INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES

ATLANTIC PROVINCES BENEFIT TRUST FUND

Plan Number: 8033

(AD&D Benefits AIG Insurance Company of Canada
Policy Number: BSC 9425194)

Classes - A, B, C, D, E & F

Updated Effective Date: April 1, 2021

IMPORTANT INFORMATION
ABOUT YOUR BENEFITS

1. This booklet contains important information from Medavie Blue Cross about certain of your benefits that are administered and/or underwritten by Medavie Blue Cross.
2. This booklet may contain information provided by others about certain of your benefits that are administered and/or underwritten by others.
3. Medavie Blue Cross has not reviewed and is not responsible for the content of any materials provided by others.
4. The ABOUT THIS BOOKLET section of this booklet contains important information for you and should be reviewed carefully.
5. This booklet is being provided for your convenience and ease of reference only. ***In all cases the details of your coverage may be found in the underlying insurance contracts.*** Information on obtaining copies of these contracts is given in this booklet.

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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 member.

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

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.

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 Website 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 methods:

www.medavie.bluecross.ca

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

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

or

privacyofficer@medavie.bluecross.ca

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

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

ABOUT THIS BOOKLET

Medavie Blue Cross administers the following benefits on behalf of International Union of Painters and Allied Trades Atlantic Provinces Benefit Trust Fund:

- Extended Health Benefit
- Vision Benefit
- Drug Benefit
- Dental Benefit
- Health Spending Account

Medavie Blue Cross underwrites Worldwide Travel Benefit and Referrals for Services Outside Canada

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

- Group Life Insurance
- Dependent Life Insurance
- Weekly Indemnity
- Enhanced Critical Illness

AIG Insurance Company of Canada administers and underwrites the following benefits:

- Accidental Death & Dismemberment Insurance

Each underwriter of insurance coverage may have different rules regarding eligibility for and termination of coverage.

The information contained in this booklet summarizes the important features of your group program; is prepared as information only; and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefit program are described in the group policies held by the International Union of Painters and Allied Trades Atlantic Provinces Benefit Trust Fund.

Where legislated, you have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to an underwriter as evidence of your health.

Regarding the benefits administered or underwritten by Medavie Blue Cross or Blue Cross Life Insurance Company of Canada, you may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of these documents should be directed to Medavie Blue Cross.

Regarding the benefits administered and underwritten by AIG Insurance Company of Canada, for instructions on obtaining further information regarding your coverage including copies of the contract for insured benefits please refer to the materials provided by AIG Insurance Company of Canada in the Accidental Death & Dismemberment section of this booklet.

ABOUT THIS BOOKLET

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

This booklet replaces any previously issued booklet.

BENEFITS ADMINISTERED OR UNDERWRITTEN BY:
MEDAVIE BLUE CROSS AND/OR
BLUE CROSS LIFE INSURANCE COMPANY OF CANADA

SCHEDULE OF BENEFITS

GROUP LIFE INSURANCE (Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay, Class D - Disabled & Class E - Early Retirees)

You are eligible for an amount of insurance equal to $75,000.

Coverage terminates the last day of the month in which you retire and/or exhaust your Hour Bank Account. However, you may arrange to have your insurance continued on a self-pay basis, and as outlined in the Termination of Insurance Section.

DEPENDENT LIFE INSURANCE

Spouse - $10,000
Each Child - $10,000

Coverage terminates the last day of the month in which you retire and/or exhaust your Hour Bank Account. However, you may arrange to have your insurance continued on a self-pay basis, and as outlined in the Termination of Insurance Section.

SCHEDULE OF BENEFITS

WEEKLY INDEMNITY INSURANCE (Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay & Class D - Disabled)

Benefit Formula:	Current Employment Insurance maximum
Benefit Amount:	Current Employment Insurance maximum
Non-Evidence Limit:	Current Employment Insurance maximum
Elimination Period:	0 days for Accident 0 days for Hospital 7 days for Sickness
Benefit Period:	52 weeks
Limitation:	Benefits will not be payable during the 15-week period beginning with the date EI benefits would normally commence unless proof can be provided that you are not eligible for EI (week 3-17). Only non-occupational injuries or illness are covered. WCB claims are excluded (i.e. no WCB top up).
Reductions:	There is no reduction for CPP/QPP or any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability.

Claim payments received are taxable benefits.

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

Coverage terminates on the last day of the month in which you attain age 70, retire and/or exhaust your Hour Bank Account, and as outlined in the Termination of Insurance Section.

ENHANCED CRITICAL ILLNESS (Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay, Class D – Disabled and Class E – Early Retirees)

AMOUNT OF INSURANCE

Full Payment Amount

Employee	$10,000
Spouse	$2,000
Each Child	$1,000

Partial Payment Amount

Employee	$1,000
Spouse	$200
Each Child	$100

Waiting Period: 30 consecutive days unless otherwise specified in the defined Covered Critical Illness Conditions. The waiting period is that continuous period of time which must elapse between the date the definition of the covered critical illness condition is met and the date the benefit is payable, as long as the Participant is still living.

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 or after the Spouse reaches 2 full benefit payments.
Each Child - Ceases at the earlier of the employee's retirement, the employee's age 65 or after the child reaches 2 full benefit payments or when a childhood condition payment is received.

SCHEDULE OF BENEFITS

HEALTH INSURANCE

EXTENDED HEALTH BENEFITS

- reimbursement to the member
- program pays 100% of the eligible expense

VISION CARE

- vision care benefits every 24 consecutive months and 12 consecutive months for dependent children less than 19 years of age
- reimbursement to the member
- program pays 100% of the eligible expense
- charges for one eye exam plus maximum eligible expense and maximum reimbursed is $400 for lenses, contact lenses and frames, $150 for visual training, $250 for contact lenses due to disease and $1,500 lifetime maximum for laser corrective eye surgery.

DRUG BENEFITS

- paid directly to the pharmacy
- the member pays 20% for each eligible drug on the prescription
- program pays 100% of the remaining 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

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 maximum payment of $500,000 per person

(Applicable to Class C - Regular Self-Pay, Class D - Disabled, Class E - Early Retirees & Class F - Spouses under 65 of Early Retirees) Coverage terminates on the last day of the month in which you attain age 65 for Worldwide Travel and Out of Canada Referrals, retire and/or exhaust your Hour Bank Account, and as outlined in the Termination of Insurance Section.

(Applicable to Class A – Group 1 – Active Members and Class B – Group 2 – Active Members) Coverage terminates on the last day of the month in which you attain age 75 for Worldwide Travel and Out of Canada Referrals, retire and/or exhaust your Hour Bank Account, and as outlined in the Termination of Insurance Section.

SCHEDULE OF BENEFITS

DENTAL INSURANCE (Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay, Class D - Disabled, Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees)

Co-insurance: 100% for Basic Benefits
60% for Major Restorative Benefits
50% for Oral Surgery
50% for Orthodontic Services (dependent children under the age of 18)

Fee Guide: Dental benefits are based on the usual and customary charges up to the current Dental Fee Guide less two years for general practitioners in effect in the covered person's province of residence. The Dental Fee Guide will be updated on January 1st of each year.

Maximum Reimbursement: $2,000 combined maximum for Basic and Major Restorative Benefits per calendar year per individual.

$2,000 lifetime maximum for Orthodontic Services (dependent children under the age of 18).

Coverage terminates on the last day of the month in which you retire and/or exhaust your Hour Bank Account, and as outlined in the Termination of Insurance Section.

SCHEDULE OF BENEFITS

65+ RETIREE HEALTH SPENDING ACCOUNT (Under Plan Number 14573)

You may be eligible for the Health Spending Account Benefit if you meet the criteria specified in the Eligibility section of this booklet.

Policy Year:	January 1st to December 31st
Account Type:	No Carry Forward
Payment Type:	Manual Reimbursement (credits will be used to pay an HSA claim as directed by you on the claim form)
Credit Allocation Frequency:	Annually
Grace Period for Active Employees:	180 days
Grace Period for Terminated Employees:	180 days

The Health Spending Account Benefit ends at the earlier of the Member's death or when they cease to be a member in good standing of IUPAT DC 39, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

If your employment ends, or your group terminates coverage with Medavie Blue Cross, you will have the Grace Period for terminated employees (specified in the About Your Health Spending Account section) within which to use the remaining balance. Only eligible expenses incurred prior to the termination of coverage are eligible.

ELIGIBILITY

WHO MAY BE INSURED

Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self Pay, Class D - Disabled, Class E - Early Retirees & Class F - Spouses under 65 of Early Retirees

This Plan is for members in good standing of the International Union of Painters and Allied Trades Atlantic Provinces Benefit Trust Fund who work for Contributing Employers and are residents of Canada.

WHO MAY BE ELIGIBLE FOR HEALTH SPENDING ACCOUNT (under Plan Number 14573)

To be eligible for the Health Spending Account Benefit, a Member must meet all the following eligibility requirements:

a. retired from employment;
b. reached age 65 on or after January 1, 2020;
c. a minimum of 20 years of service with IUPAT DC 39 (based on their union initiation date);
d. as of the earliest of age 65, date of retirement or disability, accumulated a minimum of 10,000 hours in the previous 10 years; and
e. covered for Health Care Benefits under this Plan.

If you require additional information regarding your Eligibility or Self-pay options, please call your Union office.

ELIGIBLE DEPENDENTS

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

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

Dependent children are eligible for benefits if they are less than 21 years of age or, if 21 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

ELIGIBILITY

EFFECTIVE DATE OF INSURANCE

To be eligible for group benefits, you must be a permanent member who is a resident of Canada and covered under your provincial government plan. You and your eligible dependents will become insured on the first day of the second month following accumulation of 375 hours (480 hours for Class B – Group 2 – Active Members only) in your Hour Bank Account during a 12-month period, provided you are actively at work or available for work on the day you would ordinarily become insured. Should you not be working or available for work on the day your insurance would ordinarily start, the insurance for you and your dependents will be delayed until you return to work or are available for work.

REINSTATEMENT

If your insurance has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the first day of the next month following accumulation of 250 hours in your Hour Bank Account.

Should you not be working or available for work on the day your insurance would ordinarily become reinstated, the insurance for you and your dependents will be delayed until you return to work or are available for work.

ELIGIBILITY TO PARTICIPATE

If at the end of any given month, a member covered under this Plan fails to meet the required monthly coverage cost as determined by the rules of the Trust Fund, such member will be notified by the Plan Administrator before his coverage is terminated and given the opportunity of contributing the necessary amount of money so that he may continue to be covered.

Please contact your Union Office for your self-payment options.

A member who is unemployed, self-employed, or working for a non-participating employer is entitled to self-pay and otherwise participate in the Plan in accordance with the rules if:

a. The member remains a member in good standing of the Union;

b. The member continues to actively seek work in the unionized construction industry;

c. The member does not refuse more than one dispatch for work in a three month period; and

d. The member does not engage in any employment activity which has the effect of undermining the jurisdiction of Union.

When a member with an hour bank is deemed ineligible to continue participating in the Plan, they shall regain access to their hour bank on the first day of the second month after returning to work for a participating employer.

SURVIVOR BENEFIT

In the event of a member's death, dependents can maintain the health and dental benefits to the earlier of the date the dependent ceases to be a dependent, the date the spouse remarries (children will continue to be covered), the end of 12 months from the date of death or the date the policy terminates.

CLAIMING BENEFITS

If your Group Plan contains the appropriate benefit, the following procedures should be followed in the event of a claim:

1. In reference to Group Life, Dependent Life or Weekly Indemnity benefits, please obtain the necessary forms from your employer. Certain portions must be completed by the employer, the claimant and the attending physician. Once the claim forms are completed, they should be submitted to the insurer for processing.

   - With respect to the Group Life or Dependent Life benefits, written notice of claim must be given to the insurer as soon as reasonably possible after the loss, and in no event later than one year from the date of loss.

   - With respect to the Weekly Indemnity benefits, written notice of claim must be given to the insurer within 90 days immediately following the end of the elimination period.

   An insured member who qualifies to receive Weekly Indemnity benefits under this policy may at any time be required to participate in a Rehabilitation Program, which the Company deems appropriate for his circumstances.

   Refusal to enter, participate or comply with a Rehabilitation Program deemed appropriate by the Company will result in the termination of Weekly Indemnity benefit payments.

2. All Health Benefits are on a reimbursement basis unless otherwise specified in the Schedule of Benefits. Claims must be submitted within 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 or Drug claims, the subscriber or dependent should ensure they are dealing with a Health Care Professional approved by Medavie Blue Cross. After this, the procedure below should be followed:

   Reimbursement plan: the member must pay the provider, obtain an official receipt and submit it to Medavie Blue Cross for payment. The member should also arrange for the completion of the appropriate claim forms, which are available from the International Union of Painters and Allied Trades Atlantic Provinces Benefit Trust Fund 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.

3. For Group Travel Benefits, please refer to the appropriate page in this booklet for claims filing procedures.

TERMINATION OF INSURANCE

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

- date you have fewer than 125 hours in your Hour Bank Account, provided you do not elect to self-pay at that time, subject to the self-pay provisions,
- the date you cease to be a member of the Union,
- the date you enter Military Service,
- the termination date of the Group Contract,
- the date you discontinue any required contributions,
- the date of retirement, and you have insufficient hours in your Hour Bank Account to maintain coverage, provided you do not elect to self-pay at that time (subject to the self-pay provisions),
- the earlier of attainment of age 70 or retirement for Weekly Indemnity,
- the earlier of attainment of age 65 for Worldwide Travel and Out of Canada Referrals ***(Applicable to all Classes except Class A – Group 1 – Active Members and Class B – Group 2 – Active Members)***
- the earlier of attainment of age 75 for Worldwide Travel and Out of Canada Referrals ***(Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members***
- the date the member becomes eligible (other than as a dependent) for other group insurance benefits similar to those for which they are covered under this Plan.

GROUP LIFE INSURANCE

AMOUNT OF INSURANCE

Benefit Formula: Flat Amount
Benefit Maximum: $75,000

DEATH BENEFIT

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

TERMINAL ILLNESS

A special advance payment may be provided if you are suffering from a condition that 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 Group Life Insurance. This payment will be deducted from the Group Life Insurance otherwise payable upon your death.

WAIVER OF PREMIUM

If you become totally disabled prior to your 65th birthday, and remain disabled for a period of six (6) consecutive months, insurance coverage is continued without payment of premium from the first of the month following the date of disability, provided that proof of total and continuous disability is submitted as required. Total Disability means a state of incapacity due to accidental injury or illness that prevents you from engaging in any occupation for which you are reasonably qualified by education, training or experience and you are unable to perform work for remuneration or profit.

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

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

EXTENSION OF COVERAGE

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

GROUP LIFE INSURANCE

CONVERSION PRIVILEGE

If your 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 members eligible for insurance under this plan, then the member may purchase an individual plan of the type then being offered by Blue Cross Life in an amount not to exceed $200,000.

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

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

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

DEPENDENT LIFE INSURANCE

AMOUNT OF INSURANCE

Spouse: $10,000
Children: $10,000

ELIGIBLE DEPENDENTS

An eligible dependent is as defined under the Eligibility section within this booklet.

COMMENCEMENT OF COVERAGE

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

EXCEPTIONS AND LIMITATIONS

Dependents excluded from the plan:

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

WAIVER OF PREMIUM

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

CONVERSION PRIVILEGE

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

EXTENSION OF COVERAGE

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

WEEKLY INDEMNITY BENEFIT

Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay & Class D - Disabled

AMOUNT OF INSURANCE

Benefit Formula:	Current Employment Insurance maximum
Benefit Amount:	Current Employment Insurance maximum
Non-Evidence Limit:	Current Employment Insurance maximum
Elimination Period:	0 days for Accident 0 days for Hospital 7 days for Sickness
Benefit Period:	52 weeks
Limitation:	Benefits will not be payable during the 15 week period commencing with the date EI benefits would normally commence unless proof can be provided that you are not eligible for EI (week 3-17). Only non-occupational injuries or illness are covered. WCB claims are excluded (i.e. no WCB top up).
Reductions:	There is no reduction for CPP/QPP or any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability.

Claim payments received are taxable benefits.

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

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

DISABILITY

To be eligible for this benefit, you must be under the continuing care of a physician for the period of the disability, which normally commences with your first visit to a doctor. You will be considered disabled and entitled to weekly indemnity payments if, as a result of a non-occupational accident or sickness you are unable to perform a substantial portion of the duties of your own occupation or regular employment and are not engaged in any occupation or employment for wage or profit.

RECURRENT DISABILITY

Successive periods of disability separated by fewer 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 you must wait from the onset of the disability before the insurer begins paying Weekly Indemnity benefits.

WEEKLY INDEMNITY BENEFIT

WEEKLY INDEMNITY PREMIUM REQUIREMENT

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

EXCLUSIONS AND LIMITATIONS

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

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

1. Any period of disability during which you are not under the continuing care and appropriate treatment and care of a physician who is a registered medical specialist or health care practitioner in the field of medicine that is applicable to your condition.

2. Any period during which you are not undergoing a course of medical treatment or participation in a program of rehabilitation which is deemed appropriate in the opinion of the company.

3. Any period during which you are imprisoned.

4. Any disability due to or resulting from self-inflicted injury or sickness, while sane or insane.

5. Any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion.

6. Any disability during the period:

   - of formal maternity leave taken by you pursuant to provincial or federal law, or pursuant to mutual agreement between you and the employer, or
   - in which unemployment insurance maternity benefits are being paid or would be paid if you were eligible, or

   whichever is the longer.

7. Any disability period beyond the maximum benefit period. If you attain the maximum coverage age while receiving Weekly Indemnity benefits, the maximum benefit period will be 15 weeks.

ENHANCED CRITICAL ILLNESS BENEFIT

Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self-Pay, Class D – Disabled and Class E – Early Retirees

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, then subject to the provisions under this section, the amount of coverage indicated above will be paid to you in a lump sum. You must provide medical evidence satisfactory to Blue Cross Life within 365 days following the end of the benefit waiting 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 Enhanced Critical Illness coverage will continue without further payment of premium from the date last worked. However, the waiver of premium on the Critical Illness coverage will cease if the waiver of premium benefit for the Group Life Insurance discontinues or the group contract terminates.

EXCLUSIONS AND LIMITATIONS

If there is a change in Critical Illness 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 Enhanced 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 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, Enhanced 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 major 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).

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 medical condition, Blue Cross Life will administer it using your effective date of coverage under the previous contract.

ENHANCED CRITICAL ILLNESS BENEFIT

COVERED CRITICAL ILLNESS CONDITIONS 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.

Categories for Multiple Event Coverage

Category 1: Cancer (Life Threatening)

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 conditions must be the result of illness or disease in order to be considered eligible, with the exception of burns.

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

1. Aortic Surgery: Defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary a specialist.

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

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

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

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

3. Bacterial Meningitis: Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a specialist.

   This coverage excludes viral meningitis.

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

4. Benign Brain Tumour: Defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

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

   Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

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

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

   No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

5. Blindness: Defined as a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

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

   The diagnosis of Blindness must be made by a specialist.

6. Cancer (Life Threatening): Defined as a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a specialist.

   No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

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

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

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of this plan, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of this plan, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

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

   The diagnosis of Coma must be made by a specialist.
   Exclusion: No benefit will be payable under this condition for:

   - a medically induced coma;
   - a coma which results directly from alcohol or drug use; or
   - a diagnosis of brain death.

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

   Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

   The diagnosis of Deafness must be made by a specialist.

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

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

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

    The participant must exhibit:

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

    Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

    For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

11. Heart Attack: Defined as the definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

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

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

    This coverage excludes:

    - elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
    - ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

12. Heart Valve Replacement or Repair: Defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

    Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

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

14. Loss of Independent Existence: Defined as a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a specialist.

    Activities of Daily Living are:

    Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;

    Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;

    Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;

    Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;

    Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and

    Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices

15. Loss of Limbs: Defined as a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a specialist.

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

    Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

17. Major Organ Failure on Waiting List: Defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the participant must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the waiting period, the date of diagnosis is the date of the participant's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

18. Major Organ Transplant: Defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.

19. Motor Neuron Disease: Defined as a definite diagnosis of one of the following:
    - amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
    - primary lateral sclerosis;
    - progressive spinal muscular atrophy
    - progressive bulbar palsy;
    - or pseudo bulbar palsy;
    - and limited to these conditions.

    The diagnosis of Motor Neuron disease must be made by a specialist.

20. Multiple Sclerosis: Defined as a definite diagnosis of at least one of the following:

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

    The diagnosis of Multiple Sclerosis must be made by a specialist

21. Occupational HIV Infection: Defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the participant's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the coverage or the effective date of last reinstatement of the policy.

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

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

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

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

Exclusion: No benefit will be payable under this condition if:

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

22. Paralysis: Defined as a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a specialist.

23. Parkinson's Disease and Specified Atypical Parkinsonian Disorders: Parkinson's Disease is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The participant must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

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

    Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

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

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

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

COVERED CRITICAL ILLNESS CONDITIONS FOR MULTIPLE EVENT COVERAGE (Cont'd)

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

25. Stroke:(Cerebrovascular Accident) is defined as a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

    - acute onset of new neurological symptoms; and
    - and new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of Stroke must be made by a specialist.

    Exclusion: No benefit will be payable under this condition for:

    - Transient Ischaemic Attacks;
    - Intracerebral vascular events due to trauma; or
    - Lacunar infarcts which do not meet the definition of stroke as described above.

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:

1. Coronary Angioplasty: Defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist.

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

   Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

   - signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
   - a diagnosis of Cancer (covered or excluded under the policy).

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

COVERED CRITICAL ILLNESS CONDITIONS FOR PARTIAL PAYMENT (Cont'd)

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

Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of Cancer (covered or excluded under the policy).

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

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

Exclusion: No benefit will be payable under this condition if, within the first 90 days following later of, the effective date of coverage or the date of last reinstatement of the policy, the participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of Cancer (covered or excluded under the policy).

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

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:

1. Cerebral Palsy: a definitive diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.

2. Congenital Heart Disease: any one or more diagnosis(es) from the following lists of heart conditions:

   - Total Anomalous Pulmonary Venous Connection;
   - Transposition of The Great Vessels;
   - Atresia of any heart valve;
   - Coarctation of the Aorta;
   - Single Ventricle;
   - Hypoplastic Left Heart Syndrome;
   - Double Outlet Left Ventricle;
   - Truncus Arteriosus;
   - Tetralogy of Fallot;
   - Eisenmenger Syndrome;
   - Double Inlet Ventricle;
   - Hypoplastic Right Ventricle; or
   - Ebstein's Anomaly.

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

   - Pulmonary Stenosis;
   - Aortic Stenosis;
   - Discrete Subvalvular Aortic Stenosis;
   - Ventricular Septal Defect; or
   - Atrial Septal Defect.

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

3. Cystic Fibrosis: A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

4. Muscular Dystrophy: A definitive diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

COVERED CHILDHOOD CONDITIONS (Cont'd)

5. Type 1 Diabetes Mellitus: A diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

6. Autism: An organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the child's third birthday.

7. Down Syndrome: A definitive diagnosis of Down Syndrome supported by chromosomal evidence of Trisomy 21.

WHEN AND HOW TO MAKE A CLAIM

Claim forms are available from your employer.

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

HEALTH CARE BENEFITS

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

Co-insurance: **100%**

Maximum: **$25,000 reimbursement per calendar year per participant in combination with drugs and vision benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.**

LABORATORY AND X-RAY SERVICES - Maximum $500 in a calendar year

Charges for laboratory services and X-ray examinations not covered by any provincial government plan.

OXYGEN - Charges for oxygen on the written authorization of the attending physician.

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

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

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

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

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

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

Co-insurance: 100%

Maximum: $25,000 reimbursement per calendar year per participant in combination with drug and vision benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.

PROFESSIONAL AMBULANCE - Maximum $200 per individual in any 12 consecutive months.

Charges for a professional ambulance service (ground), other than airline or railroad to the nearest hospital equipped to provide the required treatment.

ACCIDENTAL DENTAL - Maximum of $500 per tooth to a $2,000 maximum per accident.

Dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Work must be completed within 12 months of the accident.

CONTRACEPTIVE DEVICES - Maximum of $75 every 24 consecutive calendar months.

Purchase of an intrauterine contraceptive device (IUD) on the written authorization of the attending physician.

HEARING AIDS - Maximum of $1,000 per person every five (5) consecutive calendar years

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

MEDICAL SUPPLIES AND EQUIPMENT - Charges for the following medical supplies and equipment, when prescribed by an authorized physician:

- purchase of burn pressure garments is limited to a maximum of $500 in a calendar year;
- rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair or hospital-type bed;
- equipment for the administration of oxygen;
- insulin pump;
- compression pump and accompanying sleeves (limited to two (2) in a calendar year);
- transcutaneous electrical nerve stimulator (TENS machine) is limited to a maximum eligible expense of $300 in five (5) consecutive calendar years.

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

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

Co-insurance: 100%

Maximum: $25,000 reimbursement per calendar year per participant in combination with drugs and vision benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.

ORTHOPEDIC FOOTWEAR & SUPPLIES - Maximum of $300 every five consecutive calendar years for special foot appliances, and $350 every 12 consecutive months for orthopedic shoes.

Charges for special foot appliances when recommended by a physician along with a copy of the biomechanical or gait analysis from the health care professional, which have been specially designed and moulded for the insured individual and are required to correct a diagnosed physical impairment, such as arch supports, lifts, wedges, etc.

Charges for orthopedic shoes which have been specially designed and moulded for the insured individual and are required to correct a diagnosed physical impairment.

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

OTHER PRACTITIONERS - Charges for treatment, except when performed in a hospital, for the following licensed practitioners:

- speech therapist, occupational therapist, licensed osteopath, naturopath, chiropractor or chiropodist/podiatrist limited to a maximum benefit of $400 per practitioner per calendar year
- physiotherapist or massage therapist*, limited to a maximum of $50 per visit with a maximum of $400 per calendar year
- Clinical psychologist/social worker/clinical counsellor, limited to a combined maximum benefit of $1,000 per calendar year

Charges for x-rays to a maximum of $35 per practitioner per calendar year

The overall maximum eligible expense for this benefit is $1,000 in a calendar year.

*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

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

Co-insurance: 100%

Maximum: $25,000 reimbursement per calendar year per participant in combination with drugs and vision benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.

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

- artificial limbs
- breasts
- eyes
- crutches
- canes
- splints
- casts
- trusses
- braces

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

Hair prosthetics (wigs), when hair loss is due to an underlying pathology or its treatment, to a maximum eligible expense of $500 in 12 consecutive months.

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

CHRONIC DISEASE MANAGEMENT – Maximum of $500 in a calendar year

Charges for services rendered by an approved Medavie Blue Cross provider specialized in chronic disease management. Services must be delivered by the approved provider for medical conditions deemed eligible by Medavie Blue Cross. Coverage includes: initial assessment, counselling and follow up sessions; education relating to symptom management, medication usage; and development of action plans.

Initially, eligible conditions include asthma, COPD and smoking cessation by a Certified Respiratory Educator or Certified Asthma Educator.

VISION BENEFIT

Co-insurance: 100%

Maximum: $25,000 reimbursement per calendar year per participant in combination with drugs and extended health benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.

CONTACT LENSES DUE TO DISEASE - Maximum of $250 in two (2) consecutive calendar years.

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

EYE EXAMINATION - charges for one eye exam in 24 consecutive months and 12 consecutive months for dependent children less than 19 years of age.

Charges of a licensed optometrist or ophthalmologist for eye examinations.

LENSES, FRAMES, CONTACT LENSES AND LASER CORRECTIVE EYE SURGERY - Maximum of $400 in 24 consecutive months for adults and 12 consecutive months for dependent children less than 19 years of age and a maximum of $1,500 in a lifetime for laser corrective eye surgery.

Charges for corrective eyeglasses, including lenses, frames, contact lenses and safety glasses but excluding glasses/contacts for cosmetic purposes.

VISUAL TRAINING - Maximum of $150 in a lifetime.

Charges of a registered, licensed optometrist or ophthalmologist for visual training and remedial eye exercises.

DRUG COVERAGE

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

Co-payment:	**20% for each eligible drug on the prescription with the exception of diabetic supplies**
Co-insurance:	**100% of the remaining eligible expense**
Co-insurance:	**100% of the eligible expense for diabetic supplies**
Method of payment:	**paid directly to the pharmacy**
Maximum:	**$25,000 reimbursement per calendar year per participant in combination with extended health and vision benefits. Only applicable to Class E - Early Retirees and Class F - Spouses under 65 of Early Retirees.**

Includes prescription drug items approved by Medavie Blue Cross and certain over-the-counter items that are considered life-sustaining in nature and that are approved by Medavie Blue Cross.

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

Smoking Cessation Products - eligible products covered to a combined maximum of $500 per participant per lifetime.

Diabetic Supplies - charges for needles, syringes, swabs, test tapes and lancets for the treatment and control of diabetes on the written authorization of the attending physician.

(Generic) Drugs* - unless medically unsuitable, Interchangeable Drugs, when available, will be used in place of brand name drugs.

*Interchangeable (Generic) Drug coverage for prescription drugs will be limited to the cost of the least expensive product when interchangeable products are available from more than one manufacturer.

Also includes eligible pharmacy services as confirmed by Medavie Blue Cross, when provided by a pharmacy partner, up to the usual, customary and reasonable charges.

A pharmacy partner is a pharmacy confirmed to be in the Medavie Blue Cross Pharmacy Partner Preferred Network (not applicable to pharmacies in Quebec).

HEALTH EXCLUSIONS AND LIMITATIONS

Medavie Blue Cross does not cover the following expenses:

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

WORLDWIDE TRAVEL BENEFIT

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

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

Co-insurance: 100%

ACCIDENTAL DENTAL
Maximum: $1,000

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

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

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

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

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

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

WORLDWIDE TRAVEL BENEFIT

EMERGENCY AND PAYMENT ASSISTANCE

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

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

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

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

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

HOSPITAL ACCOMMODATION

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

MEALS AND ACCOMMODATION

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

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

MEDICAL APPLIANCES

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

NURSE

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

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

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

RETURN OF DECEASED
Maximum: $3,000

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

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

VEHICLE RETURN
Maximum: $500

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

EXCLUSIONS AND LIMITATIONS

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

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

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

4. No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol, suicide or attempted suicide, criminal acts, war or other hostilities.

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS (Cont'd)

7. 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.

8. 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.

REFERRAL FOR SERVICES OUTSIDE CANADA

When covered persons 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 usual, customary and reasonable amount for charges in excess of provincial government health care allowances up to a lifetime maximum of $500,000.

Co-insurance: 100%

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.

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

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

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

REFERRAL FOR SERVICES OUTSIDE CANADA

LIMITATIONS AND EXCLUSIONS

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

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

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

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

5. Payment will not be made for treatment of any illness commencing within 12 months after the covered person's effective date of group coverage for which the covered person 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 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 BENEFIT

Applicable to Class A – Group 1 – Active Members, Class B – Group 2 – Active Members, Class C - Regular Self Pay, Class D - Disabled, Class E - Early Retirees & Class F - Spouses under 65 of Early Retirees

Your dental program covers you and your dependents for a wide range of dental services including the following benefits. Dental benefits are based on the usual and customary charges up to the current Dental Fee Guide less two years for general practitioners in effect in the covered person's province of residence. The Dental Fee Guide will be updated on January 1st of each year.

BASIC BENEFITS

Co-insurance:	100%
Maximum:	$2,000 reimbursement in combination with Major Restorative Benefits

Diagnostics
- complete examinations once every two (2) consecutive calendar years
- recall examinations once (1) every nine (9) consecutive months
- bitewing four (4) films every calendar year
- full series or panoramic x-rays once every calendar year
- tests/analysis/laboratory procedures

Preventive Services
- polishing once, up to one (1) unit of time* every nine (9) consecutive months
- fluoride treatment one (1) every nine (9) consecutive months
- scaling, up to eight (8) units of time per calendar year
- pit and fissure sealants
- protective appliance (mouth guard) one (1) appliance every calendar year
- space maintainers (for dependent children only)
- protective appliance (mouth guard) one (1) appliance every calendar year
- periodontal, TMJ or Myofascial appliances once every 24 consecutive months
- periodontal, TMJ or Myofascial appliance adjustments, maintenance and repair, limited to one (1) upper and one lower once every 24 consecutive months
- occlusal equilibration

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

Endodontic Services
- root canal therapy

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

*one unit of time is equal to 15 minutes

BASIC BENEFITS (Cont.)

Prosthodontic Services
- denture adjustments and repairs (after three (3) months of initial insertion)
- denture reline or rebase once every three (3) consecutive calendar years (using existing framework for complete or partial dentures)
- tissue conditioning

The replacement of existing fixed prosthetic devices is not covered except if:

- The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or

- The replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least five (5) years old and no longer serviceable.

Surgical Services
- extraction of teeth and roots
- surgical movement of teeth
- removal of benign tumours, cysts

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

MAJOR RESTORATIVE BENEFITS

Co-insurance: 60%
Maximum: $2,000 reimbursement in combination with Basic Benefits

Extensive Restoratives
- inlays/onlays/crowns

Prosthodontic Services
- complete and partial dentures, limited to one (1) upper and one (1) lower, once every five (5) consecutive calendar years
- bridgework

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

ORTHODONTIC SERVICES

Co-insurance: 50%
Maximum: $2,000 reimbursement per dependent child under 18 per lifetime

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

PREDETERMINATION OF BENEFITS

When the total cost of any proposed dental treatment is expected to exceed $500, ask your dentist to complete and submit the predetermination section of the claim form to Medavie Blue Cross before the start of treatment. You will know, beforehand, the exact amount of reimbursement. If you change dentists in the course of treatment, you will be required to submit a new treatment plan.

DENTAL EXCLUSIONS AND LIMITATIONS

Medavie Blue Cross does not cover the following expenses:

1. Any item or service not listed as a benefit in this plan.
2. Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice.
3. Benefits the covered person receives or is entitled to receive from Workers' Compensation.
4. Services as a result of self-inflicted injuries or any suicide attempt, whether the covered person is sane or not.
5. Splinting for periodontal reasons, where cast, crowns or inlays are used for this purpose, with or without onlays.
6. Veneers for cosmetic purposes.
7. Accidental dental services do not form part of the Dental Benefits being offered.
8. Services rendered by a dental hygienist but not administered under the supervision of a dentist.
9. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

65+ RETIREE HEALTH SPENDING ACCOUNT (Under Plan Number 14573)

A Health Spending Account (HSA) provides additional flexibility within your group benefit plan, and allows you to cover medical expenses with pre-tax dollars (except in the province of Quebec). Under an HSA, you have access to a pre-determined amount of HSA credits. Credits represent the value allocated to the HSA in any particular policy year (specified below).

The HSA credits will be available to you according to the Credit Allocation Frequency specified below. Under no circumstances will unused HSA credits be paid out as cash.

These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits. For example, they can be used cover deductibles, co-payments, or amounts above plan maximums.

DEPENDENT COVERAGE

Your dependents can also be covered if you have chosen family coverage.

CRA dependents are eligible for coverage, according the Canada Revenue Agency definition. This could include members of your extended family, such as parents, grandparents or grandchildren.

ELIGIBLE EXPENSES

Eligible expenses will be assessed and reimbursed by Medavie Blue Cross based upon the Canada Revenue Agency guidelines, and must be deemed reasonable and medically necessary by Medavie Blue Cross. Eligible expenses include deductible amounts, co-payment amounts, amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care program, or any other private program.

ELIGIBLE EXPENSES

The following are examples of expenses which are covered:

Common Eligible Expenses			
Attendant Care (requires certification of need from physician)	• Services provided in Home, Retirement Home, Nursing Home or Group Home	• Includes Fees from: - Personal Care Worker - Registered Nurse - Respite Care	• Includes Fees for: - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	• Diagnostic Services (x-rays) • Dentures • Orthodontics	• Preventive Services, such as: - Recall Examinations, - Polishing, and - Application of Fluoride	
Diagnostic Services*	• Diagnostic laboratory, radiological tests and scans		
Drugs	• Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner*	• Fertility Treatments • Flu Shots • Insulin* • Liver Extract Injections*	• Smoking • Cessation Drugs* • Vaccines • Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	• Convalescent care home • Hospital	• Nursing home • Psychiatric facility • Substance abuse facility	
Medical Devices and Services*	• Air Conditioners (required for severe chronic ailment, disease or disorder) • Artificial Eyes and Limbs • Blood Transfusion Fees • Breast Prosthesis • Cochlear Implants • Crutches • Diabetic Supplies	• Electronic Bone Healing Devices • Electronic Speech Synthesisers • Hearing Aids • Heart Monitoring Devices • Needles and Syringes • Ostomy Supplies • Oxygen Equipment • Physician Fees	• Prosthetics • Repairs to Eligible HSA Devices • Respirators • Scooters • Trusses • Walkers • Wheelchairs (excluding accessories)
Medical Practitioner Services	• Acupuncturist • Athletic Therapist • Audiologist • Chiropodist/Podiatrist • Chiropractor • Dental Hygienist • Dentist	• Dietician • Homeopath • Massage Therapist** • Naturopath • Occupational Therapist • Osteopath	• Personal Care Worker* • Physiotherapist • Psychiatrist • Psychologist • Registered Nurse • Social Worker • Speech Therapist
Medical Transportation Services	• Ambulance Services • Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses	• Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required)	• Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	• Health and Dental Plan Premiums (private insurance)	• Home or Vehicle Modifications, when required for disabled persons	• Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	• Lip Reading	• Sign Language	
Vision Care	• Contact Lenses • Eye Examinations	• Laser Eye Surgery	• Prescription Lenses and Frames

* Prescription Required

** For therapeutic massage services only

EXPENSES NOT REIMBURSED BY THE PLAN

The following are examples of expenses which are not covered:

Common Ineligible Expenses			
Adoption Fees	• Adoption Fees		
Cosmetic Procedures (aimed at purely enhancing appearance)	• Augmentations • Botox Injections • Liposuction	• Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions)	• Laser Hair Removal • Tattoo Removal • Teeth Whitening
Cosmetics and Hygiene Products	• Contact Lens Solution • Lotions and Creams	• Make-up • Sunscreen	• Toothpaste
Dietary Supplements	• Food (except when required for enteral feeding)	• Minerals and Supplements	• Meal Replacements
Esthetic Massage Therapy	Such as:	• Aromatherapy Massage	• Body Wraps
Fees for missed appointments	• Fees for missed appointments		
Health Programs	• Weight loss program fees		
Home Appliances	• Air Conditioners • Air Purifiers	• Dehumidifiers • Fans	• Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	• Hot Tubs	• Saunas	
Life and Disability Plan Premiums	• Life and Disability Plan Premiums		
Over the counter medications	Such as: • Acid Controllers • Allergy Medications • Cough and Cold Items	• Creams and Lotions Digestive Aids • Herbal Remedies • Pain Relievers	• Smoking Cessation Products • Vitamins
Personal Response Systems	• Lifeline Services • Health Line Services		
Shoes	• Off the shelf	• Athletic	
Sports Equipment	• Treadmills		

* Prescription Required

Further to this list, please refer to About Your Health Spending Account section for Specific Benefit Exclusions or Specific Expense Exclusions (if any).

ABOUT YOUR HEALTH SPENDING ACCOUNT (NO CARRY FORWARD)

This plan does not allow unused credits to be carried forward into the next policy year.

Credits may be used to reimburse eligible medical expenses incurred in the same policy year in which the credits were allocated. At the end of a policy year, any unused credits are forfeited.

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

WHEN AND HOW TO MAKE A CLAIM

You must first submit expenses through any other benefits plan (government sponsored or private). You can submit any remaining expenses through your HSA account.

Available credits will be used to pay an HSA claim, as directed by you.

ADDITIONAL BENEFIT INFORMATION

DEFINITIONS

ACTIVELY AT WORK – Shall mean that a member is working for a contributing employer or available for work as determined by his name appearing on the out-of-work list of the Union.

EARNINGS – The amount of money, based on the number of hours in the regular work week, as per the Collective Agreement, multiplied by the hourly wage rate for each particular member in the wage rate classification to which he belongs.

LEAVE OF ABSENCE – Shall mean a period of time away from work mutually agreed to by the member and the member's employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by the member and the member's employer or as required by Provincial or Federal law.

CO-ORDINATION OF BENEFITS

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

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

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

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

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

CONVERSION PRIVILEGE

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

ALTERNATIVE BENEFIT

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

SUBROGATION

Medavie Blue Cross and Blue Cross life retain the right to subrogate on all applicable lines of benefit.

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

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

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

ON THE PLAN MEMBER WEBSITE

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

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

Member Information

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

Member Statements

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

Submit Claims electronically

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

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

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

PLEASE NOTE

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

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

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, 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, 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.

BENEFITS ADMINISTERED OR UNDERWRITTEN BY OTHERS

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Underwritten by:

AIG INSURANCE COMPANY OF CANADA.

Policy Number: BSC 9425194

November 2019

A PROGRAM OF

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

FOR

THE MEMBERS

INTERNATIONAL UNION OF PAINTERS & ALLIED TRADES

ATLANTIC PROVINCES BENEFIT TRUST FUND

POLICY # BSC 9425194

INTRODUCTION

This information booklet has been prepared to give you an informal summary of the main features of your Health and Welfare Program in regards to the Accidental Death & Dismemberment Benefit.

This booklet is not an insurance policy, and it does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policy and by applicable law.

INTERNATIONAL UNION OF PAINTERS & ALLIED TRADES
ATLANTIC PROVINCES BENEFIT TRUST FUND

Basic Accidental Death & Dismemberment Insurance Plan
For: International Union of Painters & Allied Trades (IUPAT) District Council 39
Policy No: BSC 9425194

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to fulfill their financial responsibilities.
Your Employer has provided you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum amount of $ 75,000.00.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Employee" means you, if you are a group 1 active member, group 2 active member, regular self-pay member, disabled member or early retiree member of the Policyholder who is under the age of 70.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation
You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current Group Life policy. If there is no written designation then the benefit will be paid to your estate.
All other benefits will be payable to you.

Benefits and Coverages
Accidental Death, Dismemberment, Paralysis and Loss of Use
If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses
Loss of life……The Principal Sum
Loss of both hands or both feet……The Principal Sum
Loss of entire sight of both eyes……The Principal Sum
Loss of one hand and one foot……The Principal Sum
Loss of one hand and the entire sight of one eye……The Principal Sum
Loss of one foot and the entire sight of one eye……The Principal Sum
Loss of one arm or one leg……Four-fifths of the Principal Sum
Loss of one hand or one foot……Three-quarters of the Principal Sum
Loss of the entire sight of one eye……Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand……One-third of the Principal Sum
Loss of speech and hearing……The Principal Sum
Loss of speech or hearing ……Three-quarters of the Principal Sum
Loss of hearing in one ear ……Two-thirds of the Principal Sum
Loss of four fingers of one hand…… One-third of the Principal Sum
Loss of all toes of one foot……One-quarter of the Principal Sum

Loss of Use
Loss of use of both arms or both hands……The Principal Sum
Loss of use of one hand or one foot …… Three-quarters of the Principal Sum
Loss of use of one arm or one leg …… Four-fifths of the Principal Sum

Paralysis
Quadriplegia (total paralysis of both upper and lower limbs)……
Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)……
Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)……
Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit
Pays the expenses incurred for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit
Pays a one-time benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit
Pays a benefit of up to $5,000 to your Employer if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order for you to return to work full-time.

Psychological Therapy
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit
Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage
Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:
(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
(i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
(ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
(iii) riding as a passenger in an aircraft owned or leased by the Policyholder;
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Aggregate Limit per Accident
The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date
Your coverage begins on the date you satisfy the definition of "Insured Employee".

Termination Date
Coverage ends on the earliest of:
1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

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