your own occupation for any employer.

Thereafter, you are not considered totally disabled for the period following the first 24 months of benefits if you are deemed able, by Blue Cross Life, to perform at least 60% of the regular duties of any occupation for any employer for which you are reasonably fitted, or could so become, by education, training or experience.

Regular duties are defined as those work related activities which are considered essential to your performance in the occupation and which proportionately take the majority of time to complete.

PARTIAL DISABILITY

To be considered partially disabled, you must be deemed totally disabled throughout the elimination period. If, following the elimination period, you are only capable of returning to the workforce in a reduced capacity, Blue Cross Life will apply the regular provisions under the Long Term disability coverage.

RECURRENT DISABILITY

Successive periods of total disability occurring while this coverage is in force will be considered to be one period of total disability as long as you become totally disabled from the same or related causes for which your claim for Long Term disability was previously approved by Blue Cross Life and the intervals of total disability have not been separated by a period longer than six months.

If you return to work for a new employer and you are without disability coverage, you may be eligible to claim under this provision as long as your employment with the new employer is part of a return to work program that has been pre-approved by Blue Cross Life. Your claim for disability benefits cannot be approved under any other plan and you must become totally disabled from the same or related causes within six months of returning to active employment.

ELIMINATION PERIOD

The benefit elimination period is the period of time which you must wait from the onset of the disability before the insurer begins paying Long Term Disability benefits.

When the disability is not continuous, the days you are disabled may be accumulated to satisfy the elimination period, provided coverage remains in force during the accumulation of the elimination period, no interruption is longer than 30 days, disabilities are due to the same or related causes and each period of total disability is completed within 365 days after the start of the elimination period, or as pre-approved by Blue Cross Life if longer.

PRE-EXISTING CONDITIONS (3-6-12)

A pre-existing condition means a sickness or injury for which you received medical treatment, consultation, care or services (including diagnostic measures) or have been prescribed medication, during the three (3) months immediately prior to the effective date of Long Term Disability coverage.

Long Term Disability benefits are not payable for any disability caused by or resulting from a Pre-existing condition unless:

- You have not received medical treatment, consultation, care or services (including diagnostic measures) or have not been prescribed medication for any six (6) consecutive months within the 15 month time period beginning three months before and ending 12 months after your effective date of Long Term Disability coverage, or
- The disability begins after 12 consecutive months of employment from your effective date of Long Term Disability coverage.

INTEGRATION OF BENEFITS

Direct Offset plan

Monthly benefits are co-ordinated with other income payments to which you become entitled as a result of the current disability. The benefit co-ordination is applied as follows:

1. The amount of monthly income otherwise payable is reduced directly by any disability benefits available from the Canada or Quebec Pension plan* (primary benefits only), the Workers' Compensation Act and "income from all other sources". "Income from all other sources" includes:

- disability benefits available under any other government program excluding secondary benefits under the Canada or Quebec Pension plan,
- retirement benefits provided by any employer or government program,
- income or benefits payable under any group program provided by or through the employer,
- income or benefits payable under a plan sponsored by an association, union or fraternal organization of which you are a member,
- income replacement benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, and
- wages or remuneration payable from any employer or from self-employment, but excluding 50% of earnings received under an approved rehabilitation program.

*Blue Cross shall deduct any income amounts to which you are eligible under the Quebec Pension Plan, regardless of whether such income amounts are characterized as disability benefits, retirement benefits, or a combination thereof.

2. The amount determined in "1" above is further reduced if necessary, so that the amount of monthly income, including all amounts of income mentioned in "1" above, does not exceed 85% of your pre-disability earnings.

If it appears to Blue Cross that there are income amounts to which you were, are or may be eligible, but are not receiving because you opted out of, waived, failed to apply for, or terminated receipt of such amounts in whole or in part, Blue Cross may include these amounts in its calculations by estimating the income amounts to which you were, are or may be eligible.

During the period of an approved rehabilitation program, the amount of monthly income as defined above, will be further reduced if necessary, so that the amount of monthly income together with all amounts of income in "1" above, including 100% of earnings received from an approved rehabilitation program does not exceed 100% of pre-disability earnings.

Canada/Quebec Pension plan Freeze

Once the initial CPP/QPP offset has been established on a Long Term Disability claim, it will not be changed due to cost-of-living adjustments to the CPP/QPP payments.

EXCLUSIONS AND LIMITATIONS

Long Term Disability benefits will not be payable if disability, illness, injury or accident occurs while participating in or while engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.

Long Term Disability benefits are not payable for any of the following:

1. any period of disability during which you are not under the appropriate treatment and care of a physician who is a registered medical specialist or health care practitioner in the field of medicine which is applicable to your condition,
2. any period during which you are not undergoing a course of medical treatment or participating in a program of rehabilitation which is deemed appropriate in the opinion of Blue Cross Life,
3. any period during which you are imprisoned,
4. any disability due to or resulting from self-inflicted injury or sickness, while sane or insane,
5. any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion,
6. any disability during the period:
   - of formal maternity leave taken by you pursuant to provincial or federal law, or pursuant to mutual agreement between you and the employer, or
   - in which employment insurance maternity benefits are being paid or would be paid if you were eligible,

   whichever is longer.

WAIVER OF PREMIUM

If you are totally disabled and qualify for Long Term Disability benefits, any premium due under this benefit will be waived commencing with the first full calendar month following the end of the elimination period. Premiums will be waived until you return to active permanent employment or no longer qualify for benefits.

WHEN AND HOW TO MAKE A CLAIM

To make a claim, complete the notice of claim for Long Term Disability benefits that is available from your employer.

We must receive written notice of claim on the earlier of the following dates:

- within 90 days immediately following the end of the elimination period,
- within six (6) months of the termination of this Long Term Disability benefit.

ADDITIONAL BENEFIT INFORMATION

ELIGIBLE EMPLOYEES

To be eligible for group benefits, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work and working a minimum of 20 hours per week on a regular basis. Coverage commences immediately upon employment.

Employees may elect coverage, within 31 days of becoming eligible following the waiting period, by completing an application. Coverage is effective on the date of eligibility, except when: (a) the employee is not actively at work on the day that coverage would otherwise become effective, or (b) the application is made after the 31 day period.

If not actively at work when you would normally have become eligible, your coverage will commence when you return to work on a full-time basis.

All benefits described in this booklet are available to employees of the group, subject to application by the employee and underwriting approval.

ELIGIBLE DEPENDENTS

Dependents are defined as your legal spouse (as described below), and unmarried, unemployed dependent children including natural, legally adopted or step-children. Children of a common-law spouse may be covered if they are living with the employee. All dependents must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

The term “spouse” is defined as a person of the opposite or same sex who is legally married to the employee, or has continuously resided with the employee for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation ("common law" spouse), the employee may elect to continue membership of the former spouse or to provide notice to Medavie Blue Cross to terminate coverage for the spouse. Medavie Blue Cross will at no time provide coverage for more than one spouse under the same plan.

Dependent children are eligible for benefits if they are less than 21 years of age or, if 21 years of age but less than 26 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

Unmarried, unemployed children 21 years of age or older qualify if they are dependent upon the employee by reason of a mental or physical disability and have been continuously so disabled since the age of 21. Unmarried, unemployed children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to the age of 26 and have been continuously disabled since that time also qualify as a dependent.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, evidence of health on the dependents may have to be submitted and approved before coverage begins.

ADDITIONAL BENEFIT INFORMATION

EVIDENCE OF HEALTH

Proof of good health is not required if application is made within 31 days of first becoming eligible. If coverage is not applied for within this 31 day period, evidence may be requested for the employee and his dependents, if any, before benefits commence.

Certain other situations may require the submission of evidence of health before coverage will be approved. The cost of obtaining evidence of health is to be provided at your own expense if you or your dependents do not apply for coverage within 31 days of becoming eligible.

ALTERNATIVE BENEFIT

Where more than one form or alternative form of treatment exists, Medavie Blue Cross, in consultation with its Health Care Consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure or supply with a lower cost, when deemed appropriate and consistent with good health management.

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

Medavie Blue Cross is continually developing its Web technology to respond to the needs of our customers. One such innovation, the Plan Member Website, will help you better understand, manage and co-ordinate your benefit plan.

The Plan Member Website is simple to use and is delivered in a secure environment. Now, when you want to access general information about your plan, view your claims and payment history, or print generic claim forms, you just have to click your mouse. The Plan Member Website is available 24 hours a day; seven days a week from home or work, all you need is an Internet connection. The Plan Member Website makes life easier for you.

ON THE PLAN MEMBER WEBSITE

There are a variety of options available to you on the Plan Member Website.

Coverage Inquiry: Detailed information about the Medavie Blue Cross benefit plan
Forms: Printable versions of generic Medavie Blue Cross claim forms

Member Information

- Members can view and/or update address information (where access is available)
- Request new identification cards
- Add/update banking information for direct deposit of claim payments (where applicable)

Member Statements

- Members can view claims history for member and dependents
- View record of payments issued to member and/or the service provider
- View Health Spending Account balances (where applicable)

Submit Claims electronically

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

To register for the Plan Member Website, visit **www.medaviebc.ca** and log in.

Please ensure you make note of your password for future reference.

PLEASE NOTE

For security reasons, the Plan Member Website is for use of the plan member only.

We look forward to helping you take advantage of our online technology. For further information on the Plan Member Website, or for any questions about your Medavie Blue Cross benefit plan, please contact our Customer Information Center toll free at the number on the back of your identification card or e-mail *inquiry@medavie.bluecross.ca.*

BLUE CROSS CONTACT INFORMATION

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

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

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

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

CONNECT WITH BLUE CROSS
Like us on Facebook at **facebook.com/MedavieBlueCross**

Follow us on Twitter at @**MedavieBC**

My Good Health®

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

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

BLUE ADVANTAGE®

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

HOW TO OBTAIN MORE INFORMATION

HOW TO OBTAIN A CLAIM FORM

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

- the plan member website;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed above.

All claim forms for Life, Accidental Death and Dismemberment or Disability benefits can be obtained through your group benefits administrator.

HOW TO SUBMIT A CLAIM

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

- Provider eClaims for approved providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our eClaim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefit plan (if any);
- eClaims through our secure plan member website;
- Mobile App (visit www.medaviebc.ca/app for more information or to download the app);
- Mail your completed claim form to the nearest Medavie Blue Cross office. To find the Medavie Blue Cross office nearest you, visit our website at www.medaviebc.ca.

You can submit your claims for Life, Accidental Death and Dismemberment or Disability benefits by:

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