Group Benefits Booklet

Carillion Canada Inc.

Flex Plan

Plan Number:
91862

Effective Date:
April 1, 2016

Welcome to your Group Benefits Plan

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

In this plan, drug, extended health and dental benefits are self-insured by the plan sponsor and are administered by Medavie Inc. Travel benefit is insured by Medavie Inc. and all other benefits are insured by Blue Cross Insurance Company of Canada.

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

Blue Cross has been a trusted health services partner for individuals, employers and governments across Canada for over 70 years. Our core purpose is to help improve the health and well-being of people and their communities.

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

About this Booklet

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

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

Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.

- **Coverage Details:** Contains important information regarding the eligibility requirements for your group benefits coverage. In addition, these details explain when your coverage begins and ends, plus other useful information that will help you take advantage of the coverage available to you.

- **Rights and Responsibilities under the Plan:** Outlines your responsibilities under the group plan, such as notifying your employer upon change in status, and your rights, for example your right to privacy.

- **How to Submit a Claim and Obtain More Information:** Additional information on the various options available to you for submitting claims and how you can obtain more information regarding your coverage.

- **Helpful Tips:** Throughout this booklet we have provided useful tips to help you better understand and get the most out of your group benefits.

Medavie Mobile App

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

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Carillion Flex Benefits at a Glance

Life Options	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Member Life Benefit	Hire2016	Hire2016 Corp2 Roads2	Hire2016 Corp3 Roads2	Hire2016 Corp4 Roads2
Dependent Life Benefit	No coverage	Coverage	Coverage	No coverage
Optional Life Benefit	No coverage	Coverage	No coverage	No coverage
Accidental Death and Dismemberment Options	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Accidental Death and Dismemberment Benefit	Coverage	Coverage	Coverage	No coverage
LTD Options	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Long Term Disability	Coverage	Coverage	Coverage	No coverage
Health Options	**Option 1**	**Option 2**	**Option 3**	**Option 4***
Drug Benefit	No coverage	Coverage	Coverage	Coverage
Extended Health Care *Hospitalization*	 No coverage	 Coverage	 Coverage	 Coverage
Travel Benefit	Coverage	Coverage	Coverage	Coverage
Health Spending Account Benefit	Coverage	Coverage	Coverage	Coverage
Vision Options	**Option 1**	**Option 2***	**Option 3***	**Option 4**
Vision Benefit	No coverage	Coverage	Coverage	No coverage
Dental Options	**Option 1**	**Option 2**	**Option 3**	**Option 4***
Dental Benefit *Preventive and Basic Care* *Major Restoration* *Orthodontic Services*	 No coverage No coverage No coverage	 Coverage Coverage No coverage	 Coverage Coverage Coverage	 Coverage Coverage Coverage

***Requires minimum two year lock-in coverage period.**

Extended Health Care Option 2 is not available to Quebec Employees.

Plan	**Name of Group and Class Description**
Hire2016	Carillion Ontario Roads: Employees hired prior to January 1, 2016 Carillion Ontario Roads: Employees hired on or after January 1, 2016 Carillion Canada Inc.: Employees hired on or after January 1, 2016 Carillion Alberta Roads: Employees hired on or after January 1, 2016
Corp2	Carillion Canada Inc.: Employees hired prior to January 1, 2016 with less than 2 years of service
Corp3	Carillion Canada Inc.: Employees hired prior to January 1, 2016 with 2 years but less than 5 years of service
Corp4	Carillion Canada Inc.: Employees hired prior to January 1, 2016 with 5 years of service or more
Roads2	Carillion Alberta Roads: Employees hired prior to January 1, 2016
Corp UK	Carillion Canada Inc.**:** UK employees

Summary of Benefits

Member Life Benefit Options 1, 2, 3, 4*

Benefit Formula	
Option 1	1 times the annual Salary
Option 2	2 times the annual Salary
Option 3	3 times the annual Salary
Option 4	4 times the annual Salary
Benefit Minimum	$25,000
Benefit Maximum	$500,000
Non-Evidence Limit	$500,000
Terminal Illness Benefit	Included
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement

*Please refer to *Carillion Flex Benefits at a Glance* to determine which Options apply to you.

Member Life Benefit

(Corp UK Members with Basic Life coverage under UK Pension Plan)

Benefit Formula	Flat amount
Benefit Maximum	$10,000
Non-Evidence Limit	$10,000
Terminal Illness Benefit	Included
Termination	Age 70 or retirement

Dependent Life Benefit Options 2, 3

Benefit Formula	
Option 2 - Spouse	$10,000
Option 2 - Child*	$5,000/Child
Option 3 - Spouse	$20,000
Option 3 - Child*	$10,000/Child
Termination	When the Member reaches age 70 or retires

*From birth or 28 weeks gestation if stillborn.

Summary of Benefits

Optional Life Benefit Option 2

Benefit Formula	
Member Maximum	Units of $10,000 to a maximum of $300,000 $800,000 combined with member life benefit amount
Spouse Maximum	Units of $10,000 to a maximum of $300,000
Non-Evidence Limit	Proof of health is required for all amounts of coverage
Termination	
Member	Age 65 or retirement
Spouse	When the Member or Spouse reaches age 65 or when the Member retires

Optional Life Benefit

(Corp UK Members with Basic Life coverage under UK Pension Plan)

Benefit Formula	
Member Maximum	Units of $10,000 to a maximum of $300,000 $310,000 combined with member life benefit amount
Spouse Maximum	Units of $10,000 to a maximum of $300,000
Non-Evidence Limit	Proof of health is required for all amounts of coverage
Termination	
Member	Age 65 or retirement
Spouse	When the Member or Spouse reaches age 65 or when the Member retires

Summary of Benefits

Member Accidental Death and Dismemberment Benefit Options 1, 2, 3

Benefit Formula	
Option 1	1 times the annual Salary
Option 2	2 times the annual Salary
Option 3	3 times the annual Salary
Benefit Minimum	$25,000
Benefit Maximum	$500,000
Non-Evidence Limit	$500,000
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement

Member Accidental Death and Dismemberment Benefit Options 1, 2, 3

(Corp UK Members with Basic Life coverage under UK Pension Plan)

Benefit Formula	
Option 1	1 times the annual Salary
Option 2	2 times the annual Salary
Option 3	3 times the annual Salary
Benefit Minimum	$25,000
Benefit Maximum	$500,000
Non-Evidence Limit	$500,000
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement

Summary of Benefits

Long Term Disability Benefit Option 1

Benefit Formula	50% of monthly Pre-Disability Salary not exceeding the All Source Maximum
Benefit Maximum	$8,000/month
Non-Evidence Limit	$8,000
Elimination Period	17 weeks (119 days)
Benefit Period	The lesser of 10 years or age 65
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Survivor Benefit	Equal to 3 times the Member's take-home monthly long term disability benefit. The benefit payable to the beneficiary is non-taxable.
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Long Term Disability Benefit Option 2

Benefit Formula	60% of monthly Pre-Disability Salary not exceeding the All Source Maximum
Benefit Maximum	$8,000/month
Non-Evidence Limit	$8,000
Elimination Period	17 weeks (119 days)
Benefit Period	The lesser of 10 years or age 65
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Survivor Benefit	Equal to 3 times the Member's take-home monthly long term disability benefit. The benefit payable to the beneficiary is non-taxable.
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Long Term Disability Benefit Option 3

Benefit Formula	60% of monthly Pre-Disability Salary not exceeding the All Source Maximum
Benefit Maximum	$10,000/month
Non-Evidence Limit	$8,000
Elimination Period	17 weeks (119 days)
Benefit Period	To age 65
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Survivor Benefit	Equal to 3 times the Member's take-home monthly long term disability benefit. The benefit payable to the beneficiary is non-taxable.
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Drug Benefit Options 2, 3, 4

Policy Year	April 1st to March 31st
Deductible	None
Reimbursement Level	
Option 2	60% of any amount in excess of the $7.50 dispensing fee
Option 3	80%* of any amount in excess of the $7.50 dispensing fee
Option 4	100%* of any amount in excess of the $7.50 dispensing fee
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Open Formulary
Benefit Maximum	
Smoking Cessation Aids	
Option 2	$300/lifetime
Option 3	$300/lifetime
Option 4	$500/lifetime
Vaccines	$100/policy year
Intrauterine Contraceptive Device	$75/2 policy years
Allergy Sera	Unlimited
Sclerosing Agents	Unlimited
Injectable Vitamins	Unlimited
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	Age 70 or retirement
Survivor Coverage	24 months

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

Summary of Benefits

Extended Health Care Options 2, 3, 4

Policy Year	April 1st to March 31st		
Deductible			
Hospitalization	None		
Vision Care	None		
All Other Extended Health Care	None		
	Reimbursement Level	**Benefit Maximum**	**Accommodation**
Hospitalization			
Hospital	100%	Unlimited*	Semi-private
Convalescent Care/Physical Rehabilitation (combined)	100%	to a maximum of 180 days/policy year	Semi-private
Medical Services and Supplies			
Ambulance Transportation	100%	Unlimited*	
Nursing Care	100%	$10,000/policy year	
Health Practitioners:		**Maximum per policy year**	
Option 2			
*Psychologist/Social Worker (combined) **	100%	$400*	
Chiropractor	100%	$400*	
Naturopath	100%	$400*	
Acupuncturist	100%	$400*	
*Dietitian**	100%	$400*	
Osteopath	100%	$400*	
Chiropodist/Podiatrist (combined)	100%	$400*	
Audiologist	100%	$400*	
*Speech Therapist**	100%	$400*	
*Physiotherapist**	100%	$400*	
*Massage Therapist**	100%	$400*	
X-rays (Chiropractor)	100%	1 x-ray/policy year up to a maximum of $25/x-ray	

*Hospital and Ambulance Transportation, reimbursement is limited to usual, customary and reasonable charges. Health Practitioners, reimbursement per visit is limited to usual, customary and reasonable charges.

**When prescribed by a physician.

Extended Health Care Option 2 is not available to Quebec Employees.

Minimum two year lock-in coverage period for Extended Health Care Option 4.

Summary of Benefits

Extended Health Care

	Reimbursement Level	Benefit Maximum
Health Practitioners:		**Maximum per policy year**
Option 3		
*Psychologist/Social Worker (combined) **	100%	$500*
Chiropractor	100%	$500*
Naturopath	100%	$500*
Acupuncturist	100%	$500*
*Dietitian**	100%	$500*
Osteopath	100%	$500*
Chiropodist/Podiatrist (combined)	100%	$500*
Audiologist	100%	$500*
*Speech Therapist**	100%	$500*
*Physiotherapist**	100%	$500*
*Massage Therapist**	100%	$500*
X-rays (Chiropractor)	100%	2 x-rays/policy year up to a maximum of $25/x-ray

Extended Health Care

	Reimbursement Level	Benefit Maximum
Health Practitioners:		**Maximum per policy year**
Option 4		
*Psychologist/Social Worker (combined) **	100%	$600*
Chiropractor	100%	$600*
Naturopath	100%	$600*
Acupuncturist	100%	$600*
*Dietitian**	100%	$600*
Osteopath	100%	$600*
Chiropodist/Podiatrist (combined)	100%	$600*
Audiologist	100%	$600*
*Speech Therapist**	100%	$600*
*Physiotherapist**	100%	$600*
*Massage Therapist**	100%	$600*
X-rays (Chiropractor)	100%	2 x-rays/policy year up to a maximum of $25/x-ray

*Reimbursement per visit is limited to usual, customary and reasonable charges.
**When prescribed by a physician.
Minimum two year lock-in coverage period for Extended Health Care Option 4.

Summary of Benefits

Extended Health Care Option 2

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 policy years for approved purchase
Wheelchair (manual/electric)	100%	$3,000/60 consecutive months for approved purchase
Outdoor wheelchair ramp	100%	$2,000/lifetime
Intermittent positive pressure breathing machine/ventilator (combined)	100%	$2,000/60 consecutive months
BiPAP/CPAP/breathing monitors (combined)	100%	$2,000/60 consecutive months
Compression pump	100%	$1,500/lifetime
Patient lifter	100%	$2,000/lifter/5 policy years
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	1/4 policy years
Hearing Aids	100%	$500/48 consecutive months
Custom Orthopedic Shoes/Custom Made Foot Orthotics	100%	$250 each/policy year
Diagnostic Tests**	100%	
Other Medical Services and Supplies	100%	See benefit details
Graduated Compression Garments	100%	2 pairs/policy year
Accidental Dental	100%	Predetermination of claim required
Vision Care Option 2	100%	
Eye Examination	100%	$75/24 consecutive months
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	100%	$200/24 consecutive months
Lenses/Frames/Contact Lenses/Intraocular Lenses following Cataract Surgery	100%	1 pair/lifetime for frames 1/eye/lifetime for corrective lenses, contact lenses or intraocular lenses
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

*Pre-authorization required.

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

Extended Health Care Option 2 is not available to Quebec Employees.

Minimum two year lock-in coverage period for Vision Care Option 2.

Summary of Benefits

Extended Health Care Option 3

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 policy years for approved purchase
Wheelchair (manual/electric)	100%	$3,000/60 consecutive months for approved purchase
Outdoor wheelchair ramp	100%	$2,000/lifetime
Intermittent positive pressure breathing machine/ventilator (combined)	100%	$2,000/60 consecutive months
BiPAP/CPAP/breathing monitors (combined)	100%	$2,000/60 consecutive months
Compression pump	100%	$1,500/lifetime
Patient lifter	100%	$2,000/lifter/5 policy years
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	1/4 policy years
Hearing Aids	100%	$500/48 consecutive months
Custom Orthopedic Shoes/Custom Made Foot Orthotics	100%	$400 each/policy year
Diagnostic Tests**	100%	
Other Medical Services and Supplies	100%	See benefit details
Graduated Compression Garments	100%	4 pairs/policy year
Accidental Dental	100%	Predetermination of claim required
Vision Care Option 3	100%	
Eye Examination	100%	$120/24 consecutive months
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	100%	$300/24 consecutive months
Lenses/Frames/Contact Lenses/Intraocular Lenses following Cataract Surgery	100%	1 pair/lifetime for frames 1/eye/lifetime for corrective lenses, contact lenses or intraocular lenses
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

*Pre-authorization required.

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

Minimum two year lock-in coverage period for Vision Care Option 3.

Summary of Benefits

Extended Health Care Option 4

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Durable Medical Equipment*	100%	1/month for rental, 1/5 policy years for approved purchase
Wheelchair (manual/electric)	100%	$3,000/60 consecutive months for approved purchase
Outdoor wheelchair ramp	100%	$2,000/lifetime
Intermittent positive pressure breathing machine/ventilator (combined)	100%	$2,000/60 consecutive months
BiPAP/CPAP/breathing monitors (combined)	100%	$2,000/60 consecutive months
Compression pump	100%	$1,500/lifetime
Patient lifter	100%	$2,000/lifter/5 policy years
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	1/4 policy years
Hearing Aids	100%	$500/48 consecutive months
Custom Orthopedic Shoes/Custom Made Foot Orthotics	100%	$500 each/policy year
Diagnostic Tests**	100%	
Other Medical Services and Supplies	100%	See benefit details
Graduated Compression Garments	100%	4 pairs/policy year
Accidental Dental	100%	Predetermination of claim required
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

*Pre-authorization required.

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

Minimum two year lock-in coverage period for Extended Health Care Option 4.

Summary of Benefits

Dental Benefit Option 2

Policy Year	April 1st to March 31st	
Deductible	None	
Fee Guide Schedule	Current less one year/Province of Provider (Specialist fees paid at GP rate)	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	60%	$2,000/policy year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		1/9 consecutive months
Preventive Treatment		
Polishing of teeth		1/9 consecutive months
Fluoride treatment		1/9 consecutive months
Scaling		8 Units/12 consecutive months (combined with Root Planing)
Basic Care	60%	$2,000/policy year combined with Preventive Care and Major Restoration
Endodontic Services		Included
Periodontic Services		Included
Root Planing		8 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$2,000/policy year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services		See benefit details
Implants		1/tooth every 10 policy years
Restorations over implants		1/tooth every 10 policy years
Lowest Cost Alternative Benefit	Inlays and crowns Amalgam, acrylic, silicate or composite restorations on posterior teeth	
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

Summary of Benefits

Dental Benefit Option 3

Policy Year	April 1st to March 31st	
Deductible	None	
Fee Guide Schedule	Current less one year/Province of Provider (Specialist fees paid at GP rate)	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	80%	Unlimited*
Oral Exam and Diagnosis		
Recall oral exams		1/9 consecutive months
Preventive Treatment		
Polishing of teeth		1/9 consecutive months
Fluoride treatment		1/9 consecutive months
Scaling		12 Units/12 consecutive months (combined with Root Planing)
Basic Care	80%	Unlimited*
Endodontic Services		Included
Periodontic Services		Included
Root Planing		12 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$1,500/policy year
Restorative and Prosthodontic Services		See benefit details
Implants		1/tooth every 10 policy years
Restorations over implants		1/tooth every 10 policy years
Orthodontic Services	50%	$1,500/lifetime (Participants under age 19)
Lowest Cost Alternative Benefit	Inlays and crowns Amalgam, acrylic, silicate or composite restorations on posterior teeth	
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

*Reimbursement is limited to usual, customary and reasonable charges.

Summary of Benefits

Dental Benefit Option 4

Policy Year	April 1st to March 31st	
Deductible	None	
Fee Guide Schedule	Current year/Province of Provider (Specialist fees paid at GP rate)	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	100%	Unlimited*
Oral Exam and Diagnosis		
Recall oral exams		1/6 consecutive months
Preventive Treatment		
Polishing of teeth		1/6 consecutive months
Fluoride treatment		1/6 consecutive months
Scaling		16 Units/12 consecutive months (combined with Root Planing)
Basic Care	100%	Unlimited*
Endodontic Services		Included
Periodontic Services		Included
Root Planing		16 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$2,000/policy year
Restorative and Prosthodontic Services		See benefit details
Implants		1/tooth every 10 policy years
Restorations over implants		1/tooth every 10 policy years
Orthodontic Services	50%	$2,000/lifetime (Adult and Child)
Lowest Cost Alternative Benefit	Inlays and crowns Amalgam, acrylic, silicate or composite restorations on posterior teeth	
Termination	Age 70 or retirement	
Survivor Coverage	24 months	

*Reimbursement is limited to usual, customary and reasonable charges.

Minimum two year lock-in coverage period for Dental Benefit Option 4.

Summary of Benefits

Travel Benefit Options 1, 2, 3, 4

Policy Year	April 1st to March 31st
Deductible	None
Reimbursement Level	100%
Coverage Duration*	
Under age 65	First 60 days of Trip outside province of residence
Age 65 and over	First 30 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$2,000,000/Participant/Incident**
Worldwide Travel Assistance	Yes
Referral Outside of Canada* **	$500,000/Participant/lifetime
Termination	When the Member reaches age 70 or retires
Survivor Coverage	24 months

*Coverage duration will be determined based on the age of the Participant on their departure date.

**Incident: An individual occurrence of Emergency illness or injury.

***Pre-authorization required.

Summary of Benefits

Health Spending Account Benefit Options 1, 2, 3, 4

Policy Year	April 1st to March 31st
Deductible	None
Plan Administration	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member on the claim form)
Credit Allocation Frequency	Annually
Benefit Details	
Account Type	Credit Carry Forward
Grace Period for Active Members	12 months
Grace Period for Terminated Members	12 months
Termination	When the Member retires

You and Your Dependents

Throughout this booklet we use several key terms when we refer to you and your Dependents:

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

Employee: A person who:

- resides in Canada; and
- works a minimum of 20 hours per week for the employer.

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

Dependent: Your Spouse or Child.

Spouse: The person who:

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

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

Helpful Tip

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

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

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

Helpful Tip

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

Child: A person who:

- is a resident of Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
  a) is under age 21;
  b) is under age 25 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

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

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

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

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

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

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

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

Helpful Tip

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

Activities of Daily Living: The following 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.

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

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

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

Helpful Tip

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

Eligible Expenses: Charges incurred by the Participant 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 Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- recommended or prescribed by a Physician or Health Practitioner who:
  - does not normally reside in the Participant's home;

  - is not the Participant's Family Member; and
  - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant's home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the plan is in effect, unless otherwise specified.

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

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

Helpful Tip

Family member refers to a Participant's:

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

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

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.

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

In this plan, member life, dependent life, optional life, member accidental death and dismemberment, long term disability and travel benefits are Insured Benefits.

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

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- Dependent no longer meets eligibility criteria;
- involuntary loss or gain of spousal benefits coverage; or
- death of a Dependent.

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

Helpful Tip

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

diagnosed injury or Illness.

Policy Year: April 1st to March 31st of each year.

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

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

Salary: A Member's regular earnings paid by the Employer that are received as at end of December 31st of each policy year. It does not include dividends or any irregular gains, such as bonuses, gratuities or overtime.

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

Helpful Tip

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

In determining benefits, Salary will be the lesser of:

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

Self-Insured Benefits: Benefits that are:

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

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

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

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

Who is Eligible for Coverage?

You are eligible for coverage if you:

- meet the definition of Employee and are Actively at Work; and
- have completed the waiting period which is first of the month following 3 months of continuous employment.

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

Helpful Tip

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

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

You must continue to work the minimum number of hours per week to maintain eligibility under the plan.

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

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted in the following circumstances:

- if the coverage for yourself or your Dependents exceeds the non-evidence limit specified in the Summary of Benefits; or
- for all applications for the optional life benefit (if applicable).

Helpful Tip

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

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

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

How do I Enrol for Coverage?

Application

To obtain coverage, you must complete and submit your application within the enrolment period designated by your employer, in the format agreed on by Blue Cross. You must also submit proof of health, if required for one of the reasons listed above.

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the plan, except for the flexible benefit options detailed in the Summary of Benefits. In addition, when you enrol for coverage you must also enrol all of your eligible Dependents, subject to the exceptions noted below:

- it is your choice whether or not to obtain coverage for optional benefits. If you choose not to enrol for these benefits, you will not be able to obtain coverage until the next enrolment period; and
- you are allowed to waive the health benefits coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. In this case, you or your Dependents will again be eligible for health benefits if there is a change in your family status or if you or your Dependents' other coverage terminates for reasons outside of your control.

Helpful Tip

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

Annual Enrolment

Your employer will advise you about your plan's annual enrolment period. You will be able to move up or down one plan option level during this designated time period, except for those plan options with a two year minimum coverage period detailed in the Summary of Benefits. After you have completed your annual enrolment, any changes you made to your coverage will become effective April 1st.

Once you have made your benefit plan selections, no changes can be made until the following enrolment period, except in the case of a Life Event change.

When Does My Coverage Begin?

Employees

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

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

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

Dependents

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

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

Helpful Tip

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

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

Illness/Accident

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

If you are not actively at work due to illness or accident for a prolonged period of time and are unable to perform the duties of your job, and in receipt of disability benefits, coverage for Health and Dental benefits will be continued for a maximum of 24 months from the date of disability.

The extension of these benefits shall terminate at the earlier of recovery from the disability, termination of disability payments or termination of employment.

Maternity Leave/Parental Leave

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

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

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

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

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

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the plan terminates;
- you no longer meet one or more of the eligibility requirements;
- your employment is terminated;
- you (or your Spouse in the case of optional life benefits, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire from the employer, unless otherwise specified in the Summary of Benefits;
- you die;
- you or your Dependents commit a fraudulent act against Blue Cross or the plan sponsor; or
- the plan sponsor defaults in payment of premiums.

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

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

Helpful Tip

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

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

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

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

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

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

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

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

Survivor Coverage

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

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

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

What if I Have Coverage Elsewhere?

Blue Cross will co-ordinate your group benefits coverage with other health plans when similar coverage is available. The co-ordination of benefits process helps ensure you get the most out of your coverage, and also means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Helpful Tip

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

Government Health Care Coverage

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

Other Health Plans

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

Helpful Tip

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

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

Expenses for Yourself:

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

Expenses for Your Spouse:

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

Expenses for Your Child:

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

Helpful Tip

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

Purpose of Coverage

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

Advance Payment Due to Terminal Illness

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

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

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

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

Payment of Claims

Beneficiary

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages, without exceeding age 65.

Terms and Conditions of the Converted Policy

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

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

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the individual life policy will be a 1-year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options:
  - a non-convertible term life policy that provides level term coverage to age 65; or
  - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;

- the maximum amount of coverage available under the individual life policy is the lesser of:
  - the amount of member life benefit coverage in effect on the termination date;
  - the amount of any scheduled reduction of the member life benefit coverage;
  - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination;
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec; and
- the coverage provided by the individual life policy cannot be less than:
  - the minimum amount that Blue Cross will normally issue for the type of policy selected; or
  - $10,000 for residents of Quebec.

Purpose of Coverage

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

Payment of Claims

All benefits will be paid directly to the Member.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Right to Convert to Individual Coverage

Eligibility for Conversion

A Spouse residing in any province and a Child who is a resident of Quebec have the right to purchase an individual life policy from Blue Cross if their dependent life coverage terminates for one of the following reasons:

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

Terms and Conditions of the Converted Policy

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

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

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

Purpose of Coverage

This benefit provides additional amounts of life insurance to those available through the member life benefit and the dependent life benefit (if applicable).

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

Eligibility for Coverage

To be eligible for this benefit, the Member and Dependent must submit proof of health deemed satisfactory by Blue Cross.

Amount of Coverage

The benefit is equal to the amount of optional life benefit selected by the Member for themselves or their Dependent(s), up to the maximum amount specified in the Summary of Benefits.

A Member may request a change in the amount of their coverage or their Dependent's coverage under this benefit at any time. However, requests to increase coverage will not be granted without submission of proof of health deemed satisfactory by Blue Cross.

Payment of Claims

Beneficiary

In the case of the Member's death, benefits will be paid directly to the Member's beneficiary. In the case of a Dependent's death, all benefits are payable to the Member.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Exclusions and Limitations

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

Right to Convert to Individual Coverage

Eligibility for Conversion

A Member has the right to purchase an individual life policy from Blue Cross if their optional life benefit coverage terminates on or before the Member reaches age 65 due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Member belongs.

A Spouse has the right to purchase an individual life policy from Blue Cross if their optional life benefit coverage terminates for one of the following reasons:

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

Terms and Conditions of the Converted Policy

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

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

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the individual life policy will be a 1-year term life policy that may be exchanged, prior to its expiry date, for 1 of the following 2 life policy options:
  - a non-convertible term life policy that provides level term coverage to age 65; or
  - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage provided by the Member's individual life policy is the lesser of:
  - the amount of member life benefit coverage plus optional life coverage in effect on the date of termination of the optional life benefit; and
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec;
- the amount of coverage provided by the Member's individual life policy cannot be less than the minimum amount that Blue Cross will normally issue for the type of policy selected, or $10,000 for residents of Quebec; and
- the amount of coverage provided by the Dependent's individual life policy cannot be more than the amount of the Dependent's optional life benefit, and for residents of Quebec, less than $5,000.

Purpose of Coverage

If, as a result of an Accident, the Member dies, falls into a Coma or suffers a Loss defined in this benefit, Blue Cross will pay a specified percentage of the amount shown in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

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

Coma or comatose: 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.

Hemiplegia: Total and irrecoverable paralysis of the upper and lower limbs on one side of the body.

Loss: Any loss specified in the Table of Benefits.

Loss of arm: Complete severance at or above the elbow joint.

Loss of finger: Complete loss of two entire bones of a finger.

Loss of foot: Complete severance at or above the ankle joint but below the knee joint.

Loss of hand: Complete severance at or above the wrist joint but below the elbow joint.

Loss of hearing, sight or speech: Total and irrecoverable loss of hearing, sight or speech, certified by a physician.

Loss of leg: Complete severance at or above the knee joint.

Loss of thumb: Complete loss of one entire bone of a thumb.

Loss of toe: Complete loss of one entire bone of the big toe or of all bones of any other toe.

Loss of use: Complete and irreversible loss of use of a limb for at least 12 months.

Quadriplegia: Total and irrecoverable paralysis of both the upper and lower limbs.

Paraplegia: Total and irrecoverable paralysis of both lower limbs.

Coverage

To be covered under this benefit, a Loss must:

- result from an Accident that occurs while the Member is covered under this benefit; and
- occur within 365 days after the date of this Accident.

A Member will be considered to have suffered loss of life as a result of an Accident if the Member's death is due to accidental drowning.

What Blue Cross Will Pay

Table of Benefits

In the event of Loss, Blue Cross will pay the following percentages of the coverage amount specified in the Summary of Benefits:

Loss of	Amount of coverage
Life	100%
Both hands or both feet	100%
Both arms or both legs	100%
Speech and hearing in both ears	100%
Sight in both eyes	100%
Sight in one eye and one hand	100%
Sight in one eye and one foot	100%
One hand and one foot	100%
One arm and one leg	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Sight in one eye	66 2/3%
Speech or hearing in both ears	50%
Thumb and index finger of any one hand	33 1/3%
At least four fingers of one hand	33 1/3%
Hearing in one ear	16 2/3%
All toes of one foot	12 1/2%
Paralysis	
Quadriplegia	200%
Hemiplegia	200%
Paraplegia	200%
Loss of use of	
Both arms or both legs	100%
Both hands or both feet	100%
One hand and one foot	100%
One arm and one leg	100%
One arm or one leg	75%
One hand or one foot	66 2/3%

Additional Benefits

Blue Cross will also pay the following additional benefits, if applicable:

Coma

If the Member falls into a Coma as a result of an Accident, Blue Cross will pay a monthly benefit equal to 1% of the amount of coverage specified in the Summary of Benefits.

For benefits to be payable, the Coma must occur within 30 days of the Accident and persist uninterrupted for at least 30 days. Benefits are then payable for the duration of the Coma or until the amount of coverage has been paid in full, whichever occurs first.

Exposure and Disappearance

If a Member 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 deemed to be the result of an Accident.

A Member will be deemed to have suffered loss of life as a result of an Accident if:

- the Member 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 Member is still alive).

Repatriation

If benefits are payable for loss of life that occurred at least 150 kilometres from the Member's place of residence, Blue Cross will pay the expenses incurred to:

- prepare the body for burial or cremation; and
- ship the body to the place of burial or cremation, or bury or cremate the body at the place of death.

The benefit maximum for all expenses under this benefit provision is $10,000. Amounts payable will be paid to any person who appears to Blue Cross to be fairly entitled to the benefit as a result of having incurred any of the above mentioned expenses.

On receipt of written proof of anticipated expenses, Blue Cross may make an advance payment, provided that the plan sponsor confirms to Blue Cross:

- the name of the Member and the date and cause of death; and
- that the Member was eligible for this benefit on the date of death.

This coverage excludes the cost of a coffin.

Rehabilitation

If benefits are payable to a Member as a result of a Loss, Blue Cross will pay reasonable and necessary expenses incurred by the Member for special training, provided that:

- these expenses are incurred within 3 years of the date of the Accident; and
- the training is needed:
  - as a result of the Loss; or
  - to enable the Member to work in an occupation for which they were not qualified before the Loss.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

Occupation Training for the Spouse

If benefits are payable for loss of life of a Member, Blue Cross will pay the reasonable and necessary expenses incurred by their Spouse for a formal training program provided that:

- the Spouse is taking the program to gain active employment in any occupation for which they would not otherwise be qualified; and
- the expenses are incurred within 3 years of the Member's death.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

Education for Children

If benefits are payable for loss of life of a Member, Blue Cross will pay tuition fees and other reasonable and necessary expenses incurred by each Child enrolled in a post-secondary education institution, provided that this enrolment is:

- on a full-time basis; and
- in effect at the time of the Member's death or occurs within 365 days of the Member's death.

The maximum amount payable per Child is the lesser of:

- 5% of the Member's coverage specified in the Summary of Benefits;
- the actual eligible expenses incurred; or
- $5,000 for each year a Child continues their post-secondary education on a full-time basis to a maximum of 5 years or until the Child reaches age 25, whichever occurs first.

The amount payable will be paid in annual instalments to the Child (if age 18 and over) or to the surviving parent or legal guardian of the Child (if the Child is under age 18).

Each payment instalment will be issued on receipt by Blue Cross of written proof of enrolment and of expenses incurred.

This coverage excludes travel, clothing, room, board and ordinary living expenses.

Family Travel

If a Member is confined to a hospital more than 150 kilometres from the Member's normal place of residence as a result of:

- a Loss or a Coma; or
- an illness or injury not specified in the Table of Benefits but which requires at least 4 days of hospital confinement

Blue Cross will pay the reasonable and necessary travel and accommodation expenses for 1 or more family members to travel to the Member's place of confinement.

The maximum amount payable under this benefit provision is the lesser of:

- hotel accommodation and transportation costs actually incurred; or
- $3,000.

If personal transportation is used instead of public transportation, a rate of $0.35 per kilometre applies.

Payment of Claims

Beneficiary

In the case of loss of life, Blue Cross will pay benefits directly to the Member's beneficiary, unless otherwise specified in this benefit. For any other Loss or Coma, benefits will be paid to the Member.

Maximum Amount Payable

The total amount payable for one or more Losses or a Coma that results from the same Accident will not exceed 100% of the amount of coverage specified in the Summary of Benefits, except for Quadriplegia, Paraplegia and Hemiplegia which are paid at 200%.

Blue Cross will only pay one amount, the largest applicable, for injuries to the same limb that result from the same Accident.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of the loss.

Exclusions and Limitations

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

a) any medical or surgical treatment or illness or disease of any kind, other than septic infection caused through a wound sustained as a result of an Accident;
b) suicide, attempted suicide or voluntary injury or illness, whatever the state of mind of the Member;
c) voluntary ingestion of poison or drugs;
d) inhalation of fumes, unless an occupational health and safety board has deemed such inhalation to be an Accident;
e) any Accident or injury occurring while the Member 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 Member's participation in any riot or civil commotion;
g) injuries sustained while the Member is flying or attempting to fly an airplane or other type of aircraft, if the Member is part of the crew or is performing any other flight duties; or
h) any Accident or injury that occurs while the Member 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.

Purpose of Coverage

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

Additional Definitions

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

Benefit Period: The maximum duration for which Blue Cross will pay benefits. This maximum is specified in the Summary of Benefits.

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

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

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

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

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

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

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

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

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

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

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

Helpful Tip

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

Payment of Benefits

When Benefit Payments Begin

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

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

Calculation of the Benefit Amount

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

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

Step 2. Blue Cross subtracts from this monthly benefit amount any income amounts that are payable to the Member as a result of the same or a subsequent disability under any one or more of the following:
a) the Quebec Pension Plan or the Canada Pension Plan;
b) any workers' compensation board/commission;
c) any automobile insurance bureau, if applicable;
d) the Canada Employment Insurance Commission (CEIC) ; or
e) any federal or provincial law or legislation;

Helpful Tip

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

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

Additional Sources of Income means:
a) any of the following income amounts payable to the Member, as a result of their current or subsequent disability, under one of the following plans:
   i. any fringe-benefits plan offered by the employer as defined by the Income Tax Act;
   ii. any plan under which the Member is covered as a member of an association; or
   iii. any fringe-benefits plan set up according to any provincial or federal law, including the disability payments from any of the plans specified in Step 2; and
b) any income amounts payable to the Member under any retirement or pension plan funded in whole or in part by the Employer. This includes the Quebec Pension Plan or Canada Pension Plan if the application for retirement benefits is made following the date of Total Disability.

With respect to the income amounts calculated in Step 2 and Step 3:
- income amounts received for children are not included;
- if it appears to Blue Cross that there are income amounts to which the Member is eligible, Blue Cross may include these amounts in its calculations even if the Member fails to apply for or exercise their right to these amounts;
- Blue Cross may estimate income amounts pending their actual award;
- Blue Cross will perform its calculations without including subsequent increases to these income amounts by way of cost-of-living adjustments; and
- if an income amount is paid by lump sum rather than monthly instalments, Blue Cross will include in its calculations the amount obtained by dividing this lump sum by:
  - the number of monthly instalments the lump sum represents, if known to Blue Cross; or
  - 60, if Blue Cross does not know the number of months represented.

Survivor Benefit

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

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;
- the Member fails to:
  - provide Blue Cross with satisfactory proof of continued Total Disability;
  - submit to an independent examination requested by Blue Cross; or
  - participate in any reasonable Treatment or rehabilitation program considered appropriate by Blue Cross;
- the Member reaches the termination age specified in the Summary of Benefits;
- the Benefit Period expires;
- the Member engages in any occupation, employment or volunteer work other than a rehabilitation program pre-approved by Blue Cross;
- the Member refuses to accept any reasonable offer of modified duties or alternative employment from the employer; or
- the Member dies.

Time Limit to Submit a Claim

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

If this 90-day time limit is not met for reasons Blue Cross considers unacceptable, the Elimination Period will begin on the date Blue Cross receives all relevant documents needed to establish proof of disability.

Helpful Tip

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

Recurrent Disabilities

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

- the same or related causes within the first 6 consecutive months of the Member returning to work according to their normal work schedule; or
- different and unrelated causes and the Member did not fully recover from the first disability and did not return to work for at least a full day before the start of the recurrent disability.

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

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

Total Disability During Periods of Absence

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

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

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

Rehabilitation Program

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

- medical care, Treatment, diagnostic measures or prescribed medications;
- full-time work, part-time work or volunteer work whether or not wages or remuneration are received for such work; or
- a vocational assessment, training or re-training program for the purpose of rehabilitation.

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

- the Member's Total Disability will not be considered to have ended simply because they undertook a rehabilitation program;
- if the Member becomes Totally Disabled again while participating in a rehabilitation program, the terms and conditions of this benefit will apply as if the Member had remained Totally Disabled for the full duration of the rehabilitation program;
- the Benefit Period continues despite participation in the rehabilitation program; and
- during the rehabilitation program, monthly benefits will be reduced by 50% of the remuneration received by the Member from such a program and will further be reduced as necessary to ensure that the Member's total income from all sources does not exceed 100% of the Member's Pre-Disability Salary.

Exclusions and Limitations

1. Benefits are not payable for any Total Disability that results, directly or indirectly, from any of the following causes:
   a) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
   b) any accident or injury occurring while operating a motor vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the accident occurred;
   c) attempted suicide or voluntary injury or illness, whatever the state of mind of the Member;
   d) medical care or treatment that is not Medically Necessary or that is performed for cosmetic purposes only; or
   e) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

2. Benefits are not payable during any periods in which the Member:
   a) receives maternity or parental benefits under any provincial or federal law or takes maternity or parental leave in accordance with any provincial or federal law or any agreement between the Member and the employer, subject to the following exception:
      - benefits will be payable during the health-related portion of the maternity leave when required by applicable law or legislation, provided coverage has been continued for the Member. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Blue Cross;
   b) is absent from Canada for any reason, unless Blue Cross agrees in writing, in advance, to pay benefits during the period; or
   c) is imprisoned in a correctional facility or community residence or while under house arrest by order of a criminal court.

Pre-Existing Conditions

A Pre-Existing Condition is any Illness or injury for which, during the 3 months immediately before the effective date of the Member's long term disability benefits (under this plan or a Previous Policy), the Member has:

- had a medical consultation;

- been prescribed or taken medication; or
- received treatment, including diagnostic measures.

If the Summary of Benefits specifies the Pre-Existing Conditions provision of this benefit applies, then benefits are not payable if Total Disability results from a Pre-Existing Condition unless:

- Total Disability begins after the Member has been covered for long term disability benefits (under this plan or a Previous Policy) for at least 12 consecutive months; or
- within a 15-month period (beginning 3 months before and ending 12 months after the effective date of the Member's long term disability benefits under this plan or a Previous Policy), there has been 6 consecutive months during which the Member has not:
  - had a medical consultation;
  - been prescribed or taken medication, including a change in dosage in an existing prescription; or
  - received treatment, including diagnostic measures for this condition.

Purpose of Coverage

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

Additional Definitions

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

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) or a natural health product number (NPN) 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;
- approved by Blue Cross as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

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

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

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

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 Participant. 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.

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 benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
  - Special Authorization; and/or
  - co-ordination with patient assistance programs;
- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit; and
- payment is limited in accordance with the Limitations and Exclusions provision of this benefit.

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

- diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM) sensors and insulin pump supplies;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formulary:
  - **Open Formulary:** List of all Life-Sustaining Drugs and Eligible Drugs that require a prescription by law. This list is not subject to the Medication Advisory Panel decisions.

Helpful Tip

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

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

Special Authorization

Certain Eligible Drugs require 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 Participant to participate in related patient support programming.

How does the Special Authorization process affect my claim?

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

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

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

Helpful Tip

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

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

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

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug.

Helpful Tip

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

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

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

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

Payment of Claims

How Payments are Made

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

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

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

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

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

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

Helpful Tip

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

Helpful Tip

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

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

a) varicose vein injections;
b) antihistamines and allergy sera;
c) smoking cessation aids;
d) vaccines;
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 treatments;
i) erectile dysfunction treatments;
j) hair growth stimulants;
k) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only;
    iii. are elective in nature; or
    iv. have experimental or investigative indication;
l) procedures related to drugs injected by a Health Care Professional in a private clinic;
m) drugs that Blue Cross determines are intended to be administered in

Helpful Tip

Shop around for the best price for your prescription drugs.

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

hospital, based on the way they are administered 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, treatment or supplies the Participant receives free of charge;
p) charges that would not have been incurred if no coverage existed; or
q) drugs that are eligible under the travel benefit provided by the group plan (if applicable).

Right to Convert to Individual Coverage

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

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

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

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

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

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

Out-of-pocket Maximum per Calendar Year

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

Participants Age 65 Years and Over

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

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

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

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

Exception: If the Summary of Benefits specifies this benefit is supplemental to the RAMQ public drug plan coverage, the following expenses are eligible:

- the Deductible and coinsurance paid by the Quebec Participant under the RAMQ public drug plan; and

- reimbursement for any Eligible Drug that is not included in the RAMQ public drug plan but is covered under this benefit, subject to the Deductible and reimbursement level specified in the Summary of Benefits.

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

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

Purpose of Coverage

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

Helpful Tip

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

To receive savings, present your Blue Cross identification card and mention **Blue Advantage®** to any participating provider prior to processing your transaction.

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

Additional Definitions

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

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

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

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

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

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

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

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

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

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

What Blue Cross Will Pay

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

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

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

Hospitalization

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

Convalescent Care/Physical Rehabilitation: Room accommodation when a Participant is admitted to a Convalescent Care Facility or a Physical Rehabilitation Facility within 14 days of their discharge from a Hospital where they received Acute Care.

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

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

Medical Services and Supplies

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

This coverage excludes inter-Hospital transfers.

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

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

Helpful Tip

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

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

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

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

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

Helpful Tip

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

This coverage excludes:

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

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

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

Helpful Tip

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

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

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

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

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

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

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A $10,000 maximum applies to myoelectric limbs;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of $200 per 24 consecutive months, includes replacement, repairs and adjustments; 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 policy year.

This coverage excludes:

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

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

Insulin pumps are eligible under the durable medical equipment benefit.

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

Exception**:** for a Child less than age 21 who requires a hearing aid for each ear, the benefit maximum specified in the Summary of Benefits is per ear.

This coverage excludes batteries and exams.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

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

Helpful Tip

For more information on which expenses qualify under your orthopedic shoes and orthotics coverage, visit our website. www.medavie.bluecross.ca/benefitupdates.

This coverage excludes the purchase and repair of:

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

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

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

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

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

- allergy testing materials to a maximum of $50 per policy year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per policy year;
- burn pressure garments to a maximum of $500 per policy year;
- graduated compression garments to the maximum specified in the Summary of Benefits;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;
- spacing devices to a maximum of 1 per policy year;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per policy year;
- surgical brassieres to a maximum of 2 per 12 consecutive months;
- ear plugs to a maximum of 1 pair per 24 consecutive months; and

- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $700 per lifetime.

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

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

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the Employer;
- initiated within 180 days of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval and approved within that period; and
- performed and completed within 12 months of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

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

This coverage excludes accidental damage to teeth that occurs while eating. Charges for implants and implant related or supported services are not eligible under this benefit.

Vision Care

Eye Examination: Charges for an eye examination performed by an ophthalmologist or optometrist.

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

- corrective eyeglasses (frames and lenses) and contact lenses; and
- laser eye surgery.

Lenses, Frames, Contact Lenses and Intraocular Lenses following Cataract Surgery: Charges for the following products and services are eligible when prescribed by an ophthalmologist or optometrist:

- corrective eyeglasses (frames and lenses), contact lenses; or
- intraocular lenses following cataract surgery.

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

Payment of Claims

How Payments are Made

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

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

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

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

a) services, treatment, articles or supplies that are not mentioned in the categories of Eligible Expenses listed in this benefit;
b) health care covered under any government health care coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;
c) health care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies that the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) services, treatment or supplies that are:
    i. not Medically Necessary;
    ii. for cosmetic purposes only;
    iii. elective in nature; or
    iv. experimental or investigative.
g) all services relating to family planning (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) charges that are eligible under the travel benefit provided by the group plan (if applicable);
i) services or supplies normally intended for recreation or sports;
j) extra supplies that are spares or alternates;
k) charges for missed appointments or the completion of forms;
l) medical examinations or routine general checkups;
m) mileage or delivery charges to or from a Hospital or Health Practitioner; or
n) services or expenses incurred as a result of:
    i. attempted suicide or voluntary injury or illness, whatever the state of mind of the Participant;
    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.

Right to Convert to Individual Coverage

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

Purpose of Coverage

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

> **Helpful Tip**
> Blue Cross limits its payments to the amount listed in the fee guide specified in the Summary of Benefits.
>
> Before starting your Treatment, ask your dentist if they follow the provincial fee guide.

Additional Definition

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

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

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

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

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

What Blue Cross Will Pay

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

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

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

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

Preventive Care

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

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 2 policy years;
- recall oral examination;
- emergency oral examination to a maximum of 2 per provider per 12 consecutive months; and

- limited or specific oral examination to a maximum of 2 per provider per 12 consecutive months.

X-rays: Charges for:

- complete series films and panoramic film to a combined maximum of 1 per 36 consecutive months;
- intra-oral films:
  - periapical and bitewings to a maximum of 1 procedure each per 9 consecutive months; and
  - occlusal to a maximum of 1 procedure per policy year;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

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

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- oral hygiene instruction to a maximum of 1 Unit per lifetime;
- pit and fissure sealants (limited to Participants under age 15);
- mouth guard; and
- scaling.

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

Space maintainers: Limited to Participants under age 18.

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth;
- retentive pins;
- pre-fabricated steel or plastic restorations (limited to Participants ages 3-10); and
- pulp capping.

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

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy to a maximum of 1 per tooth per 36 consecutive months;
- endodontic surgery;
- bleaching (endodontically treated teeth); and
- apexification.

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

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- desensitization to a maximum of 3 Units per policy year;
- periodontal curettage;
- root planing;
- occlusal adjustments to a maximum of 8 Units per 12 consecutive months;
- periodontal appliances to a maximum of 1 upper and 1 lower per 36 consecutive months;
- adjustments to appliances to a maximum of 3 Units per policy year; and

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

- other adjunctive periodontal services.

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments;
- rebasing or relining to a maximum of 1 upper and 1 lower per 36 consecutive months; and
- prophylaxis and polishing.

Oral Surgery: Charges for:

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

General adjunctive services: Charges for:

- anesthesia (related to surgery);
- temporary dressing for the emergency relief of pain; and
- finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- inlays;
- onlays; and
- 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 policy years.

Other Restorative Services: Charges for:

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

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 policy years;
- bridgework to a maximum of 1 per tooth per 5 policy years;
- implants, if specified in the Summary of Benefits;
- restorations over implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per tooth per 10 policy years, if specified in the Summary of Benefits;
- implant related services, if implants are covered;
- construction and insertion of an initial permanent denture or bridgework; and
- replacement of an existing denture or bridge with a permanent denture or bridge so long as the existing appliance is at least 5 years old.

Helpful Tip

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

Orthodontic Services

Charges for:

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

Helpful Tip

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

Payment of Claims

How Payments are Made

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

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Predetermination for Claims over $500

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

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

Date of Treatment

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

Reimbursement for Orthodontic Services

Orthodontic services will be reimbursed in accordance with the following schedule:

- at the time the Participant makes their payment for orthodontic services, Blue Cross will reimburse the lesser of:
  - the initial payment made by the Participant; or
  - one half of the total Eligible Expense amount in relation to the Treatment; and
- the balance of the total Eligible Expense amount will be divided by the months of active Treatment remaining and reimbursed in equal monthly instalments for the duration of Treatment.

Exclusions and Limitations

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

a) services, treatment, articles or supplies that are not mentioned in the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable

under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;

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

Purpose of Coverage

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

Additional Definitions

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

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

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

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

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

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

Hospital: A facility that:

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

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

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

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

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

What Blue Cross Will Pay

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

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and/or in the Summary of Benefits;
- prior approval of Blue Cross must be obtained before the Eligible Expense is incurred;

- the charges must be usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount typically charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- payment is limited in accordance with the Limitations and Exclusions provision of this benefit;
- payment is limited to amounts that are in excess of coverage provided by any other plan; and
- payment is subject to post-payment audit.

Emergency Hospital and Medical Travel Coverage

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

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

Helpful Tip

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

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

Physician Fees: Fees charged for physician or surgeon services.

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

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the Participant or 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, but only in a quantity sufficient to treat the condition for the duration of the Trip. The Participant must provide satisfactory proof of purchase of this medication that includes:

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

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

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

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

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

- Treatment must begin while the Participant is covered by this benefit and end within 6 months of the accident, unless deferred Treatment is approved by Blue Cross due to the age of the Participant; and
- the maximum reimbursement per Participant per Incident is $2,000.

With respect to Treatment under category (c), the maximum reimbursement per Participant per Incident is $200.

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

Repatriation to the Province of Residence: The cost of repatriating the Participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the plan. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- economy fare to the Participant’s home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Participant is not possible for medical reasons considered acceptable by Blue Cross, Blue Cross may require repatriation of any Participant or transfer to other medical facilities. If the Participant refuses repatriation or transfer, all rights to benefits in relation to the Incident are terminated.

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

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

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

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

Meals and Accommodation: The cost of commercial accommodation and meals when the Participant’s travel is delayed due to an Emergency illness or injury of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending physician. The maximum reimbursement is $150 per Participant per day for a maximum of 20 days (up to a total maximum of $3,000 per Incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

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

Medical Assistance

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

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

General Assistance

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

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

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

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

Referral Outside of Canada

When an attending physician refers a Participant outside of Canada for medical services not available in Canada, Blue Cross will cover the portion of expenses listed below which exceed those covered by the Participant's government health care coverage.

Hospital Services: Charges for:

- hospital room accommodation;
- intensive care room accommodation;
- nursing services;
- operating and recovery room services;
- diagnostic and laboratory services, including X-rays;
- oxygen and blood;
- prescription drugs including intravenous solutions; and
- physiotherapy.

Physicians and Surgeons: Charges for services rendered by a physician or surgeon.

Ambulance Transportation and Attendant: Charges for licensed ambulance services needed to transport a stretcher patient to and from the nearest hospital able to provide Acute Care, including any charges for travel expenses of an accompanying registered nurse or qualified medical attendant, other than a relative.

To be eligible for coverage under this category, all expenses must be pre-approved by Blue Cross and the Participant's government health care coverage must agree to cover a portion of the expenses.

Payment of Claims

How Payments are Made

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

Time Limit to Submit a Claim

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

Blue Cross will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts Blue Cross would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

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

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

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:
    i. are not incurred as a result of an Emergency;
    ii. are not Medically Necessary;
    iii. are performed for cosmetic purposes only;
    iv. are not required for the immediate relief of acute pain and suffering; or

   v. could be delayed until the Participant's return to Canada;
b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or
c) 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; or
   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.

Referral Outside of Canada

No payment will be made for:

a) services available in Canada;
b) health care services or treatments unavailable in Canada due to waiting lists;
c) health care services or treatments that physicians in Canada have refused to perform;
d) services, treatment or supplies that are experimental or investigative;
e) services provided while the Participant is not under the active Treatment of a physician; and
f) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition: An illness:

- that begins within 12 months of the date the Participant obtained coverage under this benefit; and
- for which, in the 12 month before the date the Participant obtained coverage under this benefit, the Participant has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

Purpose of Coverage

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

Additional Definitions

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

(CRA) Dependent: Defined by the Canada Revenue Agency. This could include family members who are financially reliant on you such as parents, grandparents or grandchildren.

Grace Period – Credits Carry Forward: The period of time commencing at the end of a policy year within which claims for reimbursement must be submitted to Blue Cross. This period of time is specified in the Summary of Benefits.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses based upon the Canada Revenue Agency guidelines. Eligible Expenses include Deductible amounts, co-payment amounts, amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care coverage, or any other private program.

HSA Credits

Under an HSA, you have access to a pre-determined amount of HSA credits. Credits represent the value allocated to the HSA in any particular policy year (specified in the Summary of Benefits).

The HSA credits will be available to you according to the Credit Allocation Frequency specified in the Summary of Benefits.

Under no circumstances will unused HSA credits be paid out as cash.

These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits. For example, they can be used to cover Deductibles, co-payments, or amounts above plan maximums.

Common Eligible Expenses			
Attendant Care (requires certification of need from physician)	• Services provided in Home, Retirement Home, Nursing Home or Group Home	• Includes Fees from: - Personal Care Worker - Registered Nurse - Respite Care	• Includes Fees for: - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	• Diagnostic Services (x-rays) • Dentures • Orthodontics	• Preventive Services, such as: - Recall Examinations, - Polishing, and - Application of Fluoride	
Diagnostic Services*	• Diagnostic laboratory, radiological tests and scans		
Drugs	• Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner*	• Fertility Treatments • Flu Shots • Insulin* • Liver Extract Injections*	• Smoking Cessation Drugs* • Vaccines • Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	• Convalescent care home • Hospital	• Nursing home • Psychiatric facility • Substance abuse facility	
Medical Devices and Services*	• Air Conditioners (required for severe chronic ailment, disease or disorder) • Artificial Eyes and Limbs • Blood Transfusion Fees • Breast Prosthesis • Cochlear Implants • Crutches • Diabetic Supplies	• Electronic Bone Healing Devices • Electronic Speech Synthesisers • Hearing Aids • Heart Monitoring Devices • Needles and Syringes • Ostomy Supplies • Oxygen Equipment • Physician Fees	• Prosthetics • Repairs to Eligible HSA Devices • Respirators • Scooters • Trusses • Walkers • Wheelchairs (excluding accessories)
Medical Practitioner Services	• Acupuncturist • Athletic Therapist • Audiologist • Chiropodist/Podiatrist • Chiropractor • Dental Hygienist • Dentist	• Dietician • Homeopath • Massage Therapist** • Naturopath • Occupational Therapist • Osteopath	• Personal Care Worker* • Physiotherapist • Psychiatrist • Psychologist • Registered Nurse • Social Worker • Speech Therapist
Medical Transportation Services	• Ambulance Services • Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses	• Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required)	• Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	• Health and Dental Plan Premiums (private insurance)	• Home or Vehicle Modifications, when required for disabled persons	• Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	• Lip Reading	• Sign Language	
Vision Care	• Contact Lenses • Eye Examinations	• Laser Eye Surgery	• Prescription Lenses and Frames

*Prescription required

**For Therapeutic massage services only

Exclusions and Limitations

The following are examples of expenses which are not covered:

Common Ineligible Expenses			
Adoption Fees	• Adoption Fees		
Cosmetic Procedures (aimed at purely enhancing appearance)	• Augmentations • Botox Injections • Liposuction	• Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions)	• Laser Hair Removal • Tattoo Removal • Teeth Whitening
Cosmetics and Hygiene Products	• Contact Lens Solution • Lotions and Creams	• Make-up • Sunscreen	• Toothpaste
Dietary Supplements	• Food (except when required for enteral feeding)	• Minerals and Supplements	• Meal Replacements
Esthetic Massage Therapy	Such as:	• Aromatherapy Massage	• Body Wraps
Fees for missed appointments	• Fees for missed appointments		
Health Programs	• Weight loss program fees		
Home Appliances	• Air Conditioners • Air Purifiers	• Dehumidifiers • Fans	• Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	• Hot Tubs	• Saunas	
Life and Disability Plan Premiums	• Life and Disability Plan Premiums		
Over the counter medications	Such as: • Acid Controllers • Allergy Medications • Cough and Cold Items	• Creams and Lotions • Digestive Aids • Herbal Remedies • Pain Relievers	• Smoking Cessation Products • Vitamins
Personal Response Systems	• Lifeline Services • Health Line Services		
Shoes	• Off the shelf	• Athletic	
Sports Equipment	• Treadmills		

Further to this list, please refer to the Summary of Benefits for Specific Benefit Exclusions or Specific Expense Exclusions (if any).

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the type of Plan Administration that applies to Participants under this policy.

Account Type

Credit Carry Forward

Credits may be used to reimburse Eligible Expenses incurred in the same policy year the credits were allocated.

Unused credits can also be carried forward into the following policy year. Credits cannot be carried forward more than one year. At the end of the second policy year, unused credits from the first are forfeited.

Claims must be applied to any carry forward credits before current policy year credits are used.

Claims must be submitted in the policy year they were incurred. However, there is a Grace Period specified in the Summary of Benefits, within which claims may be submitted after the policy year end.

Grace Period for Terminated Member

If your employment ends, or your group terminates coverage with Blue Cross, you will have the Grace Period for terminated Members (specified in the Summary of Benefits) within which to use the remaining balance. Only eligible expenses incurred prior to the termination of coverage are eligible.

What Are My Responsibilities Under the Plan?

Keeping Your Employer Informed

It is your responsibility to provide complete and accurate information when enrolling for your group benefits, including accurate information on your family status, as well as your beneficiary designation(s). You should complete the group benefits enrolment within 31 days from the date you become eligible for coverage.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Failure to do so could result in the need for proof of health before your requested change in coverage takes place. Changes that must be reported to your employer include:

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

Helpful Tip

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

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

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

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

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

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

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

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

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

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

Providing Proof of Claim

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

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

Costs associated with providing proof of claim are your responsibility.

Helpful Tip

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

Submitting Claims After Your Group Plan Terminates

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

- for disability benefits, **within 6 months** of the onset of disability or the time limit specified by applicable provincial legislation, whichever period is longer;
- for accidental death and dismemberment benefits or accidental damage to natural teeth, **within 6 months** following the termination date of this group plan; or
- **within 90 days** following the termination date of this group plan for all other benefits.

Recovering Damages From a Third Party (Subrogation)

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

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

Reporting Health Insurance Fraud

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

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

Helpful Tip

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

How You Can Help

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

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

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

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

Helpful Tip

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

Toll free:
1-877-412-8809

StopFraud@medavie.bluecross.ca

www.medavie.bluecross.confidenceline.net

What Are My Rights Under the Plan?

Privacy

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

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

What is personal information?

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

How is Your Personal Information Used?

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

To Whom Could This Personal Information be Disclosed?

Helpful Tip

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

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

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

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

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

Disputing a Claim Decision

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

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

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

Copy of the Group Plan

Where legislated, you have the right to request a copy of your application for benefits and any written statements or other record provided to Blue Cross as proof of your health. You may also request, with reasonable notice, a copy of the contract for Insured Benefits.

The Rights of Blue Cross Under the Plan

Right to Audit

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

Helpful Tip

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

Recovery of Overpaid amounts

Blue Cross has the right to recover from a Participant:

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

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

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

Termination or Suspension of Benefit Payments

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

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

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

How to Obtain a Claim Form

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

- the plan member website (see instructions below);
- one of our Quick Pay locations;
- your group benefits administrator; or
- our Customer Information Contact Center at the toll-free number listed below.

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

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

Helpful Tip

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

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

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

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

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

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

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

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

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

You can submit your claims for **life, accidental death and dismemberment, or disability benefits** to Blue Cross by:

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

Plan Member Website

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

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

Helpful Tip

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

To register for the plan member website:

1. Visit the Blue Cross website at **www.medavie.bluecross.ca**.
2. Select *For Plan Members* from the e-Service Centre.
3. Choose Go To Secure Site and select *First Time, Register Now*.
4. Complete the online registration form.
5. A temporary password will be e-mailed to the e-mail address entered during registration.
6. Return to the plan member website and enter the user ID and temporary password.
7. You will be prompted to change the password. Click *Submit* to save the new password.
8. Click *Done* once the changes are saved.
9. Access the site by entering the user ID and selected password.

Helpful Tip

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

Blue Cross Contact Information

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

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

Helpful Tip

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

Alternatively, you can email your question(s) to **inquiry@medavie.bluecross.ca**. or visit our website at **www.medavie.bluecross.ca**.

Connect with Blue Cross

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

Follow us on Twitter at @**MedavieBC**

Visit our wellness blog, a useful resource to assist you in making those important steps towards a healthy life at **www.medaviesmallsteps.com**

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!