Your Benefits

moveUP
MOVEMENT OF UNITED PROFESSIONALS

Master Construction Trade Union Benefit Plan

Active Members

PACIFIC BLUE CROSS®

Group Name and Policy Number

Master Construction Trade Union Benefit Plan

Active Members

Policy Number 1515

The Co-operators Group Number 404-001

Reissue Date: February 1, 2023

Introduction – PBC/Blue Cross Life

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

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

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and Blue Cross Life Insurance Company of Canada (Blue Cross Life) are referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/Member, as "you" or "your" in this booklet.

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

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

Blue Cross Life
Short Term Disability (STD)

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

Privacy Policy

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

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

Table of Contents

Schedule of Benefits

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

Extended Health Care		
Deductible	None	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Vision Care, Laser Eye Surgery & Eye Examinations	100%
	All Other Eligible Expenses	90%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency	100%
	Non-Emergency	Same as In-Province/ Territory
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract.	
Dependent Children	See definition of Dependent.	

Dental Care			
Deductible	No Deductible		
Reimbursement	**Plan A**	**Plan B**	**Plan C**
	Basic Services	Major Restorative Services	Ortho–dontics
	100%	80%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	Not Applicable	Not Applicable	$3,000
Financial Limit Per Member or Spouse	Not Applicable	Not Applicable	$3,000
Dependent Children	See definition of Dependent.		

Short Term Disability (STD)				
Weekly Benefit Amount	75% of the weekly basic earnings rounded to the next higher $1, if not already a multiple of $1, to a maximum of $650.			
Elimination Period	**Injury**	**Hospital**	**Sickness**	**Day Surgery**
	0 days	0 days	5 days	0 days
Maximum Benefit Period	39 weeks			
Employment Insurance (EI) Carve-Out	If you are eligible for Employment Insurance (EI) sickness benefits: 1) we will pay the weekly Benefit amount for the first 4 weeks of disability, and 2) EI will provide benefits from the 5th to 30th week of disability inclusive, and 3) we will pay benefits for an additional 9 weeks of disability. If you are not eligible for EI sickness benefits, Blue Cross Life will pay benefits for a maximum period of 39 weeks.			
Termination	Insurance terminates when employment terminates.			

Definitions

Benefit amount
means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review
means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Coverage effective date
means the date coverage becomes effective based on
1) your date of hire, and
2) the average number of hours you work each week or each year, and,
3) the waiting period selected by your employer, and
4) the Enrolment grace period.

Customary
means the usual or traditional and well-established as determined by us.

This refers to:
1) the charges for products, services or supplies, and/or
2) the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is incurred for a medical condition comparable in nature and severity to

that being treated. The term "area" means a region large enough to obtain a representative cross section of similar Providers.

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

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

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

1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

You must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

Duplicate coverage
means that you (and your Dependents) are eligible to claim certain benefits under more than 1 plan.

Eligible drug
means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

Eligible expense
means a charge for any service, supply and/or Eligible drug included in this booklet as a benefit that:
1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and
3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and
4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by us.

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

Enrolment grace period
means,
1) within 18 months for Extended Health Care benefits, or
2) within 4 months for Dental Care benefits, or
3) within 90 days for Blue Cross Life benefits

from the coverage effective date.

Fee guide
means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

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

Government plan
means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital
means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

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

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

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner
means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

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

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

Vendor
means an organization we have retained as an external Provider.

Member Information/Access to Records

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.
2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with 1 copy of:
    a) the Member's application for coverage
    b) the current Contract/Policy
    c) any written statement or other record provided to us as evidence of insurability of the Member.

6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

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

Effective Date of Coverage and Enrolment

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

You should apply for Dependent coverage (when applicable):
1) on the same date you apply for your own coverage, or
2) within the Enrolment grace period if you have a new Dependent.

Limitations:
1) If you are not actively at work on your coverage effective date, your coverage effective date will be delayed until you return to active full-time employment.
2) If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

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

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

Late Applicants

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

Beneficiary

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

Identification (ID) Cards

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

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

Claims

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.
4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/member
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your Spouse work for the same employer, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

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

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to

determine whether it is to your advantage to enrol under more than 1 plan.

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

Coordination of Benefits

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

1) The Member is always the primary claimant. The Spouse is always the secondary claimant.
2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.
4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.
2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion

b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
e) false pretences or fraudulent misrepresentation
f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

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

Termination of Coverage

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

Right of Recovery

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

Conversion to an Individual Plan

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

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

If you qualify for 1 of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

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

Call our Individual Products Department at 604 419-2000 for an application form.

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

Individual Travel Benefits

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

Member Profile

Your Pacific Blue Cross Member Profile is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in you will be able to make and track online claims, get information on benefit coverage and downloadable claim forms. To login, visit: **www.pac.bluecross.ca/member/**

Extended Health Care

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

Definitions

Compounded drug
means a drug prepared in a pharmacy following the National Association of Pharmacy Regulatory Authorities for pharmacy compounding, and meeting eligibility criteria as determined by us.

Dispensing fee
means a Pharmacy's fee for dispensing a prescription including professional and technical services as defined by the applicable provincial/territorial legislation.

Experimental
means not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate, and essential treatment of an illness or injury.

Life-sustaining non-prescription drugs
means drugs that are necessary to sustain life, do not legally require a prescription and that meet eligibility criteria as determined by our Benefit review.

Markup
means the total of all amounts added to the manufacturer's list price, meaning the published price at which the drug is available for purchase

from the manufacturer in the applicable province/territory, and including any wholesale upcharge, retail markup, and any other amounts in excess of the manufacturer's list price.

Nurse practitioner
means a person legally licensed, certified, or registered to deliver specific health care services, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Nurse practitioners. This excludes a Nurse practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Nurse practitioner based on ineligibility, or based on the Nurse practitioner's qualifications or conduct.

Pharmacist
means a person legally licensed, certified, or registered to practice pharmacy and/or dispense drugs, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Pharmacists. This excludes a Pharmacist residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Pharmacist based on ineligibility, or based on the Pharmacist's qualifications or conduct.

Preferred pharmacy
means a pharmacy that participates in our preferred Provider network. A list of current participating pharmacies is available on our website: **www.pac.bluecross.ca/member/**.

In-Province/Territory Eligible Expenses

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

1) Hospital
   The additional charge for semi-private or private room accommodation in a Hospital or the extended care unit of a Hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance
   a) charges for licensed ambulance service to and from the nearest Canadian Hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
   c) emergency transport from one Hospital to another, only when the original Hospital has inadequate facilities
   d) charges for an attendant when medically necessary.

3) Drugs
   Charges for an Eligible expense in a quantity we consider reasonable, and as approved by our Benefit review, and
   a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, legally licensed, certified, or registered to practice by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license, including:
      i) Life-sustaining non-prescription drugs
      ii) insulin preparations, diabetic test strips, lancets, needles, and syringes for diabetes management
      iii) injectable vitamin B12 for the treatment of pernicious anemia
      iv) allergy serums when administered by a Practitioner, or

b) which legally require a prescription from a Provider legally authorized to do so, including:
    i) Compounded drugs
    ii) contraceptive drugs
    iii) drugs indicated for weight loss.

The ingredient cost of multi-source brand drugs plus Markup will be reduced to the ingredient cost of the lowest cost equivalent generic plus Markup. The ingredient cost of generic drugs and single source brand drugs plus Markup are eligible.

If we receive written confirmation from the prescribing Practitioner that there is a specific adverse effect that prevents the Member from taking the generic, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

The maximum allowable Markup is 15% of the manufacturer's list price.

Specific high cost BC PharmaCare limited coverage drugs are identified by us as our Special Authority Enforcement list. We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once the BC PharmaCare decision (approved or declined) is on file with us, we will consider this drug as eligible based on:

a) if BC PharmaCare approval is confirmed, the approval period determined by BC Pharmacare, or
b) if the BC PharmaCare decision is to decline, and if the request otherwise meets our definition of an Eligible drug, the approval period as determined by us.

Dispensing fees up to the amount allowed by provincial/territorial plans are eligible.

4) Practitioners
Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Nurse practitioner.*

a) acupuncturist $1,000
b) chiropractor $1,000
c) massage Practitioner.....$1,000
d) naturopath.....$1,000
e) physiotherapist.....$1,000
f) podiatrist.....$1,000
g) psychologist, clinical counsellor and Online cognitive behavioural therapy combined.....$1,250
h) speech language pathologist $1,000
i) private duty care by a registered nurse for a person with an acute condition in the person's home.

5) Online Cognitive Behavioural Therapy
Charges for a program through an eligible Vendor to a maximum of $1,250 per calendar year combined with services of a psychologist and clinical counsellor.

"Online cognitive behavioural therapy" means an internet-based behavioural therapy program.

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

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

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

7) Medical aids and supplies provided by a medical supplier (as approved by us)
Charges for the following services and supplies:
   a) oxygen
   b) ostomy and ileostomy supplies
   c) walkers, canes and cane tips, crutches, casts, and trusses
   d) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
   e) mastectomy brassieres to a maximum of 1 brassiere per breast prosthesis to a maximum of 2 per lifetime
   f) charges for the following items to the maximum amounts indicated per calendar year:
      i) stump socks $250
      ii) surgical stocking ..... 2 pairs
   g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500
   h) orthopaedic shoes and orthotics
      i) when prescribed by a Physician, podiatrist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg

ii) when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

to a combined maximum in a calendar year of $500 for adults and $300 for a Dependent child.

i) hearing aids and repairs to a maximum of $700 in a 60 month period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

8) Standard durable medical equipment
   a) Preauthorization is required from us for expenses in excess of $5,000
   b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a Provider may be considered.
   c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
   d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
   e) Standard durable equipment includes:
      i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent
      ii) medical heart monitors and cardiac screeners
      iii) continuous glucose monitors and supplies to a maximum of $2,000 in a calendar year period
      iv) blood glucose monitors to a lifetime maximum of $250
      v) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
      vi) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)

vii) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
viii) insulin infusion pumps for diabetics – when basic methods are not feasible
ix) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
x) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

9) Vision Care, Laser Eye Surgery and Eye Examinations
Charges for the following when prescribed by a Physician or legally authorized optical Provider (as applicable):
a) purchase and/or repair of eyewear and charges for contact lens fittings, and
b) laser eye surgery, and
c) routine eye examinations
to a combined maximum of $500 in a 24 month period. Charges for non-prescription eyewear are not covered.

10) Medical Examinations
Charge of Physician or Nurse Practitioner, for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement.

Extended Health Benefit – Second Opinion™

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

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

1) AIDS
2) ALS
3) Alzheimer's disease

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

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

If you or your Dependents have been diagnosed with 1 of the conditions listed above, you can seek Second Opinion by calling 1-877-676-6439 (toll-free) between 5:00 am and 5:00 pm (Pacific time). You will be asked for your Pacific Blue Cross policy number, as shown on your ID card.

This benefit terminates:

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

Disease Support Programs

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

Services available, including but not limited to:

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

Conditions and Limitations:

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

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

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

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

Out-of-Province/Territory Emergency Eligible Expenses

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

1) Local ambulance services when immediate transportation is required to the nearest Hospital equipped to provide the treatment essential to the patient.
2) The Hospital room charge and charges for services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days.
   If reasonably possible, we should be notified within 5 days of the patient's admission to Hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the Hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.

5) Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.

We will only cover Eligible expenses obtained within 60 days of the date you or your Dependent left the country of residence. If hospitalization occurs within the 60 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 60 days after you initially leave your country of residence, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

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

Exclusions

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

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, Hospital coinsurance, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2) except as specifically included in this booklet, we pay no drug expenses for:
    a) food replacements, food supplements, and infant foods
    b) administrative charges for injectable medications or infusions
    c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital
    d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility
    e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process
    f) any expenses identified as exclusions under the Extended Health Care Benefit
3) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or Experimental purposes, public ward accommodation, rest cures, and medical laboratory tests

4) except as specifically included in this booklet: charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals, or charges for translating documents into English
5) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government plan
6) that portion of a claim normally covered by the Government plan which has been refused on the basis that the claim was not submitted within the Government plan's time limits
7) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
8) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date
9) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence
10) expenses of a Dependent hospitalized at the time of enrolment
11) services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse
12) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
13) fees for ambulance services when an ambulance is called but not used
14) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
15) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
16) any other item not specifically included as a benefit
17) legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

Claims

Electronic Claims

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

Pay Direct

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

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

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.
2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. 2 separate claim forms (1 for the primary plan and 1 for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
3) Certain medical expenses are covered under the provincial/territorial plans. If you submit your claim to us before you submit your claim to the provincial/territorial plans, we will deduct what the provincial/territorial plans, would normally pay from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer.
4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
    a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca/member
    b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
    c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.
    Example: We must receive your receipts for 2023 before June 30, 2024.
    d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

Payment of Benefits

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

Plan A – Basic Preventive & Restorative Services

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

1) Diagnostic services
   a) examinations:
      i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3 year period
      ii) recall – 2 per calendar year
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment)
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 24 month period
      iii) complete mouth series – 1 per 36 month period

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing – 2 per calendar year
   c) topical application of fluoride – 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth only

      On permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
   b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period.
   c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planing
   c) gingival curettage – 1 per sextant in a 5 year period
   d) osseous surgery – 1 per sextant in a 5 year period

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances
   b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
   c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
   d) gold foil – only when used to repair existing gold restorations.

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

Plan B – Major Restorative Services

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

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

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

1) Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures
   b) fixed bridges.

2) Restorative Services
   a) inlays or onlays involved in bridgework
   b) veneers
   c) crowns and related services.

3) Periodontal Appliances
   bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

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

Plan C – Orthodontics

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

Limitations

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

Emergency Treatment Outside Your Province/Territory of Residence

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

Exclusions

The following are not Eligible expenses under your dental plan:

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

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

Claims

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

4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of 2 ways:
   a) If you have paid your Dentist directly, we will reimburse you the Benefit amount when we receive:
      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
   b) For pay direct claims, we will pay the Benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
5) Orthodontic Claims Procedures
   a) Receipts
      Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.
   b) Claiming deadlines
      i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
      ii) Reimbursement is made if the complete and correct claims information is received within 12 months of the due date. However, no benefit is payable for claims not received within **12 months** of the due date.

c) Treatment plan
   i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
   ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
   iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
      - your initial fee/down payment
      - your monthly/quarterly fees
      - 1 time appliance fees
   iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees
   i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 12 months old will not be reimbursed.
   ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
   iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Definitions

Day surgery
means admission to a public general Hospital for a surgical procedure where the patient is released from the Hospital the same day. Note: diagnostic procedures do not qualify as a surgical procedure.

Hospitalization
means admission to a public general Hospital for at least 1 overnight stay as an in-patient.

Recurrent disability
means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

Benefit

We will pay short term disability (STD) benefits when you are disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a Physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under their regular care and

following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a Physician.

The weekly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Recurrent Disability

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Graduated Return to Work

If you return to work on a gradual rehabilitative basis you will have your benefit reduced by 50% of any income earned from the rehabilitative employment. The combined total of your benefit plus the rehabilitative income will not exceed 100% of your earnings prior to the date your disability started.

Benefits will continue for a maximum of 1 period of disability as outlined under *Recurrent Disability*, whether due to 1 or more illnesses.

In consultation with you, your employer, and with your Physician's agreement, we will determine your eligibility for this program and its duration.

Extended Benefit

If you are disabled when this insurance terminates, your STD benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

Coordination with other Income Sources

Your STD payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became disabled.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable if your employer contributes to the cost of your STD Plan. Benefits are nontaxable if you pay the entire cost.

Termination of Benefit

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer receiving continuing medical care and treatment from your Physician
2) you fail to submit satisfactory proof of continuing disability as required by us
3) you refuse a medical examination by a Physician chosen by us
4) you are no longer following the treatment recommended for your disability
5) you are not entitled to benefits payable by the Employment Insurance Sickness benefit because you are not in Canada
6) you are no longer disabled
7) you perform any work for compensation or profit
8) the end of the maximum benefit period indicated in the Schedule of Benefits

9) you retire
10) you die.

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
   a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
   b) participation in a criminal offense
   c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
   d) a pregnancy related sickness
      i) during any period of formal maternity leave and/or parental leave
      ii) during any period in which Employment Insurance (EI) benefits are being paid
   e) substance abuse, including alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician
   f) medical or surgical care which is cosmetic, unless such care is rendered as a result of injury or sickness
   g) any injury sustained directly or indirectly as a result of a motor vehicle accident
2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
   a) in a jail or penitentiary
   b) on leave of absence or paid vacation
   c) receiving benefits for the same or related disability from WCB or similar legislation

4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Claims

1) Obtain a claim form from your Plan Administrator, as soon as possible after you become disabled.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail.
6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.

Incomplete claim forms will cause a delay in the payment of your benefits.

Introduction – The Co-operators

Coverage is provided through **Co-operators Life Insurance Company (The Co-operators)** for the following benefits:
Basic Life Insurance
Accidental Death, Disease and Dismemberment Benefits
Long Term Disability

Pacific Blue Cross has included the following documentation in this booklet based on information we have received from The Co-operators and as such, accepts no liability for errors or omissions that may have occurred.

WELCOME TO YOUR GROUP INSURANCE PLAN

We are pleased to provide you with a comprehensive package of group insurance benefits provided by your employer through Co-operators Life Insurance Company. Your group benefit plan provides valuable security in the event of sickness or death. This booklet outlines your benefit plan as of the date shown on the cover.

This booklet outlines the general coverage information for your group benefit plan. We encourage you to read and understand the benefits that your employer is providing for you and save this booklet in a safe place. If you have any questions, please contact your employer or the person who administers your group benefit plan.

Your employer and/or plan administrator is responsible for making sure that all members are covered for the benefits they are entitled to by submitting all required premiums, reporting all new enrolments, terminations, any salary or benefit changes and by keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer/plan administrator with the necessary information to perform such duties.

This booklet is meant to provide general information about your group benefit plan. It is not a legal contract. The master Policy G. 404-001 issued by Co-operators Life Insurance Company to THE TRUSTEES OF THE MASTER CONSTRUCTION TRADE UNION BENEFIT determines the benefits, amounts and effective dates that apply to you and shall be the final basis for the settlement of all claims. Where there is a discrepancy or conflict between the description in this booklet and the Policy, the terms and conditions of the Policy prevail.

Your employer reserves the right to amend, modify, qualify, reduce, suspend or terminate any of the benefits provided under the master group policy and/or plan covering members and if applicable former members, including retirees, at any time, including after a member's retirement

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Schedule of Benefits

This Schedule of Benefits must be read together with the benefits described in this booklet.

BASIC LIFE INSURANCE

Benefit Formula:	Flat $75,000 per Member.
Amount of Insurance:	The amount calculated using the benefit formula. The maximum amount of insurance is: Non-Evidence Maximum: $75,000 Health Evidence Maximum: $75,000 At age 65, the Amount of Insurance shall be reduced by 50%.
Termination age:	Member's 70th birthday
Life waiver of premium waiting period:	Is after 9 months of Total Disability The definition of Total Disability for the Basic Life Waiver matches the definition of Total Disability for Long Term Disability Benefit as defined in the Policy. Waiver of premium terminates at age 65.

ACCIDENTAL DEATH, DISEASE AND DISMEMBERMENT BENEFITS

Amount of Insurance:	An amount equal to the Member's Basic Life Insurance amount.
Critical Disease Benefit:	10% of the Amount of Insurance to a maximum amount of $50,000. Terminates at age 65.
Termination age:	Member's 70th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

DEPENDENT LIFE INSURANCE

Amount of Insurance:	$10,000 Spouse amount $5,000 Child amount (from Birth)
Pre-Natal (Stillbirth) benefit:	Indemnity Benefit not to exceed the child amount
Termination age:	Employee's 70th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

LONG TERM DISABILITY BENEFITS

Benefit Formula:	75% of monthly Salary, rounded to the next highest $1 if not already a multiple thereof.
Monthly Benefit:	The amount calculated using the benefit formula. The maximum Monthly Benefit is the lesser of $2,200 or the amount calculated using the formula for the All Source Maximum. Non-Evidence Maximum: $2,200 Health Evidence Maximum: $2,200
All Source Maximum:	85% of pre-disability gross Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	for Injury 273 consecutive Days for Sickness 273 consecutive Days
Own Occupation Period:	24 months from the Disability Date, thereafter must be Totally Disabled from any and all occupations
Maximum Benefit Duration:	to age 65
Recurrent Total Disability:	6 months
Tax Status:	Taxable
CPP/QPP Offset:	Indirect offset only
Termination age:	Member's 65th birthday

Waiver of premium waiting period:	is equal to the Long Term Disability Elimination Period. Waiver of premium terminates at age 65.

GENERAL INFORMATION

To be eligible to participate in this plan you must be:

- actively working on a regular permanent basis, for the minimum number of hours per week as indicated in the schedule of benefits,
- insured under a government health insurance plan and reside in Canada,
- under age 65, and
- have met the eligibility requirements as defined by the Master Construction Trade Union Benefit Plan.

We consider you to be actively working if you are:

- actually working at your employer's place of business or a place where your employer requires you to work in Canada,
- able to perform and actually performing all the usual and customary duties of your occupation on a full pay status and on a regular and continuous basis for the number of hours regularly scheduled for that day, or
- absent due to scheduled vacation, weekends, statutory holidays or shift variances.

Eligible Dependents

Your dependent spouse and children will be eligible to participate in this plan on the date you are eligible or if later, the date he/she becomes an eligible dependent. To be eligible for insurance, each of your dependents must be insured under a provincial government health insurance plan and reside in Canada.

- Your spouse is your legal spouse or a person continuously living with you in a role like that of a marriage partner for at least 12 months. The 12 month requirement can be waived if you and your spouse have had or adopted a child together.

- Note that you can only insure one person as your spouse for all benefits at any given time.

- Your dependent children are your or your spouse's unmarried natural, adopted, or step children, or any other unmarried children for whom you or your spouse have been appointed legal guardian.

- Your dependent child is eligible for coverage if he/she:
  - is under age 21 and not working more than 30 hours a week, unless a full-time student,
  - is under age 25 and registered as a student at a college, university, trade school or similar educational facility and attending on a full-time basis, or
  - is permanently incapacitated either prior to age 21 or while an eligible student (must be suffering from a permanent mental or physical infirmity and incapable of supporting himself/herself financially due to a medically diagnosed physical or psychiatric condition).

  ⇨ If your child is suffering from a medically diagnosed permanent mental or physical infirmity, or is a student, in order for coverage to continue beyond the maximum dependent age you must submit a written application within 31 days of your child reaching age 21 and supply proof of infirmity, or status as a student.
- Your spouse's child is an eligible dependent if the child is also your natural or adopted child and your spouse is residing with you, insured under your plan and has custody of the child.
- A child for whom you or your spouse has been appointed guardian is not an eligible dependent unless we have received satisfactory proof of guardianship. If your insured spouse is the guardian, your spouse must be residing with you.
- A child is not considered a full-time student if the child is being paid while attending a training or re-training program at an educational institution, excluding scholarships. If you have dependent children who are students over age 21, you must submit proof of student status annually by completing the student declaration form.

How do I apply for coverage?

Your employer/plan administrator can provide you with the group enrolment form and/or other forms necessary to apply for or change your group insurance coverage. You must enroll within 31 days of becoming eligible to join the plan. If you enrol after 31 days, your application will be considered late and you and your dependents will be required to provide health evidence of insurability.

Health Evidence of Insurability

When you submit your enrolment form, you may be asked to provide evidence of good health before coverage begins if:

- you or your dependents are a late applicant (you applied more than 31 days after becoming eligible),
- you apply for an amount of insurance that is more than the amount available without evidence of insurability,
- you apply for coverage you previously declined.

When does my coverage begin?

Your coverage takes effect on the later of the following dates, provided you are actively at work on that date:

- the date you satisfy the eligibility requirements provided you enrol within 31 days of becoming eligible
- if health evidence is required, the date we approve your application.

If you were not actively at work on the date your insurance would normally become effective or increase, then that insurance will not take effect until the first full day you are again actively at work.

When does coverage for my dependents begin?

Your dependent coverage takes effect the later of:

- the date your coverage begins
- the date your dependent becomes eligible for coverage
- if health evidence is required, the date we approve the application.

Updating your records:

To ensure that coverage is kept-up-to-date, it is important that you report changes to your employer/plan administrator as soon as possible:

- change of dependents
- loss of spousal benefits
- change of name or address
- change of beneficiary

Designating your beneficiary:

Your designated beneficiary receives any benefits payable under the basic life benefit and if applicable, optional life and AD&D plans in the event of your death. As such, it's very important that you name a beneficiary when you enrol.

You have the right to name a beneficiary at the time you apply for insurance and you can change your beneficiary at any time, where permitted by law, by completing a form available from your employer/plan administrator. If your beneficiary dies before you do or if you do not name a beneficiary, payment will be made to your estate. If your beneficiary is a minor, payment will be made to the trustee (if you named one) or a public trustee (if you have not appointed a trustee for minor beneficiaries). A beneficiary named under the basic life benefit is, unless stipulated to the contrary, the beneficiary for all benefits under your plan. You should review any beneficiary designations under this plan from time to time to ensure that they reflect your current intentions.

When do changes in the amount of my insurance take effect?

Increase in insurance:

If the change would result in an increase, the increase will be effective on the later of:

- the date of the change,
- the first full day you return to work for full pay if you were not actively at work on the date of the change, and
- if health evidence is required, the date we approve your application.

Decrease in insurance:

Decreases will be effective on the date of the change.

What is meant by salary?

Your salary is your regular annual earnings (before deductions) paid to you by your employer not including commissions, bonuses, dividends, overtime pay, expense allowances and any other extra compensation. Your net salary is your gross earnings less deductions (taxes, EI and Canada or Quebec pension plan).

What happens if my salary is understated or overstated?

To determine the amount of your benefit at the time of claim, your salary will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer/plan administrator to Co-operators Life and for which premiums have been paid.

When does coverage end?

Your coverage terminates the earliest of:

- the date your employment terminates.
- the date you are no longer actively at work (except for maternity/parental leave where legislated).
- the date you are no longer actively at work, except for leave of absence or lay-off, where coverage may be extended provided that you continue to meet to hour bank requirements as defined in the Master Construction Trade Union Benefit Plan. The extension must be requested by your employer on a basis that does not discriminate against another member and premiums must be paid.
- the date you are no longer actively at work, except for retirement, where Life Insurance may be extended provided that you continue to meet to hour bank requirements as defined in the Master Construction Trade Union Benefit Plan but not beyond 8 months from the date you ceased to be actively at work for retirement. The extension must be requested by your employer on a basis that does not discriminate against another member and premiums must be paid.
- the end of a period for which premiums have been paid for your insurance.
- the date you cease to be in a class of members eligible for insurance.

- the date you reach the termination age specified in the schedule of benefits under each benefit.
- the date your employer's group policy or plan terminates.
- ***Your dependents' coverage terminates the earliest of:***
- the date your coverage terminates
- the date your dependent is no longer an eligible dependent
- the end of a period for which premiums have been paid for dependent coverage

The Claims Process

Where do I find a claim form?

Claim forms are available from your employer, plan administrator or from our website at www.cooperators.ca/group

Our team in the Group Client Service Centre would also be happy to assist you via telephone, email, or you can ask a question through Benefits Now® for Plan Members, our secure plan member website.

Visit www.cooperators.ca/group>Plan Members and select Benefits Now® for Plan Members to find details regarding your benefit plan. Once logged in, you can submit or check the status of a health or dental claim, sign up for direct deposit of claim funds to your bank account, print claim forms and find cost control tips, links to health and wellness sites and much more.

To avoid delays, complete the claim form in its entirety, and always include:

- your full name as it appears on your pay stub
- your personal identification number (i.e. certificate number)
- your employer's name, and
- your group policy number

Be sure to also include all supporting receipts and the explanation of benefits from another benefit plan. Remember to date and sign the claim form and keep a photocopy of your claim form and all supporting documents for your records.

How long will it take to process my claim?

This will depend on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form or access Benefits Now® for Plan Members for electronic claims submission.

Health and dental e-claim submission offers a number of benefits over paper claim submission.

Faster– mailing time is eliminated
Convenient – access e-claim submission exclusively though Benefits Now® for Plan Members
Sustainable– no need to complete a paper claim form
Reliable – you'll receive a message with your e-claim number to confirm receipt of your submission

As part of e-claims submission, you'll be asked to provide your banking information for direct deposit of claims payment and your email address for electronic notification (including claims confirmation). Because we will receive your claims faster and deposit your claims payments directly in your bank account, you'll receive your claims payment faster than with paper submission.

Proof of Claim

You are required to prove your entitlement to benefits under your plan and to provide notice of claim in accordance with the master policy provisions. You must provide information required to prove your entitlement to benefits and must also authorize us to obtain information from other sources for this purpose (if required). From time to time, we will ask you to provide us with proof of your total disability. Whenever we request information or authorization, it must be submitted within the time limit requested. If not submitted within this time, you will not be entitled to benefits. Expenses incurred for providing this information will be your responsibility.

When should I submit my claim form?

To permit prompt assessment, initial notice of claim should be submitted no later than the time limits described in each benefit section.

Limitation of Action

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or any other applicable legislation.

Where or when applicable legislation permits the use of a different limitation period, no action or proceeding at law or in equity shall be brought against Co-operators Life for payment of benefits under the policy or for any other related damages:

- prior to the expiration of 60 days after the claim form has been filed in accordance with the requirements of the master Policy; or
- unless brought:
  - where no benefits have been paid, within one year from the expiration of the time within which the claim form is first required by the Policy or from the date on which Co-operators Life first denies the claim for benefits, whichever first occurs; or
  - where benefits have been paid under the provision of the Policy, within 1 year of the date on which Co-operators Life terminates the payment of benefits.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).

Accessing your records

As required by legislation, for insured benefits, you have the right, to request a copy of your enrollment form or application for insurance and any written statements or other record not otherwise part of the application that you provided to Co-operators Life as evidence of insurability. For insured benefits, on reasonable notice, you may also request a copy of the master policy subject to certain limitations. The first copy will be provided at no cost to you but a fee will be charged for subsequent copies. All requests for copies of documents should be directed to our Group Client Service Centre.

Claim forms can be mailed to:
Group Claims Department
The Co-operators
1900 Albert Street
REGINA, Saskatchewan
S4P 4K8

Third Party Liability

If you and/or your insured dependent become totally disabled due to an injury or sickness or become eligible for reimbursement of insured medical or dental expenses as a result of an injury or sickness for which a third party is, or may legally become liable, you or your dependent must sign a reimbursement agreement and submit it to Co-operators Life before any benefits will be paid. The reimbursement agreement outlines the terms for reimbursing Co-operators Life when you settle the claim with the third party. To continue to qualify for any future benefits, it is important that you and/or your dependent obtain written consent from Co-operators Life before settling any claim with the third party.

Basic Life Insurance Benefit

What am I insured for?
If you die while insured, we will pay the amount of basic life insurance for which you are insured, as described in the schedule of benefits, to your named beneficiary.

If you qualify for an amount of insurance in excess of the non-evidence maximum (NEM) shown in the schedule of benefits, your basic group life insurance may be increased to an amount not exceeding the health evidence maximum (HEM) shown in the schedule of benefits, provided we approve your health evidence application.

What if I become terminally ill?
The living assistance benefit is available to you as an advance payment of your basic life insurance to help meet your medical or other health and welfare expenses if you become terminally ill and have been approved for the total disability life waiver of premium prior to age 65.

Your employer must approve your application for this benefit and Co-operators Life will confirm that your medically diagnosed condition meets the program's requirements before approving payment. The amount of money available as a living benefit payment is 50% of your basic life insurance benefit, to a maximum of $50,000.

When to submit a life claim
Your beneficiary or estate must submit a claim within 6 months of the date of death.

If you become totally disabled (as defined in the policy) prior to age 65, you can apply for a premium waiver and if approved your life insurance coverage will continue without payment of premium until the earlier of; your 65th birthday or your recovery, retirement or death.

Proof of your total disability must be submitted to us within 6 months from the date you became disabled and periodically thereafter.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after the date of loss or disability.

Life Insurance Conversion Privilege

If your insurance terminates on or before your 65th birthday, you may be able to convert your group life insurance to an individual policy, without needing to provide evidence of good health. Your application for the individual policy and the first premium must be received by Co-operators Life within 31 days of the termination of your group life insurance. If your insurance terminates on your 65th birthday, your application must be received by Co-operators Life within 31 days of your 65th birthday. If you die during this period, the amount of group life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege is not available after your 65th birthday.

Not all types of individual plans are available for conversion and the individual plan will not include any disability, accidental death benefits or any other special benefit. The maximum amount of group life insurance that can be converted cannot exceed the full amount of your basic life insurance benefit amounts less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed $200,000.

Depending on your plan specifics you may also be able to convert your spouse's optional life coverage to an individual policy. When you are entitled to convert coverage under another benefit provided under your plan, the sum of the amounts available for conversion cannot exceed $200,000. The individual life insurance contract becomes effective at the end of the 31 day conversion period.

If you are interested in applying for conversion, please contact a Co-operators office near you for an application form.

Accidental Death, Disease and Dismemberment Benefit

Covered Loss means a critical disease, accidental death, accidental dismemberment or disease dismemberment covered under this benefit. The covered loss must occur prior to your 65th birthday for critical disease or the termination age indicated in the schedule of benefits for other covered losses, and while you are insured for this benefit. In the case of a covered loss which qualifies under the accidental death, accidental dismemberment and/or disease dismemberment benefit, the loss must occur within 365 days of your covered loss. The amount of insurance is indicated in the schedule of benefits.

Critical Disease Benefit

We will pay you an amount equal to 10% of the amount of insurance (maximum $50,000) if you:

- have been medically diagnosed with one of the covered critical diseases **after the effective date of your coverage under this benefit** and prior to age 65, and
- you have been totally disabled (from any and all occupations as defined in the policy) from that critical disease for at least 9 months.

Benefits are limited to the first covered critical disease in your lifetime. Covered critical diseases are: Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type I Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Accidental Death Benefit

If your death occurs as a direct result of accidental bodily Injuries occasioned solely through external, violent and accidental means without gross negligence on your part, we will pay your beneficiary an amount equal to 100% of the amount of insurance.

Accidental/Disease Dismemberment Benefit Schedule

If you sustain one of the following losses, resulting directly and independently of all other causes from a covered loss occasioned solely through external, violent and accidental means, without gross negligence on your part, we will pay:

AD&D Schedule of losses:

200% of the amount of insurance for:

- paraplegia (total paralysis of both lower limbs), or
- hemiplegia (total paralysis of one side of the body), or
- quadriplegia (total paralysis of all four limbs), or
- loss of use of both arms, or
- loss of use of both legs, or
- loss of use of one arm and one leg on the same side of the body.

100% of the amount of insurance for:

- loss of both hands or both feet, or
- loss of both arms or both legs, or
- loss of sight of both eyes, or
- loss of one hand and one foot, or
- loss of use of both hands, or
- loss of use of both feet, or
- loss of speech and hearing in both ears, or
- loss of use of one hand or arm and one leg, or
- loss of sight of one eye and one hand or one foot.

75% of the amount of insurance for:

- loss of one arm, or
- loss of use of one arm, or
- loss of one leg, or
- loss of use of one leg.

66 2/3% of the amount of insurance for:

- loss of one hand, or
- loss of one foot, or
- loss of speech, or
- loss of hearing in both ears, or
- loss of sight of one eye, or
- loss of use of one hand, or
- loss of use of one foot.

33 1/3% of the amount of insurance for:

- loss of the thumb and index finger of the same hand, or
- loss of four fingers of one hand, or
- loss of hearing in one ear.
-

We will pay 25% of the amount of insurance if you lose all toes on one foot.

Rehabilitation Benefit

If within 2 years from the date of the covered loss, you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such covered loss. We will pay the reasonable and customary expenses incurred while you are participating in a formal occupational training program approved by us. Payment for the total of all expenses incurred will not exceed $10,000 as the result of any one covered loss. No benefits will be payable for charges for room and board, ordinary living, travelling or clothing expenses.

Family Transportation Benefit

If you sustain a covered loss and are confined as an inpatient in an approved hospital located at least 150 kilometres from your residence and you are receiving reasonable and customary treatment from a physician or surgeon, we will pay the reasonable and customary expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the approved hospital and return transportation by the most direct route to and from the hospital.

The amount payable under this benefit will not exceed the aggregate amount of $3,000 for all accommodation and transportation expenses.

If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to $0.20 per kilometre travelled.

Home Alteration and Vehicle Modification Benefit

If you sustain a covered loss and subsequently require the use of a wheelchair to be ambulatory, we will pay the reasonable and customary expenses incurred for the purpose of making your home and vehicle wheelchair accessible. Benefits are payable for the cost of alterations to your principal residence and the cost of modifications to 1 motor vehicle utilized by you, when such modifications are approved by licensing authorities where required. The expenses must be incurred within 2 years from the date of your covered loss and are limited to a lifetime maximum of $10,000.

Continuation of Education Benefit

If you die as a direct result of a covered loss, we will pay your beneficiary the education benefit stated below for each of your dependent children who are, at the time of your death enrolled as full-time students:

- in an institution for higher learning above the secondary school level as defined in the province or territory of residence, or
- at the secondary school level but who will enrol as a full-time student in an institution for higher learning within 365 days after your death.

The education benefit is equal to the reasonable and customary expenses actually incurred for tuition and books, subject to the lesser of a maximum of 5% of the amount of insurance or $5,000, for each year the dependent child continues the education, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

This benefit will be paid each year on receipt of satisfactory proof that the dependent child is enrolled as a full-time student in an institution for higher learning. Payment will not be made for expenses incurred prior to your death or for room, board or other ordinary living, travelling or clothing expenses. If none of your dependent children satisfy the above requirements, we will pay $2,500 to your beneficiary.

Spousal Occupational Training Benefit

If your death occurs as a direct result of a covered loss, we will pay the reasonable and customary expenses actually incurred for tuition and books for your insured spouse to participate in a formal occupational training program to become qualified for active employment in an occupation for which your spouse would not otherwise be qualified. Expenses must be incurred within 2 years from the date of your death and are subject to a maximum lifetime payment of $10,000.

Repatriation Benefit

If you die, from any cause outside of Canada, or if in Canada, you die at least 150 kilometres from your normal place of residence, we will pay your beneficiary the reasonable and customary expenses incurred for the preparation of the body and its transportation to the funeral home or the place of interment in proximity to your normal place of residence in Canada. Benefits will not exceed $10,000 for all eligible expenses.

Seat Belt Benefit

If you die or become injured as a direct result of an accident, which results in a benefit payable under the schedule of losses, while driving or riding in a vehicle and wearing a properly fastened seat belt, the benefit payable under the schedule of losses will be increased by 10%.

At the time of the accident, the driver of the vehicle, must hold a valid driver's license and must not have been under the influence of drugs, or have been driving the vehicle with a blood alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred millilitres of blood or have had his or her ability to operate the vehicle impaired by drugs or alcohol or a combination of the two.

The person claiming the benefit must establish that you were wearing a seat belt at the time of the accident

Maximum Benefit

In no case will an amount greater than the amount of insurance indicated in the schedule of benefits be paid for all losses identified in the schedule of losses sustained by you resulting directly or indirectly from the same accident with the exception of: paraplegia, hemiplegia, quadriplegia, loss of use of both arms, loss of use of both legs, or loss

of use of one arm and one leg on the same side of the body, where the benefit payable is 200%.

Exposure

If you are exposed to the elements following the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, such exposure will be deemed a covered loss by accidental means.

Disappearance

If your body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, then it will be deemed that you have suffered loss of life within the meaning of this coverage.

Total Disability Waiver of Premium

If premiums for your basic life insurance coverage are being waived, then premiums for the accidental death, disease and dismemberment benefit will also be waived, but only so long as this benefit and your employer's coverage under this benefit, remains in force.

ADD&D Definitions

- loss of a hand will mean complete severance at or above the wrist.
- loss of an arm will mean complete severance through or above the elbow joint.
- loss of a leg will mean complete severance through or above the knee joint.
- loss of a foot will mean complete severance at or above the ankle.
- loss of a thumb will mean complete loss of one entire phalanx of the thumb.
- loss of a finger will mean the complete loss of two entire phalanges of the finger.
- loss of a toe will mean the complete severance at or above the knuckle joining the toe to the foot.
- loss of sight, loss of hearing or loss of speech will mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or

rehabilitative program, it will be deemed that there was no loss for the purposes of this provision.

- loss of use must be caused by tendon, nerve or bone damage as a result of a covered loss. Such loss of use must be total and irrecoverable and must be continuous for a period of 12 months. No benefits will be payable for loss of use if benefits for loss by dismemberment are paid or payable as a result of the same covered loss.
- Paralysis will mean complete and irreversible paralysis caused by spine or brain damage as a result of a covered loss which has continued for a period of 12 months from the date of the covered loss.
- Institution for higher learning for the education benefit includes any university, college or trade school.
- Immediate family, for the Family Transportation benefit, means a person who is your spouse, child, father, mother, brother or sister. Other relatives may be considered in the event that no immediate family is living.

Accidental Death, Disease and Dismemberment Exclusions

No benefits will be paid if the covered loss is caused by or results directly or indirectly from one or more of the following:

- suicide or attempted suicide or self-inflicted injury, regardless of mental state, or
- committing, attempting or provoking an assault or criminal offense, or
- a situation where the covered loss results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving the vehicle involved in the accident and had either:
  - ⇨ alcohol in your blood in excess of 80 milligrams of alcohol per hundred millilitres of blood, or
  - ⇨ your ability to operate the vehicle was impaired by drugs or alcohol or a combination of the two, or
- disease or bodily or mental infirmity, or medical or surgical treatment of any kind, except surgical reattachment, or
- death where there is no visible contusion on the exterior of the body (except death by drowning), or

- any drug, poison, gas or fumes, voluntarily or otherwise taken administered, absorbed or inhaled, other than as a result of an occupational accident, or
- insurrection or war (whether war be declared or not) or participation in any riot, or active service in the armed forces of any country, or
- travel or flight in any aircraft, or descent from such aircraft, if you are a pilot or a member of the crew of the aircraft, or if such flight is made for the purpose of instruction, training or testing.

When to submit an ADD&D claim

Accidental Death Claim
If the claim is the result of an accidental death, the claim must be submitted to us within 6 months from the date of death.

Critical Disease or Accidental/Disease Dismemberment Claims
If the claim is for a Critical Disease or Accidental/Disease Dismemberment benefit, the claim form must be submitted to us within 9 months from the date of total disability or 12 months from the date of the accidental/disease dismemberment.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after first becoming eligible for accidental death benefits or Critical Disease benefits or 18 months for accidental/disease dismemberment benefits.

Dependent Life Insurance

What am I insured for?

If an eligible dependent should die while you are insured under this benefit, the amount of dependent life insurance shown in the schedule of benefits will be paid to you.

Pre-Natal Benefit

Upon receipt by Co-operators Life of satisfactory proof that you or your spouse while covered under this benefit have a stillbirth, we will reimburse you for funeral expenses to a maximum not exceeding the dependent life insurance amount shown in the schedule of benefits for a dependent child.

Stillbirth means the complete expulsion or extraction from the mother of a fetus weighing 500 grams or more; or with a body length of 25 centimetres or more; or gestational age of 20 weeks or more which, after complete separation from the mother, does not breathe or show any sign of life at or after birth.

Total Disability Waiver of Premium

If premiums for your basic life insurance coverage are being waived, premiums for the dependent life benefit will also be waived, but only so long as this benefit and your employer's coverage under this benefit remains in force.

When to submit a Dependent Life claim

The claim form must be submitted to us within 6 months from the date of death.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish

the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after the date of death.

Long Term Disability Benefits

What am I insured for?
To qualify for benefits, your claim must provide satisfactory proof that, while insured under this plan, you became totally disabled (as that term is defined in the policy) and therefore unable to work.

The purpose of this benefit is to insure for wage loss should you become totally disabled as a result of a medically diagnosed sickness or injury and unable to work. Therefore, if there is no lost income, benefits are not payable.

The monthly benefit for which you are covered is based on your monthly salary and the benefit formula indicated in the schedule of benefits. The amount payable is the monthly benefit amount less the reductions listed under the benefit reduction section in this booklet.

Excess Long Term Disability Insurance:
If your salary qualifies you for an amount of insurance in excess of the non-evidence maximum (NEM) shown in the schedule of benefits, your long term disability insurance may be increased to an amount not exceeding the health evidence maximum (HEM) shown in the schedule of benefits, provided evidence of good health is approved in writing by Co-operators Life.

What conditions do I need to satisfy before and during payment of benefits?
Independent Medical Assessment
It is a condition prior to the initial payment of benefits and any continuing payment of benefits that you will, if we require, undergo medical assessment(s), by one or more medical practitioners chosen by us.

Continuous Obligation

Your obligation to undergo medical assessment exists during any period for which you claim benefits.

Participation in Rehabilitation Program

It is a condition prior to and while you are receiving benefits, that you will, where requested by Co-operators Life, participate in a rehabilitation program considered appropriate by Co-operators Life, including but not limited to an approved rehabilitation program offered through worker's compensation legislation or similar statute.

Payment of Monthly Benefits

During the own occupation period

Where Co-operators Life receives satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a general physician or specialist where considered appropriate by Co-operators Life, and
- have satisfied all of the other relevant conditions contained in the policy,

Co-operators Life will, subject to the provisions of the policy, pay to you a monthly benefit effective the day following the completion of the elimination period and payable for the maximum duration of your own occupation period as indicated in the schedule of benefits.

After the own occupation period

Not applicable to Long Term Disability plans that only have 24 month benefit duration.

Where we receive satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a physician or where we consider appropriate, a specialist, and

- have satisfied all of the other relevant conditions contained in the policy,

We will, subject to the provisions of the policy, continue to pay you're a monthly benefit.

When will benefits begin?
Your benefits will begin the day following the end of the elimination period indicated in the schedule of benefits or the day following the end of the period during which you are receiving short term disability benefits under this plan or salary continuation benefits from any other source, whichever is later.

The elimination period refers to the time frame of total disability that must be satisfied before you qualify to make a claim for benefits. Benefits are not payable and premiums are not waived during this period.

What if I work during the Elimination Period? (if your elimination period is less than 180 days)
If you return to active work for 7 consecutive days or less, your elimination period will be considered to be uninterrupted, but the days you worked will be added to the end of your elimination period. If you return to active work for more than 7 days, your elimination period will be reinstated and you will be required to satisfy the complete elimination period before benefits are eligible to be paid.

What if I work during the Elimination Period? (if your elimination period is 180 days or more)
If you return to work for a period of 14 consecutive days or less, your elimination period will be considered to be uninterrupted, but the days you worked will be added to the end of your elimination period. If you return to work for more than 14 days, your elimination period will be reinstated and you will be required to satisfy the complete elimination period before benefits are eligible to be paid.

Recurrence of Total Disability

Your total disability is considered a recurrence if it arises from the same or related sickness or injury within 6 months from the date your benefits ended.

Benefits are pro-rated for partial months

Monthly benefits payable for periods less than a full month will be pro-rated based on the actual number of days in the applicable month.

Are my benefits taxable?

Your benefit payments are taxable if your employer pays any portion of the premium. According to information provided by your employer and our current records the tax status is stated in the schedule of benefits.

Rehabilitation Program

A Rehabilitation Program is provided at our discretion and may include rehabilitation assessment, and/or rehabilitative employment, and/or rehabilitative treatment, and/or rehabilitation services recommended and approved by us.

Approval of Rehabilitation Program

Co-operators Life will have sole discretion in determining whether or not a rehabilitation program is appropriate and/or provided for any member. Once the rehabilitation program is approved, Co-operators Life may issue, if eligible, monthly benefits to a totally disabled member who continues to participate and co-operate in an approved rehabilitation program.

The rehabilitation program duration will be determined by us, however it will not extend beyond the end of the own occupation period indicated in the schedule of benefits or 24 months from the date of your disability, whichever is later, unless an extension of the duration is recommended and approved in writing by Co-operators Life.

Calculation of Monthly Benefits during a rehabilitation employment period

If you participate in rehabilitative employment approved by us, your benefit will be reduced by 50% of your rehabilitative earnings. The monthly benefit payable during rehabilitative employment will be

calculated after 4 weeks of earnings have been reported to us, payable monthly and adjusted periodically.

Your benefit may be further reduced by any amount necessary to reduce the total income you receive from all sources to 100% of the monthly salary for which you were insured immediately prior to the start of your disability. If your benefit is non-taxable, your total income from all sources will be limited to 100% of the salary for which you were insured immediately prior to the start of your disability less your deductions for income tax, EI and CPP/QPP.

Your monthly benefits will cease on the earliest of:

- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by us including but not limited to any rehabilitation program offered through any worker's compensation legislation or similar statute, auto plan benefits or Canada Pension Plan, or
- the withdrawal of our approval of your rehabilitation program.

Benefit Reductions:
What reductions occur when determining my Monthly Indemnity Benefit payment?

All Source Maximum - Ceiling on the Monthly Benefit
For non-taxable long term disability plans, the amount of your non-taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your pre-disability net monthly salary.

Your net salary is your gross salary minus involuntary deductions for federal and provincial income tax, employment insurance premiums (EI) and Canada/Quebec Pension Plan contributions.

For taxable long term disability plans, the amount of your taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your pre-disability gross monthly salary.

All Source Compensation - Direct Reductions

Your monthly benefit will be reduced directly by one or more of the following, which you are receiving or entitled to receive at the time your benefits commence and/or while benefits, are paid:

- any government plan benefits,
- any auto plan benefits,
- any Canada or Quebec Pension Plan retirement benefits you apply for, were approved for and received after your disability date,
- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.

All Source Compensation - Indirect Reductions

Your benefit will be further reduced if the total of the following all source compensation and your monthly benefit exceeds 85% of your pre-disability gross monthly salary for taxable plans, your net monthly salary for non-taxable plans. If it does, your monthly benefit will be reduced by the amount in excess of 85% by:

- CPP/QPP benefits, and
- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply or Accept Other Benefits

Except for retirement benefits, any benefit is considered paid when you are entitled to it, whether or not it has been awarded or received. If it has not been awarded or received, Co-operators Life will have the right to estimate the income according to the terms of any plans or legislation involved. Retirement benefits are considered payable when they are actually received.

Where you do not qualify for part or all of the all source compensation because of failure to apply in a timely and satisfactory manner (or appeal where so advised by Co-operators Life), we reserve the right to reduce your monthly benefit by the amount of all source compensation which you would have been eligible for or received had a proper application or appeal been made.

Lump sum conversion to Monthly Benefit

Where you receive or have the option of receiving part or all of the all source compensation as a lump sum payment, we will, acting reasonably, pro-rate the lump sum payment and reduce your monthly benefit as if the lump sum had been paid on a monthly basis.

Repayment of Benefits

Where you receive all source compensation that includes compensation for a period for which monthly benefits have been paid, we will convert the payment to a monthly payment and recalculate your monthly benefit that should have been paid. You are responsible to repay Co-operators Life any overpayment of long term disability benefits.

Total Disability Waiver of Premium

We will waive your long term disability premiums while you are receiving benefits.

When do my Long Term Disability Benefits terminate?

No monthly benefits will be paid beyond:

- the date you cease to be totally disabled, or
- the benefit duration indicated in the schedule of benefits or your 65th birthday, whichever first occurs, or
- the date you begin working in any occupation, except as provided for under the rehabilitation program, or
- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through workers compensation legislation or similar statute, or
- the date you refuse to participate or co-operate in a reasonable and customary treatment program approved by Co-operators Life, or
- the date of your death, or
- the date you retire, or were scheduled to retire, or

- the date you withdraw or receive employer funded pension funds.

A reasonable and customary treatment program is systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of the medically diagnosed condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the medically diagnosed condition involved, and
- prescribed and rendered by a physician or where considered appropriate by Co-operators Life for the nature of the medically diagnosed condition, the treatment must be prescribed and rendered by a specialist.

No monthly benefits will be payable during any period while you are:

- serving a sentence for a criminal or provincial offense whether you are imprisoned in a half-way house, a correctional facility, or any other form of detention, or
- absent from Canada longer than 3 months due to any reason, unless we agree in writing in advance to continue to pay your benefits during this period, or
- receiving short term disability benefits under this plan or salary continuation benefits from any other source, or
- on maternity/parental leave and receiving or eligible to receive employment insurance (EI) benefits or maternity or parental benefits from any other source, or
- becomes disabled during a work stoppage, including but not limited to strike, lay-off, lock-out, suspension or leave of absence, except as provided below:

Maternity/Parental Leave or Temporary Leave or Lay-off

If you become totally disabled while on maternity/parental leave, temporary leave or lay-off, provided premiums have been paid the elimination period will commence on your disability date and benefits will begin on the later of the end of the elimination period or the date you were scheduled to return to active work.

A scheduled leave is deemed to commence on the date agreed upon by you and your employer and end on the date you were scheduled to return to active work. If a child is born prior to the date upon which your maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

If your employer is required to provide benefits during the health related portion of your maternity leave as a result of law or legislation, the elimination period will begin on the date your child is born and benefits will begin after you have satisfied the elimination period.

What limitations are there on LTD benefits?

No monthly benefits will be payable for any period of disability resulting directly or indirectly from any of the following:

- insurrection, war (whether declared or not), voluntary participation in a civil riot or commotion, or
- committing or provoking an assault, committing or attempting to commit a criminal offense, or
- a situation where the disability results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving a vehicle involved in the accident and had either:
  - alcohol in your blood in excess of 80 milligrams of alcohol per hundred millilitres of blood
  - your ability to operate the vehicle impaired by drugs or alcohol or a combination of the two
- medical care which is not medically necessary to treat an injury or sickness or which is of a cosmetic nature. The donation of an organ or tissue will be considered necessary medical care, or
- any injury or sickness for which a third party is, or may legally be liable, except as provided for under the third party liability provision in the policy.

When to submit an LTD claim

Co-operators Life must receive written notice of a claim for monthly benefits within 60 days from the end of the elimination period.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish

the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 180 days from the end of the elimination period.

If you are totally disabled and receiving benefits under any worker's compensation legislation or similar statute, you should still submit an application for long term disability benefits to Co-operators Life according to the above procedure. You may also be eligible to receive Canada Pension Plan (CPP) or Quebec Pension plan (QPP) disability benefits. Applications can be obtained from your nearest CPP or QPP office.

Co-operators Privacy Statement

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

When you apply for coverage or benefits, Co-operators must gather personal information about you, your spouse or dependents.

We use this personal information for the purposes of providing group benefit plan administration services and insurance products to you.

Maintaining the security of your personal information is a top priority. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security is emphasized in our Code of Ethics and extends to the contracts and agreements that we sign with external suppliers and service providers.

Co-operators does not collect, use or disclose your personal information without your consent, except where authorized by law.

Co-operators may require your medical information to administer the group benefits plan. We do not share your medical information without your express consent.

You have the right to access your personal information. Send us your requests in writing and ask us to correct inaccurate information. The medical information not collected directly from you may only be released directly through your physician. For more information on how to obtain access to your file, you may write directly to:

The Co-operators Privacy Office
130 Macdonell Street, Guelph, ON, N1H 6P8

privacy@cooperators.ca
1-888-887-7773

Notes

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