Schedule of Benefits

J. D. IRVING, LIMITED

IRVING GROUP BENEFIT PLAN

SUSSEX SAWMILL UNION

6975 031 - 033

IRVING GROUP: HEALTH AND DENTAL FLEXIBLE BENEFITS PROGRAM
GROUP LIFE, AD&D AND DISABILITY

Effective Date: January 1, 2019

EMPLOYEES ARE ELIGIBLE FOR BENEFITS IF THEY ARE:

- A permanent employee
- Working full-time hours
- Actively at work on the date of eligibility
- A resident of Canada and
- A member of a provincial health care program in their province of residence (required for the Health & Dental plan)

ELIGIBILITY PERIOD - Completed 45 days of continuous work.

Date of Issue: Ocotber 24, 2018

The **QUEBEC DRUG PLANS (Drug Plans O, IT and 11)** will be applicable only to employees who:

- work for a company with an actual place of business in Quebec **and,**
- are working in Quebec **and,**
- are residing in Quebec.

The **STANDARD DRUG PLANS (Drug Plans PX, PY and PZ)** will be applicable to all other employees.

CHANGES TO FLEX PLAN OPTIONS – YOUR ADMINISTRATOR WILL ADVISE YOU WHEN YOU MAY CHANGE FROM ONE OPTION TO ANOTHER.

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

New legislation, or changes to Canadian Life and Health Insurance Association (CLHIA) guidelines, may occur after the date of issue which may result in certain information in this booklet no longer being current**.**

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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 takes the privacy policies and procedures we have in place to ensure that confidentiality 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

*Not applicable in Ontario and Quebec.

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

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

SCHEDULE OF BENEFITS

Underwritten by
Blue Cross Life Insurance Company of Canada

GRADED CRITICAL CONDITIONS

AMOUNT OF INSURANCE

Single coverage is elected under Health & Dental
Employee Maximum: $20,000*

Family coverage is elected under Health & Dental
Employee Maximum: $20,000*

Spouse Maximum: $ 4,000*

Each child Maximum: $ 2,000*

***Refer to the Covered Conditions under Graded Critical Conditions provisions of this booklet for detailed description.**

The subscriber, spouse and each child are eligible to submit a claim for the above amount of insurance following a 30 day waiting period. This means the insured must survive the onset of the critical condition for a period of 30 days before the benefit is paid. At the end of this 30-day period, the insured must still meet the definition of the critical condition. A pre-existing conditions clause applies and late applicants will be medically underwritten.

Medical certification must be provided within 365 days following the expiration of the 30 day waiting period described above.

Termination: Coverage ceases the earlier of retirement, termination of employment or age 65 of the employee.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

HEALTH Option A:

HOSPITAL BENEFITS – No coverage

WORLDWIDE TRAVEL BENEFITS – Plan F
- benefits are provided for an accident or unexpected illness outside the province of residence
- payment assistance through World Assistance
- program pays 100% of the eligible expense
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

OUT OF CANADA REFERRALS – Plan F
- medical services incurred outside of Canada on a referral basis when those services are unavailable in Canada
- program pays 100% of the eligible expense up to a lifetime maximum payment of $500,000 per person
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

HEALTH NON DRUG BENEFITS

Deductibles
Plan TA **(single)**
- $100 deductible per calendar year
- $200 maximum out-of pocket expense per calendar year (including deductible)

Plan TB (**family)**
- $200 accumulated family deductible per calendar year
- $400 maximum out-of-pocket expense per calendar year (including deductible)

EXTENDED HEALTH BENEFITS – Plan TA, TB
- reimbursement to the employee
- program pays 65% of the eligible expense after the deductible is satisfied
- program pays 100% after the total out-of-pocket expense per calendar year is satisfied (subject to internal maximums).

VISION CARE BENEFITS – No coverage

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

HEALTH Option B:

HOSPITAL BENEFITS - IN CANADA ONLY – Plan SP
- semi-private or private room accommodation
- paid directly to the hospital
- program pays 80% of the eligible expense

WORLDWIDE TRAVEL BENEFITS – Plan F
- benefits are provided for an accident or unexpected illness outside the province of residence
- payment assistance through World Assistance
- program pays 100% of the eligible expense
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

OUT OF CANADA REFERRALS – Plan F
- medical services incurred outside of Canada on a referral basis when those services are unavailable in Canada
- program pays 100% of the eligible expense up to a lifetime maximum payment of $500,000 per person
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

HEALTH NON DRUG BENEFITS

Deductibles
- Plan JN **(single)**
- $50 deductible per calendar year

- Plan JP **(family)**
- $100 accumulated family deductible per calendar year

EXTENDED HEALTH BENEFITS – Plan JN, JP
- reimbursement to the employee
- program pays 80% of the eligible expense after the deductible is satisfied (subject to internal maximums).

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

HEALTH Option B:

VISION CARE – Plan JN, Plan JP (HealthWise)

Payment is on a reimbursement basis to the employee after the $50 / $100 (Single / Family) deductible has been satisfied.

Spectacle/Contact Lenses Benefit
The spectacle lens benefit is designed to provide reimbursement for spectacle lens costs **(maximum two lenses) and 100% of the applicable dispensing fees**, up to a maximum amount established by Medavie Blue Cross.

If there has been a significant change in vision, then the spectacle lens benefit is available:
- whenever there has been a certain change in the refractive error.

If there has not been a significant change in vision, then the spectacle lens benefit is available:
- every two consecutive calendar years for a person under 19 years of age; and
- every four consecutive calendar years for a person 19 years of age or older.

Eye Examination / Frames
Payment is at 80% of the eligible expense; maximum reimbursed is $160, and is available:
- once every two consecutive calendar years for a person under 19 years of age; and
- once every four consecutive calendar years for a person 19 years of age and over.

For a more detailed explanation of benefits, refer to the appropriate Health Care Benefits page in this booklet.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

HEALTH Option C:

HOSPITAL BENEFITS - IN CANADA ONLY – Plan 5
- semi-private or private room accommodation
- paid directly to the hospital
- program pays 100% of the eligible expense

WORLDWIDE TRAVEL BENEFITS – Plan F
- benefits are provided for an accident or unexpected illness outside the province of residence
- payment assistance through World Assistance
- program pays 100% of the eligible expense
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

OUT OF CANADA REFERRALS – Plan F
- medical services incurred outside of Canada on a referral basis when those services are unavailable in Canada
- program pays 100% of the eligible expense up to a lifetime maximum payment of $500,000 per person
- benefits cease at the earlier of retirement, termination of employment or age 75 of the employee

HEALTH NON DRUG BENEFITS

EXTENDED HEALTH BENEFITS – Plan JR
- reimbursement to the employee
- program pays 100% of the eligible expense (subject to internal maximums).

VISION CARE – Plan JR (HealthWise)

Spectacle/Contact Lenses Benefit
The spectacle lens benefit is designed to provide reimbursement for spectacle lens costs **(maximum two lenses) and 100% of the applicable dispensing fees**, up to a maximum amount established by Medavie Blue Cross.

If there has been a significant change in vision, then the spectacle lens benefit is available:
- whenever there has been a certain change in the refractive error.

If there has not been a significant change in vision, then the spectacle lens benefit is available:
- every two consecutive calendar years for a person under 19 years of age; and
- every four consecutive calendar years for a person 19 years of age or older.

Payment is on a reimbursement basis to the employee.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

HEALTH Option C:

VISION CARE – Plan JR (HealthWise)

Eye Examination / Frames
Payment is at 100% of the eligible expense; maximum reimbursement is $200 and is available:
- once every two consecutive calendar years for a person under 19 years of age; and
- once every four consecutive calendar years for a person 19 years of age and over.

Payment is on a reimbursement basis to the employee.

For a more detailed explanation of benefits, refer to the appropriate Health Care Benefits page in this booklet.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

Standard Drug Plans

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

DRUG Option A:
DRUG BENEFITS – Plan PX (HealthWise Benefit List FLX)
Includes prescription drug items approved by Medavie Blue Cross and prescribed items approved by Medavie Blue Cross. Excludes "lifestyle" drugs such as but not limited to - oral contraceptives, erectile dysfunction treatments, smoking cessation products, fertility drugs, obesity medications, weight loss products and cough and cold medications.

- paid directly to the pharmacy
- the employee pays the mark-up plus the dispensing fee for each eligible drug on the prescription. After $350 single / $700 accumulated family out-of-pocket per calendar year*, the plan pays 100% of the total eligible expense

*Select Specialty High Cost Drugs are not included in the out-of-pocket maximum, nor are they paid at 100% once the out-of-pocket maximum is reached.

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

DRUG Option B:
DRUG BENEFITS – Plan PY (HealthWise Benefit List MA+MA3)
Includes prescription drug items approved by Medavie Blue Cross and certain "lifestyle" drugs, including oral contraceptives. Excludes smoking cessation products.

- paid directly to the pharmacy
- the employee pays the mark-up plus the dispensing fee to a maximum of $15 for each eligible drug on the prescription
- the plan pays 100% of the remaining eligible expense

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

SCHEDULE OF BENEFITS

Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

Standard Drug Plans

DRUG Option C:

DRUG BENEFITS – Plan PZ (Benefit List CM)

Includes prescription drug items approved by Medavie Blue Cross and certain prescribed life-sustaining items approved by Medavie Blue Cross. Excludes smoking cessation products.

- paid directly to the pharmacy
- the employee pays the mark-up plus the dispensing fee to a maximum of $15 for each eligible drug on the prescription
- the plan pays 100% of the remaining eligible expense

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

Quebec Drug Plans

Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums, dollar maximums, deductibles, co-payments or other maximums as approved by Medavie Blue Cross. All drug expenses are subject to usual, customary and reasonable charges and are supplemental to the RAMQ public drug plan.

DRUG Option A:
DRUG BENEFITS – Plan O
Benefit List RAMQ - Medications that are eligible are those products legislated by the province of Quebec, as determined by the Régie de l'assurance-maladie de Québec (RAMQ). Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums.

- paid directly to the pharmacy
- the employee pays the RAMQ copay for each eligible drug on the prescription. After the RAMQ out-of-pocket per participant, per calendar year maximum has been reached, the plan pays 100% of the total eligible expense

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

DRUG Option B:
DRUG BENEFITS – Plan IT
Benefit List MA - Includes prescription drug items approved by Medavie Blue Cross and certain "lifestyle" drugs, including oral contraceptives.

Benefit List RAMQ - Medications that are eligible are those products legislated by the province of Quebec, as determined by the Régie de l'assurance-maladie de Québec (RAMQ). Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums.

- paid directly to the pharmacy
- the employee pays 20% for each eligible drug on the prescription. After the $350 single / $700 accumulated family out-of-pocket per calendar year, the plan pays 100% of the remaining eligible expense

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

Quebec Drug Plans

DRUG Option C:
DRUG BENEFITS – Plan 11
Benefit List CM - Includes prescription drug items approved by Medavie Blue Cross and certain prescribed life-sustaining items approved by Medavie Blue Cross. Excludes smoking cessation products.

Benefit List RAMQ - Medications that are eligible are those products legislated by the province of Quebec, as determined by the Régie de l'assurance-maladie de Québec (RAMQ). Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums.

- paid directly to the pharmacy
- the employee pays 20% to a maximum of $15 for each eligible drug on the prescription
- the plan pays 100% of the remaining eligible expense

Certain eligible drugs require prior or ongoing authorization by Medavie Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Medavie Blue Cross and may include requiring the Participant to participate in related patient support programming.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

DENTAL CARE BENEFITS

***DENTAL Option A*:**

DENTAL BENEFITS – Plan XR (HealthWise)

Note: This Plan is limited and restricts services that are of a maintenance nature. Please refer to the Dental Benefits section in this booklet for more information.

CORE SERVICES – No coverage

PREVENTIVE SERVICES – No coverage

PERIODONTICS
- program pays 70% of the eligible expense
- maximum payment for periodontic services is $2,450 per person in any five consecutive calendar year period

MAJOR SERVICES
- program pays 70% of the eligible expense
- maximum payment is $1,500 in a calendar year
- certain services require **"Special Authorization"**. Please refer to the appropriate Dental Benefits page in this booklet for more information.

ORTHODONTIC SERVICES
- program pays 50% of the eligible expense
- maximum lifetime payment of $2,000 per person

FEE SCHEDULE
- current Dental Society Fee Guide for General Practitioners in the employee's province of residence
- eligible Major Services are reimbursed based on the fee guide for specialists if the services are rendered by a specialist

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

DENTAL CARE BENEFITS

***DENTAL Option B*:**

DENTAL BENEFITS – Plan XS (HealthWise)

CORE SERVICES
- program pays 80% of the eligible expense

PREVENTIVE SERVICES
- program pays 80% of the eligible expense

PERIODONTICS
- program pays 70% of the eligible expense
- maximum payment for periodontic services is $2,450 per person in any five consecutive calendar year period

MAJOR SERVICES
- program pays 70% of the eligible expense
- maximum payment is $1,500 in a calendar year
- certain services require **"Special Authorization"**. Please refer to the appropriate Dental Benefits page in this booklet for more information.

ORTHODONTIC SERVICES
- program pays 50% of the eligible expense
- maximum lifetime payment of $2,000 per person

FEE SCHEDULE
- current Dental Society Fee Guide for General Practitioners in the employee's province of residence
- eligible Major Services are reimbursed based on the fee guide for specialists if the services are rendered by a specialist

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

DENTAL CARE BENEFITS

***DENTAL Option C*:**

DENTAL BENEFITS – Plan XT (HealthWise)

CORE SERVICES
- program pays 100% of the eligible expense

PREVENTIVE SERVICES
- program pays 100% of the eligible expense

PERIODONTICS
- program pays 70% of the eligible expense
- maximum payment for periodontic services is $2,450 per person in any five consecutive calendar year period

MAJOR SERVICES
- program pays 70% of the eligible expense
- maximum payment is $1,500 in a calendar year
- certain services require **"Special Authorization"**. Please refer to the appropriate Dental Benefits page in this booklet for more information.

ORTHODONTIC SERVICES
- program pays 50% of the eligible expense
- maximum lifetime payment of $2,000 per person

FEE SCHEDULE
- current Dental Society Fee Guide for General Practitioners in the employee's province of residence
- eligible Major Services are reimbursed based on the fee guide for specialists if the services are rendered by a specialist

SCHEDULE OF BENEFITS

Underwritten by
Blue Cross Life Insurance Company of Canada

BASIC GROUP LIFE INSURANCE

AMOUNT OF BASIC INSURANCE

Benefit Formula:	Two times base annual earnings
Benefit Maximum:	$100,000
Benefit Reduction:	Reduces on the first of January coincident with or next following: Age 65 - 50% of the amount of insurance Age 70 - $5,000

All amounts of insurance are rounded up to the next higher $500 amount.

Termination: Coverage ceases at the earlier of retirement or termination of employment.

SCHEDULE OF BENEFITS
Underwritten by
Blue Cross Life Insurance Company of Canada

OPTIONAL GROUP LIFE INSURANCE

AMOUNT OF OPTIONAL INSURANCE

Benefit Formula: Units of $25,000

Benefit Maximum: $500,000

Evidence of insurability is required for all amounts of Optional Life insurance.

Termination: Employee coverage ceases at the earlier of retirement, termination of employment or age 70.

Termination: Spouse coverage ceases at the earlier of the employee's retirement, termination of employment or employee's age 70, the spouse's age 70 or when no longer an eligible spouse.

RATES
Monthly Rates (per $1,000)

Age of Employee or Spouse	Smoker		Non-Smoker	
	Male	Female	Male	Female
Under 30	0.06	0.04	0.04	0.02
30-34	0.09	0.05	0.04	0.02
35-39	0.10	0.05	0.06	0.03
40-44	0.17	0.10	0.09	0.05
45-49	0.26	0.17	0.13	0.09
50-54	0.55	0.32	0.27	0.17
55-59	0.83	0.47	0.43	0.30
60-64	1.35	0.74	0.75	0.43
65-69	2.38	1.28	1.32	0.75

SCHEDULE OF BENEFITS
Underwritten by
Blue Cross Life Insurance Company of Canada

DEPENDENT LIFE INSURANCE

AMOUNT OF INSURANCE

Spouse: $10,000

Children: $5,000

Termination: Coverage ceases at the earlier of the employee's retirement or termination of employment.

SCHEDULE OF BENEFITS

Underwritten by
Blue Cross Life Insurance Company of Canada

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

AMOUNT OF BASIC INSURANCE

The principal amount is equal to the amount of Basic Group Life Insurance.

Benefit Reduction:	Reduces on the first of January coincident with or next following: Age 65 - 50% of the amount of insurance Age 70 - $5,000

All amounts of insurance are rounded up to the next higher $500 amount.

Termination: Coverage ceases at the earlier of retirement or termination of employment.

SCHEDULE OF BENEFITS
Underwritten by
Blue Cross Life Insurance Company of Canada

SHORT TERM DISABILITY INSURANCE

AMOUNT OF INSURANCE

Benefit Formula:	67% of regular weekly earnings
Benefit Maximum:	EI maximum
Elimination Period:	0 calendar days for accident 0 calendar days for hospital 7 calendar days for sickness

Hospitalization means that the member was admitted to a licensed general hospital as an in-patient for a minimum period of an overnight stay.

Maximum Benefit Period:	15 weeks (Excludes the elimination period for sickness)

Claim payments received are taxable benefits.

Termination: Coverage ceases at the earlier of retirement or termination of employment.

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

SCHEDULE OF BENEFITS
Underwritten by
Blue Cross Life Insurance Company of Canada

LONG TERM DISABILITY INSURANCE

AMOUNT OF INSURANCE

Benefit Formula:	50% of base monthly earnings
Benefit Maximum:	$1,800 per month
Elimination Period:	The earlier of the expiration of the Short Term Disability benefit period or 112 calendar days
Benefit Period:	To the earlier of the employee's cessation of disability, death or age 65.

Claim payments received are non-taxable benefits.

Termination: Coverage ceases at the earlier of retirement, termination of employment or age 65. Coverage for active employees ceases at age 65 less the elimination period.

GENERAL INFORMATION FOR ALL BENEFITS

For convenience of reference, "the company" shall mean Blue Cross Life Insurance Company of Canada for Life Benefits, Accidental Death and Dismemberment Benefits, Disability Insurance Benefits and Critical Conditions Benefit, Medavie Inc. for Health Benefits and Dental Benefits.

ELIGIBLE EMPLOYEES

You are eligible to enrol for benefits if you meet the eligibility requirements outlined in the Schedule of Benefits (see the first page of this booklet).

Employees must elect coverage, within 31 days of becoming eligible, 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.

An employee is considered to be actively at work on the effective date if he reports for work at his usual place of employment with the policyholder and is able to perform the regular duties of his occupation on a permanent basis. If an employee is not required to report for work for reasons such as holidays, shift variances, vacations or weekends, he shall be considered to be actively at work as long as he is capable of performing the regular duties of his occupation.

ELIGIBLE DEPENDENTS

Dependents are defined as your legal spouse and children (as described below). 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.

The term "spouse" refers to the person to whom you are married, or the person that you introduce as your spouse and with whom you have been living in a conjugal relationship for at least one year.

Dependent children, refers to a child or person who:

- is a resident of Canada;
- is the natural or adopted child of you or your spouse, or the child over whom you or your spouse have been court appointed as legal guardian with parental authority;
- is financially reliant on you or your spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:

    a) is under age 21;
    b) is under age 26 and is attending an accredited educational institution, college or university on a full-time basis; or
    c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

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

GENERAL INFORMATION FOR ALL BENEFITS

EVIDENCE OF HEALTH

Proof of good health is not required if application is made within 31 days of first becoming eligible, with the exception of Optional Group Life benefits for you or your spouse. 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.

BENEFICIARY DESIGNATION

Any beneficiary designation made under your previous group policy has been carried forward to this policy. You should review the existing designation to ensure it reflects your current intentions.

TERMINATION OF BENEFITS

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

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

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 which provides the greatest benefit to the subscriber.

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).

Benefit payments will be co-ordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines, so that the total amount received from all sources will not be greater than the actual expense incurred.

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.

GENERAL INFORMATION FOR ALL BENEFITS

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE

During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

RECOVERING DAMAGES FROM A THIRD PARTY (SUBROGATION)

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

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

ADDITIONAL INFORMATION

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.

GRADED CRITICAL CONDITIONS

LIVING BENEFIT

This benefit will be paid in a lump-sum payment to you if you or your covered dependents are afflicted with a critical condition. You must provide medical evidence satisfactory to Blue Cross Life within 365 days following the end of the benefit waiting period.

The aggregate amount payable for a covered condition with a graded benefit schedule will not exceed 100% of the amount of coverage in force. An insured individual who received payment at the lesser amount of the graded benefit schedule can apply to receive the balance of the principle sum provided coverage remains in force and the criteria for payment at the 100% benefit level is met.

The benefit amount will be paid once for any covered condition resulting from the same or related illness or disease. Multiple unrelated occurrences will be covered, so long as all payments combined do not exceed the lifetime maximum allowable amount. The lifetime maximum amount payable for all critical conditions is two times the amount shown in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

No Critical Conditions benefit will 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.

Critical Conditions benefits are not payable for any condition due to or resulting directly or indirectly from any of the following:

- an accident, except for severe burns, or
- attempted suicide, self-inflicted injury or sickness, whatever the state of mind of the participant, or
- insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion, or
- any accident or injury occurring while operating a motor vehicle with a blood alcohol in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat)

PRE-EXISTING CONDITIONS

Critical Conditions benefits are not payable as a result of any pre-existing condition unless commencement of the critical condition occurs after 24 consecutive months of coverage.

A pre-existing condition means an illness or condition for which you or your covered dependent has received medical treatment, consultation, care or services (including diagnostic measures) or has been prescribed medication during the 24 months immediately prior to the effective date of the Critical Conditions coverage.

GRADED CRITICAL CONDITIONS

COVERED CONDITIONS

In the following three (3) critical conditions, the Graded Critical Condition Benefit allows for payment at either 100% or 40% of the coverage amount depending on the degree of severity of the condition. Please contact your group administrator for specific contract wording.

Cancer - 40% of the benefit is payable for some cancers that are not life threatening (certain exclusions apply).

100% of the benefit is payable for most cancers that metastasized as well as inoperable brain tumors. Metastasized means the cancer has spread to other parts of the body.

Heart Attack - 40% of the benefit is payable for a Class III heart attack, which means significant limitations of physical activity.

100% of the benefit is payable for Class IV heart attack, resulting in the inability to carry out physical activity without discomfort.

Stroke - 40% of the benefit is payable for stroke that produces evidence of neurological sequelae lasting more than 30 days.

100% of the benefit is payable for a stroke that produces evidence of neurological sequelae lasting more than 30 days, resulting in the inability to perform at least two of the five Activities of Daily Living without assistance.

In the remaining critical conditions, the benefit is payable at 100%.

Alzheimer's disease - definite diagnosis of a progressive degenerative disease of the brain where there is a significant reduction in mental and social functioning.

Blindness - definite diagnosis of the permanent loss of sight in both eyes.

Burns - third degree burns, as a result of a single event, covering at least 20 per cent of the body surface.

Coma - state of unconsciousness with no reaction to external stimuli or response to internal needs, for a continuous period of 30 days.

Deafness - definite diagnosis of the permanent loss of hearing in both ears.

Loss of speech - total and irreversible loss of speech as a result of physical disease.

Major organ failure - advanced or rapidly progressing incurable terminal kidney, liver, lung or heart failure where you or your covered dependent is not a candidate for organ transplant.

GRADED CRITICAL CONDITIONS

COVERED CONDITIONS (Cont'd)

Major organ failure requiring transplant - the irreversible failure of the kidney, liver, lungs or heart requiring receipt of a transplant of that organ. Acceptance in a satisfactory program is required.

Motor neuron disease - includes conditions that result in loss of voluntary muscle control, such as Lou Gehrig's disease. A definite diagnosis is required and the condition must be so severe that you or your covered dependent is unable to perform at least two of the five Activities of Daily Living without assistance.

Multiple Sclerosis - definite diagnosis by a certified neurologist. The condition must be so severe that you or your covered dependent is unable to perform at least two of the five Activities of Daily Living without assistance.

Paralysis - the complete and permanent loss of use of two or more limbs resulting from a neurological deficit.

Parkinson's disease - definite diagnosis by a certified neurologist. The condition must be so severe that you or your covered dependent is unable to perform at least two of the five Activities of Daily Living without assistance.

Senile dementia - definite diagnosis of a progressive degenerative disease of the brain resulting in a significant reduction in mental and social functioning.

All diagnoses are to be made by an acceptable medical specialist.

ACTIVITIES OF DAILY LIVING

Four (4) of the conditions outlined above make specific reference to the five (5) Activities of Daily Living a person would normally perform without assistance. They are:

Eating - manipulating prepared food or liquid into the mouth.

Dressing - putting on and removing necessary articles of clothing that are normally worn, including leg braces.

Bathing - the ability to cleanse the entire body using soap and water, including turning on faucets and shower mechanisms, getting into and out of the bath itself and drying oneself.

Ambulation - the ability to move independently from place to place with or without the use of equipment.

Toileting - (including continence) the ability to use a toilet, bedside commode or urinal.

HOW TO MAKE A CLAIM

Claim forms are available from your employer.

Claims must be received by Blue Cross Life within one (1) year after the loss.

If you suffer a loss other than death, a claim must be received by Blue Cross Life within one year after the loss.

HEALTH CARE BENEFITS

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the reasonable and customary charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown in the Schedule of Benefits and the benefit maximums listed below.

EXTENDED HEALTH BENEFITS - IN CANADA (OPTION A)

PHYSICIAN SERVICES - charges outside the participant's province of residence in excess of the allowance under a government health plan.

PROFESSIONAL AMBULANCE - professional ambulance or air transportation, if necessary for a stretcher patient, up to three economy seats on a regularly scheduled flight. The maximum eligible expense is $1,000 in a calendar year.

SPECIAL AMBULANCE ATTENDANT - travel expenses of a Registered Nurse (not a relative) where medically necessary. The maximum eligible expense is $500 in a calendar year.

PRIVATE DUTY NURSING - home nursing care by an RN, VON, RNA or CNA (but not a relative) at the participant's residence (other than a convalescent or nursing home) on the written authorization of the attending physician.

In addition, services provided by an approved personal care worker are eligible under this benefit for up to four hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. You may be eligible for services in your home if you are under the active care of a nurse or have been discharged from the hospital and require temporary home care during your recuperation period. Services that are not eligible under this benefit include custodial care, light housekeeping, meal preparation, shopping, transportation and respite care (patient care provided in the home intermittently in order to provide temporary relief to the family home caregiver).

Only those services pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross provider will be considered for reimbursement. If you or one of your dependents require this service, please call Medavie Blue Cross's toll-free number: **1-800-667-4511**

The maximum eligible expense for each participant is $10,000 in a calendar year. Payment for eligible expenses will be based on payment schedule for Private Duty Nurses established by Medavie Blue Cross for the participant's province of residence.

DIAGNOSTIC SERVICES - charges for diagnostic services, when carried out by a Medavie Blue Cross approved laboratory which, in the opinion of Blue Cross, is qualified to render such services. These services will include laboratory services.

OXYGEN - charges for oxygen.

HEALTH CARE BENEFITS

EXTENDED HEALTH BENEFITS - WORLDWIDE (OPTION A)

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.

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

DIABETIC EQUIPMENT - charges for the following equipment used for treatment and control of diabetes: preci-jet, glucometer, insulin pump (excluding batteries), or equipment approved by Medavie Blue Cross that performs similar functions. The overall maximum eligible expense is $5,000 in five calendar years.

OSTOMY SUPPLIES - charges for essential ostomy supplies.

SPEECH AIDS - speech aid equipment, (approved by a qualified speech therapist and the attending physician), for persons who do not have normal oral communication ability, limited to a lifetime maximum eligible expense of $500.

OTHER PRACTITIONERS - charges for treatment, except when performed in a hospital, by a licensed speech therapist and a clinical psychologist. The maximum eligible expense for each type of practitioner is $500 in a calendar year.

PROSTHETIC APPLIANCES - charges for the following remedial prosthetic appliances:
- artificial limbs (limited to one prosthetic appliance to each limb per lifetime),
- breasts (limited to a left and a right prosthesis every two consecutive calendar years),
- eyes (limited to one left and one right prosthesis per lifetime),
- crutches, splints, casts,
- trusses (limited to one truss per five consecutive calendar years),
- braces (limited to one cervical collar per calendar year and all other braces are limited to one per lifetime),
- a cane (limited to one per lifetime), and
- hair, when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $300 per lifetime. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

Repairs and/or adjustments are provided to a maximum eligible expense of $300 in a calendar year.

HEALTH CARE BENEFITS

EXTENDED HEALTH BENEFITS - WORLDWIDE (OPTION A)

MEDICAL SUPPLIES AND EQUIPMENT - charges for the purchase of burn pressure garments, charges for rental (or purchase, if approved by Medavie Blue Cross) of a wheel chair, hospital bed, equipment for the administration of oxygen and cranial remolding helmet (limited to two per lifetime). Burn pressure garments are limited to a maximum eligible expense of $500 per calendar year.

HEARING AIDS - charges for hearing aids (excluding batteries and exams), up to a total eligible expense of $600 in three consecutive calendar years, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist. 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 $600 for each hearing aid in three consecutive calendar years.

HEALTH CARE BENEFITS

HOSPITAL BENEFITS - IN CANADA (OPTIONS B and C)

HOSPITAL ROOM - the difference between standard ward accommodation and the room accommodation indicated in the Schedule of Benefits.

EXTENDED HEALTH BENEFITS - IN CANADA (OPTIONS B and C)

PHYSICIAN SERVICES - charges outside the participant's province of residence in excess of the allowance under a government health plan.

PROFESSIONAL AMBULANCE - professional ambulance or air transportation, if necessary for a stretcher patient, up to three economy seats on a regularly scheduled flight. The maximum eligible expense is $1,000 in a calendar year.

SPECIAL AMBULANCE ATTENDANT - travel expenses of a Registered Nurse (not a relative) where medically necessary. The maximum eligible expense is $500 in a calendar year.

PRIVATE DUTY NURSING - home nursing care by an RN, VON, RNA or CNA (but not a relative) at the participant's residence (other than a convalescent or nursing home) on the written authorization of the attending physician.

In addition, services provided by an approved personal care worker are eligible under this benefit for up to four hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. You may be eligible for services in your home if you are under the active care of a nurse or have been discharged from the hospital and require temporary home care during your recuperation period. Services that are not eligible under this benefit include custodial care, light housekeeping, meal preparation, shopping, transportation and respite care (patient care provided in the home intermittently in order to provide temporary relief to the family home caregiver).

Only those services pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross provider will be considered for reimbursement. If you or one of your dependents require this service, please call Medavie Blue Cross's toll-free number: **1-800-667-4511**

The maximum eligible expense for each participant is $10,000 in a calendar year. Payment for eligible expenses will be based on payment schedule for Private Duty Nurses established by Medavie Blue Cross for the participant's province of residence.

DIAGNOSTIC SERVICES - charges for diagnostic services, when carried out by a Medavie Blue Cross approved laboratory which, in the opinion of Blue Cross, is qualified to render such services. These services will include laboratory services.

OXYGEN - charges for oxygen.

HEALTH CARE BENEFITS

EXTENDED HEALTH BENEFITS - WORLDWIDE (OPTIONS B and C)

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.

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

DIABETIC EQUIPMENT - charges for the following equipment used for treatment and control of diabetes: preci-jet, glucometer, insulin pump (excluding batteries), or equipment approved by Medavie Blue Cross that performs similar functions. The overall maximum eligible expense is $5,000 in five calendar years.

OSTOMY SUPPLIES - charges for essential ostomy supplies.

SPEECH AIDS - speech aid equipment, (approved by a qualified speech therapist and the attending physician), for persons who do not have normal oral communication ability, limited to a lifetime maximum eligible expense of $500.

OTHER PRACTITIONERS - charges for treatment, except when performed in a hospital, by a licensed: speech therapist, masseur*, clinical psychologist, chiropractor, osteopath, chiropodist/podiatrist, physiotherapist/athletic therapist, acupuncturist or naturopath. The maximum eligible expense for each type of practitioner is $500 in a calendar year. The overall maximum eligible expense is $1,500 in a calendar year. In addition, the maximum eligible expense for X-rays in a calendar year is $35 per practitioner.

* requires a physician's written referral (valid for one year). The Claim must be accompanied by a claim form completed by a Medavie Blue Cross approved massage therapist

PROSTHETIC APPLIANCES - charges for the following remedial prosthetic appliances:
- artificial limbs (limited to one prosthetic appliance to each limb per lifetime),
- breasts (limited to a left and a right prosthesis every two consecutive calendar years),
- eyes (limited to one left and one right prosthesis per lifetime),
- crutches, splints, casts
- trusses (limited to one truss per five consecutive calendar years),
- braces (limited to one cervical collar per calendar year and all other braces are limited to one per lifetime),
- a cane (limited to one per lifetime), and
- hair, when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $300 per lifetime. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

Repairs and/or adjustments are provided to a maximum eligible expense of $300 in a calendar year.

HEALTH CARE BENEFITS

EXTENDED HEALTH BENEFITS - WORLDWIDE (OPTIONS B and C)

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

CUSTOM ORTHOPEDIC SHOES AND FOOT ORTHOTICS - charges for:

1. the purchase and repair of custom made orthopedic shoes or prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
   - the shoes have been prescribed by an attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;
   - the participant provides a copy of the biomechanical or gait analysis from the prescribing health practitioner; and
   - the orthopedic shoes are dispensed by an approved provider of orthopedic shoes.

2. custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:
   - they have been prescribed by the attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist; and
   - the custom made foot orthotics are dispensed by an approved provider of custom made foot orthotics.

Maximum eligible expense of $200 in a calendar year. For dependent children less than 21 years of age, the maximum eligible expense in a calendar year is $300.

HEARING AIDS - charges for hearing aids (excluding batteries and exams), up to a total eligible expense of $600 in three consecutive calendar years, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist. 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 $600 for each hearing aid in three consecutive calendar years.

HEALTH CARE BENEFITS

VISION CARE (OPTIONS B and C)

VISION CARE – Plan JN, Plan JP and Plan JR (HealthWise)

Spectacle lens benefit
The spectacle lens benefit is designed to provide reimbursement for spectacle lens costs (maximum two lenses) and the applicable dispensing fees, up to a maximum amount established by Medavie Blue Cross.

The lens benefit is available whenever there has been a certain change in the refractive error, which is defined as a change in one or more of the following spectacle lens prescription components: equal to or greater than a one-half diopter in the sphere or cylinder; at least ten degrees in the axis when the cylinder is two diopters or less; at least five degrees in the axis when the cylinder is greater than two diopters; one diopter of horizontal prism (in or out); or one-half diopter of vertical prism (up or down).

If there has not been a significant change in vision, then the spectacle lens benefit is available:
- every two consecutive calendar years for a person under 19 years of age; and
- every four consecutive calendar years for a person 19 years of age or older.

Special lenses and lens coatings
Special lenses/coatings required as a result of a specified medical condition are eligible benefits if approved through the Special Authorization process. The maximum eligible expense for lenses/coatings approved through the Special Authorization process will be based on the amount established by Medavie Blue Cross.

Special lenses and lens coatings are available whenever there has been a significant amount of change in vision as defined for spectacle lenses.

Special Eye Examinations
Special Eye Examinations, required as a follow-up for a specific medical condition, are assessed through Special Authorization. The maximum payment and the frequency limitations for Special Eye Examinations approved through the Special Authorization process will be determined by Medavie Blue Cross.

HEALTH CARE BENEFITS

VISION CARE (OPTIONS B and C)

VISION CARE – Plan JN, Plan JP and Plan JR (HealthWise)

Contact lenses - Elective
Contact lenses are eligible as benefits in lieu of spectacle lenses. The contact lens benefit is designed to provide reimbursement for contact lenses, and the applicable dispensing fee, up to the maximum amount established by Medavie Blue Cross.

The contact lens benefit is available whenever there has been a certain change in the refractive error, which is defined as a change in one or more of the following lens prescription components: equal to or greater than one-half diopter in the sphere or cylinder; at least ten degrees in axis when the cylinder is two diopters or less; at least five degrees in the axis when the cylinder is greater than two diopters.

If there has not been a significant change in vision, then the contact lens benefit is available:
- once every two consecutive calendar years for a person under 19 years of age;
- once every four consecutive calendar years for a person 19 years of age or over.

Contact lenses - Required due to Medical Conditions
Contact lenses and the initial contact lens fitting procedures required as a result of keratitis, corneal perforation or scarring, keratoconus, aphakia, or other medical condition(s) as approved by Medavie Blue Cross are eligible if approved through the Special Authorization process.

When contact lenses are approved under the Special Authorization process for the medical conditions specified, the elective contact lens benefit is not available.

Replacement contact lenses which are required due to a medical condition will follow the same benefits and frequency criteria as elective contact lenses.

Visual Training
Visual training services, as required for the treatment of ocular muscle imbalance, or other medical condition(s) as approved by Medavie Blue Cross, are eligible benefits if approved by Medavie Blue Cross through the Special Authorization process.

Eye Examination / Frames – Plan JN, Plan JP ***(Option B)***
Payment is at 80% of the eligible expense up to $160, and is available:
- once every two consecutive calendar years for a person under 19 years of age; and
- once every four consecutive calendar years for a person 19 years of age and over.

Eye Examination / Frames – Plan JR ***(Option C)***
Payment is at 100% of the eligible expense up to $200, and is available:
- once every two consecutive calendar years for a person under 19 years of age; and
- once every four consecutive calendar years for a person 19 years of age and over.

Payment of all Vision Care Benefits is on a reimbursement basis to the employee.

HEALTH CARE BENEFITS

PRESCRIPTION DRUG COVERAGE (OPTIONS A, B and C)

Please refer to the Schedule of Benefits page to determine if the drug benefit is on a direct-payment or reimbursement basis, the payment features, and the benefit list applicable to this plan.

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

Certain prescription-requiring drugs on the eligible drug benefit list are eligible benefits on an individual participant basis based on specific medical needs when approved by Medavie Blue Cross under the Special Authorization process.

Medavie Blue Cross agrees to make payment for eligible prescription drugs, which are prescribed by a physician or dentist, in the quantity prescribed and deemed reasonable by Medavie Blue Cross in consultation with its Health Care consultants.

SPECIALTY HIGH COST DRUG

An eligible drug that requires prior-authorization, and:

- costs $10,000 or more per treatment or per calendar year; and
- is used to treat complex chronic and/or life threatening conditions such as cardiac, rheumatoid arthritis, cancer, multiple sclerosis and hepatitis c.; and
- is prescribed by a specialist; or
- is considered a Specialty High Cost Drug by the Medication Advisory Panel and may include required participation in a related Patient Support Program. Medavie Blue Cross can reduce the amount of a Specialty High Cost Drug by an amount up to the amount of financial assistance the person is entitled to receive for that service or supply under a patient support program.

PATIENT SUPPORT PROGRAM

A Program that provides assistance to persons with respect to the purchases of services or supplies and is included but not limited to Specialty High Cost Drugs.

HEALTH CARE BENEFITS

Minimum Requirements for Drug Coverage in Quebec
This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance
The group plan must be administered in accordance with the Act Respecting Prescription Drug Insurance ("the Act") for Quebec Participants, including the Act's provisions about maximum coinsurance, out-of-pocket maximums, eligible drugs, exception drugs and eligible pharmacy services.
Under no circumstances will the exclusions and limitations provision of this benefit render drug benefit coverage for Quebec participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Calendar Year
If, in any calendar year, a member spends more than the maximum contribution amount established by the RAMQ on eligible expenses for themselves or their dependents, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that calendar year. The contribution amount includes the deductible, amounts in excess of the reimbursement level or co-payment, if applicable.

Participants Age 65 Years and Over
At age 65, a Quebec participant is automatically registered as a beneficiary of the RAMQ public drug plan. Therefore, on reaching age 65, a Quebec participant must decide whether to:
- cancel their automatic registration with the RAMQ drug plan in order to continue their coverage under this benefit; or
- accept coverage under the RAMQ public drug plan.

The decision to cancel the automatic registration with RAMQ is revocable.

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

For Quebec participants who decide to accept coverage under the RAMQ public drug plan the following expenses are eligible under this benefit:
- the deductible and coinsurance paid by the Quebec participant under the RAMQ public drug plan; and
- reimbursement for any eligible drug that is not included in the RAMQ public drug plan but is covered under this benefit, subject to the deductible and reimbursement level specified in the Schedule of Benefits.

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

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

HEALTH CARE BENEFITS

EXCEPTIONS AND LIMITATIONS

Health Care Benefits will not be payable for charges in connection with the following:

- convalescent, custodial or rehabilitation services
- conditions not detrimental to health
- services or supplies normally provided without cost or at nominal cost by the participant's government health plan
- benefits the participant receives or is entitled to receive from Workers' Compensation
- mileage or delivery charges
- insurrection or war
- participation in the commission of a criminal offense
- a service or supply which is experimental or investigative in nature
- a service or supply which is not medically necessary.

CONVERSION PRIVILEGE

If you should terminate employment, you may convert to an Individual Health Plan currently issued by Medavie 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 in the event of your death.

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

HEALTH CARE BENEFITS

HOW TO MAKE A CLAIM FOR HEALTH CARE AND DENTAL BENEFITS

Health and Dental Benefits: are on a reimbursement basis unless otherwise specified in the Schedule of Benefits. Claims must be submitted within twelve (12) months of receiving services or supplies. To claim benefits on a reimbursement basis, please follow the procedures described in paragraph (b) below.

For Health Care, Drugs, or Dental claims, the subscriber or dependent should ensure they are dealing with a Health Care Professional approved by Medavie Blue Cross. After this, one of the procedures below should be followed:

a) Direct payment plan: the subscriber's Medavie Blue Cross identification card should be shown and the provider will arrange to bill Medavie Blue Cross directly, or

b) Reimbursement plan: the subscriber must pay the provider, obtain an official receipt and submit this to Medavie Blue Cross for payment. The subscriber should also arrange for the completion of the appropriate claim forms, which are available from your employer or the provider of services. For drug claims on a reimbursement basis, receipts must indicate the following information for each prescription item:
   - patient's name
   - prescription number and date dispensed
   - D.I.N. (Drug Identification Number) or drug name, strength and quantity.

c) Certain benefits will require Special Authorization by Medavie Blue Cross. To apply for Special Authorization from Medavie Blue Cross, you must arrange for the Health Care Professional rendering the service to complete a Special Authorization form. Any costs incurred for completion of Special Authorization forms is the subscriber's responsibility.

Note: It is in your best interest to submit your claim as soon as possible to ensure timely claims processing.

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

The Group Travel Plan covers a wide range of benefits which may be a result of an accident or unexpected illness incurred outside the participant's province of residence while this plan is in effect. Subject to the maximum amounts indicated below, the plan pays 100% of the eligible expense with no overall maximum, less the amount allowed under any Government Health Program.

Eligible expenses include:

HOSPITAL ACCOMMODATION - the cost of hospital room accommodation (not a suite) and medically necessary inpatient/outpatient services.

PHYSICIANS AND SURGEONS - customary charges by physicians and surgeons for services rendered.

MEDICAL APPLIANCES - the cost of casts, canes, slings, splints, trusses, braces and/or temporary rental of a wheelchair, when required due to an accident or sudden illness which 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.

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 patient 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 patient 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.

PARAMEDICAL SERVICES - charges made by a licensed chiropractor, osteopath, chiropodist, podiatrist or physiotherapist, up to the usual and customary fee excluding charges for x-rays.

PRESCRIPTIONS - charges for drugs, serums and injectables, approved by Medavie Blue Cross, and purchased on the prescription of a physician (vitamins, patent and proprietary drugs excluded).

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

DENTAL SERVICES - up to $1,000 Canadian for dental treatment necessitated by a direct accidental blow to the mouth. Such services must be rendered or reported and approved within 180 days of the accident and be supported by details of the accident.

VEHICLE RETURN - up to $500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

RETURN OF DECEASED - up to $3,000 Canadian towards the cost of preparation and homeward transportation of a deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

MEALS AND ACCOMMODATION - up to $1,200 Canadian ($150 per day for eight days) per trip for extra costs of commercial accommodation and meals incurred by the subscriber, or by a covered dependent 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.

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

EMERGENCY AND PAYMENT ASSISTANCE - the services of a 24-hour emergency hotline are available to participants who need assistance while travelling. By telephoning the Worldwide Travel Assistance number on your Identification Card when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the participant. In addition, the following services are offered.

Medical Assistance - the patient 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 patient's condition and communication with the subscriber and family
- return home or transfer of patient if medically permissible
- transport of a family member to the patient's bedside or to identify the deceased.

Non-Medical Assistance - the patient may call to obtain:

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

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

EXCLUSIONS

1. No benefits are available under the plan unless the participant has approved Provincial Health Care coverage. Each participant should ensure they have Provincial Health Care coverage in place for the duration of their travel. It is important to note that the rules relating to absences from their home province vary from province to province and are subject to change at any time. It is strongly recommended that each traveler contact their applicable Provincial Health Care program for confirmation of their provincial coverage prior to each departure.

2. No benefits are available under this plan for residents 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, unless:

   a) an emergency occurs resulting from an accident or unexpected illness which is unrelated to the purpose of your trip, and
   b) any subsequent investigation that may occur does not prove that emergency to be related.

3. No benefits are available under the plan for elective (nonemergency) 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.

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

5. 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.

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

EXCLUSIONS (Cont'd)

6. 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.

7. 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. ***If you are uncertain of your health status, please call the Medavie Blue Cross toll-free number 1-800-667-4511 for a pre-determination prior to travelling.***

   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.

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.

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

CLAIMING BENEFITS

When not using the Emergency and Payment Assistance services, obtain detailed receipts in duplicate for any expenses incurred outside your province of residence. Upon your return, send one of the receipts to your Provincial Government Health Plan for their consideration and payment. When a reply has been received from them, send proof of their payment together with appropriate receipts to Medavie Blue Cross - Claims Department for payment of the remaining eligible benefits. Always provide your Medavie Blue Cross Identification Number when submitting a claim to Medavie Blue Cross.

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

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

REFERRAL SERVICES OUTSIDE CANADA

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

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

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

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

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

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

All claims and required government forms must be submitted within twelve (12) months of the date of service.

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS (OPTIONS A, B and C)

REFERRAL SERVICES OUTSIDE CANADA

LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

6. The services to be provided outside Canada must not be Experimental or Investigative in nature.

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

DENTAL BENEFITS

Your dental program covers you and your dependents for a wide range of dental services, including the following benefits. Medavie Blue Cross will pay for the following eligible services in accordance with the payment schedule shown in the Schedule of Benefits and as specified below. Eligible expenses, benefit limitations and frequencies are those authorized by Medavie Blue Cross.

PREVENTIVE SERVICES (OPTIONS B and C)

DIAGNOSTIC

- Recall examinations - one per calendar year for participants 19 years of age and over; two per calendar year for participants under 19 years of age
- Specific examinations - one each per calendar year
- Mixed Dentition Analysis - one per lifetime

PREVENTIVE

- Polishing and scaling - two units of each per calendar year for participants 19 years of age and over; one unit of each per calendar year for participants under 19 years of age
- Fluoride - one every calendar year for person under 19 year of age
- Sealants - one per permanent posterior tooth per lifetime for persons under 19 years of age

CORE SERVICES (OPTIONS B and C)

DIAGNOSTICS

- Complete examination once per provider every five calendar years
- Bitewing and periapical radiographs - limit of four films per calendar year
- Emergency examination - one per calendar year

SCALING

- Two units per calendar year

RESTORATIVE

- Caries, trauma and pain control
- Composite fillings on anterior, bicuspid and molar teeth
- Non Bonded Amalgam fillings on all teeth. Bonded amalgam fillings up to the cost of a comparable non bonded amalgam.
- Prefabricated full coverage restorations on primary and permanent teeth

ORAL SURGERY

- Extractions of erupted teeth; Hemorrhage Control; Minor post-surgical care

DENTAL BENEFITS

PERIODONTICS (OPTIONS A, B and C)

The maximum eligible expense for periodontic services is as specified in the Schedule of Benefits.

Non-Surgical Procedures - Management of Oral Disease - one each per calendar year.

Surgical Procedures - Curettage, gingivoplasty, gingivectomy, flap approach, grafts.

Adjunctive Services
- Splinting - one per area per three calendar years
- Splint Removal & Occlusal Adjustments - two units each per calendar year.
- Scaling/Root Planing - combined limit of eight units per calendar year
- Periodontal Appliances* - including bruxism appliance
- Temporomandibular Joint Appliance*
- Myofascial Pain Syndrome Appliance*
- Appliances Maintenance, Adjustment, Repair - two units per calendar year
- Appliances Relines - one per two calendar years

*Limited to any one maxillary (upper) and any one mandibular (lower) appliance in two calendar years.

DENTAL BENEFITS

MAJOR SERVICES (OPTIONS A, B and C)

DIAGNOSTIC

- Each complete speciality examination - one per three calendar years
- Each specific/limited speciality examination - one per calendar year
- Complete radiograph series - one per five calendar years
- Panoramic radiographs - one per five calendar years
- Occlusal and Extraoral radiographs - 2 films each per calendar year
- Skull/Facial Bone radiographs & Radiopaque Dyes - 2 films each per five calendar years
- Sialography radiographs - 2 films per two calendar years
- TMJ radiographs - 2 films per calendar year
- Tests and Laboratory Examinations - microbiological, caries susceptibility, histological, cytologic, laboratory reports, and diagnostic casts
- Pulp Vitality and Interpretation of Models - 2 units each per calendar year
- Treatment Planning and Patient Consultation - 2 units each per calendar year

RESTORATIVE

- Single Crowns* - One per tooth every five consecutive calendar years
- Inlays/Onlays* - One per tooth every five consecutive calendar years

- Recontouring and Recementation - 2 units each per calendar year
- Removal and Staining - 2 units each per calendar year

*Special Authorization is required on all single crowns, inlays or onlays.

ENDODONTICS

- Treatment of Pulp Chamber - Pulpotomy/Pulpectomy
- Root Canal Therapy
- Periapical Services
- Endodontic Procedures (Miscellaneous)

DENTAL BENEFITS

MAJOR SERVICES (OPTIONS A, B and C) (Cont'd)

PROSTHODONTICS - REMOVABLE (dentures)

- Standard dentures - Complete and Partial - limit of one upper and one lower every five consecutive calendar years.

- Specialized dentures and services must be performed by a prosthodontist and require Special Authorization* - limit of one every five consecutive calendar years.

- Minor Denture Adjustments - 2 units per calendar year
- Occlusal Equilibration
- Denture Repairs/Additions
- Denture Prophylaxis & Scaling, Rebuilding Worn Teeth, Custom Staining - 2 units each per calendar year
- Relining/Rebasing Remake/Dentures using existing frame - limit of one upper and one lower denture reline or rebase or remake once in two consecutive calendar years
- Tissue Conditioning - 1 per calendar year
- Miscellaneous Services

PROSTHODONTICS - FIXED (bridges)

- Abutments/Retainers* - limit of one per tooth every five consecutive calendar years
- Pontics* - limit of one per tooth every five consecutive calendar years
- Replacement, Removal, Recementation - limit of two units each per calendar year
- Other Miscellaneous Services

*Special Authorization is required on all claims for abutments/retainer and pontics.

ORAL SURGERY

- Surgical Removals - Impacted teeth, Residual roots
- Surgical exposure and movement of teeth
- Remodelling and Recontouring Oral Tissues
- Surgical Excision - Benign tumors, cysts/granulomas
- Surgical Incision - Drainage, Sequestrectomy
- Treatment of Fractures - Replantation of avulsed teeth and repositioning of traumatically displaced teeth
- Treatment of Deformities - Frenectomy/Frenoplasty

ADJUNCTIVE GENERAL SERVICES

- Anesthesia - limit of 5 units per calendar year
- Professional Consultation - 2 units per calendar year
- Professional Visit - House call, Office/Institutional Visits - 1 unit each per calendar year

DENTAL BENEFITS

ORTHODONTIC DENTAL SERVICES (OPTIONS A, B and C)

DIAGNOSTIC
- Limited Oral Orthodontic Examination - one per three consecutive calendar years
- Specific Orthodontic Examination - one per calendar year
- Cephalometric radiographs - 3 films per three consecutive calendar years
- Cephalometric tracing - 2 units per three consecutive calendar years
- Hand & wrist radiographs
- Diagnostic photographs - 6 per calendar year
- Orthodontic cast

PREVENTIVE
- Control of oral habits. Motivation, myofunctional therapy, appliance adjustments and repairs
- Space maintainers and maintenance

COMPREHENSIVE
- Comprehensive Orthodontic procedures approved by Medavie Blue Cross

DENTAL BENEFITS (OPTIONS A, B and C)

EXCEPTIONS AND LIMITATIONS

The dental plan does not cover:

- services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement,
- dental treatment required as a result of insurrection, war or engaging in a riot,
- services for which the government prohibits the payment of benefit,
- services provided without charge or paid for by the employer,
- services performed by an unqualified practitioner,
- charges for missed appointments or the completion of claim forms,
- services not listed as a covered benefit.

BENEFITS FOR LATE APPLICANTS

If application for dental benefits (subscriber or dependent) 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 participant 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.

DENTAL SERVICES SPECIAL AUTHORIZATION

1. Special Authorization is mandatory for the following benefits and services:
   - crowns
   - inlays/onlays
   - certain periodontic dental services when rendered by a general practitioner
   - specialized dentures provided by a prosthodontist
   - bridges - abutments/retainers and pontics

2. An alternate benefit provision will be applied within the Special Authorization process. Under this provision, in all cases in which the patient selects a more expensive plan of treatment than is customarily provided for necessary and adequate dental treatment, Medavie Blue Cross’s payment will be based on the lesser fee.

DENTAL BENEFITS (OPTIONS A, B and C)

HOW TO MAKE A CLAIM FOR HEALTH CARE AND DENTAL BENEFITS

Health and Dental Benefits: are on a reimbursement basis unless otherwise specified in the Schedule of Benefits. Claims must be submitted within twelve (12) months of receiving services or supplies. To claim benefits on a reimbursement basis, please follow the procedures described in paragraph (b) below.

For Health Care, Drugs, or Dental claims, the subscriber or dependent should ensure they are dealing with a Health Care Professional approved by Medavie Blue Cross. After this, one of the procedures below should be followed:

a) Direct payment plan: the subscriber's Medavie Blue Cross identification card should be shown and the provider will arrange to bill Medavie Blue Cross directly, or

b) Reimbursement plan: the subscriber must pay the provider, obtain an official receipt and submit this to Medavie Blue Cross for payment. The subscriber should also arrange for the completion of the appropriate claim forms, which are available from your employer or the provider of services. For drug claims on a reimbursement basis, receipts must indicate the following information for each prescription item:
   - patient's name
   - prescription number and date dispensed
   - D.I.N. (Drug Identification Number) or drug name, strength and quantity

c) Certain benefits will require Special Authorization by Medavie Blue Cross. To apply for Special Authorization from Medavie Blue Cross, you must arrange for the Health Care Professional rendering the service to complete a Special Authorization form. Any costs incurred for completion of Special Authorization forms is the subscriber's responsibility.

Note: It is in your best interest to submit your claim as soon as possible to ensure timely claims processing.

For further information on the Special Authorization claims process, contact your local Medavie Blue Cross office or call toll free 1-800-667-4511.

BASIC AND OPTIONAL GROUP LIFE INSURANCE

DEATH BENEFIT

The death benefit provides for payment to your last named beneficiary, beneficiaries or estate for the amount of Life Insurance in force on the date of death.

Optional Spousal Group Life Insurance benefits are payable to you, if living, otherwise to your last named beneficiary, beneficiaries or estate.

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 lesser 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.

BASIC LIFE PREMIUMS WHILE ON DISABILITY

If you become approved and are in receipt of payments for Short Term Disability, Long Term Disability or Workers' Compensation benefits prior to your 65th birthday, Basic Group Life Insurance coverage is continued with no premium payment required by you.

WAIVER OF PREMIUM – OPTIONAL LIFE INSURANCE

If you qualify to receive the Long Term Disability benefit, any premium due under the Optional Life Insurance benefit will be waived commencing on the first full calendar month following the end of the Long Term Disability benefit elimination period. The Optional Life Insurance benefit premium will be waived until you return to active permanent employment or when you no longer qualify for the Long Term Disability benefit.

If you are in receipt of Long Term Disability benefits and become totally disabled again after you have returned to work, and qualify for the Long Term Disability benefit under the Recurrent Disability provision, the premiums will also be waived for the Optional Life Insurance benefit without completing the elimination period a second time.

BASIC AND OPTIONAL GROUP LIFE INSURANCE

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, then you may purchase an individual plan, without evidence of insurability, of the type then being offered by Blue Cross Life in an amount not to exceed the amount terminated, or $200,000 (Basic & Optional Life Combined), whichever is less, or the maximum amount prescribed by applicable provincial legislation. Written application must be made and the required premium submitted during the 31 day period immediately following the date of termination. In the event of your death within 31 days following termination of your group coverage, the amount of benefit available to you under the conversion privilege will be paid to your designated beneficiary or estate provided that any individual plan issued under the conversion privilege is surrendered. During the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge.

Limited conversion rights are available on termination of the group contract in accordance with the Superintendents of Insurance Guidelines.

If the life insurance on a spouse under this benefit terminates on or before attaining 65 years of age because of:

- the death of the insured employee, or
- the termination of the employee's Group Life Insurance for any reason which entitles the employee to convert this life insurance, or
- the dependent ceases to be an eligible dependent

then the spouse may purchase an individual life insurance plan from the insurer in an amount not to exceed the amount of Optional Group Life insurance on the spouse which terminated.

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE

During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

LIMITATION OF COVERAGE

In the event of the death of you or your covered spouse by suicide, whatever the state of mind of the participant, 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 you or your covered spouse's lifetime, will be limited to the return of premiums. This limitation is applicable to Optional Group Life Insurance on you and your covered spouse.

BASIC AND OPTIONAL GROUP LIFE 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 of retirement,
- the day on which you attain the age limitation for this plan,
- the end of the grace period for which any premium has not been paid in full, or
- the date before any naval, military or air force deployment.

The Optional Group Life Insurance on your spouse will cease at the earlier of the employee's retirement, termination of employment or employee's age 70, the spouse's age 70 or when no longer an eligible spouse.

HOW TO MAKE A CLAIM

Basic Group and Optional Life: must be made as soon as reasonably possible. Claim forms are available from your employer.

DEPENDENT LIFE INSURANCE

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 General Information For All Benefits found previously in this booklet.

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 their live birth, even if confined to a hospital. In the case of a still birth, coverage will be effective from 28 weeks gestation.

EXCEPTIONS AND LIMITATIONS
Dependents excluded from the plan are persons for whom evidence of insurability, if required, is not approved by the insurer.

DEPENDENT LIFE PREMIUMS WHILE ON DISABILITY
If you become approved and are in receipt of payments for Short Term Disability, Long Term Disability or Workers' Compensation benefits prior to your 65th birthday, Dependent Life Insurance coverage is continued with no premium payments required by you.

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE
During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

DEPENDENT LIFE INSURANCE

CONVERSION PRIVILEGE

If a dependent's life coverage terminates on or before reaching age 65 because of:

- death of the member,
- termination of the member's life coverage, or
- the spouse or child is no longer eligible for coverage as a dependent

then the eligible spouse residing in any province or an eligible child who is a resident of Quebec has the right to purchase an individual life policy, without evidence of insurability, of the type then being offered by Blue Cross Life in an amount not to exceed the amount terminated.

Written application must be made and the required premium submitted during the 31 day period immediately following the date of termination. In the event of a dependent's death within 31 days following termination of your group coverage, the amount of benefit available under this conversion privilege will be paid to you (the member) provided that any individual plan issued under this conversion privilege is surrendered. During the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge.

Limited conversion rights are available on termination of the group contract in accordance with the Superintendents of Insurance Guidelines.

HOW TO MAKE A CLAIM

Dependent Life: must be made as soon as reasonably possible. Claim forms are available from your employer.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS

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

Table of Benefits

Loss of	**Percentage of the amountof insurance**
Life	100%
Sight of both eyes	100%
One hand and the entire sight of one eye	100%
One foot and the entire sight of one eye	100%
Speech and hearing in both ears	100%
Entire sight of one eye	100%
Speech or hearing in both ears	100%
Hearing in one ear	33 1/3%
All toes on one foot	33 1/3%
Loss of use	
Both hands or both feet	100%
One hand and one foot	100%
One arm or one leg	100%
One hand or one foot	100%
Thumb and index finger on the same hand	33 1/3%
At least four fingers on the same hand	33 1/3%
Paralysis	
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

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

Loss of use - the total and irrecoverable loss of use for twelve continuous months after which the benefit is payable, provided the loss of use is determined to be permanent.

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

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS (Cont'd)

Coma Benefit - 1% of the coverage amount payable monthly, following 30 consecutive days of complete and total unconsciousness caused by accidental injury.

Should any claim for a loss as provided in the Table of Benefits be paid due to the same accidental injury, benefits payable in the event of subsequent coma will be based on the balance of the principal sum.

Coma or comatose means a state of unconsciousness with no reaction to external stimuli or response to internal needs, for a continuous period of 30 days.

Repatriation - If accidental loss of life occurs while at least 50 kilometers from your place of residence and results in the company making a payment under the "Table of Benefits", maximum reimbursement of $15,000 for:

1. the preparation and transportation of your body to the city of permanent residence and/or
2. lodging and board of an immediate family member while en route and/or during the stay in the city or town where your body is located (not to exceed a maximum of three consecutive nights) and transportation by the most direct route by a licensed common carrier to and from such location, for the purpose of identifying your body.

Payment is not made for ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses is limited to a maximum of $0.20 per kilometer travelled.

Rehabilitation - If an accidental injury does not cause your loss of life and results in the company making a payment under the "Table of Benefits", an additional amount is paid for the reasonable and necessary expenses actually incurred up to $15,000 for your special training, provided:

1. you are required to undergo training as the result of the injury in order to be qualified to engage in an occupation in which you were previously not qualified for prior to such injury and
2. expenses are incurred within three years from the date of the accidental injury.

Occupational Training for Spouse - $10,000 maximum reimbursement for a formal training program within three years of your date of death.

Education Benefit - the company will pay an education benefit subject to the lesser of 5% of your principal sum, or $5,000 for each year your child continues his education on a full-time basis for a maximum of four consecutive years at:

1. an institution for higher learning or
2. a post-secondary education in which he enrolls within 365 days following the date of the accident.

If, at the time of your death, there are dependent children not eligible for the education benefit, the company pays 1% of your principal sum to your beneficiary, subject to a minimum of $500 to a maximum of $2,500.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS (Cont'd)

Family Travel - $10,000 maximum reimbursement for an immediate family member to attend the hospital of your confinement when such confinement occurs more than 100 kilometres from your normal place of residence. If personal transportation is used instead of public transportation, a rate of $0.20 per kilometre applies.

Child Care Benefit - the lesser of 5% of your principal sum, or $5,000 per year for each child enrolled in a licensed day care facility, for a maximum of four years. A dependent child is eligible for this benefit if at the time of the accident, he is enrolled in a day care centre, or he enrolls in a day care centre within 90 days following the date of the accident. If, at the time of your death, there are dependent children not eligible for the child care benefit, the Company pays 1% of your principal sum to your beneficiary, subject to a minimum of $500 to a maximum of $2,500.

Seat Belt - if you are injured in a car accident while wearing a seat belt, and suffer a loss that is payable under this benefit, the amount of insurance payable will be increased by 10% provided that:

1. The loss occurs while you are a passenger or the driver of a private motor vehicle,
2. The driver of the motor vehicle must have a valid driver's license to operate the type of vehicle involved in the accident.

The seat belt was properly fastened at the time of the accident, and the use of the belt is verified in the official accident report or by the investigator.

Home Alteration and Vehicle Modification - $10,000 maximum reimbursement for the initial cost of converting your home or motor vehicle so that it is wheelchair accessible, provided the use of a wheelchair is required due to the accident that caused the loss payable under this benefit that:

1. The modifications to your home must be made by qualified professionals who are recommended by a licensed organization that offers support and assistance to wheelchair users.
2. The modifications to your motor vehicle must be made by qualified professionals authorized by the provincial motor vehicle office in your provinces of residence.

DEATH BENEFIT

The death benefit provides for payment to your last named beneficiary, beneficiaries or estate for the amount of Accidental Death & Dismemberment Insurance in force on the date of death. Benefit will be payable to you for any other loss, coma or for the death of your covered spouse or dependents.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

EXCLUSIONS AND LIMITATIONS

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

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

1. intentionally self-inflicting injuries, committing suicide, or attempting suicide, whatever the state of mind of the participant.

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

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

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

5. Travel or flight in, or descent from, any kind of aircraft (except while travelling as a pilot or crew member of an aircraft owned, operated or leased by your employer while on the authorized business for your employer) if you or your covered spouse:

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT PREMIUMS WHILE ON DISABILITY

If you become approved and are in receipt of payments for Short Term Disability, Long Term Disability or Workers' Compensation benefits prior to your 65th birthday, Basic Accidental Death and Dismemberment Insurance coverage is continued with no premium payment required by you.

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE

During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

CONVERSION PRIVILEGE

If your Basic Accidental Death and Dismemberment Insurance coverage ceases on or before attaining 65 years of age because of retirement, termination of employment or termination of membership in the class of employees, then you may purchase an individual plan, without evidence of insurability, of the type then being offered by Blue Cross Life in an amount not to exceed the amount terminated, or $200,000, whichever is less, or the maximum amount prescribed by applicable provincial legislation. Written application must be made and the required premium submitted during the 31 day period immediately following the date of termination.

Limited conversion rights are available on termination of the group contract in accordance with the Superintendents of Insurance Guidelines.

TERMINATION OF INSURANCE

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

- the date you cease to be eligible for Basic Group Life Insurance, or
- the day of termination of this coverage, or
- the date of retirement, or
- the earlier of retirement or the day on which you attain the termination age, or
- the date you cease to pay the premium for this benefit or
- the date before any naval, military or air force deployment.

HOW TO MAKE A CLAIM

Basic Accidental Death and Dismemberment: must be received by Blue Cross Life within one (1) year after the loss. If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

SHORT TERM DISABILITY INSURANCE

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 Short Term Disability payments if, as a result of sickness or accident you are unable to perform the regular duties of your own occupation and are not engaged in any occupation or employment for wage or profit.

Regular duties are defined as the essential tasks or actions you are required to perform as part of the occupation. You cannot be working other than in a partial disability or rehabilitation program approved by the company.

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 Short Term Disability Benefit payments begin.

REHABILITATION PROGRAM

An employee may, at any time, be required to enter, engage or comply with a Rehabilitation Program, which the company deems appropriate for his circumstances.

A Rehabilitation Program shall mean a program of medical, employment or vocational rehabilitation deemed appropriate by the company. It shall consist of:

1. any medical care or treatment, diagnostic measures or any medication prescribed, or
2. full-time work, part-time work, volunteer work or any other employment for an employee, whether or not wages or remuneration are payable, or
3. any vocational assessment training or re-training program or period of work for the purpose of rehabilitation.

Benefits payable under this policy while an employee is participating in a Rehabilitation Program will be co-ordinated in accordance with integration of benefits.

Refusal to enter, participate or comply with a Rehabilitation Program will result in the termination of Short Term Disability benefit payments.

SHORT TERM DISABILITY INSURANCE

INTEGRATION OF BENEFITS

The amount of Short Term Disability benefit will be reduced by the amount of payments you are entitled to receive from any of the following:

- any workers' compensation board/commission,
- any disability payments from the Canada/Quebec Pension (CPP/QPP) Plan, or
- any provincial automobile insurance plan, provided they are deemed acceptable limitations under the Employment Insurance Premium Reduction Regulation.

In the event you are required to apply or have applied for any of the above and have not received notice, the plan will estimate your benefits until they receive written notice that your application has been declined.

If you are in receipt of CPP Retirement Benefits during your disability, you may be required to convert your CPP/QPP Retirement Benefits to CPP/QPP Disability Benefits if eligible.

During an approved rehabilitation program, the amount of Short Term Disability benefit payments will be reduced by 50% of the income received from the rehabilitative employment and if necessary, will further be reduced so that the total amount of income and benefits received does not exceed 100% of pre disability earnings.

SHORT TERM DISABILITY INSURANCE

EXCLUSIONS AND LIMITATIONS

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

1. any period of disability during which you are not under the continuing care of a physician or surgeon legally licensed to practice medicine,
2. any period of disability directly or indirectly related to the committing of or the attempt to commit a criminal offence,
3. an accident occurring while operating a motor vehicle either while under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, ATV, bicycle, snowmobile, boat or any recreational vehicle),
4. any period during which you are absent from work due to imprisonment in a correctional facility, community residence or while under house arrest by order of a criminal court,
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 period during which you are absent from Canada due to any reason unless the company agrees in writing, in advance, to pay benefits during the period,
7. any period of disability during which you do not make reasonable efforts to recover from the disability, including participating in any appropriate treatment or rehabilitation program. This determination will be made by Blue Cross,
8. any medical care or treatment that is performed for cosmetic purposes only, unless it is required as a result of an illness or accident,
9. if you become disabled while on strike, lockout or lay-off,
10. during the period in which you receive maternity, parental or compassionate care benefits under any provincial or federal law or take maternity, parental or compassionate care leave in accordance with any provincial or federal law, subject to the following exception:
    - benefits will be payable during the health-related portion of the maternity leave, provided coverage has been retained for you and the Short Term Disability waiting period has been completed. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Blue Cross,
11. 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,
12. any period of disability during which you do not accept any reasonable offer of modified duties or alternative employment from the employer,
13. to any claimant who is terminated, provides notice of retirement or resignation effective as of the date of the termination, retirement or resignation,
14. no payment will be made after the date of lay-off or termination of employment if the disability commenced within two months of the date of lay-off or termination and the notice of lay-off or termination of employment was given prior to the occurrence of the disability,
15. any period during which you are in receipt of benefits from the Canada Employment Insurance Commission (CEIC).

SHORT TERM DISABILITY INSURANCE

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE

During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

If you become totally disabled during a leave of absence from work where disability coverage has been discontinued, no disability benefit will be payable.

If you become totally disabled during a leave of absence from work during which disability coverage has been retained and premiums have been paid:

- the elimination period will begin on the onset of total disability;
- the benefit period will be deemed to begin on expiry of the elimination period; and
- benefit payments will begin on the later of the expiry of the elimination period or the date you were scheduled to return to work.

WHEN AND HOW TO MAKE A CLAIM

To make a claim, complete the notice of claim for Short 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 Short Term Disability benefit.

LONG TERM DISABILITY INSURANCE

DISABILITY

To be eligible for this benefit, you must be under the continuous care of a physician. Blue Cross Life 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 for the first 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 the essential tasks or actions you are required to perform as part of the occupation. You cannot be working other than in a partial disability or rehabilitation program approved by the company. If you engage in any business or occupation except in a rehabilitation program you will be deemed to no longer be disabled.

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

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

PARTIAL DISABILITY

To be considered partially disabled and eligible to receive benefits under this provision, you must meet the definition of total disability throughout the elimination period and must qualify for Long Term Disability benefits.

If, following the commencement of Long Term Disability benefits, you are only capable of returning to the workforce in a reduced capacity and are not engaged in an approved rehabilitation program, you may continue to be eligible to receive a portion of your Long Term Disability benefits in addition to regular earnings for a period of time deemed appropriate by the company, subject to the provisions under this section.

The amount of monthly Long Term Disability benefit to which you are entitled to receive will be reduced by 50% of all wages or remuneration payable from any employer or from self-employment. Benefits will further be reduced so that income from all sources does not exceed 100% of pre-disability earnings.

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.

LONG TERM DISABILITY INSURANCE

REHABILITATION PROGRAM

An employee may, at any time, be required to enter, engage or comply with a Rehabilitation Program, which the company deems appropriate for his circumstances.

A Rehabilitation Program shall mean a program of medical, employment or vocational rehabilitation deemed appropriate by the company. It shall consist of:

1. any medical care or treatment, diagnostic measures or any medication prescribed, or
2. full-time work, part-time work, volunteer work or any other employment for an employee, whether or not wages or remuneration are payable, or
3. any vocational assessment training or re-training program or period of work for the purpose of rehabilitation.

Benefits payable under this policy while an employee is participating in a Rehabilitation Program will be co-ordinated in accordance with integration of benefits.

Refusal to enter, participate or comply with a Rehabilitation Program will result in the termination of Long Term Disability benefit payments.

ELIMINATION PERIOD

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

When the total disability is not continuous, the days you meet the definition of total disability 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 14 days, disabilities are due to the same or related causes and each period of total disability is completed within 365 days after the start of the elimination period, or as pre-approved by Blue Cross Life if longer.

PRE-EXISTING CONDITIONS (24-12)

A pre-existing condition means a sickness or injury for which you received medical treatment, consultation, care or services (including diagnostic measures) or have been prescribed medication, during the twenty four (24) months immediately prior to the effective date of Long Term Disability coverage.

Long Term Disability benefits are not payable for any disability caused by or resulting from a pre-existing condition unless the disability begins after 12 consecutive months of active employment from your effective date of Long Term Disability coverage.

LONG TERM DISABILITY INSURANCE

INTEGRATION OF BENEFITS

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 Long Term Disability benefit is first reduced directly by any benefits payable from the workers' compensation board/commission and 92.5% of any disability benefits available under the Canada or Quebec Pension plan (primary benefits only) and any Canada or Quebec Pension plan retirement benefits.

   If you are in receipt of CPP Retirement Benefits during your disability, you may be required to convert your CPP/QPP Retirement Benefits to CPP/QPP Disability Benefits if eligible.

2. The amount of monthly Long Term Disability benefit is further reduced as necessary, so that the amount of monthly income from all sources does not exceed 60% of your Pre-Disability net earnings. Income from all sources includes:

   a) Blue Cross Short Term and Long Term Disability benefits,
   b) any benefit payable to you under the workers' compensation board/commission,
   c) any disability benefits under the Canada/Quebec Pension plan,
   d) any retirement benefits payable to you under the Canada/Quebec Pension plan,
   e) any retirement income or benefits payable under any group program provided by or through the employer,
   f) any income or benefits payable under a plan sponsored by an association, union or fraternal organization of which you are a member for which the employer contributes the premiums of such plan,
   g) any income or benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, or is not required to be reimbursed to the auto insurer,
   h) any wage or remuneration payable from any employer or from self-employment, other than those received under an approved rehabilitation program,
   i) any damages for loss of income recovered from a third party and arising out of the same circumstances that caused your disability and
   j) any continuation of salary or paid sick leave from your employer.

3. During an approved rehabilitation program, the amount of monthly Long Term Disability benefit payments will be reduced by 50% of the income received from the rehabilitative employment and if necessary, will further be reduced so that the total amount of income and benefits received 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.

LONG TERM DISABILITY INSURANCE

EXCLUSIONS AND LIMITATIONS

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

1. any period of total disability during which you are not under the continuing care of a physician or surgeon legally licensed to practice medicine,

2. any period of total disability directly or indirectly related to the committing of or the attempt to commit a criminal offence, or provoking an assault, regardless of whether changes are laid or a conviction obtained,

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

4. any period during which you are absent from work due to imprisonment in a correctional facility, community residence or while under house arrest or by order of a criminal court,

5. any total 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 period during which you are absent from Canada due to any reason, unless the company agrees in writing in advance to pay benefits during the period,

7. any period of total disability during which you do not make reasonable efforts to recover from the total disability, including participation in any appropriate treatment or rehabilitation program. This determination will be made by Blue Cross,

8. any total disability resulting from or associated with medical care which is not medically necessary or is performed for cosmetic purposes only,

9. if you become disabled while on strike, lockout or lay-off,

10. during the period in which you receive maternity, parental or compassionate care benefits under any provincial or federal law or take maternity, parental or compassionate care leave in accordance with any provincial or federal law,

11. any period of total disability during which you do not accept any reasonable offer of modified duties or alternative employment from the employer,

12. any period during which you are eligible for benefits from the Canada Employment Insurance Commission (CEIC) or an employer sponsored Short Term Disability plan.

LONG TERM DISABILITY INSURANCE

WAIVER OF PREMIUM

If you 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.

CONTINUATION OF COVERAGE DURING A LEAVE OF ABSENCE

During an approved leave of absence for a maternity leave, parental leave, compassionate care leave or other statutory leave your coverage continues by the payment of premiums up to a maximum period provided under any applicable legislation. Continuation of coverage during this leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the maximum period under applicable legislation.

During any other approved leave of absence your coverage continues by the payment of premiums up to a maximum period of 12 months. Continuation of coverage during a leave of absence ends on the earlier of the date you were scheduled to return to work, the date you return to active full-time employment, the policy is terminated or at the end of the 12 month period.

If you become totally disabled during a leave of absence from work where disability coverage has been discontinued, no disability benefit will be payable.

If you become totally disabled during a leave of absence from work during which disability coverage has been retained and premiums have been paid:

- the elimination period will begin on the onset of total disability;
- the benefit period will be deemed to begin on expiry of the elimination period; and
- benefit payments will begin on the later of the expiry of the elimination period or the date you were scheduled to return to work.

HOW TO MAKE A CLAIM

Long Term Disability benefits: complete the notice of claim 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 or the time limit specified by applicable provincial legislation, of this Long Term Disability coverage.

Note: It is in your best interest to submit your claim as soon as possible to ensure timely claims processing.

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	550 Sherbrooke Street West, Suite 12 Montreal, QC H3A 6T6

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