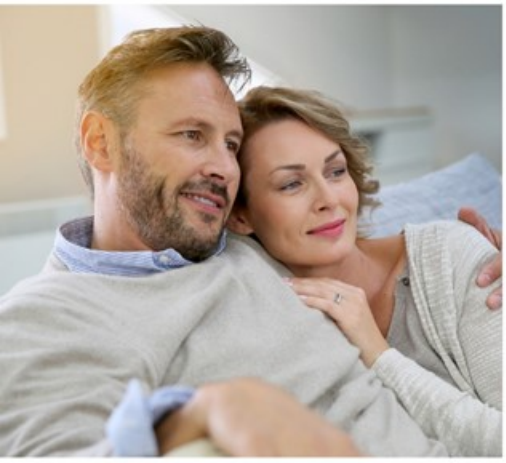

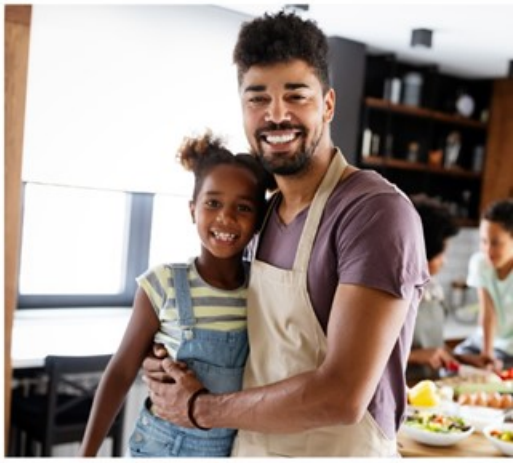

Your Group Benefits Booklet

Omnicom Canada Corp

All Active Employees

Group Policy Number:
93547

Updated Effective Date:
January 1, 2022

MEDAVIE BLUE CROSS™

Welcome to your Group Benefits Plan

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

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

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

Blue Cross has been a trusted health services partner for individuals, employers and governments across Canada for over 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 means you can rest easy because at Blue Cross, we're always there for you.

About this Booklet

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

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

Helpful Tip

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

Your booklet is divided into the following sections:

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

Medavie Mobile App

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

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Summary of Benefits

Member Life Benefit

Benefit Formula	2 times the annual Salary
Benefit Maximum	$1,000,000
Non-Evidence Limit	$900,000
Terminal Illness Benefit	Included
Benefit Reduction	The amount of coverage reduces by 50% at age 65, and to a flat amount of $10,000 at age 70
Termination	When the Member retires
Waiver of Premium	Yes

Dependent Life Benefit

Benefit Amount	
Spouse	$10,000
Child*	$5,000/Child
Termination	When the Member retires
Waiver of Premium	Yes

*From birth or 28 weeks gestation if stillborn.

Summary of Benefits

Optional Life Benefit

Benefit Formula	
Member Maximum	Units of $10,000 Maximum of $500,000
Spouse Maximum	Units of $10,000 Maximum of $500,000
Per Child Maximum	Units of $5,000 Maximum of $50,000
Non-Evidence Limit	
Member	$20,000*
Spouse	$10,000*
Child	Same as Child Maximum
Termination	
Member	Age 70 or retirement
Spouse	When the Member or Spouse reaches age 70 or when the Member retires
Child	When the Member reaches age 70 or retires
Waiver of Premium	Yes

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

Summary of Benefits

Optional Accidental Death and Dismemberment Benefit

Benefit Formula	
Member Maximum	Units of $10,000 to a maximum of $500,000
Dependent Maximum	Dependent coverage is as follows: – Spouse is covered for 50% of the amount purchased by the Member if there are Children, or for 60% of the amount purchased by the Member if there are no Children. – Each Child is covered for 15% of the amount purchased by the Member if there is a Spouse, or for 20% of the amount purchased by the Member if there is no Spouse, to a maximum of $50,000 per Child.
Termination	
Member	Age 70 or retirement
Spouse	When the Member or Spouse reaches age 70 or when the Member retires
Child	When the Member reaches age 70 or retires
Waiver of Premium	Yes

Summary of Benefits

Enhanced Critical Illness Benefit (Member only)

Benefit Amount	
Full Benefit Payment	
Member	$25,000
Partial Benefit Payment	10% of the full benefit payment
Maximum Conditions Payable	Up to 2 unrelated covered conditions eligible for full benefit payment/lifetime 1 per covered condition eligible for partial benefit payment/lifetime
Survival Period	30 consecutive days unless otherwise specified in the defined covered conditions
Termination	The earlier of when the Member receives 2 full payments or when the Member reaches age 70 or retires.
Waiver of Premium	Yes

Summary of Benefits

Optional Enhanced Critical Illness Benefit

Benefit Amount	
Full Benefit Payment	
Member	Units of $10,000 Maximum of $200,000
Spouse	Units of $10,000 Maximum of $200,000
Child	Units of $5,000 Maximum of $25,000/Child
Partial Benefit Payment	10% of the full benefit payment
Non-Evidence Limit	
Member	$20,000*
Spouse	$10,000*
Child	Same as Benefit Amount
Maximum Conditions Payable (combination of Enhanced Critical Illness and Optional Enhanced Critical Illness benefit)	Up to 2 Unrelated Covered Conditions eligible for full benefit payment/lifetime 1 per covered condition eligible for partial benefit payment/lifetime 1 covered childhood condition/lifetime
Survival Period	30 consecutive days unless otherwise specified in the defined covered conditions
Termination	The earlier of when the Participant receives 2 full payments or when the Member or Spouse reaches age 70 or when the Member retires. In addition, coverage for a Child will terminate when a childhood condition payment is received.
Waiver of Premium	Yes

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

Summary of Benefits

Salary Continuance Disability Plan (Provided by the Policyholder)

Please contact your group benefits administrator for information on Salary Continuance Disability Plan coverage.

Summary of Benefits

Long Term Disability Benefit

Benefit Formula	70% of the first $3,500 of monthly Pre-Disability Salary, plus 60% of the next $3,500, plus 45% of the remainder, not exceeding the All Source Maximum
Benefit Maximum	$18,000/month
Non-Evidence Limit	$10,750
Elimination Period	26 weeks (182 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	3 years
Survivor Benefit	Equal to 3 times the Member's take-home monthly long term disability benefit. The benefit is payable to the Member's estate.
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Drug Benefit

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Reimbursement Level	70%*	80%*	100%*
Benefit Maximum			
Diabetic Supplies	Included	Included	Included
CGM Sensors and Transmitters	$4,000/calendar year	$4,000/calendar year	$4,000/calendar year
Fertility Treatments	Not included	$20,000/lifetime	$20,000/lifetime
Allergy Sera	Included	Included	Included
Vaccines	Included	Included	Included
Intrauterine Contraceptive Device (IUD)	Included	Included	Included
Method of Payment	Pay Direct		
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes		
Drug Formulary	Open Formulary		
Substitution Provision	Mandatory Generic Substitution		
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)		
Termination	When the Member retires		
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

Hospitalization

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Reimbursement Level	100%	100%	100%
Benefit Maximum			
Hospital	Semi-private accommodation		
Convalescent Care/Physical Rehabilitation (combined)	$75/day for a Participant under age 65, $35/day for a Participant over age 65		
Chronic Care	120 days/calendar year		

Medical Services and Supplies

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Reimbursement Level	Not applicable	100%	100%
Benefit Maximum			
Ambulance Transportation	Not included	Included	
Nursing Care	Not included	$10,000/calendar year	$25,000/calendar year
Chronic Disease Management	Not included	$500/calendar year	
Health Practitioners:			
Psychologist/Social Worker/Psychotherapist/Marriage Counsellor (combined)	Not included	$1,000 per calendar year*	$1,500 per calendar year*
Chiropractor/Naturopath/Acupuncturist/ Osteopath/Podiatrist/Chiropodist /Occupational Therapist/Physiotherapist/Massage Therapist (combined)	Not included	$500 per practitioner type, to a total combined maximum of $1,500 per calendar year*	$700 per practitioner type, to a total combined maximum of $2,100 per calendar year*
Speech Therapist	Not included	$500 per calendar year*	$700 per calendar year*
X-rays (Chiropractor, Osteopath, Naturopath, Chiropodist/Podiatrist)	Not included	Included, combined with applicable Health Practitioner maximum	

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

Summary of Benefits

Extended Health Care

Medical Services and Supplies

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Reimbursement Level	Not applicable	100%	100%
Benefit Maximum			
Durable Medical Equipment*	Not included	1/month for rental, 1/5 calendar years for approved purchase	
Mobility Aids and Orthopedic Appliances	Not included	See benefit details	
Prostheses	Not included	See benefit details	
Diabetic Equipment	Not included	$200/calendar year	
Hearing Aids	Not included	$500/3 calendar years	$700/3 calendar years
Custom Orthopedic Shoes & Custom Made Foot Orthotics (combined)	Not included	$300/2 calendar years	$400/2 calendar years
Diagnostic Tests**	Not included	$1,000/calendar year	
Other Medical Services and Supplies	Not included	See benefit details	
Accidental Dental	Not included	Predetermination of claim required	
Vision Care			
Eye Examination	Not included	$100/24 consecutive months	
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	Not included	$200/24 consecutive months	$300/24 consecutive months
Termination	When the Member retires		
Survivor Coverage	24 months		

*Pre-authorization required.

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

Summary of Benefits

Dental Benefit

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Fee Guide Schedule	Current year/Province of Provider (Specialist fees paid at GP rate)		Current year/Province of Provider (Specialist fee guide)
Overall Benefit Maximum (Preventive Care, Basic Care and Major Restoration Combined)	$1,000/calendar year	$1,500/calendar year	$2,500/calendar year

Preventive Care	Included	Included	Included
Reimbursement Level	70%	80%	100%
Benefit Maximum			
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	6 Units per 12 consecutive months (combined with Root Planing)	12 Units per 12 consecutive months (combined with Root Planing)	16 units per 12 consecutive months (combined with Root Planing)
Oral Hygiene Instruction	Not included	1 per 12 consecutive months (Participants under age 19)	
Basic Care	Included	Included	Included
Reimbursement Level	70%	80%	100%
Benefit Maximum			
Endodontic Services	Included		
Periodontic Services	Included		
Root Planing	6 Units per 12 consecutive months (combined with Scaling)	12 Units per 12 consecutive months (combined with Scaling)	16 units per 12 consecutive months (combined with Scaling)

Summary of Benefits

Dental Benefit

Plan Option	Basic	Enhanced	Premium
Deductible	None	None	None
Fee Guide Schedule	Current year/Province of Provider (Specialist fees paid at GP rate)		Current year/Province of Provider (Specialist fee guide)
Overall Benefit Maximum (Preventive Care, Basic Care and Major Restoration Combined)	$1,000/calendar year	$1,500/calendar year	$2,500/calendar year

Major Restoration	Not included	Included	Included
Reimbursement Level	Not applicable	50%	60%
Benefit Maximum			
Restorative and Prosthodontic Services	Not included	See benefit details	
Implants	Not included	1/tooth every 10 calendar years	
Restorations on implants	Not included	1/tooth every 10 calendar years	
Orthodontic Services	Not included	Included	Included
Reimbursement Level	Not applicable	50%	60%
Benefit Maximum	Not applicable	$1,500/lifetime	$2,500/lifetime
Lowest Cost Alternative Benefit	Not applicable	Inlays and crowns	
Termination	When the Member retires		
Survivor Coverage	24 months		

Summary of Benefits

Travel Benefit

Deductible	None
Reimbursement Level	100%
Coverage Duration*	
Under age 75	First 180 days of Trip outside province of residence
Age 75 and over	First 60 days of Trip outside province of residence
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$2,000,000/Participant/Incident**
Worldwide Travel Assistance	Yes
Trip Cancellation and Interruption Coverage	$5,000/Participant/Trip
Baggage Coverage	$500/Participant/Trip
Termination	When the Member 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.

Summary of Benefits

Health Spending Account (HSA) Benefit

Method of Payment	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member)
Credit Allocation Frequency	Annually
Benefit Details	
Policy Year	January 1st to December 31st
Carry Forward Type	Credit Carry Forward
(CRA) Dependent Coverage	Yes
Grace Period	
Active Members	60 days
Terminated Members	60 days
Termination	When the Member retires

Summary of Benefits

Personal Spending Account (PSA) Benefit (Member only)

Method of Payment	Reimbursement Upon Request (credits will be used to pay a PSA claim as directed by the Member)
Credit Allocation Frequency	Annually
Benefit Details	
Policy Year	January 1st to December 31st
Carry Forward Type	Credit Carry Forward
Covered Benefit Categories	Health and Wellness Support Alternative Health Treatments Fitness and Sports Activities and Equipment Personal Development Family Care Recreation and Leisure Supplements and Meal Replacement Other Eligible Medical Expenses Insurance Premiums Green Living
Grace Period	
Active Members	60 days
Terminated Members	60 days
Termination	When the Member retires

Summary of Benefits

Second Opinion®

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

Termination	
Member	Age 85 or retirement
Spouse	When the Member or Spouse reaches age 85 or when the Member retires
Child	When the Member reaches age 85 or retires

Summary of Benefits

inConfidence®

Refer to the *inConfidence®* provisions for a detailed description.	
Termination	When the Member retires

You and Your Dependents

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

- the terms that may refer to you are: 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 policy.

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.

Helpful Tip

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

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

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

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

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

Child: A person who:

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

*Exception: A Child who is a Quebec resident is eligible to continue drug coverage if under age 26 and attending an accredited educational institution, college or university on a full-time basis.

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

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

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

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

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

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

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

Helpful Tip

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

Activities of Daily Living: The following 6 activities:

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

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

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

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

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

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

Helpful Tip

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

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

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

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

Helpful Tip

Family member refers to a Participant's:

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

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

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

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

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

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

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

Lock-in Period: The minimum period of time that the Member must remain in their chosen benefit option for drug, health and dental benefits. The Lock-in Period for each benefit option is one year. The Lock-in Period does not apply in the case of a Life Event change.

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

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

Helpful Tip

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

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

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

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

Helpful Tip

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

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

In determining benefits, Salary will be the lesser of:

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

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

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

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

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

Who is Eligible for Coverage?

You are eligible for coverage if you meet the definition of Employee and are Actively at Work.

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

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

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

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.

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

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

How do I Enrol for Coverage?

Please consult your Human Resources department for information on obtaining your group benefits coverage.

Can I Opt Out of Coverage for Certain Benefits?

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

Helpful Tip

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

When Does My Coverage Begin?

Employees

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

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

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

Dependents

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

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

Helpful Tip

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

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

Illness/Accident

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

Maternity Leave/Parental Leave

During a maternity or parental leave of absence, you must continue to pay your premium contributions for employee-paid benefits for the whole duration of the absence, up to the maximum period provided under applicable legislation. Please contact your group benefits administrator for further information.

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

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

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the policy terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your employment is terminated;
- you (or your Spouse, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire, unless otherwise specified in the Summary of Benefits;
- you die;
- you or your Dependents commit a fraudulent act against Blue Cross; or
- the policyholder 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 applicable provincial legislation.

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

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

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

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

- You must, within 31 days of the date of termination of your group coverage:
  - submit the application form provided by Blue Cross for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by Blue Cross;
- the individual policy will be issued without requiring proof of health;

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.

- 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

In the event of your death, coverage for your Dependents will continue without payment of premiums 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?

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

Government Health Care Coverage

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

Helpful Tip

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

Other Health Plans

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

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

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.

Helpful Tip

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

Expenses for Your Spouse:

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

Helpful Tip

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

Expenses for Your Child:

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

Purpose of Coverage

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

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, proof of Total Disability must be submitted to Blue Cross within 12 months of the onset of Total Disability and while Total Disability persists.

Definition of Total Disability

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

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, the definition of Total Disability or Totally Disabled is as follows:

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

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

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

Amount of Coverage Provided

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

Date the Waiver of Premium Begins

Premiums due will be waived beginning on the first day following the end of the Elimination Period of the long term disability benefit if the Member meets the definition of Total Disability found under the *Additional Definitions* provision in the *Long Term Disability Benefit* provisions of this booklet.

However, if the policy does not include long term disability benefit, or the Member belongs to a class of Employees not covered under this benefit, premiums will be waived beginning on the first day following the expiry of 6 consecutive months of Total Disability, as defined in this section of the booklet.

Date the Waiver of Premium Ends

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

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

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

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

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

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

Purpose of Coverage

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

Advance Payment Due to Terminal Illness

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

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

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

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

Payment of Claims

Beneficiary

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 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 their 65th birthday due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Member belongs.

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

Terms and Conditions of the Converted Policy

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

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

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

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

Purpose of Coverage

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

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

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

Terms and Conditions of the Converted Policy

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

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

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

Purpose of Coverage

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.

Amount of Coverage

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

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

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

Payment of Claims

Beneficiary

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

On or before their 65th birthday, a Spouse residing in any province and a Child who is a resident of Quebec also have 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 or Member's optional life coverage for a reason that entitles the Member to convert their member life benefit to an individual policy; or
- the Spouse or Child is no longer eligible for coverage as a Dependent.

Terms and Conditions of the Converted Policy

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

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

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the types of individual life policies available for conversion are:
    a) a 1 year term life policy that may be exchanged, prior to its expiry date, for 1 of the following 2 life policy options (b) or (c);
    b) a non-convertible term life policy that provides level term coverage to age 65; or
    c) a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage provided by the Member's individual life policy is the lesser of:
    - the amount of member life benefit coverage plus optional life coverage in effect on the date of termination of the optional life benefit; and
    - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec;
- 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 or Dependent dies, falls into a Coma or suffers a Loss defined in this benefit, Blue Cross will pay a specified percentage of the amount of the optional accidental death and dismemberment in effect at the time of the Accident, 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 or Dependent is covered under this benefit; and
- occur within 365 days after the date of this Accident.

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

What Blue Cross Will Pay

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

Table 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 or Dependent 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 or Dependent 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 or Dependent will be deemed to have suffered loss of life as a result of an Accident if:

- the Member or Dependent 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 or Dependent is still alive).

Repatriation

If benefits are payable for loss of life that occurred at least 150 kilometres from the Member's or Dependent'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 policyholder confirms to Blue Cross:

- the name of the Member or Dependent and the date and cause of death; and
- that the Member or Dependent 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 or Dependent is confined to a hospital more than 150 kilometres from the Member's or Dependent'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 or Dependent'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.

Common Disaster

If the Member and their Spouse die as a result of, and within 90 days of, the same Accident, the amount payable for the loss of life of the Spouse will be increased to equal the amount payable for the loss of life of the Member.

Extended Family Benefit

If amounts are payable under this benefit due to the Member's loss of life, any coverage in effect for any of the Member's Dependents under this benefit will be automatically extended for 6 months without payment of premiums.

Payment of Claims

Beneficiary

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

In the case of coverage for a Dependent, all benefits are payable 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 that 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.

In the event that the Member is also covered by the member accidental death and dismemberment benefit, the total maximum amount payable under this benefit and the member accidental death and dismemberment benefit is limited to the following amounts:

- Repatriation - total of $10,000;
- Rehabilitation - total of $10,000;
- Occupation Training for the Spouse - total of $10,000;
- Education for Children - total of $5,000 per year to a maximum of 5 years;
- Family Travel - total of $3,000.

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;
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 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 participation in any riot or civil commotion;
g) injuries sustained while flying or attempting to fly an airplane or other type of aircraft if the Member or Dependent is part of the crew or is performing any other flight duties; or
h) any Accident or injury that occurs while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurred.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

On or before their 65th birthday, a Spouse has the right to purchase an individual accidental death and dismemberment policy from Blue Cross if their optional accidental death and dismemberment benefit coverage terminates or reduces for any reason other than at the request of Member.

Terms and Conditions of the Converted Policy

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

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual accidental death and dismemberment policy will be 31 days after the group coverage terminates;
- the individual accidental death and dismemberment policy will not include any disability or other supplementary benefits;
- the amount of coverage provided by the individual accidental death and dismemberment policy cannot be less than the minimum amount Blue Cross will normally issue for the type of policy selected;
- the maximum amount of coverage provided by the individual accidental death and dismemberment policy is:
  - the lesser of $200,000 or the Member's combined accidental death and dismemberment coverage and optional accidental death and dismemberment coverage, in effect on the date of termination of the optional accidental death and dismemberment; and
  - the lesser of $200,000 or the Spouse's optional accidental death and dismemberment coverage, in effect on the date of the termination of the optional accidental death and dismemberment benefit.

Purpose of Coverage

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

Helpful Tip

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

For example, you may use the money to:

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

Additional Definitions

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

Pre-Existing Condition: Any condition for which, during the 24 months immediately before the effective date of coverage (under this policy or a Previous Policy), the Participant has:

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

This definition does not apply to a Child born while family coverage is in force.

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

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

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

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

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

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

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

Covered Conditions Eligible for Full Benefit Payment

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

Category 1: Cancer

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

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

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

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

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

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

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

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

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

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

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

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

This coverage excludes viral meningitis.

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

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

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

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

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

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

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

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

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

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

The diagnosis of Blindness must be made by a Specialist.

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

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

For purposes of this condition:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF.
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

No benefit is payable under this condition for the following:

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

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

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

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

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

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

This coverage excludes:

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

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

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

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

The diagnosis of Deafness must be made by a Specialist.

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

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

The Participant must exhibit:

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

This coverage excludes affective or schizophrenic disorders or delirium.

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

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

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

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

No benefit is payable under this condition for:

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

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

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

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

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

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

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

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

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

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

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

This coverage excludes all psychiatric related causes.

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

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

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

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

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

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

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

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

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

No benefit is payable for the following:

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

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

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

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

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

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

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

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

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

No benefit is payable under this condition if:

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

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

The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

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

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

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

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

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

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

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

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

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

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

The diagnosis of Stroke must be made by a Specialist.

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

No benefit is payable under this condition for:

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

Covered Childhood Conditions

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

Coverage includes the following childhood conditions:

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

  List A

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

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

List B

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

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

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

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

Covered Conditions Eligible for Partial Benefit Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Payment of Claims

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

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

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

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

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

Time Limit to Submit a Claim

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

Exclusions and Limitations

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

a) a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage;
b) an Accident, unless the covered condition is a Severe Burn;
c) attempted suicide or voluntary injury or Illness;
d) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
e) any Accident or injury occurring while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or
f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

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

Terms and Conditions of the Converted Policy

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

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

Purpose of Coverage

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

Helpful Tip

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

For example, you may use the money to:

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

Amount of Coverage

The benefit is equal to the amount of optional critical illness benefit selected by the Member for themselves or their Dependents, up to the maximum amount specified in the Summary of Benefits.

The Member and Dependent must submit Proof of Health deemed satisfactory by Blue Cross to be eligible for any amount of coverage in excess of the Non-Evidence Limit specified in the Summary of Benefits.

A Member may request a change in the amount of their coverage or their Dependent's coverage under this benefit at any time. However, requests to increase coverage in excess of the Non-Evidence Limit or more than 31 days after a Life Event will not be granted without submission of Proof of Health deemed satisfactory by Blue Cross.

Additional Definitions

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

Pre-Existing Condition: Any condition for which, during the 24 months immediately before the effective date of coverage (under this policy or a Previous Policy), the Participant has:

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

This definition does not apply to a Child born while Child optional critical illness coverage is in force.

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

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

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

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

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

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

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

Covered Conditions Eligible for Full Benefit Payment

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

Category 1: Cancer

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

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

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

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

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

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

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

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

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

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

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

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

This coverage excludes viral meningitis.

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

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

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

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

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

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

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

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

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

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

The diagnosis of Blindness must be made by a Specialist.

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

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

For purposes of this condition:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF.
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

No benefit is payable under this condition for the following:

- lesions described as benign, non-invasive, pre-malignant, of low or uncertain malignant potential, borderline, carcinoma in situ or tumours classified as Tis or Ta;
- malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

- any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- gastro-intestinal stromal tumours classified as AJCC Stage 1;
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

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

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

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

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

This coverage excludes:

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

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

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

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

The diagnosis of Deafness must be made by a Specialist.

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

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

The Participant must exhibit:

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

This coverage excludes affective or schizophrenic disorders or delirium.

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

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

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

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

No benefit is payable under this condition for:

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

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

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

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

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

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

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

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

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

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

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

This coverage excludes all psychiatric related causes.

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

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

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

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

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

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

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

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

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

No benefit is payable for the following:

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

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

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

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

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

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

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

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

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

No benefit is payable under this condition if:

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

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

The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

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

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

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

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

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

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

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

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

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

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

The diagnosis of Stroke must be made by a Specialist.

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

No benefit is payable under this condition for:

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

Covered Childhood Conditions

If a Member has selected coverage for their Child, the benefit amount selected for a Child is payable for up to 1 covered childhood condition per lifetime.

Coverage includes the following childhood conditions:

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

  List A

  a) Total Anomalous Pulmonary Venous Connection;
  b) Transposition of The Great Vessels;
  c) Atresia of any heart valve;
  d) Coarctation of the Aorta;
  e) Single Ventricle;

f) Hypoplastic Left Heart Syndrome;
g) Double Outlet Left Ventricle;
h) Truncus Arteriosus;
i) Tetralogy of Fallot;
j) Eisenmenger Syndrome;
k) Double Inlet Ventricle;
l) Hypoplastic Right Ventricle; or
m) Ebstein's Anomaly.

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

List B

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

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

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

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

Covered Conditions Eligible for Partial Benefit Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Payment of Claims

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

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

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

Participant is eligible to receive a second full benefit amount for a covered condition specified under a different category.

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

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

Time Limit to Submit a Claim

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

Exclusions and Limitations

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

a) a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage;
b) an Accident, unless the covered condition is a Severe Burn;
c) attempted suicide or voluntary injury or Illness;
d) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
e) any Accident or injury occurring while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or
f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

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

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

Terms and Conditions of the Converted Policy

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

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

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

the coverage provided by the individual critical illness policy cannot be less than the minimum amount Blue Cross will normally issue for the type of policy selected.

Purpose of Coverage

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

If a Member becomes Totally Disabled following an illness or accident, the Policyholder 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 in addition to those found under the *Key Terms* provision of this booklet.

Benefit Period: The maximum number of weeks the Policyholder will pay benefits, as 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 the plan is registered with the Canada Employment Insurance Commission (CEIC), the Elimination Period will not exceed the duration specified under the Employment Insurance Premium Reduction Program.

Hospitalization: Admission to a hospital as an inpatient for a minimum period of 1 overnight stay. If so specified in the Summary of Benefits, hospitalization will include outpatient surgery performed in a hospital or at a private surgical clinic if this surgery is or would have been covered under government health care coverage.

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

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

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

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

Payment of Benefits

When Benefit Payments Begin

Benefit payments begin on expiry of the Elimination Period. Salary continuance disability benefit payments are calculated as weekly benefit payments; however, the Policyholder may pro-rate the benefit payments to match its payroll cycle. Benefits will be paid for each day a Member is Totally Disabled following the expiry of the Elimination Period.

If the Elimination Period is calculated in:

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

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

Calculation of the Benefit Amount

The weekly benefit amount is calculated in accordance with the benefit formula and benefit maximum specified in the Summary of Benefits.

The Policyholder reserves the right to subtract from this weekly benefit amount, any income amounts payable to the Member as a result of the same or subsequent disability, provided the reduction of benefits is allowed under the Employment Insurance Premium Reduction program.

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 retires from the Employer;
- the Benefit Period expires;
- the Member engages in any occupation or employment for wage or profit, 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 30 days of the expiry of the Elimination Period.

Helpful Tip

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

Recurrent Disabilities

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

- the same or related causes within the first 2 weeks of the Member 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:

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

Rehabilitation Program

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

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

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

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

Exclusions and Limitations

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

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

Purpose of Coverage

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

Additional Definitions

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

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

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

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

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

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

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

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

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

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

Helpful Tip

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

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

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

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

Payment of Benefits

When Benefit Payments Begin

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

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

Calculation of the Benefit Amount

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

> **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 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;

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:

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

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

- income amounts received for children are not included;
- if it appears to Blue Cross that there are income amounts to which the Member is or may be eligible, Blue Cross may include these amounts in its calculations even if the Member fails to apply for or exercise their right to claim these income 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 estate the lump sum amount specified in the Summary of Benefits in the event that the Member dies while receiving long term disability benefits.

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;
- the Member fails to:

  - provide Blue Cross with satisfactory proof of continued Total Disability;
  - submit to an independent examination requested by Blue Cross; or
  - participate in any reasonable Treatment or rehabilitation program considered appropriate by Blue Cross;
- the 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.

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

Recurrent Disabilities

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

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

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

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

Total Disability During Periods of Absence

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

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

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

Rehabilitation Program

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

- medical care, Treatment, 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:

   h) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
   i) 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;
   j) medical care or treatment that is not Medically Necessary or that is performed for cosmetic purposes only; or
   k) 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 Member's effective date of coverage (under this policy or a Previous Policy), the Member has:

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

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 policy or a Previous Policy) for at least 12 consecutive months.

Purpose of Coverage

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

Additional Definitions

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

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) 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.

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

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

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

What Blue Cross Will Pay

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

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

- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

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

- diabetic supplies, including test strips, lancets, needles, syringes, insulin pump supplies, continuous glucose monitoring (CGM) sensors and continuous blood glucose monitoring transmitters;
- viscosupplementation injections;
- 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 a Patient Support Program.

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.

Helpful Tip

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

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.

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.

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.

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.

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 policy.

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, despite the fact pay direct was offered, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

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

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.

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 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;

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.

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

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

Out-of-pocket Maximum per Calendar Year

If, in any calendar year, a Member spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses 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.

Additional Definitions

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

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

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

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

Helpful Tip

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

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

Such care must be provided in a public establishment that provides Chronic Care to patients who are under the direct care of a physician at all times. The establishment must be licensed by the appropriate government body and must provide 24 hour nursing care services.

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

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

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

Hospitalization

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

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.

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

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

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

Medical Services and Supplies

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

This coverage excludes inter-Hospital transfers.

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

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

Helpful Tip

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

Charges for the services of a personal support worker in the Participant's home may also be eligible if the Participant is under the active care of a nurse or requires home care for recuperation after a discharge from Hospital. Personal support workers offer essential services related to the 6 Activities of Daily Living.

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

Chronic Disease Management: Charges for the services rendered by an Approved Provider specialized in chronic disease management. Services must be delivered by the Approved Provider for medical conditions deemed eligible by Blue Cross. Coverage includes:

- initial assessment, counselling and follow up sessions;
- education relating to symptom management, medication usage; and
- development of action plans.

Helpful Tip

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

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

Helpful Tip

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

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

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

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

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

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

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A $10,000 maximum applies to myoelectric limbs;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;

- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 2 calendar years; and
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of $300 per lifetime.

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

This coverage excludes:

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

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

Insulin pumps are eligible under the durable medical equipment benefit.

Diabetic supplies and continuous blood glucose monitoring transmitters are eligible under the drug benefit.

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

This coverage excludes batteries and exams.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

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

Helpful Tip

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

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

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

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

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

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

- allergy testing materials to a maximum of $50 per calendar year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per calendar year;
- burn pressure garments to a maximum of $500 per calendar year;
- graduated compression garments (including stockings) to a maximum of $200 per calendar year;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of 2 per calendar year;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $300 per 5 calendar years;
- visual training and remedial eye exercises performed by an ophthalmologist or optometrist to a maximum of $150 per lifetime; and
- contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of $200 per 24 consecutive months. The contact lenses must improve sight to at least 20/40 and this level of improvement must not be possible with eyeglass lenses.

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

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

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the employer;
- initiated within 180 days of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval within that period; and
- performed within 2 years of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

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

Helpful Tip

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

Vision Care

Eye Examination: Charges for an eye examination performed by an 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;
- laser eye surgery; and
- intraocular lenses used in cataract surgery.

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

Payment of Claims

How Payments are Made

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

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

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

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

Time Limit to Submit a Claim

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

Right to Convert to Individual Coverage

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

Purpose of Coverage

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

Additional Definition

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

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

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

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

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

Helpful Tip

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

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

Helpful Tip

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

What Blue Cross Will Pay

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

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

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

Helpful Tip

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

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 2 calendar years;
- recall oral examination;

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

X-rays: Charges for:

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

Laboratory Tests and Examinations: Charges for:

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

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- oral hygiene instruction, if specified in the Summary of Benefits;
- pit and fissure sealants (limited to Participants under age 18); 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; and
- pulp capping.

Helpful Tip

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

Endodontic Services: Charges for:

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

Helpful Tip

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

Periodontic Services: Charges for:

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

Helpful Tip

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

Removable Denture Adjustments: Charges for:

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

Oral Surgery: Charges for:

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

General adjunctive services: Charges for:

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

Major Restoration

Extensive Restorations: Charges for:

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

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

Other Restorative Services: Charges for:

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

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 calendar years;
- bridgework to a maximum of 1 per tooth per 5 calendar years;
- implants, if specified in the Summary of Benefits; and
- restorations on implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per tooth per 10 calendar years, if specified in the Summary of Benefits.

Helpful Tip

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

Orthodontic Services

Charges for:

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

Helpful Tip

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

Payment of Claims

How Payments are Made

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

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 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.

Exclusions and Limitations

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

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been made if no coverage had existed;
f) anti-snoring or sleep apnea devices;
g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;

h) services, treatment or supplies that are:
   i. not Medically Necessary (except for Preventive Care services);
   ii. for cosmetic purposes only; or
   iii. experimental or investigative;
i) services or expenses incurred as a result of:
   i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
   ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
j) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;
k) services that are eligible under the extended health care (if applicable);
l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
m) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) veneers;
o) implants and related services;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

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: a sudden and unexpected illness or injury that requires immediate medical Treatment due to:

- an injury resulting from an accident;
- a new medical condition which begins during a Trip; or
- a medical condition that existed prior to a Trip (or prior to booking a Trip) provided that it is not part of an established treatment program.

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

Emergency Hospital and Medical Travel Coverage

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

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

Helpful Tip

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

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

Physician Fees: Fees charged for physician or surgeon services.

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

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

Trip Cancellation and Interruption Coverage

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

- they are incurred because of an Eligible Risk listed in this section;
- the Eligible Risk occurred as a result of an Emergency or reason outside of the control of the Participant or Travel Companion;
- the Participant notifies Blue Cross of the Eligible Risk within the notification periods provided in this section;
- the Participant was not aware of any event that could reasonably prevent them from taking the Trip as planned at the time travel arrangements were made; and
- the Participant submits a proof of claim that meets the requirements of this section.

Amounts payable in this section are limited to the portion of Eligible Expenses that could not be reimbursed in the form of cash or credit at the time the Eligible Risk occurred.

Eligible Risks

Participants are eligible for benefits if their Trip is cancelled, interrupted or prolonged as a result of any of the following events:

a) hospitalization or death of the Participant, an Immediate Family Member, a Travel Companion, a Travel Companion's Immediate Family Member or a business associate, key employee or caregiver of the Participant or Travel Companion;
b) illness or injury of the Participant, the Travel Companion or one of their Immediate Family Members, business associates, key employees or a caregiver that is serious enough to require that the Participant cancel, interrupt or prolong the Trip;
c) pregnancy of the Participant or a Travel Companion if:
    i. the pregnancy occurs after the date that a non-refundable deposit for the Trip has been made or a ticket has been purchased; and
    ii. the departure or return date of the Trip is within 8 weeks before or after the expected date of delivery;
d) summons of the Participant or Travel Companion to jury duty or their subpoena to appear as a witness in a trial to be heard during the Trip, excluding those intended for law enforcement officers;
e) quarantine or hijacking of the Participant, Travel Companion or their Immediate Family Member;
f) disaster that renders the main residence of the Participant or Travel Companion uninhabitable;
g) an employment transfer of the Participant, the Travel Companion or one of their spouses that requires the Participant or the Travel Companion to move permanent residences;
h) the summons to service of a Participant or Travel Companion who is a law enforcement officer, firefighter, reservist or member of the armed forces;
i) a missed flight or connection due to delay of carrier (airline, bus, train) resulting from weather conditions, mechanical failure, an accident, an emergency police-directed road closure or automobile delay resulting from a traffic accident;

j) death or hospitalization of the Participant's host at the Trip destination;
k) the Participant's or Travel Companion's involuntary loss of a permanent job that they had held for at least a full year that causes the Participant to cancel the trip;
l) an event in the country or region of destination that causes the Government of Canada to issue a travel warning to avoid all travel or avoid non-essential travel to that country or region, if the travel warning:
   i. applies to a period of time that includes the scheduled Trip; and
   ii. is issued after the date that a non-refundable deposit for the Trip has been made or a ticket has been purchased;
m) the cancellation of a business meeting, prior to departure, for reasons that are beyond the control of the Participant, the Travel Companion and their employer;
n) the Participant or Travel Companion must cancel travel to or stay in the destination country because their visa application has not been issued, provided:
   i. they are otherwise eligible for the visa;
   ii. the rejection is not due to tardy submission of the application or a prior refusal; and
   iii. the visa application has not been issued for reasons outside of the control of the Participant or Travel Companion; or
o) the legal adoption of a child by the Participant or Travel Companion if the adoption date is scheduled during the Trip.

Eligible Expenses

Unused Travel Arrangements:
Prior to Departure: Charges for non-refundable and pre-paid travel costs if the Participant must cancel the Trip because of an Eligible Risk.

*After Departure***:** Charges for the additional cost of one-way economy fare (by airline, bus or train) to the point of departure and the unused, non-refundable portion of other pre-paid travel expenses (other than the return ticket initially bought), if the Participant must interrupt the Trip because of an Eligible Risk.

Missed Flight or Connection: Charges for the additional cost of a one-way economy fare (by airline, bus or train) to the destination if, due to delay of carrier (airline, bus, train) resulting from weather conditions, mechanical failure, an accident, an emergency police-directed road closure or automobile delay resulting from a traffic accident, the Participant misses their flight or connection and is prevented from continuing on the Trip as planned, provided the Participant was due to arrive at the transfer point at least 2 hours before the scheduled departure time.

Cancellation expenses incurred because of an Eligible Risk relating to adverse weather conditions will only be paid if the adverse weather conditions cause an interruption in the Trip of at least 30% of the total duration initially planned.

Rejoining a Tour or a Group: Charges for one-way economy fare (by airline, bus or train) to join an excursion or group if the Participant misses part of the Trip because of an Eligible Risk.

Next Occupancy Charge: Charges for additional expenses incurred for next occupancy charges when a Participant decides to proceed with their Trip when the Travel Companion must cancel or interrupt their Trip because of an Eligible Risk. Additional expenses are reimbursed up to an amount equal to the cancellation penalty applicable at the time the Travel Companion cancelled.

Delayed returns: Charges for one-way economy fare (by airline, bus or train) to the point of departure, when the Participant's return must be delayed due to an Emergency illness or injury sustained by themselves, an Immediate Family Member or a Travel Companion. The proof of claim must demonstrate the Emergency illness or injury is serious enough to prevent the scheduled return.

Notification of Trip Cancellation

When an Eligible Risk occurs before the departure date, the Participant must contact the travel agent or carrier, as well as Blue Cross, within 48 hours of the occurrence of the Eligible Risk to cancel the Trip.

Proof of Claim

All claims under this benefit provision are subject to approval by Blue Cross and must be accompanied by the following, if applicable:

- proof of Eligible Expenses incurred, including unused transportation tickets, official receipts for alternate transportation and travel credits;
- documentary evidence acceptable to Blue Cross that an Eligible Risk was the cause of the cancellation, interruption or prolongation; and
- for Eligible Risks relating to:
  - delay due to a traffic accident, a police report may be required; or
  - cancellation, interruption or prolongation due to an Emergency illness or injury, there must be a medical certificate from the attending physician that confirms the diagnosis and that the Emergency illness or injury was serious enough to require cancellation, interruption or prolongation of the Trip.

Baggage Coverage

Blue Cross will pay Eligible Expenses listed in this benefit provision, subject to the following terms and conditions:

- the Participant must take all reasonable precautions to protect, safeguard or recover the property;
- in the event of loss, the Participant must notify Blue Cross as promptly as possible; and
- Blue Cross is second payer to any other liability insurance that may apply.

Loss or Damage to Baggage: If baggage owned by the Participant is lost or damaged during a Trip, Blue Cross will, at its discretion, and subject to the maximum specified in the Summary of Benefits:

- pay the Participant the actual cash value of the baggage and its contents at the time of loss or damage; or
- repair or replace any damaged or lost baggage and its contents with property of equal quality or value.

If there is loss or damage to baggage that is part of a set, the measure of loss will be in reasonable and fair proportion to the total value of the set. Blue Cross will give consideration to the importance of such article to the set, with the understanding that the set is not completely lost.

Baggage Delays: If checked baggage is delayed by the carrier for more than 12 hours and before the return to the point of departure, Blue Cross will reimburse a maximum of $250 per Participant per Incident for the purchase of toiletries and clothing, subject to the overall baggage coverage benefit maximum.

Lost or Stolen Documents: Blue Cross will cover expenses to replace a lost or stolen passport, driver's licence, birth certificate or travel visa. This benefit is subject to a maximum of $50 per Participant per Incident and is subject to the overall baggage coverage benefit maximum.

Proof of Claim

Claims for loss, damage or delay of baggage, or lost or stolen documents, are subject to approval by Blue Cross and must be accompanied by the following documentation:

- for lost baggage or documents, written confirmation from the hotel manager, tour guide or transportation authority;
- for stolen baggage or documents, proof of notification of the police and corresponding written confirmation regarding the loss; and
- for delayed baggage, proof of the delay from the carrier and all receipts for items purchased.

Payment of Claims

How Payments are Made

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

Time Limit to Submit a Claim

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

Blue Cross will accept claims up to 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.

Trip Cancellation and Interruption Coverage: Proof of cancellation or interruption of the trip must be received by Blue Cross within 90 days of the cancellation or interruption of the trip, or the claim will be ineligible for payment.

Baggage Coverage: Proof of loss or damage as well as the value of the loss must be received by Blue Cross within 90 days of the loss or damage, or the claim will be ineligible for payment.

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, with the exception of Referral Outside of Canada;
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 to avoid all travel or avoid non-essential travel, 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 a 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 medical treatment or therapy that has been prescribed;
    iv. suicide, attempted suicide or voluntary injury or illness; or
    v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

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

Trip Cancellation and Interruption Coverage

No payment will be made if:

a) the Trip was undertaken to visit or care for a sick or injured person and that person's medical condition or death is the cause of the Trip cancellation, interruption or prolongation; or
b) the Trip is cancelled or interrupted due to financial difficulties, inability to obtain desired accommodations, fear of flying or aversion to the Trip.

Baggage Coverage

No payment will be made for:

a) loss or damage as a result of:
   i. confiscation or damage by order of any government or public authority;
   ii. illegal transportation or trade;
   iii. wear and tear, gradual deterioration, moths or vermin;
   iv. theft from an unattended automobile, trailer or other vehicle unless such vehicle was securely locked or was equipped with a closed compartment that was securely locked and the theft occurred as a result of forcible entry (with visible marks); and
   v. any imprudent action or omission by the Participant;
b) loss or damage that occurs while baggage is being repaired; or
c) loss of personal property that cannot be located and where the circumstances of its disappearance do not lend themselves to a reasonable conclusion that theft has occurred.

Purpose of Coverage

HSA is administered by Blue Cross on behalf of the policyholder, who assumes the sole legal and financial liability for this benefit, subject to the conditions outlined below.

> **Helpful Tip**
>
> You should first submit any eligible medical expenses to any other health plan. Any remaining balance can be processed through your HSA.

Additional Definition

The following definition applies 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.

What Blue Cross Will Pay

Blue Cross will pay eligible medical expenses based upon Canada Revenue Agency guidelines. Eligible medical expenses include deductible amounts, co-payment amounts, and 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

The policyholder pre-determines the amount of credits allocated to the HSA at the beginning of each policy year specified in the Summary of Benefits. Credits represent the monetary value allocated to the HSA by the policyholder and the amount that may be reimbursed by Blue Cross on the policyholder's behalf.

The credits will be allocated to the HSA at the credit allocation frequency specified in the Summary of Benefits.

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

HSA credit allocation may only change in the case of a Life Event or a change in the employment status.

If a Member's coverage is terminated, the Policyholder may adjust the credits allocated to the HSA for that policy year. The Policyholder must promptly notify Blue Cross of the adjusted amount of credits.

If the terminated Member has outstanding claims which were incurred prior to their termination date, these claims may be submitted within the grace period for terminated Members specified in the Summary of Benefits. These claims will be applied against any remaining credits.

Payment of Claims

How Payments are Made

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

> **Helpful Tip**
>
> View your HSA balance through the Medavie Mobile App or the Member Centre at www.medavie.bluecross.ca

Carry Forward Type

Credit Carry Forward

This plan allows unused credits to be transferred into the next policy year.

Credits may be used to reimburse eligible medical expenses incurred in the same policy year in which the credits were allocated. Unused credits will be carried forward into the next policy year. Unused credits cannot be carried forward into further policy years. At the end of a policy year, unused credits that have been carried forward from a previous policy year are forfeited.

Claims will be applied to credits that have been carried forward from a previous policy year before being applied against credits allocated during the current policy year.

Claims must be submitted in the policy year they were incurred or within the grace period specified in the Summary of Benefits.

Exclusions and Limitations

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

a) expenses incurred by Members and (CRA) Dependents prior to the effective date of this benefit or following termination, in accordance with this policy;
b) over the counter medications that can be acquired without the intervention of a Health Practitioner, such as vitamins, minerals, and herbal remedies; or
c) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only; or
    iii. are elective in nature.

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 • Orthodontic	• Preventive Services, such as: - Recall Examinations - Polishing - 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 or Physician referral required
**For Therapeutic massage services only

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	• 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	• 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		

Purpose of Coverage

The Personal Spending Account (PSA) benefit is administered by Blue Cross on behalf of the policyholder, who assumes the sole legal and financial liability for this benefit, subject to the conditions outlined below.

What Blue Cross Will Pay

Blue Cross will pay expenses that meet the eligibility requirements of the covered benefit categories specified in the Summary of Benefits.

The expenses listed below are examples only and should not be considered an exhaustive list. Blue Cross reserves the right to make exceptions for expenses not explicitly listed in this booklet but which fall into one of the following categories.

Health and Wellness Support

Nutritional Counselling: Charges for nutritional counselling for eating disorders and weight management, including educational courses, workshops and seminars.

Stress Management: Charges for stress management counselling, including educational courses, workshops and seminars.

Smoking Cessation: Charges for over-the-counter smoking cessation products such as gum, patches and lozenges, as well as hypnotherapy, support programs and educational courses, workshops and seminars.

This coverage excludes purchase of electronic cigarettes.

Weight Management: Charges for:

- weight management programs, including registration fees, day planners and meal guides;
- weight loss surgery, including gastric banding and gastric bypass;
- hypnotherapy; and
- colon hydrotherapy and cleansing kits.

Health Assessment: Charges for online personal health assessments and personal health assessment workshops.

Prenatal Class: Charges for doula services, prenatal classes, birth plan counselling services and educational courses, workshops and seminars.

This coverage excludes birth pool rentals and postpartum services such as birth trauma counselling.

Home or Personal Aids: Charges for:

- lift chairs;
- mobility scooters;
- transfer aids, including bed rails and transfer poles;
- lifts, including elevators, stair lifts, bath lifts and floor lifts;
- ramps; and
- medical alert services and products, including charges for membership, personal help buttons, communicators and bracelets.

Alternative Health Treatments

Mind/Body Therapy: Charges for herbalists, homeopaths, athletic therapists, traditional Chinese medical practitioners, Shiatsu therapists, hypnotherapy, meditation, electrotherapy, reflexology, mind/body therapy retreats, renewal centres and addiction treatment.

Fitness and Sports Activities and Equipment

Fitness and Sports Fees: Charges for fitness centre memberships and drop-in fees, sports leagues and team registration fees, golfing fees, registration fees for marathons, triathlons and other race events, ski-lift passes and locker fees.

Instructed Fitness or Sports Class: Charges for fitness and sports-related classes and clinics, such as dance, swimming, gymnastics, rock climbing, yoga, martial arts, golf, tennis, hockey and skiing.

Personal Trainer: Charges for the services of a certified personal fitness trainer.

Fitness and Sports Equipment: Charges for purchase or rental of:

- stationary exercise equipment, including treadmills, ellipticals, rowers and weight machines;
- fitness-related equipment, including bicycles, rollerblades, trampolines, weights, yoga mats and fitness balls and bands;
- sporting equipment and protective gear, including hockey sticks, golf clubs, rackets, balls, helmets, pads and goggles;
- equipment bags, gloves and footwear (including cleats) for a specific sport activity;
- active footwear; and
- human-powered boats, including canoes and kayaks.

This coverage excludes athletic apparel.

Personal Development

Personal Development: Charges for:

- registration fees and required supplies for personal interest courses, including art, photography, pottery, music, cooking, languages, drama, driving instruction and first aid;
- exam fees and required textbooks for personal interest courses; and
- legal and financial advice, including fees for tax preparation and legal counsel.

Family Care

Child Care: Charges for child care services including daycare, nanny services and before and after school programs.

This coverage excludes field trip expenses, tutoring services and school supplies.

Elder Care: Charges for elder care services including in-home personal support workers, day program fees, assisted living fees, transportation fees and home maintenance.

Pet Care: Charges for veterinarian fees, kennelling and day care fees, obedience training, dog walking services and grooming fees.

Domestic Services: Charges for housecleaning services, landscaping and lawn maintenance, snow removal and moving services.

Safety and Security Items: Charges for smoke detectors, carbon monoxide detectors, baby safety equipment, home security systems, automated external defibrillators and tires.

Recreation and Leisure

Recreational Fees and Equipment: Charges for fees and equipment for recreational activities such as camping, fishing and hunting, as well as heritage park fees, science centre fees and survival equipment.

This coverage excludes purchase or rental of firearms or ammunition and admission fees for movies, plays, concerts or sporting events.

Gardening Supplies: Charges for gardening tools, seeds and plants.

Supplements and Meal Replacement

Supplements and Over-the-Counter Medications: Charges for vitamins, minerals, extracts, herbs, oils and over-the-counter medications.

Nutritional Products: Charges for purchase of nutritional drinks or shakes, protein powder and energy bars.

Helpful Tip

You should first submit eligible medical expenses to any other health plan, including your Health Spending Account, if applicable. Any remaining balance may be eligible for reimbursement through your PSA.

Other Eligible Medical Expenses

Health and Dental Medical Expenses: Charges for health and dental medical expenses that have been partially covered or otherwise not covered by an existing health or dental plan or Health Spending Account (if applicable).

Insurance Premiums

Premiums for Life, Critical Illness and Other Insurance: Premiums for life, disability and critical illness insurance, as well as pet insurance and long term care insurance.

Green Living

Green Living Products and Services: Charges for products and services that support a healthy and sustainable environment, including home improvements for energy efficiency, composters, recycling bins, public transit passes and car or bike sharing memberships.

PSA Credits

The policyholder pre-determines the amount of credits allocated to the PSA at the beginning of each policy year specified in the Summary of Benefits. Credits represent the monetary value allocated to the PSA by the policyholder and the amount that may be reimbursed by Blue Cross on the policyholder's behalf.

The credits will be allocated to the PSA at the credit allocation frequency specified in the Summary of Benefits.

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

PSA credit allocation may only change in the case of a change in the employment status.

If a Member's coverage is terminated, the policyholder may adjust the credits allocated to the PSA for that policy year. The policyholder must promptly notify Blue Cross of the adjusted amount of credits.

If the terminated Member has outstanding claims which were incurred prior to their termination date, these claims may be submitted within the grace period for terminated Members specified in the Summary of Benefits. These claims will be applied against any remaining credits.

Payment of Claims

How Payments are Made

Eligible PSA claims will only be reimbursed upon request. The Member will pay the expense at the time of purchase and submit the PSA claim to Blue Cross with proof of payment. PSA credits will then be used to pay the claim as directed by the Member.

Helpful Tip

Expenses reimbursed through your PSA are considered taxable benefits.

Carry Forward Type

Credit Carry Forward

This plan allows unused credits to be transferred into the next policy year.

Credits may be used to reimburse eligible medical expenses incurred in the same policy year in which the credits were allocated. Unused credits will be carried forward into the next policy year. Unused credits cannot be carried forward into further policy years. At the end of a policy year, unused credits that have been carried forward from a previous policy year are forfeited.

Claims will be applied to credits that have been carried forward from a previous policy year before being applied against credits allocated during the current policy year.

Claims must be submitted in the policy year they were incurred or within the grace period specified in the Summary of Benefits.

Exclusions and Limitations

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

a) expenses incurred by Members prior to the effective date of this benefit or following termination, in accordance with this policy;
b) expenses for services which have already been paid by any other private health care plans or any Government Health Care Coverage;
c) services, treatments, articles or supplies that do not fall within the categories of eligible expenses listed in this benefit;
d) print and media purchases such as books and magazines;
e) pre-owned equipment or supplies;
f) purchase of food, including meals associated with weight management programs, unless otherwise specified as a covered expense in this benefit; or
g) any expenses specifically noted as excluded within the PSA benefit categories.

Purpose of Coverage

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

Additional Definitions

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

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

Qualifying Medical Conditions:

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

The Qualifying Medical Conditions list may change without notice.

Exclusions and Limitations

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

Additional Information

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

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

inConfidence® – Employee and Family Assistance Program

inConfidence® is a confidential, comprehensive Employee and Family Assistance Program offering counselling and support to employees and their families. This prevention-focused service offers in-person, telephonic and e-counselling to address issues including but not limited to:

- personal well-being;
- relationships and family;
- legal assistance;
- financial assistance;
- child and elder care resources;
- workplace challenges; and
- addiction and recovery.

The inConfidence® program offers bilingual services 24 hours a day, seven days a week to you and your eligible Dependents. For more information or to access inConfidence® resources, refer to your inConfidence® brochure.

What Are My Responsibilities Under the Policy?

Keeping Your Employer Informed

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

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Changes that must be reported to your employer include:

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

Helpful Tip

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

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

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

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

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

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

Subject to the provisions of the law, the beneficiary is the person you have designated on your group benefits application 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 applicable time limitations. Proof of claim must be provided in writing and in a form acceptable by Blue Cross.

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

Costs associated with providing proof of claim are your responsibility.

Helpful Tip

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

Submitting Claims After Your Group Policy Terminates

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

- for 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 policy; or
- **within 90 days** following the termination date of this group policy for all other benefits.

Recovering Damages From a Third Party (Subrogation)

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

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

Reporting Health Insurance Fraud

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

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

Helpful Tip

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

How You Can Help

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

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

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

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

Helpful Tip

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

Toll free: 1-877-412-8809

StopFraud@medavie.bluecross.ca

www.medavie.bluecross.confidenceline.net

What Are My Rights Under the Policy?

Privacy

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

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

What is personal information?

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

How is Your Personal Information Used?

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

To Whom Could This Personal Information be Disclosed?

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

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

Helpful Tip

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

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

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

Disputing a Claim Decision

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

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

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

Copy of the Group Policy

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

The Rights of Blue Cross Under the Policy

Right to Audit

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

Helpful Tip

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

Recovery of Overpaid Amounts

Blue Cross has the right to recover from a Participant:

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

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

Termination or Suspension of Benefit Payments

Blue Cross may, without prior notice, suspend or terminate the rights and benefits of a Participant in the following circumstances:

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

Blue Cross also has the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or who has been charged with an offence in relation to the provider's conduct or practice.

How to Obtain a Claim Form

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

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

All claim forms for life, accidental death and dismemberment, disability or critical illness 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.

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

  To find the Blue Cross office or Quick Pay location nearest you, visit our website at **www.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, disability or critical illness benefits** to Blue Cross by:

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

Plan Member Website

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

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

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

Helpful Tip

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

Helpful Tip

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

Blue Cross Contact Information

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

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

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

Helpful Tip

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

Connect with Blue Cross

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

Follow us on Twitter at **@MedavieBC**

My Good Health®

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

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

BLUE ADVANTAGE®

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