Schedule of Benefits

J. D. IRVING, LIMITED

IRVING GROUP BENEFIT PLAN

JDI SAINT JOHN - SENIOR EXECUTIVES 6976 501-503

IRVING GROUP MONCTON EXECUTIVES 6975 361-363

IRVING GROUP MONCTON (MIDLAND) - EXECUTIVES 6976 681-683

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

Effective Date: January 1, 2021

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 - 1st of the month following date of hire.

Date of Issue: October 22, 2020

The **QUEBEC DRUG PLANS** 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** will be applicable to all other employees.

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

ENHANCED CRITICAL ILLNESS BENEFIT

AMOUNT OF INSURANCE

Full Payment Amount

Employee	$25,000
Spouse	$5,000
Each Child	$2,500

Partial Payment Amount

Employee	$2,500
Spouse	$500
Each Child	$250

Survival Period: 30 consecutive days unless otherwise specified in the defined covered critical illness conditions.

Coverage Terminates:

Employee
Ceases at the earlier of:
- the employee's retirement,
- termination of employment,
- age 65, or
- after 2 full benefit payments have been reached.

Spouse
Ceases at the earlier of:
- the employee's retirement,
- the employee's age 65,
- after the spouse reaches 2 full benefit payments, or
- after the spouse is no longer eligible for coverage as a dependent.

Each Child
Ceases at the earlier of:
- the employee's retirement,
- the employee's age 65,
- after the child reaches 2 full benefit payments,
- when a childhood condition payment is received, or
- after the child is no longer eligible for coverage as a dependent.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

*HEALTH – **ENHANCED OPTION***

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

WORLDWIDE TRAVEL BENEFITS
- 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
- 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

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

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

*HEALTH – **ENHANCED OPTION** (Cont'd)*

VISION CARE – (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.

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

Frames
Payment is at 100% of the eligible expense; maximum payable is $100, 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

ENHANCED OPTION

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

Tiered Formulary: Eligible drug benefits include only medically necessary drugs which by law can only be obtained with a prescription and considered by Medavie Blue Cross to be life-sustaining. Drugs are separated into two tiers with the co-pay varying between the tiers. Drugs selected for the first tier are less expensive drugs, recognized as first line therapy for the treatment of disease, and are used to treat serious medical conditions. Drugs in the second tier are drugs that are usually more expensive, may be used to treat non-life threatening conditions, and are not always considered first line therapy for the treatment of specific diseases. Any eligible medication must be authorized by Medavie Blue Cross and prescribed and dispensed by Medavie Blue Cross Approved Providers.

Conditional Co-payment: Certain Eligible Drugs that would normally be reimbursed at the lower reimbursement level (Tier 2) may be reimbursed at the higher reimbursement level (Tier 1) when established criteria are met. The criteria to be met for Conditional Co-payment are established by Medavie Blue Cross.

Substitution Provision: Mandatory Generic Substitution and Maximum Allowable Cost provisions apply.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

HEALTH CARE BENEFITS

Standard Drug Plans

DRUGS – RX CHOICES **(paid directly to the pharmacy)**	
BENEFIT DESCRIPTION	**ENHANCED OPTION**
Co-payment	Employee pays any amount above $8 dispensing fee for each eligible drug on the prescription
Co-insurance	**Tier 1:** 100% **Tier 2:** 70%
Conditional Co-payment	Applies
Out-of-pocket Maximum per Calendar Year* (After out-of-pocket per calendar year, the plan pays 100% of the total eligible expense)	$500/single $1,000/family
Erectile Dysfunction	Program pays 100% to a maximum payable of $250 per year
Fertility	Program pays 100% to a maximum payable of $1,500 per year, $3,000 per lifetime
Diabetic Supplies** (glucose monitoring systems, needles, syringes, swabs, test tapes, and lancets)	**Tier 1:** 100%

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

**Prescription required.

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.

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

Tiered Formulary: Eligible drug benefits include only medically necessary drugs which by law can only be obtained with a prescription and considered by Medavie Blue Cross to be life-sustaining. Drugs are separated into two tiers with the co-pay varying between the tiers. Drugs selected for the first tier are less expensive drugs, recognized as first line therapy for the treatment of disease, and are used to treat serious medical conditions. Drugs in the second tier are drugs that are usually more expensive, may be used to treat non-life threatening conditions, and are not always considered first line therapy for the treatment of specific diseases. Any eligible medication must be authorized by Medavie Blue Cross and prescribed and dispensed by Medavie Blue Cross Approved Providers.

Conditional Co-payment: Certain Eligible Drugs that would normally be reimbursed at the lower reimbursement level (Tier 2) may be reimbursed at the higher reimbursement level (Tier 1) when established criteria are met. The criteria to be met for Conditional Co-payment are established by Blue Cross.

Substitution Provision: Mandatory Generic Substitution and Maximum Allowable Cost provisions apply

Quebec Drug Plans

DRUGS – RX CHOICES **(paid directly to the pharmacy)** **(RAMQ list drugs not available in the Rx Choices drug list will be reimbursed at the Tier 2 level)**	
BENEFIT DESCRIPTION	**ENHANCED OPTION**
Co-insurance	**Tier 1:** 100% **Tier 2:** 70%
Conditional Co-payment	Applies
Out-of-pocket Maximum per Calendar Year* (After out-of-pocket per calendar year, the plan pays 100% of the total eligible expense)	$500/single $1,000/family
Erectile Dysfunction	Program pays 100% to a maximum payable of $250 per year
Fertility	Program pays 100% to a maximum payable of $1,500 per year, $3,000 per lifetime
Diabetic Supplies** (glucose monitoring systems, needles, syringes, swabs, test tapes, and lancets)	**Tier 1:** 100%

*Maximum Allowable Cost is not included in the out-of-pocket maximum, nor is it paid at 100% once the out-of-pocket maximum is reached.

**Prescription required.

SCHEDULE OF BENEFITS
Underwritten by
Medavie Blue Cross

DENTAL CARE BENEFITS

DENTAL CARE	
BENEFIT DESCRIPTION	**ENHANCED OPTION**
Core/Preventive Services (includes Periodontics & Endodontics)	**Co-insurance:** 100%
Major Services	**Co-insurance:** 70% to a maximum payable of $2,000 in a calendar year
Orthodontic Services	**Co-insurance:** 50% to a maximum payable of $2,500 in a lifetime

*Combined maximum for Core/Preventive and Major Services

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

SECOND OPINION®

The Second Opinion Benefit is a service that provides you and your eligible dependents the opportunity to have your medical files (including diagnosis and treatment plan) reviewed by specialists at top-ranked academic medical institutions in the world.

Coverage Terminates:	Ceases at the earlier of the employee's retirement, termination of employment or age 70. The dependent's coverage ends either on the date the employee ceases to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

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:	$1,000,000
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 $1,000 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: $25,000

Children: $10,000

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 AND OPTIONAL 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 $1,000 amount.

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

AMOUNT OF OPTIONAL INSURANCE

Coverage is provided to you and/or your spouse in units of $25,000 to a maximum of $1,000,000 per insured.

Family coverage is as follows:

- The spouse is insured for 60% of the amount purchased by you, and each dependent child is insured for 15% of the amount purchased by you.
- Each dependent child is insured for 15% of the amount purchased by you, 20% if there is no spouse to a maximum of $60,000.

Benefit Reduction: Not Applicable

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

RATES
Monthly Rates (per $1,000)

The premium rate for the employee only is $0.029 per month and $0.048 per month for the employee and family.

SCHEDULE OF BENEFITS
Administered by
Medavie Blue Cross

SALARY CONTINUANCE

AMOUNT OF COVERAGE

Benefit Formula:	Benefit payment is 100% of salary
Elimination Period:	5 working days for accident 5 working days for sickness
Maximum Benefit Period:	52 weeks (includes the elimination period)

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

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

LONG TERM DISABILITY INSURANCE

AMOUNT OF INSURANCE

Benefit Formula:	72% of the first $1,250 of monthly earnings, plus 60% of the next $2,500, plus 47% of the remainder
Benefit Maximum:	$10,000 per month
Elimination Period:	52 weeks
Benefit Period:	To the earlier of the employee's cessation of disability, death or age 65
Employee Retirement Savings Fund:	A further 4% of benefit payment to a maximum of $400 per month will be directly contributed to the employee Retirement Savings Plan on behalf of an employee who is in receipt of Long Term Disability benefit payments.

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 Illness 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.

SURVIVOR BENEFIT

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

- the contract termination date;
- twelve (12) months after the employee's death;
- the effective date of any similar coverage with another insurer;
- whenever they cease to be eligible dependents.

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.

ENHANCED CRITICAL ILLNESS BENEFIT

LIVING BENEFIT (PURPOSE OF COVERAGE)

If, while coverage is in force, you or your covered dependents meet the definition of a covered critical illness condition defined under this benefit, the amount of coverage indicated above will be paid to you in a lump sum, subject to the provisions under this section. You must provide medical evidence satisfactory to Blue Cross Life within 365 days following the end of the Survival Period.

A full benefit amount will be paid for up to two unrelated covered critical illness conditions for multiple event coverage. Once a benefit has become payable for a covered critical illness condition in one category (Category 1, 2, 3 or 4), the participant will not be covered under this benefit for any future covered critical illness condition specified under the same category.

A partial benefit amount will be paid for up to four covered critical illness conditions for partial payment. The participant is eligible for one partial payment per non-life-threatening covered critical illness conditions for partial payment.

A full benefit amount will be paid for one covered childhood condition.

WAIVER OF PREMIUM

If a claim is approved under Basic Group Life Insurance for total disability, the Critical Illness Benefit coverage will continue without further payment of premium from the date last worked. However, the waiver of premium on the Critical Illness Benefit coverage will cease if the waiver of premium benefit for the Basic Group Life Insurance discontinues or the group contract terminates.

CONVERSION PRIVILEGE

If your Critical Illness Benefit 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 critical illness policy without evidence of health.

If your spouse's Critical Illness Benefit coverage ceases or reduces on or before you attain 65 years of age, for any reason other than at your request, your spouse may purchase an individual critical illness policy without evidence of health.

The amount of the individual critical illness policy cannot exceed the lesser of $100,000 or the amount of Critical Illness Benefit coverage in effect on the date of termination of coverage.

Written application must be made and the required premium submitted during the 31-day period immediately following the date of termination of coverage.

You or your spouse must have critical illness benefit coverage in force for a minimum of 24 consecutive months (under this policy or a previous policy) in order to be eligible to purchase an individual critical illness policy.

ENHANCED CRITICAL ILLNESS BENEFIT

EXCLUSIONS AND LIMITATIONS

If there is a change in Critical Illness Benefit coverage, the coverage in force when the covered critical illness condition was diagnosed is the coverage that applies to all claims for that covered critical illness condition.

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

If a child is born within ten months of the effective date of family coverage, and that child is diagnosed with a childhood condition within those ten months, no benefit will be paid for that condition.

As well, Critical Illness 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;
- self-inflicted injury or sickness;
- 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 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, bicycle, snowmobile or boat).

DEFINITIONS

Pre-existing condition

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

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

If you were previously insured under another group contract and make a claim to Blue Cross Life due to a pre-existing condition, Blue Cross Life will administer it using your effective date of coverage under the previous contract.

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

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

ENHANCED CRITICAL ILLNESS BENEFIT

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE

Any Critical Illness benefit payment made under previous Critical Illness coverage with the company will count as an unrelated covered critical illness condition for multiple event coverage, and will be applied to the applicable category below. **Please contact your group administrator for specific contract wording.**

Categories for Multiple Event Coverage

A full benefit amount will be paid for up to two unrelated covered critical illness conditions for multiple event coverage. Once a benefit has become payable for a covered critical illness condition in one category (Category 1, 2, 3 or 4), the participant will not be covered under this benefit for any future covered critical illness condition specified under the same category.

The following covered critical illness conditions are eligible for full benefit payment with multiple event coverage:

Category 1:	Cancer
Category 2:	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair
Category 3:	Blindness, Severe Burns, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection
Category 4:	Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke

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

ENHANCED CRITICAL ILLNESS BENEFIT

COVERED CRITICAL ILLNESS CONDITIONS FOR PARTIAL PAYMENT

A benefit of 10% to a maximum of $25,000 is payable with any of the following non-life-threatening covered critical illness conditions. The participant is eligible for one partial payment per non-life-threatening covered critical illness conditions.

The partial benefit payment is in addition to the multiple event coverage benefit.

The following non-life-threatening conditions are eligible for a partial benefit payment:

- Coronary Angioplasty
- Ductal Carcinoma In Situ Of The Breast
- Stage 1A Malignant Melanoma
- Stage A (T1a or T1b) Prostate Cancer

COVERED CHILDHOOD CONDITIONS

A full benefit amount will be paid for one covered childhood condition. Once a benefit has become payable for a covered childhood condition, the participant will no longer be covered under this benefit.

The following childhood conditions are eligible for a full benefit payment:

- Cerebral Palsy
- Congenital Heart Disease:
- Cystic Fibrosis
- Muscular Dystrophy
- Type 1 Diabetes Mellitus
- Autism
- Down Syndrome

WHEN AND HOW TO MAKE A CLAIM

Claim forms are available from your employer.

If you suffer a loss other than death, the claim must be received by Blue Cross Life as soon as reasonably possible after the loss, and in no event later than 1 year following the date of diagnosis.

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.

ENHANCED OPTION

HOSPITAL BENEFITS - IN CANADA

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

EXTENDED HEALTH BENEFITS - IN CANADA

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 payable is $1,000 in a calendar year.

SPECIAL AMBULANCE ATTENDANT - travel expenses of a Registered Nurse (not a relative) where medically necessary. The maximum payable 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 payable 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.

HEALTH CARE BENEFITS

ENHANCED OPTION

EXTENDED HEALTH BENEFITS – WORLDWIDE

OXYGEN - charges for oxygen.

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 EQUIPMENT - charges for the following equipment used for treatment and control of diabetes: preci-jet, glucometer or equipment approved by Medavie Blue Cross that performs similar functions. The overall maximum payable is $250 per calendar year.

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 payable of $500.

OTHER PRACTITIONERS - charges for treatment, (except when performed in a hospital) by a licensed:

- speech therapist - maximum payable is $1,000 in a calendar year
- clinical psychologist/clinical counsellor/psychotherapist/social worker - combined maximum payable is $2,000 in a calendar year
- masseur*, chiropractor, osteopath, homeopath, chiropodist/podiatrist, physiotherapist/athletic therapist, acupuncturist or naturopath. The maximum payable for each type of practitioner is $500 in a calendar year. The overall maximum payable is $1,000 in a calendar year.

In addition, the maximum payable 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.

EXTENDED HEALTH BENEFITS – WORLDWIDE (Cont'd)

ENHANCED OPTION

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 payable of $300 in a calendar year.

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) transcutaneous electrical nerve stimulator (TENS machine) and insulin pump (excluding batteries) on the written authorization of a physician. The TENS machine is limited to a maximum payable of $300 in five calendar years. Burn pressure garments are limited to a maximum payable 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.

EXTENDED HEALTH BENEFITS – WORLDWIDE

ENHANCED OPTION

CUSTOM ORTHOPEDIC SHOES AND FOOT ORTHOTICS (Cont'd)

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 payable of $250 every two calendar years. For dependent children less than 21 years of age, the maximum payable is in a calendar year is $250.

HEARING AIDS - charges for hearing aids (excluding batteries and exams), up to a maximum payable of $500 per ear every three consecutive calendar years, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist.

VISION CARE (HealthWise)

ENHANCED OPTION

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).

Special lenses and lens coatings
Special lenses/coatings required as a result of a specified medical condition are eligible benefits if approved through the Prior Authorization process. The maximum eligible expense for lenses/coatings approved through the Prior 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 Prior Authorization. The maximum payment and the frequency limitations for Special Eye Examinations approved through the Prior Authorization process will be determined by Medavie Blue Cross.

VISION CARE (HealthWise) Cont'd

ENHANCED OPTION

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.

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 Prior Authorization process.

When contact lenses are approved under the Prior 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 Prior Authorization process.

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

HEALTH CARE BENEFITS

PRESCRIPTION DRUG COVERAGE

ENHANCED OPTION

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.

MANDATORY GENERIC SUBSTITUTION

If an interchangeable drug has been prescribed, Medavie Blue Cross will reimburse to the lowest ingredient cost interchangeable drug when prescribed by a physician and dispensed by an approved provider. Regardless of whether your physician indicates the prescribed interchangeable drug cannot be substituted, Medavie Blue Cross will only reimburse to the lowest ingredient cost interchangeable drug.

You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs. For participants with an adverse reaction to the interchangeable drug dispensed, Medavie Blue Cross will consider reimbursement to another interchangeable drug on a case by case basis only, through the defined exception process once your physician has submitted a side effect reporting form to Health Canada.

MAXIMUM ALLOWABLE COST

In addition to Mandatory Generic Substitution, Medavie Blue Cross will only reimburse to the most cost effective drug cost within a therapeutic category. A therapeutic category consists of therapeutically similar drugs that treat the same condition and offer similar effectiveness and safety. Maximum Allowable Cost will apply to 3 drug categories prescribed to treat Gastrointestinal (Proton Pump Inhibitors), High Cholesterol (Statin's) and High Blood Pressure (Angiotensin-Converting-Enzyme Inhibitors) conditions. The plan pays at the Tier 1 level based on the reference drug for each category. Maximum Allowable Cost is only applied to Gastrointestinal (Proton Pump Inhibitors) for those members covered on the Quebec drug plans.

For Participants with an adverse reaction to, or treatment failure from the drug dispensed, Medavie Blue Cross will consider reimbursement to another interchangeable or therapeutically similar drug on a case by case basis only through the defined exception process once your physician has submitted a side effect reporting form to Health Canada.

PRESCRIPTION DRUG COVERAGE *(CONT'D)*

ENHANCED OPTION

GLUCOSE MONITORING SYSTEMS

Charges for continuous glucose monitoring (CGM) receivers, transmitters or sensors for participants prescribed insulin for the treatment of diabetes, to a maximum payable of $4,000 in a calendar year.

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
- services or treatment performed for cosmetic purposes only.

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 Prior Authorization by Medavie Blue Cross. To apply for Prior Authorization from Medavie Blue Cross, you must arrange for the Health Care Professional rendering the service to complete a Prior Authorization form. Any costs incurred for completion of Prior 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

ENHANCED OPTION

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.

Emergency: A sudden and unexpected illness or injury that requires immediate medical Treatment due to an Accident or medical condition which begins during a Trip.

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.

ACCIDENTAL DENTAL AND OTHER DENTAL EMERGENCIES
Fees of a dental practitioner for treatment:

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

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

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

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

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS

ENHANCED OPTION

REPATRIATION TO THE PROVINCE OF RESIDENCE
The cost of repatriating the participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the policy. If medically necessary, this cost may include an accompanying medical attendant.
If returning on a commercial aircraft, coverage includes:

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

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

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).

VEHICLE RETURN - up to $1,000 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 $5,000 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.

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS

ENHANCED OPTION

MEALS AND ACCOMMODATION - up to $3,000 Canadian ($150 per day for 20 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 coordinated 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

ENHANCED OPTION

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.

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.

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS

ENHANCED OPTION

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.

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.

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.

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

HEALTH CARE BENEFITS

WORLDWIDE TRAVEL BENEFITS

ENHANCED OPTION

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.

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.

ENHANCED OPTION

PREVENTIVE SERVICES

DIAGNOSTIC
- Recall examinations – two per calendar year
- Specific examinations - one each per calendar year.
- Mixed Dentition Analysis - one per lifetime

PREVENTIVE
- Polishing - two units 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.
- Scaling – ten units per calendar year
- Fluoride - one every calendar year for person under 19 year of age.
- Sealants - one per bicuspid and molar tooth per lifetime for persons under 19 years of age

CORE SERVICES

DIAGNOSTIC
- 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.

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
- 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

DENTAL BENEFITS

ENHANCED OPTION

CORE SERVICES *(Cont'd)*

PERIODONTIC SERVICES
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 ten 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.

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

MAJOR SERVICES

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

DENTAL BENEFITS

ENHANCED OPTION

MAJOR SERVICES *(Cont'd)*

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

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

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 Prior 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

*Prior Authorization is required on all claims for bridgework.

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

ENHANCED OPTION

ORTHODONTIC DENTAL SERVICES

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

ENHANCED OPTION

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 or treatment performed for cosmetic purposes only.
- 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.

PREDETERMINATION FOR CLAIMS OVER $500

1. If the total cost of any treatment is expected to exceed $500, the Member must submit to Medavie Blue Cross, before the treatment begins a detailed treatment plan outlining the type of treatment to be provided and the amounts to be charged.
   Medavie Blue Cross will then notify the Member of the amount eligible for reimbursement. The treatment must be performed by the dentist who prepared the treatment plan; otherwise a new treatment plan must be submitted to Medavie Blue Cross for re-assessment.

2. An alternate benefit provision will be applied within the Prior 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

ENHANCED OPTION

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 Prior Authorization by Medavie Blue Cross. To apply for Prior Authorization from Medavie Blue Cross, you must arrange for the Health Care Professional rendering the service to complete a Prior Authorization form. Any costs incurred for completion of Prior 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 Prior Authorization claims process, contact your local Medavie Blue Cross office or call toll free 1-800-667-4511.

SECOND OPINION®

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

QUALIFYING MEDICAL CONDITIONS:

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

The list of Qualifying Medical Conditions may change without notice.

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

HOW TO ACCESS

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

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 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,
- 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 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 for one of the following reasons:

- 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 AND OPTIONAL 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 AND OPTIONAL 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.

*Only payable under one of the Accidental Death and Dismemberment policies issued to the policyholder by the company.

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS (Cont'd)

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.

The maximum benefit amount provided for the purposes of educational expenses does not exceed, in the aggregate, $5,000 per year per dependent child between all policies issued to the Policyholder by the Company.

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.

The maximum benefit amount provided for the purposes of child care expenses does not exceed, in the aggregate, $5,000 per year per dependent child between all policies issued to the Policyholder by the Company.

*Only payable under one of the Accidental Death and Dismemberment policies issued to the policyholder by the company.

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS (Cont'd)

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.

*Only payable under one of the Accidental Death and Dismemberment policies issued to the policyholder by the company.

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 AND OPTIONAL 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.

AGGREGATE BENEFIT

Benefits for the following are payable under the Basic Accidental Death and Dismemberment coverage or the Optional Accidental Death and Dismemberment coverage, but not both:

- Repatriation - aggregate of $15,000
- Rehabilitation - aggregate of $15,000
- Occupational Training for Spouse - aggregate of $10,000
- Family Travel - aggregate of $10,000
- Home Alteration and Vehicle Modification - annual aggregate of $10,000

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT PREMIUMS WHILE ON DISABILITY

If you become approved and are in receipt of payments for Long Term Disability or Workers' Compensation benefits prior to your 65th birthday, Basic and Optional 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 or Optional 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 (Basic & Optional Accidental Death and Dismemberment 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.

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

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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.

All Optional Accidental Death and Dismemberment insurance will terminate on the earliest of:

- the date that you cease to be eligible for Group Life Insurance,
- the date of retirement, or
- the date that you cease to pay the premium for this benefit.

The Optional Accidental Death and Dismemberment insurance on your dependents will cease on the date that person ceases to be an eligible dependent.

HOW TO MAKE A CLAIM

Basic and Optional 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.

SALARY CONTINUANCE

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 Salary Continuance 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 Salary Continuance 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 Salary Continuance disability benefit payments.

SALARY CONTINUANCE

INTEGRATION OF BENEFITS

The amount of Salary Continuance 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 Salary Continuance 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.

SALARY CONTINUANCE

EXCLUSIONS AND LIMITATIONS

Salary Continuance 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 Salary Continuance 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. any period during which you are in receipt of benefits from the Canada Employment Insurance Commission (CEIC).

SALARY CONTINUANCE

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 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 Salary Continuance disability coverage.

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 disability benefits available under the Canada or Quebec Pension plan (primary benefits only), the workers' compensation board/commission 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 85% 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, paid sick leave or Salary Continuance benefits 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.

BLUE CROSS CONTACT INFORMATION

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

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

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

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

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My Good Health®

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

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

BLUE ADVANTAGE®

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

HOW TO OBTAIN MORE INFORMATION

HOW TO OBTAIN A CLAIM FORM

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

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

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

HOW TO SUBMIT A CLAIM

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

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

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

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