



Mission

Pacific Blue Cross, a not-for-profit service organization, together with its subsidiary BC Life & Casualty Company, share a common mission to be the most trusted and reliable provider of cost-effective health, life and disability coverage for our members.

Vision

To continue our position as the leader and most experienced provider of benefits coverage for our members. To be recognized as being innovative and responsive to change. To set the service standard against which all other providers are measured.



the colour of **trust**



Dental Claims
604 419-2300

Short Term Disability Claims
604 419-8080

Extended Health Claims
604 419-2600

Life & Long Term Disability Claims
604 419-8040

Toll-free
1 888 275-4672

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Corporate Address
4250 Canada Way
Burnaby, BC

WE Insurance
Services Ltd.
039054



Secure online access to your claims
and benefit coverage information available at:

www.pac.bluecross.ca

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CUPE 1816

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| Group Name and Number |
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WE Insurance Services Ltd.

All Employees

Group Number 039054

Reissue Date: October 1, 2006

Introduction

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

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

BC LIFE
Group Term Life
Optional Term Life
Dependent Life
Accidental Death & Dismemberment (AD&D)
Long Term Disability (LTD)

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

Privacy Policy

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

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

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| Schedule of Benefits |
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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 | |
|-----------------------------|--|

| <i>Deductible</i> | No Deductible |
|---------------------------|---|
| <i>Reimbursement</i> | <p>In-Province 80% Eligible Expenses and Out-of-Province Non-Emergency Eligible Expenses:</p> <hr/> <p>Out-of-Province 100% Emergency Eligible Expenses:</p> |
| <i>Plan Maximum</i> | The lifetime maximum amount of benefits payable for a member or Dependent is unlimited, subject to the terms and conditions of the Group Contract. |
| <i>Dependent Children</i> | See definition of Dependent. |

| | | | |
|--------------------|--|--|--|
| Dental Care | | | |
|--------------------|--|--|--|

| <i>Deductible</i> | No Deductible | | |
|---|---|---|------------------------------------|
| <i>Reimbursement</i> | Plan A Basic Services | Plan B Major Restorative Services | Plan C Ortho- dontics |
| | 80% | 80% | 60% |
| <i>Frequency Plan Limits</i> | Each Calendar Year | Each Calendar Year | Lifetime |
| <i>Financial Limit Per Dependent Child</i> | \$2,500 Combined with Plan B | \$2,500 Combined with Plan A | \$3,000 |
| <i>Financial Limit Per Member or Spouse</i> | \$2,500 Combined with Plan B | \$2,500 Combined with Plan A | No Coverage |
| <i>Financial Limit for Late Applicants</i> | \$250 per person for all dental services for first 12 months of coverage | | |
| <i>Dependent Children</i> | See definition of Dependent. | | |

Group Term Life

| | |
|------------------------------|--|
| <i>Benefit Amount</i> | 2 times annual basic earnings rounded to the next higher \$1,000, if not already a multiple of \$1,000, to a maximum of \$170,000. |
| <i>Living Benefit Amount</i> | 50% of the Group Term Life Benefit Amount, to a maximum of \$25,000 |
| <i>Non Evidence Limit</i> | \$125,000 |
| <i>Benefit Reduction</i> | Amount of insurance reduces by 50% at age 65 |
| <i>Termination</i> | Age 70 or earlier retirement |

Dependent Life

| <i>Benefit Amount</i> | Spouse | Child |
|---------------------------|---|--------------|
| | \$2,000 | \$1,000 |
| <i>Dependent Children</i> | Eligible from 14 days of age to the ages specified in the definition of Dependent. | |
| <i>Termination</i> | Dependent insurance terminates on your 65 th birthday or earlier retirement. | |

Optional Term Life

| | |
|---------------------------|--|
| <i>Plan</i> | Employee only. |
| <i>Benefit Amount</i> | Multiples of \$25,000 as selected, to a maximum of \$250,000. |
| <i>Non Evidence Limit</i> | We require health evidence for all amounts of insurance. |
| <i>Termination</i> | Employee insurance terminates at age 65 or earlier retirement. |

Accidental Death & Dismemberment (AD&D)

| | |
|--------------------------|---|
| <i>Principal Sum</i> | An amount equal to the amount payable under your current group term life insurance. |
| <i>Aggregate Limit</i> | \$1,000,000 |
| <i>Benefit Reduction</i> | Amount of insurance reduces by 50% at age 65. |
| <i>Termination</i> | Age 70 or earlier retirement. |

Long Term Disability (LTD)

| | |
|-------------------------------|---|
| <i>Benefit Amount</i> | 66 2/3% of monthly basic earnings rounded to the next higher \$1, if not already a multiple of \$1, to a maximum of \$3,500 |
| <i>Non Evidence Limit</i> | \$2,500 |
| <i>Elimination Period</i> | 119 Days |
| <i>Maximum Benefit Period</i> | Age 65 or earlier retirement |
| <i>Termination</i> | Age 65 or earlier retirement |

General Information**Definitions****Allowable enrolment period**

means,

- 1) within 4 months (for Pacific Blue Cross benefits), or
 - 2) within 31 days (for BC LIFE benefits)
- from the coverage effective date.

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 Allowable enrolment period.

Deductible

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

Dentist

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

Dependent

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

- 1) one Spouse, and
- 2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
- 3) under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
- 4) any unmarried handicapped child to any age who is living with you or your Spouse, is financially dependent and is incapable of self-sustaining employment.

Duplicate coverage

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

Fee guide

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

Fee schedule

means Schedule 1 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.

Non evidence limit

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

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.

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 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 Allowable enrolment 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 Allowable enrolment 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.

Coverage begins on the coverage effective date shown on your identification (ID) card(s), provided you and your Plan Administrator have complied with our enrolment rules.

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

Late Applicants

If you did not apply during the Allowable enrolment 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 – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Beneficiary

You must designate a beneficiary on your application card. If at any time you wish to change this beneficiary, contact your Plan Administrator for the appropriate form.

Identification (ID) Cards

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

Only you and your enrolled Dependents are entitled to use this card. Should you (or your Dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

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.
- 4) The necessary claim forms are available from your Plan Administrator.
- 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 enroll under more than one plan.

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

Coordination of Benefits

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

- 1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
- 2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
- 3) In situations of separation or divorce, the following order applies:
 - a) the plan of the parent with custody of the child
 - b) the plan of the Spouse of the parent with custody of the child
 - c) the plan of the parent not having custody of the child
 - d) the plan of the Spouse of the parent in c) above.
- 4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

- 1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
 - a) under any other group or individual benefit plan or insurance policy, or
 - b) due to the legal liability of any other party.
- 2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
 - a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
 - b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
 - c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
 - d) false pretences or fraudulent misrepresentation

- e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

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.

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. Coverage will become effective immediately after your group coverage terminates.

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

Preexisting condition

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

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

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

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

CARESnet

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

<http://www.pac.bluecross.ca/caresnet/>

Extended Health Care

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

Definitions

Eligible expense

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

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

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. PharmaCare's low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Physician

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

Practitioner

means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-Province Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. 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
Drugs and medicines dispensed by a licensed pharmacist or a Physician, in a quantity we consider reasonable:
 - a) drugs and medicines which legally require a prescription from a Physician or Dentist, and included with the above:
 - i) contraceptives
 - b) insulin preparations, testing supplies, needles, and syringes for diabetics
 - c) vitamin B12 for the treatment of pernicious anemia
 - d) allergy serums when administered by a Physician.
- 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.*
 - a) acupuncturist\$500
 - b) chiropractor and chiropractic x-rays combined\$500
 - c) massage practitioner.....\$500
 - d) naturopath.....\$500
 - e) physiotherapist\$500
 - f) podiatrist.....\$500
 - g) psychologist.....\$500
 - h) speech language pathologist.....\$500
 - i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence, limited to a maximum of \$10,000 per calendar year or \$25,000 per lifetime, whichever occurs first.
- 5) Dental Accident
Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

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

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

6) Medical aids and supplies

Charges for the following services and supplies:

- a) oxygen, blood, and blood plasma
- b) ostomy and ileostomy supplies
- c) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports
- d) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
- e) charges for the following items to the maximum amounts indicated per calendar year:
 - i) mastectomy brassieres.....\$250
 - ii) stump socks.....\$250
 - iii) surgical stocking.....\$250
- f) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of \$500
- g) orthopedic shoes and orthotics
 - i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopedic shoes (including repairs) and modifications to stock item footwear to a maximum in a calendar year period of \$500 for an adult and \$300 for a Dependent child. A custom made orthopedic 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, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a maximum of \$250 in a calendar year. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet
- h) hearing aids and repairs to a maximum of \$500 in a 5 calendar year period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

7) Standard durable medical equipment

- a) Preauthorization is required from us for expenses in excess of \$5,000
- b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
- c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
- d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
- e) Standard durable equipment includes:
 - i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent
 - ii) medical heart and blood glucose monitors, and cardiac screeners
 - iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
 - iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
 - v) insulin infusion pumps for diabetics – when basic methods are not feasible

- vi) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
- vii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Vision Care

Charges for the purchase of eyewear when prescribed by a Physician or optometrist and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or optometrist to a maximum of \$150 in a 2 calendar year period. Charges for non-prescription eyewear are not covered.

Out-of-Province Non-Emergency Eligible Expenses

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

Out-of-Province Emergency Eligible Expenses

While travelling outside your province 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 of residence.

Emergency Travel Assistance

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

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

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

Exclusions

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

- 1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, contraceptives, fertility drugs, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence
- 2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
- 3) any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
- 4) allergy testing unless rendered by a naturopath
- 5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests
- 6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
- 7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
- 8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
- 9) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
- 10) expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
- 11) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence
- 12) expenses of a Dependent hospitalized at the time of enrolment
- 13) services performed by a Physician who is related to or resident with you or your Spouse
- 14) fees for ambulance services when an ambulance is called but not used
- 15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
- 16) retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare
- 17) any other item not specifically included as a benefit.

Claims

- 1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.
- 2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

- 3) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming PharmaCare expenses may be obtained from your pharmacist.
- 4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
- Obtain a claim form from your Plan Administrator.
 - 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).
 - We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **December 31st** 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 2006 before December 31, 2007.

Dental Care

Payment of Benefits

- We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule.
- We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
 - for services performed in British Columbia or outside Canada, if your province of residence is British Columbia—the fees in the Fee schedule
 - for services performed in Canada but outside British Columbia—the fees in the Fee guide in the province/territory of service
 - for services performed outside Canada if your province of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
- 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 3 year period
 - iii) complete mouth series – 1 per 3 year 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) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.
- 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 and onlays
 - b) veneers
 - c) crowns and related services.
- 3) Periodontal Appliances
 - bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

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

Plan C – Orthodontics

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

Limitations

- 1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
- 2) No benefit is payable for the replacement of appliances which are lost or stolen.

- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- 4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule.

Exclusions

The following are not Eligible expenses under your dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
- 2) any item not specifically included as a benefit
- 3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
- 4) procedures performed for congenital malformations or for purely cosmetic reasons
- 5) charges for drugs, pantographic tracings, and grafts
- 6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
- 7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
- 9) incomplete or temporary procedures
- 10) recent duplication of services by the same or different Dentist
- 11) any extra procedure which would normally be included in the basic service performed
- 12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
- 13) travel expenses incurred to obtain dental treatment.

Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment submitted later than **1 year** 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 group, ID, and Dependent(s) numbers (this information is on your ID card)
 - d) your home mailing address
 - e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
- 4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
 - a) We will pay the Dentist directly for services provided under this dental plan when we receive a claim form signed by the Dentist, certifying these services were performed and the fee charged.
 - b) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your Dentist. We will send you a cheque when the claim is processed.
- 5) Orthodontic Claims Procedures
 - a) Receipts
Because we do not return original receipts, we will accept photocopies. 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 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.
 - c) Treatment plan
 - i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
 - ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
 - iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
 - your initial fee/down payment
 - your monthly/quarterly fees
 - one time appliance fees
 - iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

- d) Monthly or quarterly fees
 - i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 1 year 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.

Group Term Life

Payment of Benefit

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

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

Living Benefit

Terminal condition

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

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

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

Waiver of Premium

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

Conversion Option

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

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

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

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

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

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

Claims

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

Dependent Life

Payment

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

Waiver of Premium

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

Exclusions

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

Claims

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

Optional Term Life

Definitions

Insured person
means you (the employee) provided we have approved the evidence of insurability.

Non-smoker
means the Insured person has abstained from smoking any tobacco products within the past 12 months from application for coverage.

Smoker
means the Insured person has smoked tobacco products within the past 12 months from application for coverage.

Coverage Effective Date

If an Insured person wishes to apply for optional term life insurance, ask your Plan Administrator for the special application. The application and medical evidence of insurability must be submitted to us for our approval before this insurance becomes effective.

Changes in Amounts of Insurance

- 1) An Insured person may elect to change the amount of this insurance. The change will be effective:
 - a) for an increase, on the January 1 coincident with or next following the date of application, provided we approve the evidence of insurability, and
 - b) for a decrease, on the January 1 coincident with or next following the date of application.
- 2) If you are not actively at work on the date an increase would otherwise become effective, you will not be insured for the additional amount until you return to active employment.

Payment of Benefit

If an Insured person dies, the beneficiary will receive payment of the benefit amount. If no beneficiary survives, the benefit amount will be paid to the Insured person's estate.

Waiver of Premium

Premiums will be waived for your optional term life insurance during the period that premiums are waived for your group term life insurance.

Conversion Option

You may be eligible to convert your optional life insurance coverage to a personal life insurance policy. Please see the conversion option under group term life insurance. The maximum coverage you can purchase will be the lesser of:

- 1) \$200,000, or
- 2) the sum of the group life insurance and optional life insurance you had with us, or

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

Suicide Exclusion

No benefit amount is payable if death results from suicide within 2 years of the effective date of the Insured person's coverage under this optional term life insurance.

Claims

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

Accidental Death & Dismemberment

Payment of Benefit

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

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

Repatriation Benefit

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

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

Rehabilitation Benefit

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

Occupational Training Benefit for the Spouse

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

Education Benefit

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

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

Family Travel Benefit

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

Waiver of Premium

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

Exclusions

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

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

Claims

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

Long Term Disability

Definitions

Disability

means that during the Elimination period and the subsequent 24 months of disability you are prevented, by injury or sickness, from performing each of the essential duties of your own occupation. After that you are prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

Eligible survivor

means your Spouse, if living, otherwise your children under age 25. If there are no Eligible survivors, payment will be made to your estate.

Elimination period

means a period of time, when you are continuously disabled, which must be completed before your claim will be considered. It will be calculated from the date disability begins.

Indexed pre-disability earnings

means your basic earnings adjusted (on each anniversary of the LTD benefit payments) by the lesser of 10% or the current annual percentage increase in the all item Consumer Price Index (CPI) Canada.

Partial disability

means that within 31 days of the end of a period when you received an LTD benefit payment under the disability definition above, and as a result of the same injury or sickness, you are incapacitated to the extent that, although unable to perform all the essential duties of your own occupation on a full-time basis, you are currently:

- 1) participating in a rehabilitation program, or
- 2) performing at least one of the essential duties of your own or any occupation on a part-time or full-time basis, and
- 3) earning at least 20% less per month than your Indexed pre-disability earnings, due to that same injury or sickness.

Availability of work is not considered when assessing disability.

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 long term disability (LTD) benefits when disability, as defined below, begins while you are insured for the LTD benefit.

Benefits commence on the day after the Elimination period expires and will be paid only during periods when you are receiving, from your physician, regular care which is appropriate for the condition causing your disability and following the treatment prescribed. We may require consultation and/or treatment by a physician who specializes in the treatment of your condition.

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

Rehabilitation Program

While you are disabled, we may suggest a rehabilitation program to help you return to the work force. This program requires the agreement of your physician and pre-approval by us. It may include, but is not limited to, a return to work on a part-time or full-time basis, therapy, vocational evaluation, or job preparation. Income you receive under this program will be integrated with your monthly benefit.

Recurrent Disability

A Recurrent disability will be considered part of the prior disability if, after receiving LTD benefits, you returned to any occupation on a full-time basis and were able to perform all the essential duties of this occupation for less than 6 months. If you return to any occupation on a full-time basis for 6 months or more, a recurrence of disability will be treated as a new period of disability and you must complete another Elimination period.

Extended Benefit

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

Survivor Benefit

If you die after being disabled for 180 or more consecutive days and while receiving a monthly benefit amount, a payment equal to 3 times your gross monthly benefit amount will be made to your Eligible survivor.

Coordination with other Income Sources

Your monthly LTD benefit may be reduced by any amount of disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of:

- 1) your monthly basic earnings, if benefits are taxable
- 2) your take-home pay, if benefits are nontaxable.

For details of other income sources and how your monthly benefit is calculated, contact your Plan Administrator.

Waiver of Premium

The premiums for your LTD benefit will be waived while you are receiving monthly benefits.

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 LTD Plan. Benefits are nontaxable if you pay the entire cost.

Preexisting Conditions Limitation

Increased amount of insurance

means an increased amount of insurance due to a change in either the non evidence limit or the maximum benefit amount.

Preexisting condition

means a sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures), or consumed prescribed drugs within 3 months:

- 1) prior to the date you became insured under this benefit, or
- 2) prior to the date of any Increased amount of insurance.

This exclusion will not apply if you become disabled more than 12 months:

- 1) after you became insured under this benefit, or
- 2) after you became eligible for any Increased amount of insurance.

Termination of Benefit

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

- 1) you are no longer disabled
- 2) you are no longer receiving regular medical care and treatment from your physician
- 3) you fail to submit satisfactory proof of continuing disability as required by us
- 4) you refuse a medical examination by a physician chosen by us
- 5) you are no longer following the treatment recommended for your disability
- 6) you refuse to participate in a rehabilitation program
- 7) your current earnings exceed 80% of your Indexed pre-disability earnings
- 8) you reach age 65
- 9) the end of the maximum benefit period indicated in the Schedule of Benefits
- 10) you retire
- 11) you die.

Exclusions

Benefits are not payable for any period of disability:

- 1) arising from any of the following:
 - a) self-inflicted injury or sickness
 - b) participation in an assault or criminal offense, or an act incident thereto
 - c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military 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 but not limited to alcoholism or drug addiction, unless you are confined in a public general hospital or you are satisfactorily participating in a withdrawal program approved by us
 - f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
- 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
 - c) involved in a strike or lockout, if the disability commenced after notice of strike or lockout was given
 - d) receiving sick pay, vacation pay, or any other salary or wage from your normal or any occupation (except as provided under the rehabilitation program).

Claims

- 1) We must receive written notice of claim within **30 days** of the date disability begins. On receipt of written notice of claim, we will provide you with a claim form.

- 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) Forward the claim form (satisfactory proof of claim) to us within **90 days** following the end of the Elimination period.
- 6) We may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

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