

ACFC West
All Eligible Members

Group Name and Policy Number

ACFC West

All Eligible Members

Policy Number 900400

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Introduction

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy.

The Group Policy contains a provision removing or restricting the right of the Member to designate persons to whom or for whose benefit insurance money is to be payable.

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits, except for Life and/or AD&D benefits.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and British Columbia Life & Casualty Company (BC Life) are referred to as “we”, “us”, or “our” in this booklet. We will refer to you, the Member, as “you” or “your” in this booklet.

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

Pacific Blue Cross

Extended Health Care (EHC)

Dental Care

BC Life

Group Term Life

Dependent Life

Accidental Death & Dismemberment (AD&D)

Basic Critical Illness

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact your Plan Administrator.

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: www.pac.bluecross.ca. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

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Schedule of Benefits

The Schedule of Benefits contains a brief summary of your benefits. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care	
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<i>Deductible</i>	\$25 per person or family each calendar year.
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If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.

<i>Reimbursement</i>	In-Province/Territory Eligible Expenses and Out-of-Province/Territory Non-Emergency Eligible Expenses:	80%
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	Out-of-Province/Territory Emergency Eligible Expenses:	100%
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After \$1,000 has been paid for a person or family in a calendar year, further Eligible expenses for that person or family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.

<i>Plan Maximum</i>	The lifetime maximum amount of benefits payable for a Member or Dependent is \$1,000,000.
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<i>Dependent Children</i>	See definition of Dependent.
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Dental Care			
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<i>Deductible</i>	No Deductible		
<i>Reimbursement</i>	Plan A	Plan B	Plan C
	Basic Services	Major Restorative Services	Orthodontics
	80%	50%	50%
<i>Frequency Plan Limits</i>	Each Calendar Year	Each Calendar Year	Lifetime
<i>Financial Limit Per Dependent Child</i>	\$1,500 Combined with Plan B	\$1,500 Combined with Plan A	\$3,000
<i>Financial Limit Per Member or Spouse</i>	\$1,500 Combined with Plan B	\$1,500 Combined with Plan A	No Coverage
<i>Financial Limit for Late Applicants</i>	\$250 per person for all dental services for first 12 months of coverage		
<i>Dependent Children</i>	See definition of Dependent.		

Group Term Life

<i>Benefit Amount</i>	\$25,000
<i>Living Benefit Amount</i>	50% of the Group Term Life Benefit Amount, to a maximum of \$50,000
<i>Non Evidence Limit</i>	\$25,000
<i>Benefit Reduction</i>	Amount of insurance reduces by 50% at age 65
<i>Termination</i>	Age 70 or earlier retirement.

Dependent Life

<i>Benefit Amount</i>	Spouse	Child
	\$10,000	\$5,000
<i>Dependent Children</i>	See definition of Dependent	
<i>Termination</i>	Dependent insurance terminates on your 65 th birthday or earlier retirement.	

Accidental Death & Dismemberment (AD&D)

<i>Principal Sum</i>	An amount equal to the amount payable under your current group term life insurance.
<i>Aggregate Limit</i>	\$3,000,000
<i>Benefit Reduction</i>	Amount of insurance reduces by 50% at age 65.
<i>Termination</i>	Age 70 or earlier retirement.

Basic Critical Illness			
<i>Benefit Amount</i>	Member	Spouse	Child
	\$50,000	\$10,000	\$5,000
<i>Lifetime Maximum</i>	\$100,000	\$20,000	\$10,000
<i>Elimination Period</i>	60 days for a severe heart attack or severe stroke 30 days for all other covered illnesses		
<i>Dependent Children</i>	See definition of Dependent		
<i>Termination</i>	Age 65 or earlier retirement		

Definitions

Coverage effective date

means the date coverage becomes effective based on

- 1) the waiting period selected by ACFC West, and
- 2) the Enrolment grace period.

Deductible

means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Dependent

means any of the following persons for whom coverage is provided under this Plan:

- 1) one Spouse of the Member, and
- 2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
- 3) to any age if the unmarried child is also in full-time attendance at a recognized educational institute, and
- 4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to

approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above. You must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

Duplicate coverage

means that you (and your Dependents) are eligible to claim certain benefits under more than one plan.

Enrolment grace period

means,

- 1) within 4 months for Pacific Blue Cross benefits, or
 - 2) within 90 days for BC Life benefits
- from the coverage effective date.

Fee guide

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed. For Alberta, the Fee guide means the current Alberta Blue Cross Usual and Customary fee guide.

Fee schedule

means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Life event

means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

Member

means an employee or other person who has coverage under the Contract.

Non evidence limit

means the maximum amount of insurance we will provide without evidence of insurability as indicated in the Schedule of Benefits.

Practitioner

means a person currently licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. Pacific Blue Cross reserves the right to refuse the service, medical supply or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider

means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. Pacific Blue Cross reserves the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse

means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

Member Information/Access to Records

- 1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.

- 2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
- 3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
- 4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
- 5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
 - a) the Member's application for coverage
 - b) the current Contract/Policy
 - c) any written statement or other record provided to us as evidence of insurability of the Member.
- 6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
- 7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card within the Enrolment grace period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):

- 1) on the same date you apply for your own coverage, or
- 2) within the Enrolment grace period if you have a new Dependent.

Limitations - If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

Provided you and your Plan Administrator have complied with our enrolment rules, your coverage effective date is shown on our website at www.pac.bluecross.ca/caresnet or from your Plan Administrator.

Should you require additional information about when your coverage starts, please contact your Plan Administrator.

Late Applicants

If you did not apply during the Enrolment grace period but request coverage later (for yourself and/or your Dependents), ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan. Note: Different benefits may have different requirements – evidence of insurability or retroactive premium payment. In some instances, coverage may be denied.

Beneficiary

- 1) To the extent permitted by law, you have the right to name a personal representative or beneficiary for Life and Accidental Death and Dismemberment benefits or change this personal representative or beneficiary, by written request in a form satisfactory to us. If your designated personal representative or beneficiary does not survive you, any benefit amount due will be payable to your estate.
- 2) For all other benefits this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits.

Identification (ID) Cards

We will issue identification (ID) cards for distribution by your Plan Administrator.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

Claims

- 1) All claims must be submitted to us in English.
- 2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
- 3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.

- 4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your Spouse are members of ACFC West, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse work for different employers and you are both enrolled for similar benefits, Duplicate coverage is allowed.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enrol under more than one plan.

Your Plan Administrator will advise you if you are eligible to waive certain benefits under this group plan.

Coordination of Benefits

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

- 1) The Member is always the primary claimant. The Spouse is always the secondary claimant.
- 2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
- 3) In situations of separation or divorce, the following order applies:
 - a) the plan of the parent with custody of the child
 - b) the plan of the Spouse of the parent with custody of the child
 - c) the plan of the parent not having custody of the child
 - d) the plan of the Spouse of the parent in c) above.

- 4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

- 1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
 - a) under any other group or individual benefit plan or insurance policy, or
 - b) due to the legal liability of any other party.
- 2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
 - a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
 - b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
 - c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
 - d) false pretences or fraudulent misrepresentation
 - e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

Every action or proceeding against us for the recovery of benefits payable under the Group Contract/Policy is absolutely barred unless commenced within the time set out in the *Insurance Act*.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, leave of absence, age limitation or retirement, if you terminate your membership with ACFC West, or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract/Policy.

Right of Recovery

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

Survivor Benefit

If you die while covered under this plan, coverage for your Dependents will continue until the earliest of the following occurs:

- 1) 24 months after your death
- 2) the date your Dependent ceases to be a Dependent other than as a result of your death
- 3) the date the Contract is terminated
- 4) the date your Dependent becomes eligible for coverage under a similar group plan.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition

means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2000 or 1 877 PAC-BLUE (722-2583) outside the Lower Mainland for information.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our website: www.pac.bluecross.ca/caresnet/

Extended Health Care

The Extended Health Care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax-supported agency.

Definitions

Eligible expense

means a charge for any service and/or supply included in this booklet as a benefit that:

- 1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
- 2) was ordered or referred by a Physician, Dentist, or a Primary healthcare nurse practitioner (PHCNP), unless otherwise specified in the benefit description, and
- 3) is not a cost normally paid (in whole or part) or provided by a government plan or any other Provider of health coverage, and
- 4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received, and
- 5) is provided by a Practitioner or Provider approved by us.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging), which represents an amount in excess of the schedule of costs prescribed by the government plan. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Markup

means our reasonable and customary level, as updated from time-to-time.

Physician

means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Primary healthcare nurse practitioner

means a person duly qualified and licensed to deliver specific health care services in the jurisdiction where the services are provided and is acting within the scope of that license.

In-Province/Territory Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician, Dentist, or Primary healthcare nurse practitioner. Unless otherwise indicated, the maximums included here are on a per person basis.

- 1) Hospital
The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.
- 2) Emergency ambulance
 - a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient
 - b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
 - c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities
 - d) charges for an attendant when medically necessary.

3) Drugs

Charges for drugs in a quantity we consider reasonable, and

- a) which are dispensed by a pharmacist, Physician, Dentist, or a Primary healthcare nurse practitioner, including:
 - i) life sustaining drugs
 - ii) insulin preparations, testing supplies, needles, and syringes for diabetics
 - iii) vitamin B12 for the treatment of pernicious anemia
 - iv) allergy serums when administered by a Physician or Primary healthcare nurse practitioner, or
- b) which legally require a prescription from a medical Provider legally authorized to do so, including:
 - i) contraceptives
 - ii) anti-obesity drugs
 - iii) vaccines for tetanus, polio, rubella, measles, hepatitis B and influenza when not covered under a government plan.

The ingredient cost of multi-source brand drugs plus Markup will be cut back to the cost of the lowest cost equivalent generic drug plus Markup. The ingredient cost of generic drugs and a single source brand drug plus Markup, are eligible.

If we receive written confirmation from the prescribing Physician, Dentist, or Primary healthcare nurse practitioner, that there is a specific medical requirement that prevents the Member from taking the generic drug, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

Specific high-cost PharmaCare limited coverage drugs are identified on Pacific Blue Cross' Special Authority Enforcement list. We will reject claims for a drug on this list in British Columbia until We receive confirmation of BC PharmaCare's Special Authority approval for the drug. Once the PharmaCare approval in on File with Us, We will accept claims for this high-cost drug.

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding

appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Primary healthcare nurse Practitioner.*

- a) acupuncturist\$500
- b) chiropractor\$500
- c) massage Practitioner\$500
- d) naturopath.....\$500
- e) physiotherapist.....\$500
- f) podiatrist.....\$500
- g) psychologist and clinical counsellor combined\$500
- h) speech language pathologist.....\$500
- i) private duty care by a registered nurse for a person with an acute condition in the person’s home.

5) Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

6) Medical aids and supplies provided by a medical supplier (as approved by us)

Charges for the following services and supplies:

- a) oxygen
- b) ostomy and ileostomy supplies
- c) walkers, canes and cane tips, crutches, casts, and trusses

- d) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
- e) one mastectomy brassiere per breast prosthesis to a maximum of 2 per lifetime
- f) charges for the following items to the maximum amounts indicated per calendar year:
 - i) stump socks\$250
 - ii) surgical stockings 2 pairs
- g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis, or alopecia totalis to a lifetime maximum of \$500
- h) orthopaedic shoes and orthotics
 - i) when prescribed by a Physician, podiatrist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg, and
 - ii) when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or a Primary healthcare nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet to a combined maximum in a calendar year of \$500 for adults and \$300 for a Dependent child.
- i) hearing aids (excluding batteries, recharging devices, or other such accessories) and repairs in a 60 month period to a maximum of:
 - i) \$400 for adults, and
 - ii) \$800 for Dependent children.

Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

- 7) Standard durable medical equipment
 - a) Preauthorization is required from us for expenses in excess of \$5,000
 - b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a Provider may be considered.
 - c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
 - d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
 - e) Standard durable equipment includes:
 - i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent
 - ii) medical heart monitors and cardiac screeners
 - iii) continuous glucose monitors and supplies to a maximum of \$2,000 in a calendar year period
 - iv) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
 - v) blood glucose monitors to a lifetime maximum of \$250
 - vi) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
 - vii) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
 - viii) insulin infusion pumps for diabetics – when basic methods are not feasible
 - ix) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
 - x) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

- 8) **Vision Care**
Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical Provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical Provider, to a maximum of \$250 in a 24 month period. Charges for non-prescription eyewear are not covered.
- 9) **Eye Examinations**
Charges for routine eye examinations every 2 calendar years to a maximum of \$100 when performed by a Physician or legally authorized optical Provider.
- 10) **Medical Examinations**
Charges of a Physician or Primary healthcare nurse practitioner, for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement.
- 11) **Drug & Alcohol Rehabilitation**
Charges for the treatment of an addiction or habituation when performed at a recognized drug and alcohol treatment facility, to a lifetime maximum of \$2,500.

Extended Health Benefit – Second Opinion™

This benefit offers you and your Dependents if faced with a serious medical condition, the opportunity to obtain a second medical opinion offered by one of North America's leading medical facilities.

Serious medical conditions, which qualify for Second Opinion are diagnoses of the following:

- 1) AIDS
- 2) ALS
- 3) Alzheimer's disease
- 4) Any amputation
- 5) Any life threatening illness
- 6) Benign brain tumor

- 7) Cancer
- 8) Cardiovascular conditions
- 9) Chronic pelvic pain
- 10) Coma
- 11) Deafness
- 12) Embolism/Thrombophlebitis
- 13) Emphysema
- 14) Hip/knee replacement
- 15) Kidney failure
- 16) Loss of speech
- 17) Major or severe burns
- 18) Major organ transplant
- 19) Major trauma
- 20) Multiple sclerosis
- 21) Neuro-degenerative diseases
- 22) Paralysis
- 23) Parkinson's disease
- 24) Rheumatoid arthritis
- 25) Stroke
- 26) Sudden blindness due to illness

A medical specialist reviews the patient's medical documentation and provides recommendations to the patient and their Physician. Treatment decisions are made between the patient and their Physician.

If you or your Dependents have been diagnosed with one of the conditions listed above, you can seek Second Opinion by calling 1-866-895-1371 (toll-free) between 5:00 am and 5:00 pm (Pacific time). You will be asked for your Pacific Blue Cross policy number, as shown on your ID card.

This benefit terminates:

- 1) for you and your Dependents when your employment is terminated, on your retirement, on termination of the EHC benefit, or when you reach age 85, whichever occurs first, and
- 2) for any Dependent who reaches age 85, provided your coverage has not terminated as indicated above.

Disease Support Programs

This benefit offers you and your Dependents faced with a cancer diagnosis the opportunity to obtain tools to improve recovery and survival during and after cancer treatment. A team of Physicians and health care practitioners work with the patient to assist in recovery, improve quality of life and help prevent cancer recurrence. The programs are supported by current research and are intended to integrate with conventional treatments.

Services available, including but not limited to:

- 1) Support groups.
- 2) Tools for patient to take charge of their health.
- 3) Natural approaches to prevention and treatment.
- 4) Multidisciplinary team of Physicians and health care practitioners.
- 5) Individualized cancer survivorship plan.

Conditions and Limitations:

- 1) Diagnosis of cancer by patient's Physician.
- 2) The cancer diagnosis must have occurred within 24 months of referral by the Physician to the program.
- 3) Any service covered by the Government plan is ineligible for reimbursement.
- 4) The lifetime maximum benefit is \$300 per covered person.

For additional information visit the website at www.inspirehealth.ca or to arrange an appointment call 604 734-7125.

Out-of-Province/Territory Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency Eligible expenses incurred while travelling outside your province/territory of residence subject to the Deductible, in-province/territory reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a government plan.

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory of residence, benefits are payable for the following Eligible expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other Provider of health coverage are not eligible.

- 1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
- 2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.

If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.

- 3) Services of a Physician and laboratory and x-ray services.
- 4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, medi-assist will coordinate the following services:

- 1) locate the nearest appropriate medical care
- 2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
- 3) investigate, arrange and coordinate medical evacuations and related transportation needs

- 4) arrange and coordinate the repatriation of remains
- 5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

Exclusions

The following are not included as Eligible expenses under your EHC plan:

- 1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians, Dentists, or Primary healthcare nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
- 2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, infant food, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
- 3) except as specifically included in this booklet: anti-obesity drugs, sclerosing agents, contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury

- 4) allergy testing unless rendered by a naturopath
- 5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
- 6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
- 7) any payment to a pharmacy, a Practitioner, Physician, Dentist, or a Primary healthcare nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
- 8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
- 9) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
- 10) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
- 11) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
- 12) expenses of a Dependent hospitalized at the time of enrolment
- 13) services performed by a Physician, Dentist, or a Primary healthcare nurse practitioner, who is related to or resident with you or your Spouse
- 14) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
- 15) fees for ambulance services when an ambulance is called but not used
- 16) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility

- 17) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
- 18) any other item not specifically included as a benefit.

Claims

Electronic Claims

- 1) When submitting an electronic claim you must:
 - a) complete the claim form online and submit it electronically to us
 - b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
 - c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation electronically or by mail to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused and your ability to submit electronic claims will be removed.
- 2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
- 3) You must provide explanation or proof to support the claim or any other information we consider necessary.
- 4) We must receive an electronic claim by June 30th of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the June 30th deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission.
- 5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card.

The pharmacist will charge you only for amounts not covered by us. If you or the pharmacy do not have access to this system, or for other types of expenses, please follow the instructions below.

Paper Claims

- 1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.
- 2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
- 3) Certain medical expenses are covered under the provincial/territorial plans. If you submit your claim to us before you submit your claim to the provincial/territorial plans, we will deduct what the provincial/territorial plans, would normally pay from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer.
- 4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
 - a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
 - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
 - c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.
Example: We must receive your receipts for 2016 before June 30, 2017.

- d) We must receive the original claim form and original receipts.
We will not accept a faxed or scanned claim form and/or receipts.

Payment of Benefits

- 1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.
- 2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
 - a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee schedule
 - b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
 - c) for services performed outside Canada if your province/territory of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
- 3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

- 1) Diagnostic services
 - a) examinations:
 - i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months – 1 per 36 month period
 - ii) recall – 2 per calendar year
 - iii) specific – 2 per calendar year
 - iv) consultations (as a separate appointment)
 - b) x-rays
 - i) diagnostic
 - ii) panoramic – 1 per 24 month period
 - iii) complete mouth series – 1 per 36 month periodAll x-rays combined shall not exceed the dollar limit for a complete mouth series.
 - c) diagnostic models – 1 set per calendar year.
- 2) Preventive services
 - a) scaling
 - b) polishing – 2 per calendar year
 - c) topical application of fluoride – 2 per calendar year
 - d) fixed space maintainers
 - e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.
- 3) Restorative services
 - a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
 - i) amalgam (silver coloured) fillings
 - ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth onlyOn permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
 - b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period
 - c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

- 4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.
- 5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
 - a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
 - b) root planing
 - c) gingival curettage – 1 per sextant in a 5 year period
 - d) osseous surgery – 1 per sextant in a 5 year period.
- 6) Prosthetic repairs
 - a) removal, repairs, and recementation of fixed appliances
 - b) rebase and relin of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
 - c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
 - d) gold foil – only when used to repair existing gold restorations.
- 7) Surgical services
 - a) extractions
 - b) other routine oral surgical procedures
 - c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

- 1) Prosthodontic Services
 - a) removable
 - i) complete upper and lower dentures
 - ii) partial upper and lower dentures
 - b) fixed bridges.
- 2) Restorative Services
 - a) inlays or onlays involved in bridgework
 - b) veneers
 - c) crowns and related services.
- 3) Periodontal Appliances
bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

- 1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
- 2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
- 3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- 4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- 5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage for Dependent children only. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

- 1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
- 2) No benefit is payable for the replacement of appliances which are lost or stolen.
- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- 4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule. This will not apply to the services of a dental hygienist.

Exclusions

The following are not Eligible expenses under your dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
- 2) any item not specifically included as a benefit
- 3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
- 4) procedures performed for congenital malformations or for purely cosmetic reasons
- 5) charges for drugs, pantographic tracings, and grafts
- 6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
- 7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
- 9) incomplete or temporary procedures
- 10) recent duplication of services by the same or different Dentist

- 11) any extra procedure which would normally be included in the basic service performed
- 12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
- 13) travel expenses incurred to obtain dental treatment.

Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **12 months** from the date the service is performed.
- 3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
 - a) name of the Dentist
 - b) name and birthdate of the person receiving the dental care
 - c) your policy and ID numbers (this information is on your ID card)
 - d) your home mailing address
 - e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
- 4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:

- a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:
 - i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
 - ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
 - b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
 - i) a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
 - ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
- 5) Orthodontic Claims Procedures
- a) Receipts
Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.
 - b) Claiming deadlines
 - i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
 - ii) Reimbursement is made if the complete and correct claims information is received within 12 months of the due date. However, no benefit is payable for claims not received within **12 months** of the due date.
 - c) Treatment plan
 - i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.

- ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
 - iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
 - your initial fee/down payment
 - your monthly/quarterly fees
 - one time appliance fees
 - iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.
- d) Monthly or quarterly fees
- i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 12 months old will not be reimbursed.
 - ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
 - iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Payment of Benefit

If you die while insured, we will pay the amount of your group term life insurance to your beneficiary.

When you designate more than one person as beneficiary, we will assume the benefit amount is to be divided equally, unless you specify otherwise. If your designated beneficiary is under age 18, you should appoint a trustee for this beneficiary and have a trust agreement drawn up and signed. This trustee will receive and give discharge for any benefit amount which becomes payable while your beneficiary is a minor. If no beneficiary survives you, the benefit amount will be paid to your estate.

Living Benefit

Terminal condition

means an injury or sickness from which there is no reasonable prospect of recovery, as determined by us, and which is expected to result in your death within 12 months.

If you have a Terminal condition, we will pay you the living benefit amount shown in the Schedule of Benefits. You or your legal representative must submit a written request for this benefit and include written consent from your beneficiary (release form) and written proof of your medical condition from your attending Physician.

This benefit amount is payable once. The amount of your group term life insurance benefit or the amount of insurance you can convert outlined under the conversion option is reduced by the amount you receive under this benefit.

Waiver of Premium

Should you become totally disabled prior to your 65th birthday and remain so for six months, the premium for your group term life insurance will be waived.

Conversion Option

You will be eligible to convert your group life insurance coverage to a personal life insurance policy issued by Blue Cross Life Insurance Company of Canada without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

The maximum coverage you can purchase will be the lesser of:

- 1) \$200,000 or
- 2) the amount of group life insurance you had with us, or
- 3) the difference between the amount of group life insurance you had with us and the amount that is available through your new employer's group plan – provided you become insured within 31 days following the termination of your coverage under this policy.

You may purchase less than the maximum amount of life insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy. You will have a choice of two policies:

- 1) a term life insurance policy for one year, or
- 2) a term life insurance policy to age 65.

Your premium will be based on the prevailing standard rate charged by Blue Cross Life on the date your personal policy is issued.

Claims

In the event of your death, we must receive notice of your death within **30 days**, and a completed claim form along with any proof required, as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

Payment

Because you must enrol your Dependents for the dependent life insurance benefit, when one of your eligible Dependents dies, we will pay the benefit amount to you.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for the dependent life insurance benefit will also be waived.

Exclusions

Dependents not residing in Canada or the USA or Dependents who are members of the armed forces in any country are not eligible for the dependent life insurance benefit.

Claims

We must receive notice of the death within **30 days** and a completed claim form along with any proof required, as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

Accidental Death & Dismemberment

Payment of Benefit

- 1) When death or loss occurs because of an accidental injury and within 365 days of the accident date, we will pay the Benefit Amount in the absence of any Policy exclusions being found applicable:
 - a) to your beneficiary, for loss of life
 - b) to you, for any other loss.
- 2) Loss of use is covered, but only if such loss is permanent, total, and irrecoverable and has been continuous for 365 days from the date of the accident. In either of the following circumstances we will also consider your loss to be the result of injury:
 - a) when, due to an accident, you are unavoidably exposed to the elements and, as a result of this exposure and within 365 days of the date of the accident, you suffer a loss included in the table
 - b) when, due to the accidental wrecking, sinking, or disappearance of a conveyance in which you are riding, you disappear and your body is not found within 365 days, we will presume that you lost your life in the accident.
- 3) The benefit amount will be paid according to the following table. Only one of the amounts, the largest specified, will be paid for all injuries resulting from any one accident. The principal sum (the amount for which you are insured) is shown in the Schedule of Benefits.

<i>Table of Losses and Benefit Amounts</i>	<i>Benefit as</i>
<i>Loss (including loss of use)</i>	<i>portion of the</i>
	<i>Principal Sum</i>
Life	100%
Both Hands or Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing	100%
One Arm or One Leg	75%
One Hand or One Foot	66.6%
Entire Sight of One Eye	66.6%
Speech or Hearing	50%
Thumb and Index Finger of the Same Hand	33.3%
Four Fingers of the Same Hand	33.3%
Hearing in One Ear	16.6%
All Toes of the Same Foot	12.5%
Quadriplegia (complete paralysis of both upper and lower limbs)	100%
Paraplegia (complete paralysis of both lower limbs)	100%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	100%

Repatriation Benefit

If you die due to an accident that occurs at least 150 kilometres from your normal place of residence, we will pay the actual expenses incurred (excluding the cost of a coffin) for:

- 1) preparing your remains for burial or cremation and the shipment of your body to the place of burial or cremation, or
 - 2) the actual expense incurred (excluding the cost of a coffin) for burial or cremation at the place of death,
- to a maximum of \$7,500.

Rehabilitation Benefit

If you suffer a covered loss which requires you to take special training to enable you to work in an occupation for which you were not qualified prior to the loss, we will pay the reasonable and necessary expenses incurred within 3 years of the date of the accident, to a maximum of \$5,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Occupational Training Benefit for the Spouse

If you die due to an accident which requires your Spouse to take a formal training program to enable him or her to gain active employment in any occupation in which he or she would not otherwise be qualified, we will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of your death, to a maximum of \$5,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Education Benefit

If you die due to an accident, we will pay an education benefit for each Dependent child who enrolls full-time in a recognized post secondary institution within 365 days of your death. We will pay the necessary and reasonable expenses actually incurred, subject to the lesser of 5% of the principal sum or \$5,000 for each year your child continues his or her education on a full-time basis, for a maximum of 5 years or until the age of 26, whichever occurs first.

To be eligible for this benefit, your unmarried child (including any stepchild, legally adopted child, or legal ward, but not a foster child) must be financially dependent on you or your Spouse at the time of your death. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Family Travel Benefit

If you suffer a covered loss and are confined as an inpatient in a hospital, or if you suffer from any illness or injury resulting in hospital confinement for at least 4 days, and the confinement occurs more than 150 kilometres from your normal place of residence, we will pay the reasonable and necessary travelling expenses of one or more family members to visit you. The maximum benefit for all family members is \$1,500 for return transportation and commercial accommodation costs combined. If personal transportation is used instead of public transportation, a rate of \$0.20 per kilometre will apply.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for this coverage will also be waived, provided this benefit remains in effect.

Exclusions

No payment will be made for any loss that results from or is caused directly or indirectly, wholly or in part by any of the following:

- 1) self-inflicted injury or suicide while sane or insane
- 2) participation in an assault or criminal offense, or an act incident thereto
- 3) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
- 4) travel or flight in or descent from any kind of aircraft as a member of the aircraft crew or having duties relating to the operation, maintenance, or control of the aircraft
- 5) riding as a passenger, pilot, operator, or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated, or leased by the Policyholder
- 6) while intoxicated with a blood alcohol level of 0.08% or higher, or under the influence of any narcotics unless administered on the advice of a physician
- 7) any disease or sickness either mental or physical, or medical procedure.

Claims

In the event of any loss for which this benefit is payable, we must receive notice within **30 days** of the date of loss, and a completed claim form along with any required proof as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of accident.

Payment of Benefit

We will pay the amount of coverage in force in the event you, your Spouse, or your Dependent is afflicted with a critical illness as defined in *Covered Illnesses* below.

The lifetime maximum amount payable for all critical illnesses is shown in the *Schedule of Benefits*. The benefit amount will be paid once for any covered illness or related covered illness and only two covered illnesses per lifetime will be covered.

Definitions

As used in this benefit, the following terms apply:

Activities of Daily Living

means the five activities that a person would normally perform without assistance: eating, dressing, bathing, ambulation, and toileting.

- 1) Eating: manipulating prepared food or liquid into the mouth
- 2) Dressing: putting on and removing necessary articles of clothing that are normally worn including leg braces
- 3) Bathing: the ability to cleanse the entire body using soap and water, including turning on faucets and shower mechanisms, getting into and out of the bath itself and drying oneself off
- 4) Ambulation: the ability to move independently from place to place with or without the use of equipment
- 5) Toileting: the ability to use a toilet, bedside commode or urinal.

Elimination period

means that continuous period of time which must elapse between the date the definition of the critical illness is met and the date the benefit is payable, as long as the insured person is still living. The Elimination period is shown in the *Schedule of Benefits*.

Functional Classification Class IV

means patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Objective Assessment D

means objective evidence of severe cardiovascular disease.

Covered Illnesses

Critical illnesses resulting from sickness or disease are covered when the illness is considered severe as described in this booklet and the policy. We will determine severity using the objective standardized medical testing and clinical evidence provided by the attending physician or appropriate specialist. The degree of severity may also be determined by the ability to perform Activities of Daily Living or when a loss of cognitive function is sufficient to require daily supervision.

The only covered critical illness resulting from injury is severe burns.

The following critical illnesses are eligible for 100% of the benefit amount:

Alzheimer's disease

Unequivocal diagnosis determining a loss of cognitive function (using clinical evidence and standardized testing) to a degree sufficient to warrant supervision on a daily basis.

Blindness

Permanent and uncorrectable loss of sight from both eyes as determined by vision acuity testing and resulting in vision less than or equal to 6/60 central acuity or degree of vision less than or equal to 20 degrees.

Severe burns

Third degree burns covering at least 20% of the surface area of the body.

Coma

State of unconsciousness with no reaction to external stimuli or internal needs persisting with the use of life support systems.

Deafness

Permanent and uncorrectable functional deafness as determined by hearing testing performed and evaluated by a specialist.

Heart transplant

Medically necessary heart transplant from a donor to the life insured.

Kidney failure or transplant

End stage renal disease requiring permanent regular renal dialysis or renal transplantation.

Liver failure or transplant

End stage liver failure with permanent jaundice, encephalopathy and ascites, or liver transplantation.

Loss of speech

Complete, permanent and uncorrectable loss of speech.

Lung failure or transplant

End stage lung disease which requires permanent oxygen therapy as well as resulting in FEV 1 test results of less than 1 litre as measured

by pulmonary function testing performed by a respiratory specialist, or lung transplantation.

Motor neurone disease

Unequivocal diagnosis of motor neurone disease by a specialist in neurology resulting in the inability to perform three of the five Activities of Daily Living without assistance.

Multiple sclerosis

Unequivocal diagnosis by a specialist in neurology. There must be more than one episode of well defined neurological deficit with persisting neurological abnormalities to a degree that results in the inability to perform three of the five Activities of Daily Living without assistance.

Paralysis

Total and permanent loss of use of two or more limbs.

Parkinson's disease

Unequivocal diagnosis of permanent Parkinson's disease by a specialist in neurology and resulting in significant permanent neurological impairment to a degree that results in inability to perform three of the five Activities of Daily Living without assistance or results in a loss of cognitive function (as determined by a specialist in neurology using clinical evidence and standardized testing) to a degree sufficient to warrant supervision on a daily basis.

Senile dementia

Unequivocal diagnosis determining a loss of cognitive function (using clinical evidence and standardized testing) to a degree sufficient to warrant supervision on a daily basis.

Severe stroke

A cerebrovascular incident producing a permanent measurable neurological deficit which has persisted for at least 60 days and results in:

- 1) permanent loss of visual fields resulting in complete or partial blindness in one or both eyes (partial blindness is defined as visual loss greater or equal to 50% or loss of central vision); or
- 2) results in the inability to communicate verbally due to aphasia (total or partial loss of the ability to use words); or
- 3) results in significant neurological dysfunction (paralysis) of one or more limbs which prevents the insured person from performing three of the five Activities of Daily Living without assistance.

Severe heart attack

A heart attack is defined as an irreversible and ischemic myocardial necrosis manifested by chest pain, new electrocardiographic changes, and elevation in cardiac enzymes. An incidental finding of ECG changes suggesting prior myocardial infarction, in the absence of a corroborating event, is not covered.

Heart attacks, for the purpose of this benefit, are classified according to a functional classification and an objective assessment classification as defined below. The objective assessment classifications will be based on measurements such as electrocardiograms, stress tests, x-rays, echocardiograms, and radiological images.

The level of cardiac impairment will only be determined 60 days following the heart attack.

A heart attack, based on symptoms and diagnostic investigations, resulting in a permanent functional classification of at least a Class IV and an Objective Assessment D (see definitions above) which is:

Patients with cardiac disease resulting in the inability to carry on any physical activity without discomfort (symptoms of heart failure or the anginal syndrome may be present at rest) and objective evidence of severe cardiovascular disease.

Cancer

Incontrovertible evidence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue with distant metastasis, or any malignant tumors (with or without metastasis) listed as follows:

- 1) oral cavity
- 2) liver
- 3) pharynx (excluding larynx)
- 4) pancreas
- 5) esophagus
- 6) gallbladder
- 7) stomach
- 8) respiratory tract and lungs
- 9) level IV Melanoma

Lymphoma, leukemia, multiple myeloma and inoperable benign brain tumors will be payable at 100% only if considered to be life threatening and likely to result in death within 24 months with or without appropriate treatment.

Waiver of Premium Benefit

Subject to the terms and conditions of the *Waiver of Premium Benefit* for group term life insurance benefit, when the group term life insurance premiums are being waived for a disabled Member, the Basic critical illness premiums shall also be waived, for a period of 12 months. Notwithstanding the terms and conditions of this waiver, termination of the master contract will also cause the Waiver of Premium on the critical illness insurance to be terminated.

Pre-existing Conditions

A pre-existing condition means any condition for which you, your Spouse, or your Dependent has received medical treatment, consultation, care or services (including diagnostic measures) and/or has 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 the critical condition, as defined in *Covered Illnesses* occurs after 24 consecutive months of coverage.

This clause will not apply to a child born while family coverage is in force.

Exclusions

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

- 1) an accident except for severe burns as defined in *Covered Illnesses*, or
- 2) self-inflicted injury or sickness, while sane or insane, or
- 3) 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
- 4) driving a vehicle when the blood of the insured person contained in excess of 80 milligrams of alcohol per 100 millilitres of blood. (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), or
- 5) committing or attempting to commit a criminal offense, or provoking an assault.

Extension of Coverage

If you cease to be actively at work due to an injury, sickness, or a critical illness, you will be considered to still be employed and eligible for continued coverage until the earliest of:

- 1) recovery from the condition, or
- 2) the termination of employment, or
- 3) the termination of this Policy, or
- 4) one year from the date last worked, provided premiums are continued until such time as the group term life insurance benefit is accepted for waiver of premium.

Claims

- 1) We must receive written notice of claim within **60 days** following the end of the Elimination period. Failure to give notice of claim within the time prescribed will not invalidate the claim if the notice is given as soon as reasonably possible.
- 2) Satisfactory medical proof of claim, on the forms we provide, must be submitted to us within **365 days** following the end of the Elimination period. If not, your claim will not be paid under any circumstances.
- 3) We may require consultation and/or examination by a physician, of our choice, who specializes in the treatment of the claimant's illness.
- 4) Any cost for completion of forms or medical reports will be your responsibility.

