YOUR Benefits

BOOKLET

MEDAVIE BLUE CROSS™

Fleet Argentina

Class F

Plan Number: 2869-107

Updated Effective Date: February 1, 2020

PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and travel coverage, Medavie Blue Cross acquires and stores certain personal information about its clients and their dependents. The purpose of this document is to keep you informed about privacy protection practices at Medavie Blue Cross.

Protecting personal information is not new to Medavie Blue Cross. Ensuring the confidentiality of client information has always been fundamental to the way we do business and our staff understand that the privacy policies and procedures we have in place to ensure confidentiality are to be taken 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 to allow Medavie Blue Cross to process your application for coverage under its health, life and travel plans. Your personal information is used:

- to provide the services outlined in your contract or the group contract of which you are an eligible member
- to understand your needs so that we can recommend suitable products and services, and
- to manage our business

To whom could this personal information be disclosed?
Depending on the type of coverage you carry with us, release of selected personal information to the following may be necessary in order to provide the services outlined in your contract:

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

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

PRIVACY PROTECTION PRACTICES

To whom could this personal information be disclosed? (Cont'd)

To ensure Medavie Blue Cross is able to provide you with the best possible service, it is important that the personal information we use is accurate and up to date. You can help by keeping us informed of changes of address, marital status and the addition or deletion of dependents. Should you become aware of errors in our information about you, please contact our customer service personnel and we will ensure the data is corrected.

By becoming a Medavie 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. If you prefer that we not use or disclose your personal information in those situations where it is not necessary to administer your benefit plan, please visit our Web site or write to us at the address provided.

Please note that not allowing Medavie Blue Cross to use information about you may mean we may not be able to provide you with certain products or services that may be of use to you.

For more information on Medavie Blue Cross's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

1-800-667-4511 or 1-800-355-9133 (in Ontario)

Chief Privacy Officer
Medavie Blue Cross
Risk Management Group
644 Main Street
PO Box 220
Moncton, NB E1C 8L3

or

privacyofficer@medavie.bluecross.ca

If the issue is not resolved to your satisfaction, you may file a complaint in writing to:

Office of the Privacy
Commissioner of Canada
112 Kent Street
Ottawa, Ontario K1A 1H3

ABOUT THIS BOOKLET

Medavie Blue Cross administers the following benefits on behalf of Clearwater Seafoods Limited Partnership:

- Hospital Benefit
- Extended Health Benefit
- Vision Benefit
- Drug Benefit
- Dental Benefit

Medavie Blue Cross underwrites Worldwide Travel Benefit.

Blue Cross Life Insurance Company of Canada underwrites the following benefits:

- Basic and Optional Group Life Insurance
- Dependent Life Insurance
- Long Term Disability Insurance

Blue Cross Life Insurance Company of Canada administers Weekly Indemnity Benefit on behalf of Clearwater Seafoods Limited Partnership.

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

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

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

This booklet replaces any previously issued booklet.

BLUE ADVANTAGE®

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

Co-insurance: 100%

ANCILLARY SERVICES
Maximum: $1,000 per hospital admission

Charges for ancillary services where such services are not fully covered under a Government Health Program.

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

OUTPATIENT SERVICES
Charges for outpatient and diagnostic services of a hospital approved by Medavie Blue Cross.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Hospital benefit.

WORLDWIDE TRAVEL BENEFIT - COMPREHENSIVE

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

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

Co-insurance: 100%

ACCIDENTAL DENTAL
Maximum: $1,000

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

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

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

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

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

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

EMERGENCY AND PAYMENT ASSISTANCE

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

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

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

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

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

HOSPITAL ACCOMMODATION

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

MEALS AND ACCOMMODATION

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

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

MEDICAL APPLIANCES

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

NURSE

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

PARAMEDICAL SERVICES

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

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

RETURN OF DECEASED
Maximum: $3,000

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

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

VEHICLE RETURN
Maximum: $500

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

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

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

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

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

EXCLUSIONS (Cont'd)

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

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

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

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

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

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

   a) expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

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

9. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered person, per incidence outside the province of residence.

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

TERMINATION

Travel benefit ceases at the earlier of retirement, termination of employment or age 75.

WHEN AND HOW TO MAKE A CLAIM

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

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

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

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

EXTENDED HEALTH BENEFIT – WORLDWIDE - COMPREHENSIVE

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

Co-insurance: 90%

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

OXYGEN
Charges for oxygen.

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

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

Provided you do not reside in a convalescent nursing home and the nurse is not a relative, charges for medically necessary home nursing care performed by a registered nurse, registered nursing assistant or certified nursing assistant are eligible. Written authorization of the attending physician is required.

In addition, services provided by an approved personal care worker are eligible under this benefit for up to 4 hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. The covered person may be eligible for services in his/her home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the hospital and requires temporary home care.

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

PROFESSIONAL AMBULANCE
Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

ACCIDENTAL DENTAL

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

DIABETIC SUPPLIES

Charges for needles, syringes, swabs, test tapes, lancets and insulin pump supplies for the treatment and control of diabetes on the written authorization of the attending physician.

HEARING AIDS

Maximum $2,300 every three consecutive calendar years. Dependent children less than 21 years of age, requiring a hearing aid for each ear, are eligible for two hearing aids (one for each ear) to a maximum eligible expense of $2,300 for each hearing aid every three consecutive calendar years.

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

MEDICAL SUPPLIES AND EQUIPMENT

Charges for the following medical supplies and equipment, when prescribed by an authorized physician:

- rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair or hospital-type bed;
- equipment for the administration of oxygen;
- insulin pump;
- compression pump;
- lymphoedema sleeves (limited to 2 in a calendar year).

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every 5 consecutive calendar years.

ORTHOPEDIC FOOTWEAR & SUPPLIES

Maximum: $200 in a calendar year ($300 for dependent children less than 21 years of age)

Charges for orthopedic footwear when the footwear has been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, podiatrist or the attending Physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for footwear modifications, adjustments, supplies and/or molded arch supports when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

OSTOMY SUPPLIES
Charges for essential ostomy supplies on the written authorization of the attending physician.

PARAMEDICAL PRACTITIONERS
Overall maximum: paramedical practitioners are subject to an overall combined maximum of $1,500 per calendar year.

Charges for treatment, except when performed in a hospital, by a licensed speech therapist, massage therapist, clinical psychologist, chiropractor, osteopath, physiotherapist, acupuncturist, chiropodist/podiatrist or naturopath.

PROSTHETIC APPLIANCES
Charges for the following remedial appliances or supplies, when authorized by the attending physician:

- artificial limbs (limited to one prosthetic appliance to each limb in a lifetime);
- breasts (limited to a left and a right prosthesis every two consecutive calendar years);
- eyes (limited to one left and one right prosthesis in a lifetime);
- canes or crutches (limited to two in a lifetime);
- splints;
- casts;
- trusses (limited to one truss every five consecutive calendar years);
- braces (limited to one cervical collar in a calendar year and all other braces are limited to one in a lifetime); and
- knee brace (limited to a maximum of $3,000 in a lifetime).

Replacement must be due to pathological or physiological change. Repairs and/or adjustments are provided to a maximum eligible expense of $300 in a calendar year.

Hair prosthetics (wigs), when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $300 in a lifetime.

Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

SMOKING CESSATION PRODUCTS
Maximum: $500 in a lifetime

Charges for Nicotine patches, Nicorette gum and Zyban.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM

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

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Extended Health Benefit.

VISION BENEFIT - COMPREHENSIVE

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

Co-insurance: 90%

CONTACT LENSES DUE TO DISEASE

Maximum: $100 every two (2) consecutive calendar years for adults and every calendar year for dependent children less than 21 years of age

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

EYE EXAMINATIONS, LENSES, FRAMES AND CONTACT LENSES

Maximum: $250 for lenses, frames and contact lenses plus $65 for eye examinations every two (2) consecutive calendar years for adults under the age of 50.

Every calendar year for dependent children less than 21 years of age and adults over the age of 50.

Charges of a licensed optometrist or ophthalmologist for eye examinations. Charges for corrective eyeglasses, including lenses, frames and contact lenses, but excluding glasses/contacts for cosmetic purposes.

SAFETY GLASSES

Maximum: $250 for safety glasses every two (2) consecutive calendar years for adults under the age of 50.

Every calendar year for dependent children less than 21 years of age and adults over the age of 50.

LASER CORRECTIVE EYE SURGERY

Maximum: $1,000 in a lifetime

Charges for laser corrective eye surgery when performed by an ophthalmologist.

TERMINATION OF INSURANCE

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Vision benefit.

DRUG BENEFIT - COMPREHENSIVE

If you (or your dependents, if applicable) incur charges for certain prescription-requiring drugs, the eligible drug may be subject to quantity maximums, dollar maximums, deductibles, co-payments or other maximums as approved by Medavie Blue Cross. Benefit maximums are applied on a per covered person basis.

Co-payment: **participant pays the dispensing fee, plus 10% of each eligible drug to a maximum of $25 per prescription**
Co-insurance: **100% of the remaining eligible expense**
Method of payment: **paid directly to the pharmacy**

Includes prescription drug items approved by Medavie Blue Cross and certain prescribed over-the-counter items approved by Medavie Blue Cross.

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

Medavie Blue Cross will reimburse only for the lowest priced interchangeable drug when prescribed by a physician and dispensed by a pharmacist, unless the physician indicates no substitution.

Charges for the following are also included:
- preventive vaccines as approved by Medavie Blue Cross to a maximum of $700 every five (5) consecutive calendar years.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM
The Medavie Blue Cross Identification Card should be shown and the provider will arrange to bill Medavie Blue Cross directly.

DENTAL BENEFIT - COMPREHENSIVE

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

BASIC SERVICES
Co-insurance: 80%
Maximum: $1,500 in a calendar year in combination with Major Restorative Services

Diagnostics
- complete examinations once every three (3) consecutive calendar years
- recall examinations once in a calendar year
- bitewing four films in a calendar year
- full series or panoramic x-rays once in a calendar year
- tests/analysis/laboratory procedures

Preventive Services
- polishing once in a calendar year
- fluoride treatment once in a calendar year
- scaling
- pit and fissure sealants and space maintainers
- protective appliance (mouth guard) one (1) appliance in a calendar year
- appliances (periodontal, TMJ or Myofascial) once every two (2) consecutive calendar years
- occlusal equilibration

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

Endodontic Services
- root canal therapy

BASIC SERVICES (cont'd)

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

Prosthodontic Services
- denture adjustments and repairs (after 3 months of initial insertion)
- denture reline or rebase once every two (2) consecutive calendar years
- tissue conditioning

Surgical Services (Basic)
- extraction of teeth and roots

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

MAJOR RESTORATIVE SERVICES
Co-insurance: 50%
Maximum: $1,500 in a calendar year in combination with Basic Services

Surgical Services (Major)
- surgical exposure and movement of teeth
- removal of benign tumours and cysts

Extensive Restoratives
- inlays/onlays/crowns

Prosthodontic Services
- complete and partial dentures, limited to one upper and one lower, once every five (5) consecutive calendar years
- bridgework

This program excludes replacement of the denture unless it is at least five years old and cannot be made serviceable, and the replacement of dentures that may have been lost, mislaid or stolen.

ORTHODONTIC SERVICES
Co-insurance: 50%
Maximum: $2,500 in a lifetime

Orthodontic Services
- removable and fixed appliances (braces)
- observations and adjustments

DENTAL EXCLUSIONS AND LIMITATIONS
The dental plan does not cover the following expenses:

1. Splinting for periodontal reasons, where cast, crowns or inlays are used for this purpose, with or without onlays.
2. Veneers for cosmetic purposes.
3. Accidental dental services do not form part of the Dental Benefits being offered.
4. Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.
5. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

BENEFITS FOR LATE APPLICANTS
If application for dental benefits is made more than 31 days after the date on which the employee and/or dependent first becomes eligible, the maximum benefit will be limited to $100 per covered person during the first 12 months of coverage. This provision does not apply to dental services required as a result of natural teeth being damaged by a direct accidental blow to the mouth after the effective date of the late applicant's coverage.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

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

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Dental benefit.

HOSPITAL BENEFIT - PREMIUM

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

Co-insurance: 100%

ANCILLARY SERVICES
Maximum: $1,000 per hospital admission

Charges for ancillary services where such services are not fully covered under a Government Health Program.

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

OUTPATIENT SERVICES
Charges for outpatient and diagnostic services of a hospital approved by Medavie Blue Cross.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Hospital benefit.

WORLDWIDE TRAVEL BENEFIT - PREMIUM

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

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

Co-insurance: 100%

ACCIDENTAL DENTAL
Maximum: $1,000

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

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

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

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

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

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

EMERGENCY AND PAYMENT ASSISTANCE

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

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

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

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

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

HOSPITAL ACCOMMODATION

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

MEALS AND ACCOMMODATION

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

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

MEDICAL APPLIANCES

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

NURSE

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

PARAMEDICAL SERVICES

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

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

RETURN OF DECEASED
Maximum: $3,000

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

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

VEHICLE RETURN
Maximum: $500

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

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

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

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

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

EXCLUSIONS (Cont'd)

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

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

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

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

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

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

   a) expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

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

9. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered person, per incidence outside the province of residence.

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

TERMINATION

Travel benefit ceases at the earlier of retirement, termination of employment or age 75.

WHEN AND HOW TO MAKE A CLAIM

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

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

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

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

EXTENDED HEALTH BENEFIT – WORLDWIDE – PREMIUM

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

Co-insurance: 100%

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

OXYGEN
Charges for oxygen.

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

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

Provided you do not reside in a convalescent nursing home and the nurse is not a relative, charges for medically necessary home nursing care performed by a registered nurse, registered nursing assistant or certified nursing assistant are eligible. Written authorization of the attending physician is required.

In addition, services provided by an approved personal care worker are eligible under this benefit for up to 4 hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. The covered person may be eligible for services in his/her home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the hospital and requires temporary home care.

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

PROFESSIONAL AMBULANCE
Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

ACCIDENTAL DENTAL

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

DIABETIC SUPPLIES

Charges for needles, syringes, swabs, test tapes, lancets and insulin pump supplies for the treatment and control of diabetes on the written authorization of the attending physician.

HEARING AIDS

Maximum $2,300 every three consecutive calendar years. Dependent children less than 21 years of age, requiring a hearing aid for each ear, are eligible for two hearing aids (one for each ear) to a maximum eligible expense of $2,300 for each hearing aid every three consecutive calendar years.

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

MEDICAL SUPPLIES AND EQUIPMENT

Charges for the following medical supplies and equipment, when prescribed by an authorized physician:

- rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair or hospital-type bed;
- equipment for the administration of oxygen;
- insulin pump;
- compression pump;
- lymphoedema sleeves (limited to 2 in a calendar year).

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every 5 consecutive calendar years.

ORTHOPEDIC FOOTWEAR & SUPPLIES

Maximum: $200 in a calendar year ($300 for dependent children less than 21 years of age)

Charges for orthopedic footwear when the footwear has been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, podiatrist or the attending Physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for footwear modifications, adjustments, supplies and/or molded arch supports when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

OSTOMY SUPPLIES
Charges for essential ostomy supplies on the written authorization of the attending physician.

PARAMEDICAL PRACTITIONERS
Overall maximum: paramedical practitioners are subject to an overall combined maximum of $2,000 per calendar year.

Charges for treatment, except when performed in a hospital, by a licensed speech therapist, massage therapist, clinical psychologist, chiropractor, osteopath, physiotherapist, acupuncturist, chiropodist/podiatrist or naturopath.

PROSTHETIC APPLIANCES
Charges for the following remedial appliances or supplies, when authorized by the attending physician:

- artificial limbs (limited to one prosthetic appliance to each limb in a lifetime);
- breasts (limited to a left and a right prosthesis every two consecutive calendar years);
- eyes (limited to one left and one right prosthesis in a lifetime);
- canes or crutches (limited to two in a lifetime);
- splints;
- casts;
- trusses (limited to one truss every five consecutive calendar years);
- braces (limited to one cervical collar in a calendar year and all other braces are limited to one in a lifetime); and
- knee brace (limited to a maximum of $3,000 in a lifetime).

Replacement must be due to pathological or physiological change. Repairs and/or adjustments are provided to a maximum eligible expense of $300 in a calendar year.

Hair prosthetics (wigs), when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $300 in a lifetime.

Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

SMOKING CESSATION PRODUCTS
Maximum: $500 in a lifetime

Charges for Nicotine patches, Nicorette gum and Zyban.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM

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

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Extended Health Benefit.

VISION BENEFIT - PREMIUM

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

Co-insurance: 100%

CONTACT LENSES DUE TO DISEASE

Maximum: $100 every two (2) consecutive calendar years for adults and every calendar year for dependent children less than 21 years of age

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

EYE EXAMINATIONS, LENSES, FRAMES AND CONTACT LENSES

Maximum: $300 for lenses, frames and contact lenses plus $65 for eye examinations every two (2) consecutive calendar years for adults under the age of 50.

Every calendar year for dependent children less than 21 years of age and adults over the age of 50.

Charges of a licensed optometrist or ophthalmologist for eye examinations. Charges for corrective eyeglasses, including lenses, frames and contact lenses, but excluding glasses/contacts for cosmetic purposes.

SAFETY GLASSES

Maximum: $300 for safety glasses every two (2) consecutive calendar years for adults under the age of 50.

Every calendar year for dependent children less than 21 years of age and adults over the age of 50.

LASER CORRECTIVE EYE SURGERY

Maximum: $2,000 in a lifetime

Charges for laser corrective eye surgery when performed by an ophthalmologist.

TERMINATION OF INSURANCE

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Vision benefit.

DRUG BENEFIT - PREMIUM

If you (or your dependents, if applicable) incur charges for certain prescription-requiring drugs, the eligible drug may be subject to quantity maximums, dollar maximums, deductibles, co-payments or other maximums as approved by Medavie Blue Cross. Benefit maximums are applied on a per covered person basis.

Co-payment: **participant pays the dispensing fee for each eligible drug to a maximum of $10 per prescription**
Co-insurance: **100% of the remaining eligible expense**
Method of payment: **paid directly to the pharmacy**

Includes prescription drug items approved by Medavie Blue Cross and certain prescribed over-the-counter items approved by Medavie Blue Cross.

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

Medavie Blue Cross will reimburse only for the lowest priced interchangeable drug when prescribed by a physician and dispensed by a pharmacist, unless the physician indicates no substitution.

Charges for the following are also included:
- preventive vaccines as approved by Medavie Blue Cross to a maximum of $700 every five (5) consecutive calendar years.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

WHEN AND HOW TO MAKE A CLAIM
The Medavie Blue Cross Identification Card should be shown and the provider will arrange to bill Medavie Blue Cross directly.

DENTAL BENEFIT - PREMIUM

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

BASIC SERVICES
Co-insurance: 100%
Maximum: $2,000 in a calendar year in combination with Major Restorative Services

Diagnostics
- complete examinations once every three (3) consecutive calendar years
- recall examinations twice in a calendar year
- bitewing four films in a calendar year
- full series or panoramic x-rays once in a calendar year
- tests/analysis/laboratory procedures

Preventive Services
- polishing twice in a calendar year
- fluoride treatment twice in a calendar year
- scaling
- pit and fissure sealants and space maintainers
- protective appliance (mouth guard) one (1) appliance in a calendar year
- appliances (periodontal, TMJ or Myofascial) once every two (2) consecutive calendar years
- occlusal equilibration

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

Endodontic Services
- root canal therapy

BASIC SERVICES (cont'd)

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

Prosthodontic Services
- denture adjustments and repairs (after 3 months of initial insertion)
- denture reline or rebase once every two (2) consecutive calendar years
- tissue conditioning

Surgical Services (Basic)
- extraction of teeth and roots

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

MAJOR RESTORATIVE SERVICES
Co-insurance: 50%
Maximum: $2,000 in a calendar year in combination with Basic Services

Surgical Services (Major)
- surgical exposure and movement of teeth
- removal of benign tumours and cysts

Extensive Restoratives
- inlays/onlays/crowns

Prosthodontic Services
- complete and partial dentures, limited to one upper and one lower, once every five (5) consecutive calendar years
- bridgework

This program excludes replacement of the denture unless it is at least five years old and cannot be made serviceable, and the replacement of dentures that may have been lost, mislaid or stolen.

ORTHODONTIC SERVICES
Co-insurance: 50%
Maximum: $3,000 in a lifetime

Orthodontic Services
- removable and fixed appliances (braces)
- observations and adjustments

DENTAL EXCLUSIONS AND LIMITATIONS
The dental plan does not cover the following expenses:

1. Splinting for periodontal reasons, where cast, crowns or inlays are used for this purpose, with or without onlays.
2. Veneers for cosmetic purposes.
3. Accidental dental services do not form part of the Dental Benefits being offered.
4. Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.
5. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

BENEFITS FOR LATE APPLICANTS
If application for dental benefits is made more than 31 days after the date on which the employee and/or dependent first becomes eligible, the maximum benefit will be limited to $100 per covered person during the first 12 months of coverage. This provision does not apply to dental services required as a result of natural teeth being damaged by a direct accidental blow to the mouth after the effective date of the late applicant's coverage.

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

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

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

Claims must be submitted within 24 months of receiving services or supplies or the end of your Dental benefit.

GENERAL EXCLUSIONS AND LIMITATIONS

Medavie Blue Cross does not cover the following expenses:

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

TERMINATION OF INSURANCE

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

- the contract termination date,
- the date you terminate employment,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75), change in classification, etc.

ALTERNATIVE BENEFIT

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

CO-ORDINATION OF BENEFITS

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

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

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

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

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

CONVERSION PRIVILEGE

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

SURVIVOR BENEFIT

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

- the date that the surviving dependent ceases to qualify as a dependent under this contract;
- the date the surviving spouse remarries;
- the date any similar coverage is obtained with respect to a covered dependent; or
- twelve (12) months after the employee's death.

BASIC AND OPTIONAL GROUP LIFE INSURANCE

AMOUNT OF BASIC INSURANCE

Benefit Formula:	flat amount
Benefit Maximum:	$100,000
Non-evidence Limit:	$100,000
Benefit Reduction:	Reduces 50% at age 70

AMOUNT OF OPTIONAL INSURANCE

Benefit Formula:	1x, 2x, 3x or 4x annual earnings
Benefit Maximum:	$400,000
Non-evidence Limit:	$ 30,000 (Applicable to employees hired after 01 May 2005)

All amounts of insurance are rounded up to the next higher $1,000 amount.

Coverage may be purchased, subject to evidence of insurability in units of 1x, 2x, 3x or 4x your annual earnings to a maximum of $400,000 per insured. The combined Basic Group Life Insurance plus Optional Life cannot exceed $650,000.

Evidence of Insurability is required for all amounts of Optional insurance.

TERMINATION OF INSURANCE

All Group Life insurance will terminate on the earliest of:

- the date that you cease to be eligible for Group Life Insurance,
- the date of termination of this coverage,
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation (75),
- the end of the grace period for which any premium has not been paid in full.

DEATH BENEFIT

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

OPTIONAL LIFE INSURANCE

Optional Life Insurance benefits are payable to your designated beneficiary.

TERMINAL ILLNESS

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

WAIVER OF PREMIUM

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

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

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

EXTENSION OF INSURANCE

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

CONVERSION PRIVILEGE

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

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

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

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

LIMITATION OF COVERAGE

In the event of your death by suicide, while sane or insane, the payment to be made with respect to any amount of Optional Group Life Insurance, which has been in force less than two (2) consecutive years during your lifetime, will be limited to the return of premiums. This limitation is applicable to Optional Group Life Insurance.

WHEN AND HOW TO MAKE A CLAIM

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

DEPENDENT LIFE INSURANCE

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

Benefit ceases at the earlier of the employee's retirement, termination of employment or the employee's attainment of age 75.

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

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

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

EXCEPTIONS AND LIMITATIONS
Dependents excluded from the plan:

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

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

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

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

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

WEEKLY INDEMNITY BENEFIT

AMOUNT OF INSURANCE

Benefit Formula:	flat amount
Benefit Maximum:	Greater of $513 per week or current Employment Insurance maximum
Non-evidence Limit:	Greater of $513 per week or current Employment Insurance maximum
Elimination Period:	0 days for Accident
	0 days for Hospital
	7 days for Sickness
Benefit Period:	26 weeks*

* The benefit payment is based on a five day work week; however, the elimination period is calculated on a calendar-day basis to include weekends.

Claim payments received are taxable benefits.

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

This plan is designed to partially replace earnings lost as a result of a disability due to accident or sickness.

Hospitalization means that you must be admitted to a licensed general hospital as an in-patient for a minimum period of an overnight stay.

DISABILITY

To be eligible for this benefit, you must be under the continuing care of a physician for the period of the disability, which normally commences with your first visit to a doctor. As an insured employee, you will be considered disabled and entitled to Weekly Indemnity payments if, as a result of sickness or accident you are unable to perform the regular duties of your own job and are not engaged in any occupation or employment for wage or profit.

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

RECURRENT DISABILITY

Successive periods of disability separated by less than two consecutive weeks of permanent employment, will be considered one period of disability, unless the subsequent disability is due to an accident or sickness entirely unrelated to the cause of the previous disability and commences after return to permanent employment.

ELIMINATION PERIOD

The elimination period is the continuous period of time which you must wait from the onset of the disability before the insurer begins paying Weekly Indemnity benefits.

WEEKLY INDEMNITY PREMIUM REQUIREMENT

In the event you become disabled and receive Weekly Indemnity benefits, you must continue to submit premiums. If, at the end of the benefit period you are still considered disabled and are unable to return to active employment, your Weekly Indemnity coverage will cease and premiums will no longer be required. Your Weekly Indemnity coverage will be reinstated immediately upon your return to work and you will be required to submit premiums commencing with the first full calendar month after your return to work.

INTEGRATION OF BENEFITS - REDUCTION CLAUSE

The amount of Weekly Indemnity benefit is reduced by any compensation you may receive as a result of the following, provided they are deemed acceptable limitations under the Employment Insurance Premium Reduction Regulations:

- any benefit a claimant is entitled to under any provincial automobile insurance plan that is first payor, and
- any income or retirement benefits received by the claimant from all sources so as not to exceed 100% of pre-disability weekly income.

EXCLUSIONS AND LIMITATIONS

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

Weekly Indemnity benefits are not payable for any of the following:

1. Any period of disability during which you are not under the continuing care and appropriate treatment and care of a physician who is a registered medical specialist or health care practitioner in the field of medicine that is applicable to your condition.
2. Any period during which you are not undergoing a course of medical treatment or participation in a program of rehabilitation which, in the opinion of the company is deemed appropriate.
3. Any period during which you are imprisoned.
4. Any disability due to or resulting from self-inflicted injury or sickness, while sane or insane.
5. Any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion.
6. Any disability due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation law or other legislation of similar purpose.
7. Any disability during the period:
    - of formal maternity leave taken by you pursuant to provincial or federal law, or pursuant to mutual agreement between you and the employer, or
    - in which employment insurance maternity benefits are being paid or would be paid if you were eligible, or
    - whichever is the longer.
8. Any disability period beyond the maximum benefit period. If you attain the maximum coverage age while receiving Weekly Indemnity benefits, the maximum benefit period will be 15 weeks.

WHEN AND HOW TO MAKE A CLAIM

To make a claim, complete the notice of claim for Weekly Indemnity benefits that is available from your employer.

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

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

LONG TERM DISABILITY INSURANCE

AMOUNT OF INSURANCE

Benefit Formula:	flat amount of $800 per week	
Benefit Maximum:	$3,200 per month	
Non-evidence Limit:	$3,200	
Elimination Period:	182 days	
Benefit Period:	(if disabled prior to age 65):	to age 65
	(if disabled age 65 or after):	2 years, not to exceed age 70

Claim payments received are taxable benefits.

Benefit ceases at the earlier of retirement, termination of employment or age 70. Coverage for active employees ceases at age 70 less the elimination period.

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

DISABILITY

To be eligible for this benefit, you must be under the continuous care of a physician. Blue Cross defines total disability as:

a) The complete and continuous inability of the insured employee to perform the regular duties of his own occupation as a result of illness or injury, during the elimination period and for the following 24 months; and

b) Thereafter, "total disability" means a state of continuous incapacity, resulting from illness or injury, which wholly prevents the insured employee from performing the regular duties of any occupation for which he:

- would earn 60% or more of his pre-disability earnings; and
- is reasonably qualified, or may so become, by training, education or experience.

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

The availability of such occupations, jobs or work will not be considered while assessing the insured employee's disability.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

PARTIAL DISABILITY

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

RECURRENT DISABILITY

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

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

ELIMINATION PERIOD

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

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

INTEGRATION OF BENEFITS

Indirect Offset plan

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

1. The amount of monthly income from the Long Term Disability plan is first reduced directly by any disability benefits available under the Canada or Quebec Pension plan (primary benefits only) and the Workers' Compensation Act.

2. The amount determined in "1" above is further reduced if necessary, so that the amount of monthly income, together with "income from all other sources" and the direct offsets in paragraph "1" above, does not exceed 85% of Pre-Disability earnings. "Income from all other sources" includes:

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

During the period of an approved Rehabilitation Program, the amount of monthly income as defined above, will be further reduced if necessary, so that the amount of monthly income together with all amounts of income mentioned in 1.and 2. above, including 100% of Earnings received from an approved Rehabilitation Program, does not exceed 100% of pre-disability Earnings.

Canada/Quebec Pension plan Freeze

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

EXCLUSIONS AND LIMITATIONS

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

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

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

WAIVER OF PREMIUM

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

WHEN AND HOW TO MAKE A CLAIM

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

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

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

ADDITIONAL BENEFIT INFORMATION

ELIGIBLE EMPLOYEES

To be eligible for group benefits, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work and working a minimum of 24 hours per week on a regular basis and have completed the plan waiting period. The waiting period for your group plan is 90 days of continuous employment. Coverage commences the first of the month following completion of the plan waiting period.

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

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

ELIGIBLE DEPENDENTS

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

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

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

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

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

EVIDENCE OF HEALTH

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

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

FLEXIBLE BENEFITS OVERVIEW

The flexible benefits enrolment site provides you with the opportunity to make benefit choices that best suit your needs.

ENROLMENT DETAILS

Your Health and Dental Benefit options are as follows:

- Comprehensive
- Premium

Enrolment into the Health and Dental plan is mandatory; you may only opt out of Health and Dental Benefits if you already have alternative coverage through your spouse. Evidence of this coverage must be provided.

ENROLMENT SYSTEM

The flexible benefits enrolment site is simple to use, available 24 hours a day, 7 days a week, and is delivered in a secure environment.

Your group administrator will provide you with your log-in information.

FIRST-TIME ENROLMENT

You can enrol once your employment begins. You must make your selections within 31 days of becoming eligible.

If you have not made your plan selection within the 31 day enrolment period, you will be automatically registered as follows:

- Comprehensive single/family status

ANNUAL REENROLMENT

You will have the opportunity to move up or down various plan option levels when you annually renew your enrolment.

If you have not made your plan selection within the annual 31 day enrolment period, you will be automatically registered under your previous year's status and plan selections.

Once you have made your plan selection, no changes can be made within the policy year, except in the case of a life event change (as described in the following section).

CHANGING YOUR COVERAGE

You may change your benefit selections between annual enrolments if you experience a life event change.

Life event changes are as follows:

1) You are adding your first eligible dependent, or will no longer have any eligible dependents as a result of one of the following:
    a) Marriage or common law union
    b) Birth or adoption of a child
    c) Divorce or legal separation
    d) Dependent no longer meets eligibility criteria
    e) Death of an eligible dependent

2) You have lost coverage under your spouse's plan.

A change as a result of a life event must be made within 31 days. Evidence of health will be required if you have not applied for your change within this timeframe.

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

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

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

ON THE PLAN MEMBER WEBSITE

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

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

Member Information

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

Member Statements

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

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

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

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

PLEASE NOTE

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

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

MEDAVIE BLUE CROSS CONTACT INFORMATION

Medavie Blue Cross has branch offices at the following locations to answer any inquiries you may have relating to your benefit plan.

NEW BRUNSWICK

Fredericton	Unit 2 - 1055 Prospect Street Fredericton, NB E3B 3B9
Moncton	Blue Cross Centre 644 Main Street P. O. Box 220 Moncton, NB E1C 8L3
Saint John	47A Consumers Drive Saint John, NB E2J 4Z7

NOVA SCOTIA

Dartmouth	Street Address: 230 Brownlow Avenue Dartmouth, NS B3B 0G5 Mailing Address: P. O. Box 2200 Halifax, NS B3J 3C6
Halifax	Barrington Tower, Scotia Square 1894 Barrington Street Halifax, NS B3J 2A8

NEWFOUNDLAND

St. John's	Viking Building 136 Crosbie Road, Suite 204 St. John's, NL A1B 3K3

ONTARIO

Toronto	185 The West Mall, Suite 1200 P. O. Box 2000 Etobicoke, ON M9C 5P1

QUEBEC

Montreal	1981 McGill College Avenue, Suite 100 Montreal, QC H3A 3A7

Toll-free Customer Information Line: 1-800-667-4511