ALBERTA BLUE CROSS®

CITY OF Leduc

Benefits Booklet

for
Elected Officials

Alberta Blue Cross Group Number: 23689 - EO
Blue Cross Life Policy Number: 84414 - 000

Effective Date: January 1, 2025

Issue Date: December 2024

CITY OF LEDUC

Alberta Blue Cross Group Number:	23689 - EO
Blue Cross Life Policy Number:	84414 - 000
Effective Date:	January 1, 2025
Eligibility Period:	Exact date of hire
Employee Classification:	Elected Officials

Schedule of Benefits

Health and Dental Benefits

Underwritten by: Alberta Blue Cross

Health Benefits

Prescription Drugs
Hospital
Extended Health
Out of Province Emergency Travel
Vision Care
Second Opinion

Dental Benefits

Basic
Periodontic
Extensive
Orthodontic

Health Spending Account

Wellness Spending Account

Benefit Year

January 1st - December 31st

Life and Disability Benefits

Underwritten by: Blue Cross Life

Life Insurance Benefits

Employee Life Insurance
Accidental Death and Dismemberment
Optional Life Insurance

Optional Critical Illness

The information contained in this booklet is important to you and your family and should be kept in a safe place. You should familiarize yourself with the contents of the booklet and refer to it whenever you submit a claim for benefits.

Schedule of Benefits

Summary of Benefits

Health and Dental Benefits

Health Plan

Prescription Drug Benefits

Payment Basis:	Direct Bill
Coverage Level:	100%, unless otherwise indicated
Eligible Drugs:	Drugs defined as Eligible Drugs in the current Alberta Blue Cross Drug Benefit List®
Generic Pricing:	Applied
Prescription Substitution:	If the prescription contains a written direction from a Health Care Professional that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this benefit, the eligible cost of the prescribed product is covered
Aerosol Holding Chamber:	$40 in a consecutive 24 month period for children under 11 years of age
Allergy Serums:	Included
Blood Testing Monitor:	$150 per Participant in a 5 year period
Contraceptive Drugs:	Included
Diabetic Supplies:	Included
Sexual Dysfunction Products:	Coverage Level: 50% $500 per Participant each Benefit Year
Smoking Cessation Products:	$500 lifetime per Participant
Vaccines:	Included
Weight Loss Products:	Excluded

Definitions

1. **Alberta Blue Cross Drug Benefit List:** A listing created and varied from time to time and published by Blue Cross which contains the drugs, drug products and their respective restrictions, limitations and other criteria, defined as Benefits under this Contract.
2. **Eligible Drugs:** Drugs defined as Eligible Drugs in the current Alberta Blue Cross Benefit List.
3. **Fertility Drugs:** Drugs with at least one Health Canada indication for treatment of infertility, as defined by Blue Cross.
4. **Generic Price:** The maximum unit price as determined by Blue Cross that will be paid for a drug product (whether it is a brand or generic product) within a grouping. Groupings are determined by Blue Cross.
5. **Generic Products:** Generic drug products contain the same active ingredients, in the same amounts and comparable dosage form as a corresponding product.
6. **Sexual Dysfunction Drugs:** Drugs with at least one Health Canada indication for treatment of sexual dysfunction, as defined by Blue Cross.
7. **Smoking Cessation Drugs:** Drugs with at least one Health Canada indication for smoking cessation, as defined by Blue Cross.
8. **Vaccines:** Drugs with at least one Health Canada indication for use as a vaccine as defined by Blue Cross.
9. **Weight Loss Drugs:** Drugs with at least one Health Canada indication for weight loss, as defined by Blue Cross.

Hospital Benefits	
Coverage Level:	100%
Private Rooms:**	Direct payment basis
Semi-Private Rooms:**	Direct payment basis
Long Term Care Facility:**	180 days per Participant each Benefit Year

Definitions

1. **Hospital**: An institution located in Canada which is legally licensed and operates under any federal, provincial or territorial health insurance act or law, with facilities to provide active in-patient treatment and care in the acute phase. The term Hospital shall not include a rehabilitation facility, rest facility, nursing home, convalescent home, health spa, hospice, clinic or institutions to treat addiction.
2. **Long Term Care Facility**: An establishment located in Canada that is legally licensed to provide treatment of long term or chronic illnesses, diseases or infirmities and include any auxiliary Hospital but does not include a nursing home.
3. **Private Room**: A room in a Hospital or Long Term Care Facility which holds only 1 bed.
4. **Semi-Private Room**: A room in a Hospital or Long Term Care Facility which holds only 2 beds.

Limitations

1. ** Services subject to a Reasonable and Customary daily maximum as determined by Blue Cross.

Extended Health Benefits

Coverage Level:		100%
Accidental Dental:		$2,000 per Participant per accident for repair, extraction and/or replacement of natural or permanently attached artificial teeth
Ambulance Services:		To a maximum set in the current Blue Cross schedule of ambulance rates. Response fees covered if treatment provided.
Cosmetic Surgery:		To repair disfigurement due to injury
Custom Fitted/ Custom Made Braces:	*	Once per limb in a 24 month period
Diagnostic Services and Laboratory Testing:	*	$150 per Participant each Benefit Year
Eye Examinations:		1 eye examination per Participant in a 24 month period for Participants between 19 and 64 years of age
Foot Orthotics:	*	$400 per Participant each Benefit Year
Hearing Aids:	*	$800 per Participant in a 5 year period
Home Nursing Care:	*	$15,000 per Participant each Benefit Year
Ileostomy, Colostomy, Urinary Catheters and Supplies:		$1,200 per Participant each Benefit Year
Manual Hospital Beds:	*	Rental, purchase or repair to a lifetime maximum of $1,500 per Participant
Mastectomy Prosthesis:	*	$200 per prosthesis once per Participant in a 24 month period
Supporting Brassiere		$50 each to a maximum of 2 per Participant each Benefit Year
Medical Aids:		
Casts, Canes		Included
Cervical Collars, Crutches		Included
Splints, Trusses		Included
Stump Socks		6 pair per Participant each Benefit Year
Surgical Stockings		2 pair per Participant each Benefit Year
Traction Kits, Walkers	*	Included
Wig/Hairpiece	*	$500 per Participant in a 3 year period
Medical Durable Equipment:		Included
Orthopaedic Shoes:	*	1 pair to a maximum of $400 per Participant each Benefit Year
Oxygen and Equipment:		$2,500 per Participant each Benefit Year

Paramedical Practitioners:	
Psychologist/Social Worker/ Clinical Counsellor	$2,000 per Participant each Benefit Year
	The following Paramedical Practitioner services have a combined maximum of $2,000 per Participant each Benefit Year:
Acupuncturist	Included
Audiologist	Included
Chiropractor	Included
X-ray examination	1 x-ray per Participant each Benefit Year
Dietician	Included
Massage Therapist	$1,000 per Participant each Benefit Year
Naturopath	Included
Occupational Therapist	Included
Osteopath	Included
X-ray examination	1 x-ray per Participant each Benefit Year
Physiotherapist	Included
Podiatrist/Chiropodist	Included
X-ray examination	1 x-ray per Participant each Benefit Year
Speech Language Pathologist	Included
Prosthetics:	* Conventional artificial limbs and eyes
Wheelchairs:	
Manual Wheelchair	
Purchase	* Once per Participant in a 3 year period
Rental	Included
Repair	Included
Electric Wheelchair	
Purchase	* $4,000 lifetime per Participant
Rental	Included
Repair	Included

Limitations

1. * Benefits must be purchased on the written order of a Health Care Professional.
2. Accidental Dental - The repair, extraction and/or replacement must take place within 3 years of the date of the accidental injury.
3. Wig/Hairpiece when required for hair loss due to a medical condition, illness or accidental injury.
4. Acupuncturist – Eligible Expenses for services provided by a registered acupuncturist.
5. Audiologist – Eligible Expenses for services provided by a registered audiologist.
6. Chiropractor – Eligible Expenses for services provided by a licensed chiropractor and the cost of 1 x-ray.
7. Dietician – Eligible Expenses for services provided by a registered dietician.
8. Massage Therapist – Eligible Expenses for therapeutic massages provided by a registered massage therapist to treat a medical condition.

9. Naturopath – Eligible Expenses for services provided by a licensed naturopath.
10. Occupational Therapist – Eligible Expenses for services provided by a licensed occupational therapist.
11. Osteopath – Eligible Expenses for services provided by a licensed osteopath and the cost of 1 x-ray.
12. Physiotherapist – Eligible Expenses for services provided by a licensed physiotherapist, once all provincial government funding has been fully accessed.
13. Podiatrist/Chiropodist – Eligible Expenses for services or supplies provided by a licensed podiatrist or chiropodist and the cost of 1 x-ray.
14. Psychologist/Social Worker/Clinical Counsellor – Eligible Expenses for individual or family counseling for treatment of mental or emotional illness, including assessment, provided by a psychologist, master of social work, registered social worker, clinical counsellor or other Health Care Professional approved by Blue Cross in its discretion.
15. Speech Language Pathologist – Eligible Expenses for services provided by a licensed speech language pathologist, once all provincial government funding has been fully accessed.

Out of Province Emergency Travel Benefits

Benefits are provided as a result of a Medical Emergency which occurs outside the Participant's province or territory of residence.

Coverage Level:	100%
Benefit Period:	90 Days
Maximum:	$5,000,000 in Canadian funds per Participant, per incident
Accidental Dental:	$2,000 per Participant per accident for repair, extraction and/or replacement of natural or permanently attached artificial teeth
Air Ambulance:	Included
Ambulance Services:	To the nearest qualified medical facility
Cremation or Burial:	Cost of cremation or burial at place of death, to a maximum of $2,500
Dental Pain Relief:	$300 per Participant per trip
Diagnostic Services:	Laboratory services and x-rays
Drugs:	Included
Expenses to Visit the Covered Person:	
Transportation	One round trip economy airfare
Meals/Accommodation	$250 per day to a maximum of $2,500 per incident
Hospital Accommodation:	Included
Identification of Deceased:	
Transportation	One round trip economy airfare
Meals/Accommodation	$250 per day to a maximum of 3 days per incident
Incidental Expenses:	$50 per day to a maximum of $500 per inpatient per hospital stay
Meals and Accommodations:	$250 per day per Participant to a maximum of $2,500 per incident for unavoidable additional expenses when remaining with a sick or injured travelling companion
Medical Aids:	
Casts, Canes	Included
Crutches, Slings	Included
Splints, Trusses	Included
Temporary Wheelchair Rental, Walkers	Included

Medical Evacuation:	
Air Ambulance	Included
Repatriation	Included
Nursing Care:	On the written order of a physician during and following hospitalization
Outpatient Expenses:	Included
Paramedical Practitioners:	
Chiropractor	$300 per Participant per trip
Physiotherapist	$300 per Participant per trip
Podiatrist/Chiropodist	$300 per Participant per trip
Physicians and Surgeons Fees:	Included
Return of Deceased:	Cost of preparation and homeward transportation to province of residence, excluding the cost of a coffin, to a maximum of $7,000
Return of Dependent Children:	Cost of one way economy airfare per child for the return of Dependent children
Return of Personal Items:	Cost of the return of luggage or personal items to a maximum of $500 per Participant per incident
Return of Pet(s):	Cost of one way transportation for the return of accompanying pet(s) to a maximum of $500 per incident
Travel Assistance:	In the event of a Medical Emergency contact must be made with the travel assistance service
Vehicle Services:	$1,000 per incident
Restrictions:	The Out of Province Emergency Travel Benefits will only cover the first 90 days per trip

Limitations and Exclusions

1. Blue Cross may not accept liability for hospitalization and related services if the travel assistance service is not contacted within 24 hours of admission. Failure to contact the travel assistance service may result in the payment of medical expenses being denied or delayed.
2. Blue Cross, in consultation with the Provider or travel assistance medical service advisor, reserves the right to transfer the participant to another hospital or return the participant to their province of residence. If a Participant is medically able to return to their province of residence and refuses to comply with the transfer request, Blue Cross will be absolved of any further liability, whether related to the initial incident or not.
3. Blue Cross will not pay for services if travel is booked or commenced contrary to medical advice or if medical attention is anticipated during the travel period. Blue Cross shall have the right to obtain medical information from the Participant's physician(s) and may request an assessment by an independent physician(s) or specialist(s).

4. This coverage is only available to Participants who are covered by a Canadian provincial government health program.
5. Blue Cross will not pay for services if expenses are incurred when the participant could have been returned to the province of residence without endangering their life or health, even if the treatment available in their province of residence could be of lesser quality or if the participant must go on a waiting list for that treatment.
6. Benefits are not covered if emergency medical care expenses are incurred in a country, region or city, when a written formal notice was issued by the Department of Foreign Affairs, Trade and Development of the Canadian government, or its equivalent, prior to the departure date advising Canadians to avoid non-essential travel or avoid all travel to that country, region or city unless the incident is unrelated to the posted warning.
7. Blue Cross may request proof of departure upon receipt of claim. Claims must be supported by receipts from commercial organizations.
8. Blue Cross shall not pay for any Benefit relating to pregnancy or childbirth complications, including treatment for the newborn, if the Medical Emergency occurs after the 32nd week of gestation or is a result of the deliberate inducement of a miscarriage.
9. Blue Cross will not pay for expenses incurred due to:
    - seeking medical advice, surgery, a second opinion or treatment, intentionally or incidentally, even if the trip is on the medical recommendation of a Provider; or
    - abuse of medication, toxic substances, alcohol or the use of non-prescription drugs; or
    - driving a motorized vehicle while impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood; or
    - commission of or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense; or
    - participation in an insurrection, war or act of war (declared or not), the hostile action of the armed forces of any country, service in the armed forces, hijacking, terrorism, participation in any riot or public confrontation, civil commotion, or any other act of aggression.
10. Blue Cross will not pay for the following unless prior approval is received from the travel assistance provider and are subject to the discretion of Blue Cross:
    - medical evacuation air ambulance services, or
    - medical evacuation repatriation, or
    - friend/family hospital visits, or
    - friend/family identification of deceased, or
    - vehicle services, or
    - return of Dependent children, or
    - return of personal items, or
    - return of pet(s).

Vision Care Benefits

Adult:	Participants 18 years of age and older	
Child:	Participants under 18 years of age	
Coverage Level:	100%	
Maximum:	Adult	$400 per Participant each Benefit Period
	Child	$400 per Participant each Benefit Period
Benefit Period:	Adult	24 consecutive months
	Child	12 consecutive months
Eligible Benefits:	Contact Lenses Eyewear Intraocular Lenses Laser Eye Surgery, including assessment fees	

Second Opinion

Second Opinion is a confidential service that provides you and your dependents with access to medical specialist expertise and the reassurance that you are receiving the right care at the right time. Upon the diagnosis of a qualifying medical condition, you or your dependents can contact Second Opinion to have your medical files reviewed by a medical specialist. With your signed consent, Second Opinion coordinators will assist you through the process and will collect your medical files and all relevant documentation. Your medical files will then be submitted to a medical specialist who will review your case.

The medical specialist will validate your diagnosis and treatment plan in a written report which will be delivered to you and your treating physician. If applicable, the report will include alternate or enhanced treatment options.

The Second Opinion service may be accessed toll-free Monday to Friday from 6 a.m. to 6 p.m. MST at 1-877-940-5071.

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

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

After reviewing the patient's medical documentation, the medical specialist will provide recommendations to the patient and their physician. Ongoing treatment decisions will be made between the patient and their physician.

NOTE: This Benefit does not cover the cost of the travel, accommodation or treatment; these costs are the responsibility of the patient. The Participant's Out of Province Emergency Travel Plan Benefits will not pay for emergency expenses incurred while seeking medical advice, surgery, a second opinion or treatment, outside the patient's province of residence, even if the trip is on the recommendation of a Second Opinion medical specialist or a Health Care Professional. Blue Cross shall not be responsible for the availability, quality or results of any medical treatment or the failure of the Participant to obtain recommended treatment.

Second Opinion's privacy policy complies with requirements under the Personal Information Protection and Electronic Documents Act (PIPEDA), as well as provincial privacy legislation.

Dental Plan

Fee Schedule:	Blue Cross Usual and Customary Dental Fee Schedule

Basic Benefits

Adult:	Participants 19 years of age and older
Child:	Participants under 19 years of age
Coverage Level:	100%
Maximum:	$2,000 per Participant each Benefit Year Combined maximum with Periodontic and Extensive Benefits
Diagnostic Services:	
Complete, Comprehensive and General Oral Exams	1 of each exam per Participant in a 5 year period
Recall Exams	Adult 1 per Participant in a 12 month period Child 1 per Participant in a 6 month period
Limited Oral or Specific Oral Exam	Included
Emergency Exams	Included
Complete Series/Panoramic Imaging	1 set per Participant in a 24 month period
Bitewing Imaging	Adult 2 images per Participant in a 12 month period Child 2 images per Participant in a 6 month period
Consultations	Only when performed by another Health Care Professional
Unmounted Diagnostic Casts	In conjunction with the placement of fixed or removable prosthetics
Preventive Services:	
Polishing	Adult 1 time unit per Participant in a 12 month period Child 1 time unit per Participant in a 6 month period
Scaling and Root Planing	4 time units per Participant in any 12 month period
Fluoride Treatment	1 per Participant in a 6 month period
Pit and Fissure Sealant	Child 1 per permanent posterior tooth in a 5 year period
Space Maintainers	Included
Restorative Services:	
Restorations	1 per surface in a 24 month period to a maximum of 5 surfaces per tooth (or dollar equivalent)

Oral Surgery:	
General Surgery Exam	1 per Participant in a 5 year period
Uncomplicated and Surgical Extractions	Included
General Anesthesia and Deep Sedation	Administration and facilities
Endodontics:	
Complete Endodontic Exam	1 per Participant in a 5 year period
Root Canal Therapy	1 per tooth in a 24 month period
Apicoectomy	Included
Retrofill	Included
Pulpectomy	Included
Pulpotomy	Included
Removable Appliances:	
Prosthodontic Edentulous Exam	1 per Participant in a 5 year period
Complete Dentures	1 upper and/or 1 lower per Participant in a 5 year period
Partial Dentures	1 upper and/or 1 lower per Participant in a 5 year period
Denture Services:	
Rebasing and Resetting	Providing at least 5 years has lapsed from placement of denture
Adjustments	Providing at least 3 months has lapsed from placement of denture
Relines	1 service per denture in a 24 month period
Liners	1 service per denture in a 24 month period
Tissue Conditioning	1 service per denture in a 24 month period
Repairs	Included
Pre-Authorization Amount:	$1,000

Periodontic Benefits

Adult:	Participants 19 years of age and older
Child:	Participants under 19 years of age
Coverage Level:	100%
Maximum:	$2,000 per Participant each Benefit Year Combined maximum with Basic and Extensive Benefits
Diagnostic Services:	
General Periodontal Exam	1 per Participant in a 5 year period
Treatment Procedures:	
Surgical	
Periodontic Surgery	Included
Osseous Surgery	Included
Osseous Grafts	Included
Soft Tissue Grafts	Included
Non-Surgical	
Provisional Splinting	Included
Scaling and Root Planing	6 additional time units per Participant in a 12 month period
Management of Oral Infections	Included
Periodontal Appliances	1 upper or 1 lower per Participant in a 36 month period
Repairs of Periodontal Appliances	Included
Reline of Periodontal Appliances	1 per appliance in a 12 month period
Occlusal Equilibration	4 time units per Participant in a 12 month period
Pre-Authorization Amount:	$1,000

Extensive Benefits

Adult:	Participants 19 years of age and older
Child:	Participants under 19 years of age
Coverage Level:	80%
Maximum:	$2,000 per Participant each Benefit Year Combined maximum with Basic and Periodontic Benefits
Diagnostic Services:	
Fixed Oral Rehabilitation Exam	1 per Participant in a 5 year period
Prosthodontic Services (Limited to one of the following services per tooth):	
Crowns	1 in a 5 year period when tooth cannot by adequately restored to form and function with a filling
Fixed Bridges	1 in a 5 year period
Inlays and Onlays	1 in a 5 year period when tooth cannot be adequately restored to form and function with a filling
Processed Veneers	1 in a 5 year period when tooth cannot be adequately restored to form and function with a filling
Posts & Cores	1 in a 5 year period
Implants	$750 per implant once in a 5 year period including but not limited to mesostructures, implantology and related to periodontal surgery
Pre-Authorization Amount:	$1,000

Orthodontic Benefits

Child:	Participants under 21 years of age
Coverage Level:	50%
Maximum:	$3,000 lifetime per Participant
Diagnostic Services	
General Orthodontic Exam	1 per Participant in a 5 year period In cases where a Participant chooses to obtain a second opinion from a certified specialist in orthodontics (other than the originating provider) a second general orthodontic exam will be eligible within the 5 year period
Habit-Breaking Appliances:	Included, for primary and mixed dentition only
Orthodontic Services:	
Fixed or Removable Appliances	Included
Functional Appliance Therapy	Included
Formal Banding Treatment	Included
Pre-Authorization:	Treatment Plan Required

Contract Maximums and Termination of Benefits

Health and Dental Maximum

A combined maximum of $2,000,000 per Participant each Benefit Year applies to all Benefits, excluding Out of Province Emergency Travel Benefits.

Out of Province Emergency Travel Benefits are subject to a $5,000,000 Canadian maximum per Participant, per incident.

Health and Dental Termination of Benefits

Benefit coverage terminates the exact date of the earlier of the Member's retirement or termination of employment, with the exception of Out of Province Emergency Travel Benefits which will terminate the exact date of the earlier of the Member's retirement, termination of employment or attainment of age 75.

Health Spending Account (HSA)

HSA Benefit Year:	January 1st - December 31st
Minimum Payment Amount:	$50 daily for Members who have signed up for direct deposit and paperless statements $50 monthly for Members who have not signed up for direct deposit and paperless statements
Credit Allocation:	Credits are deposited to your HSA by your employer on an annual basis.
Carry Forward:	Unused HSA Credits carry forward for 12 months from the end of the Benefit Year in which they were allocated.
Run Off:	A 2 month run-off period will exist after the end of each Benefit Year to submit claims.
Grace period:	Upon termination of employment, you have a 2 month grace period in which to claim for services incurred prior to your termination date.

Benefits of an HSA

You can draw on your HSA to pay for many health related expenses that would not otherwise be covered by your core health or dental plan - all in a tax advantaged manner.

Allowable expenses must be deemed an eligible medical expense by Canada Revenue Agency to be eligible for payment through your HSA. All expenses must meet Canada Revenue Agency's listing of eligible medical expenditures. Any medical or dental costs incurred by you or your dependents may be reimbursed through your HSA as long as they are not eligible for payment through provincial health care, and meet Canada Revenue Agency's requirement for a deduction on your tax return.

Expanded Dependent Eligibility

Canada Revenue Agency permits a broader definition of dependents for expenses claimed through your HSA - the perfect solution if you need to cover expenses for extended family members who are not eligible under your core benefit plan.

Carry Forward

Your HSA carries forward credits. You can carry forward unused credits for 12 months from the end of the Benefit Year in which they were allocated.

A 2 month run-off period will exist after the end of each Benefit Year. This run-off period shall allow active Members to claim for prior Benefit Year claims with prior Benefit Year Credits.

Allowable expenses incurred in the prior Benefit Year not claimed within that Benefit Year or the subsequent run off period will be forfeited.

How Your Health Spending Account Works

- When you submit a Health or Dental claim to Blue Cross, any unpaid portion or ineligible expense is automatically transferred into your HSA. Even claims submitted electronically by a pharmacy, dental office or other health care professional that have unpaid balances are transferred into your HSA.
- If you coordinate benefits (COB) under a spousal or other employer plan, the unpaid portion of your claim must be submitted to the other plan first for their reimbursement prior to being paid through your HSA.
- Claims to your HSA are assessed against the available credits in your account. Your employer will inform you of the amount credited to your HSA at the time your account is established and annually thereafter.
- You may submit claims for allowable expenses you want to pay through your HSA only and not through your core plan. For this you must complete and submit an HSA claim form accompanied by any original receipts or payment statements from another insurer.
- Upon termination of employment, you have a 2 month grace period in which to claim for services incurred prior to your termination date. The only funds available to pay allowable expenses that are incurred prior to your termination date are existing credits in your HSA. Any credits remaining after the grace period are forfeited.

Wellness Spending Account (WSA)

WSA Benefit Year:	January 1st - December 31st
Minimum Payment Amount:	$2 daily for Members who have signed up for direct deposit and paperless statements $2 monthly for Members who have not signed up for direct deposit and paperless statements
Credit Allocation:	Credits are deposited to your WSA by your employer on an annual basis.
Carry Forward:	Unused WSA Credits carry forward for 12 months from the end of the Benefit Year in which they were allocated.
Run Off:	A 2 month run-off period will exist after the end of each Benefit Year to submit claims.
Grace period:	Upon termination of employment, you have a 2 month grace period in which to claim for services incurred prior to your termination date.

Benefits of a WSA

You can claim many expenses through your Wellness Spending Account (WSA) that would not otherwise be covered. Expenses incurred by you or your eligible Dependent which fall under the following WSA categories are eligible for coverage. The Eligible Expenses in each category are not comprehensive and are limited to the extent that they are deemed reasonable by Blue Cross. Products and services that are deemed a non-taxable medical expense by Canada Revenue Agency (CRA) are ineligible.

Enhanced Benefits

Health Support
Products and services that improve health and wellbeing

- Smoking cessation programs
- Weight management program fees
- Natural health products
- Stress management programs
- Nutritional counseling
- Nutritional supplements and meal replacement products (e.g. meal replacement shakes and protein powder)

Fitness and Sports Activity
Participation in physical activity that promotes good health

- Fitness centre membership
- Physical activity fees (e.g. gym drop in fees, lift tickets)
- Sports league / team membership
- Instruction for physical activities / lessons

* *Excludes equipment purchase or rental*

Fitness and Sports Equipment
Fitness and sports equipment that promotes good health

- Fitness equipment (e.g. treadmill, elliptical)
- Sports equipment (e.g. hockey sticks, skates and pads, bicycle helmet)
- Athletic footwear

* *Excludes clothing*

Professional Development
Supports continuous learning and career development

- Professional membership fees
- Course, seminar, conference or class (e.g. fees, books, texts, etc.)

Professional Development Travel
Supports travel associated with professional development activities

- Transportation to course, seminar, conference or class
- Parking
- Hotel accommodation
- Meals

Personal Interest
Supporting continuous learning in personal interests

- Photography courses
- Pottery classes and supplies
- Art classes and supplies
- Text books associated with personal interest courses

* *Only supplies that are included as part of the course fee are eligible*

Family Care
Attendant care and facility costs

- Child care
- Elder care

* *Excludes lessons or activities not related to childcare, school fees*

Commuting To Work
Transportation costs associated with commuting to work

- Transit passes/bus tickets
- Parking
- Cab fare

* *Excludes private vehicle related expenses*

Personal Insurance
Expenses associated with personal insurance premiums

- Critical illness
- Life insurance
- Disability

* *Excludes home and auto insurance*

Financial Contributions
Supporting financial security

- RRSP contributions
- TFSA contributions
- RESP contributions
- Pension buy-back

* *Excludes service fees and bank charges*

Legal and Financial Advice
Expenses associated with legal and financial advice

- Legal fees
- Financial advisor fees
- Accounting fees (including tax preparation)

Personal Computing and Mobile Digital Devices
Products and services for personal computing, planning, scheduling and communication

- Computer and peripherals
- Computer equipment repairs
- Software (non-gaming)
- Internet service and data usage fees
- GPS
- Cell phone and accessories
- Digital devices that can access the internet (e.g. iPad, iPod Touch)
- E-readers

* *Excludes MP3 players without internet connection, gaming (consoles, equipment and games) and printer paper*

Pet Care
Expenses associated with caring for a personal pet

- Veterinary expenses
- Training and obedience fees
- Pet insurance

* *Excludes pet food, grooming costs and pet supplies*

Work Apparel
Industry or employer required apparel

- Steel toed boots
- Coveralls
- Hard hats
- Safety gloves

* *Excludes dress clothes*

Recreational and Leisure Activity
Participation in recreation and leisure activities

- Boating fees
- Camping fees/equipment
- Darts
- Dirt biking/motocross equipment
- Fishing equipment
- Fishing/hunting licenses
- Gun range membership
- Hot tubs
- Items associated with a hobby ex camera, sewing supplies
- Musical instruments
- National Park Pass
- Recreational activity rental fees
- Sailboats/sailboat parts
- Sailing related fees and expenses
- Snowmobiles
- Snowmobile trail fees
- Tent trailers, RVs
- Trail ride fees
- Zoo/heritage park/science centre passes

* *Excludes classes, conferences, courses, firearms and ammunition, seminars*

Recreational and Leisure Travel
Products and services associated with destination travel

- All inclusive resort or cruise ship fees
- Cabin rentals
- Car rentals
- Entertainment shows
- Flights
- Hotel accommodation
- Travel insurance
- Theme park tickets

* *Excludes professional development travel, recreational leisure activities*

Fitness Apparel
Clothing used for fitness activity

- Dance wear
- Yoga wear
- Ski gloves

* *Excludes athletic footwear (covered under fitness equipment)*

Dental Support
Products that support and improve oral health

- Manual and electric toothbrushes
- Floss
- Toothpaste
- Whitening or bleaching kits and strips
- Denture cleaners and adhesive
- Water flossers
- Mouthwash

* *Excludes products or services that are deemed non-taxable expenses per Canada Revenue Agency*

Maintenance Assistance and Green Living
Expenses associated with making your life easier or supporting the environment

- Push lawnmowers
- Composters
- Energy saving lightbulbs/appliances
- Landfill expenses
- Rain barrels
- Snow removal services
- House cleaning services
- Lawn care maintenance fees
- Landscape services
- Low flush toilets
- Auto-detailing
- Solar energy and wind products
- Lead pipe and asbestos removal from home
- Car or bike sharing memberships and usage fees
- Air purification systems and installation costs
- Energy efficient products for home heating, cooling and lighting
- Energy home audits, cost to upgrade windows, programable thermostats and weather stripping

* *Excludes services provided by a relative, items purchased from a non-licensed vendor and landscaping products (e.g. flowers, building materials, rocks etc.)*

Work From Home
Equipment and supplies required to establish/maintain a work from home environment

- Office supplies
- Desk
- Desk chair
- Ergonomic equipment/devices (e.g. standing desk, lumbar/wrist/foot support, laptop stand)
- Web cams
- Shredder
- File storage

How Your Wellness Spending Account (WSA) Works

- Claims to your WSA are assessed against the credits in your account as allocated by your employer. Your employer will inform you of the amount credited to your WSA at the time your account is established and annually thereafter.
- When submitting claims for expenses to your WSA submit a claim form accompanied by any receipts or payment statements.
- Your WSA carries forward credits. You can carry forward credits for up to but no more than 12 months from the end of the Benefit Year in which they were allocated.

  A 2 month run-off period will exist after the end of each Benefit Year. This run-off period shall allow Members to direct Blue Cross to reimburse for prior Benefit Year expenses with prior Benefit Year Credits.
- Upon termination of employment, you have a 2 month grace period in which to claim for expenses incurred prior to your termination date. The only credits available to pay for expenses that are incurred prior to termination, are existing credits in your WSA. Credits cease to be earned upon termination, and those remaining after the grace period are forfeited to the employer.

Life and Disability Benefits

Life Insurance

Employee Life Insurance

Benefit Formula:	$30,000
Non-Evidence Limit:	$30,000
Reduction:	At age 70, the amount of insurance reduces by 50%
Termination:	Ceases at the Member's retirement

Terminal Illness

A special advance payment may be provided if you are suffering from a condition which is expected to result in death within 12 months of your request. The payment must be requested in writing and will be the lessor of $50,000 or 50% of your Employee Life Insurance coverage.

Extension of Coverage

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

Accidental Death and Dismemberment

The principal amount is equal to the amount of Employee Life Insurance.

Termination: Ceases at the earlier of the Member's retirement or age 70

In the event of loss occurring within 365 days after the date of injury, the amount payable shall be the following percentage of the principal amount for which the Member is insured on the date of the injury. The principal amounts of the benefits are defined in the Schedule of Benefits. The maximum amount payable for all losses sustained as a result of the same accident shall not exceed 100% of the amount of insurance with the exception of Quadriplegia, Paraplegia and Hemiplegia which will be paid at 200%. Only one amount, the largest applicable, will be payable for injuries to the same limb resulting from any one accident:

Loss of life	100%
Loss of or loss of use of both hands or both feet	100%
Loss of or loss of use of one hand and one foot	100%
Loss of the entire sight of both eyes	100%
Loss of one hand and the entire sight of one eye	100%
Loss of one foot and the entire sight of one eye	100%
Loss of or loss of use of both arms or both legs	100%
Loss of or loss of use of one arm and one leg	100%
Loss of speech and hearing	100%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of or loss of use of one arm or one leg	75%
Loss of or loss of use of one hand or one foot	66 2/3%
Loss of the entire sight of one eye	66 2/3%
Loss of speech or hearing	50%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four fingers on the same hand	33 1/3%
Loss of hearing in one ear	16 2/3%
Loss of all toes on one foot	12 1/2%

Exposure – a loss caused by unavoidable exposure to the elements is covered.

Disappearance – caused by accidental wrecking, sinking or disappearance of a conveyance is considered to be loss of life.

Coma Benefit – 1% of the principal amount payable monthly, following 31 consecutive days of complete and total unconsciousness caused by accidental injury.

Repatriation – $10,000 maximum reimbursement of burial expenses when death occurs more than 150 kilometers from the deceased's residence.

Rehabilitation – $10,000 maximum reimbursement of special training expenses for the Member.

Occupational Training for Spouse – $10,000 maximum reimbursement for a formal training program.

Education Benefit – the lesser of 5% of the Member's principal sum, or $5,000, for each of five years for post-secondary education for eligible dependent children or until the age of 25 inclusive, whichever occurs first.

Family Travel – $3,000 maximum reimbursement for family members to attend the hospital of confinement of the Member if confinement is more than 150 kilometers from their normal place residence.

The term "loss" is defined in the Group Contract.

Exclusions and Limitations

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

No benefit will be payable in respect of any loss caused directly or indirectly, wholly or in part by one or more of the following:

1. intentionally self-inflicted injuries, committing suicide, or attempting suicide.
2. insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion.
3. any accident or injury occurring while operating a motor vehicle under the influence of Drugs, including but not limited to marijuana; and/or with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred.
4. illness or disease of any kind, or medical or surgical Treatment thereof, other than septic infection caused through a wound accidentally sustained.
5. the voluntary consumption or use of any Drug unless it is analyzed as being in a therapeutic range as determined by the laboratory analyzing the specimen or used as prescribed to the insured by the insured's Physician.
6. travel or flight in or descent from any kind of aircraft if the Participant:
    - is a member of the aircraft crew, or
    - has any duties relating to the operation, maintenance, testing or control of the aircraft, or
    - is on the aircraft for the purpose of instruction or training.

Reduction Schedule

The reduction schedule (if applicable) coincides with that of the Employee Life Insurance.

Optional Life Insurance

Benefit Description:	Coverage is provided to the Member and/or spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Employee Life Insurance benefit plus the Optional Life Insurance benefit cannot exceed $330,000.
Non-Evidence Limit:	Evidence of insurability is required for all amounts of insurance.
Termination:	Member - Ceases at the earlier of the Member's retirement or age 70 Spouse - Ceases at the earlier of the Member's retirement or age 70, the Spouse's age 70 or when no longer an eligible Spouse

Optional Critical Illness

Amount of Insurance:	Coverage is provided to the Member and/or Spouse in units of $10,000 to a maximum of $150,000 per insured
Waiting Period:	30 consecutive days
Non-Evidence Limit:	Proof of good health is required on all optional amounts of coverage, except for the first $10,000 if enrolment is made within 31 days of the eligibility date
Termination:	Member - Ceases at the earlier of the Member's retirement or age 70 Spouse - Ceases at the earlier of the Member's retirement, the Member's age 70, the Spouse's age 70 or when no longer an eligible Spouse

Living Benefit

This benefit will be paid in a lump-sum payment to you if you or your covered dependents are afflicted with a Critical Illness as shown in the contract. You must provide medical evidence satisfactory to Blue Cross Life within 365 days following the end of the benefit waiting period.

A full benefit amount will be paid for up to two unrelated Covered Critical Illness Conditions for Multiple Event Coverage. Once a benefit has become payable for a Covered Critical Illness Condition in one category (Category 1, 2, 3 or 4), the Participant will not be covered under this benefit for any future Covered Critical Illness Condition specified under the same category.

Any Critical Illness benefit payment made under previous and current Critical Illness coverage with the Company will count as an unrelated Covered Critical Illness Condition for Multiple Event Coverage, and will be applied to the applicable category below.

Categories for Multiple Event Coverage

Category 1: Cancer (Life Threatening)

Category 2: Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement

Category 3: Blindness, Severe Burns, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV

Category 4: Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumor, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease, Stroke

Overview of Enhanced Critical Illness

The following are covered. All conditions, with the exception of burns, must be the result of illness or disease. Conditions resulting from an accident (except in the case of burns) will not be eligible for coverage.

The following Covered Critical Illnesses are eligible for full payment with Multiple Event Coverage:

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

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

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

   (a) marrow stimulating agents;

   (b) immunosuppressive agents;

   (c) bone marrow transplantation.

   The diagnosis of Aplastic Anemia must be made by a Medical Specialist.

3. *Bacterial Meningitis*: The definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

   The diagnosis of Bacterial Meningitis must be made by a Medical Specialist.

   For purposes of this policy, neurological deficits must be detectable by the Medical Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

4. *Benign Brain Tumor*: The definite diagnosis of a non-malignant tumor located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The insured must have undergone surgery or radiation treatment or the tumor must have caused irreversible objective neurological deficit(s).

   These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

   The diagnosis of Benign Brain Tumor must be made by a Medical Specialist.

   For purposes of this policy, neurological deficits must be detectable by the Medical Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

(a) pituitary adenomas less than 10 mm;

(b) vascular malformations;

(c) cholesteatomas;

(d) infectious or inflammatory tumors.

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

(a) signs, symptoms or investigations leading directly or indirectly to a diagnosis of any Benign Brain Tumor (covered or not covered under this policy), regardless of when the diagnosis is made; or

(b) a diagnosis of any Benign Brain Tumor (covered or not covered under this policy).

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

5. *Blindness*: The definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

   (a) the corrected visual acuity being 20/200 or less in both eyes; or

   (b) the field of vision being less than 20 degrees in both eyes.

   The diagnosis of Blindness must be made by a Medical Specialist.

6. *Cancer (Life Threatening)*: The definite diagnosis of a malignant tumor. This tumor must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

   The diagnosis of Cancer must be made by a Medical Specialist and must be confirmed by a pathology report.

   For purposes of this policy:

   (a) T1a or T1b prostate cancer means a clinically inapparent tumor that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.

   (b) the term gastrointestinal stromal tumors (GIST) classified as AJCC Stage 1 means:

      - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5mm2, or 50 per HPF; or
      - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF.

   (c) the terms Tis, Ta, T1A, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

   (d) the term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

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

(a) lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;

(b) malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

(c) any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;

(d) prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

(e) papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;

(f) chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;

(g) gastro-intestinal stromal tumors classified as AJCC Stage 1;

(h) grade 1 neuroendocrine tumors (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumor; or

(i) thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

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

(a) signs, symptoms or investigations, leading directly or indirectly to a diagnosis of any cancer (covered or not covered under this policy), regardless of when the diagnosis is made; or

(b) a diagnosis of any cancer (covered or not covered under this policy).

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

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

   The diagnosis of Coma must be made by a Medical Specialist.

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

   (a) a medically induced coma;
   (b) a coma which results directly from alcohol or Drug use; or
   (c) a diagnosis of brain death.

8. *Coronary Artery Bypass Surgery*: Heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

   The surgery must be determined to be medically necessary by a Medical Specialist.

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

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

   The diagnosis of Deafness must be made by a Medical Specialist.

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

    (a) aphasia (a disorder of speech);

    (b) apraxia (difficulty performing familiar tasks);

    (c) agnosia (difficulty recognizing objects); or

    (d) disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

    The Participant must exhibit:

    (a) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

    (b) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six month period.

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

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

11. *Dilated Cardiomyopathy*: The definite diagnosis of a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The diagnosis must be confirmed by new, abnormal cardiac function demonstrated in echocardiography with a persistent low ejection fraction (less than 40%) for at least 3 months.

    For the purpose of this benefit, NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

    Exclusions: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

12. *Fulminant Viral Hepatitis*: The definite diagnosis of a submassive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all the following:

    (a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;

    (b) necrosis involving entire lobules, leaving only a collapsed reticular framework (available histology to be included);

    (c) rapidly deteriorating liver function tests;

    (d) deepening jaundice.

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

    (a) chronic hepatitis;

    (b) liver failure caused by alcohol, toxins and/or Drugs.

13. *Heart Attack*: The definite diagnosis of death of heart muscle due to obstruction of blood flow, that results in:

    A rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

    (a) heart attack symptoms;
    (b) new electrocardiographic (ECG) changes consistent with a heart attack; or
    (c) development of new pathological Q waves on ECG following coronary angiography and/or angioplasty.

    The diagnosis of Heart Attack (acute myocardial infarction) must be made by a Medical Specialist.

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

    (a) ECG changes suggestive of a prior myocardial infarction;
    (b) other acute coronary syndromes, including angina pectoris and unstable angina; or
    (c) elevated cardiac biomarkers markers and/or symptoms that are readily explained by diagnoses other than heart attack.

14. *Heart Valve Replacement or Repair*: The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Medical Specialist.

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

15. *Kidney Failure*: The definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

    The diagnosis of Kidney Failure must be made by a Medical Specialist.

16. *Loss of Independent Existence*: The definite diagnosis of the total inability, due to disease or injury, to perform independently:

    (a) with or without the aid of assistive devices;
    (b) at least three of six Activities of Daily Living listed below;
    (c) for a continuous period of at least 90 days;
    (d) with no reasonable chance of recovery; and
    (e) the diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

    For further clarity, a total inability to perform independently means the inability to perform by oneself three of the six Activities of Daily Living listed below, with or without the aid of assistive devices.

    Activities of Daily Living are:

    (a) bathing – washing oneself in a bathtub, shower or by sponge bath;
    (b) dressing – putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
    (c) toileting – getting on and off the toilet and maintaining personal hygiene;
    (d) bladder and bowel continence – managing your bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
    (e) transferring – moving in and out of a bed, chair or wheelchair; and
    (f) feeding – consuming food or drink that already have been prepared and made available.

    No additional survival period is required once the conditions described above are satisfied.

17. *Loss of Limbs*: The definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

    The diagnosis of Loss of Limbs must be made by a Medical Specialist.

18. *Loss of Speech*: The definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

    The diagnosis of Loss of Speech must be made by a Medical Specialist.

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

19. *Major Organ Failure on Waiting List*: The definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Participant must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Waiting Period, the date of Diagnosis is the date of the Participant's enrolment in the transplant centre.

    The diagnosis of the major organ failure must be made by a Medical Specialist.

20. *Major Organ Transplant*: The definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

    The diagnosis of the major organ failure must be made by a Medical Specialist.

21. *Motor Neuron Disease*: The definite diagnosis of one of the following:

    (a) amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
    (b) primary lateral sclerosis;
    (c) progressive spinal muscular atrophy;
    (d) progressive bulbar palsy; or
    (e) pseudo bulbar palsy; and limited to these conditions.

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

22. *Multiple Sclerosis*: The definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of the last reinstatement of this policy:

    (a) two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
    (b) a single attack, with objective neurological deficits lasting more than six months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
    (c) a single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

    The diagnosis of Multiple Sclerosis must be made by a Medical Specialist.

    For purposes of this policy, neurological deficits must be detectable by a Medical Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

(a) solitary sclerosis;

(b) clinically isolated syndrome;

(c) radiologically isolated syndrome;

(d) neuromyelitis optica spectrum disorders; or

(e) suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: No benefit will be payable under this condition if, within the first year following the later of the effective date of this policy or the date of the last reinstatement of this policy, the Participant has any of the following:

(a) signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under this policy) regardless of when the diagnosis is made; or

(b) a diagnosis of multiple sclerosis (covered or not covered under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within six months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

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

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

    (a) the accidental injury must be reported to the insurer within 14 days of the accidental injury;

    (b) a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

    (c) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

    (d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and

    (e) the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

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

    (a) the Participant has elected not to take any available licensed vaccine offering protection against HIV; or,

    (b) a licensed cure for HIV infection has become available prior to the accidental injury; or,

    (c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) Drug use.

24. *Paralysis*: The definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

    The diagnosis of Paralysis must be made by a Medical Specialist.

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

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

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

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

    (b) a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

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

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

25. *Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)*: The definite diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization), resulting in permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

    The NYHA Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment - 39th Edition) states the following about Class IV: "Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

    Exclusion: No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

26. *Progressive Systemic Sclerosis*: The definite diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The diagnosis must be unequivocally supported by biopsy and serological evidence.

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

    (a) localized scleroderma (linear scleroderma or morphea);

    (b) eosinophilic fasciitis; or

    (c) CREST syndrome.

26. *Severe Burns*: The definite diagnosis of third-degree burns over at least 20% of the body surface.

    The diagnosis of Severe Burns must be made by a Medical Specialist.

27. *Stroke (Cerebrovascular Accident)*: The definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism, with:

    (a) acute onset of new neurological symptoms; and

    (b) new objective neurological deficits on clinical examination,

    persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

    The diagnosis of Stroke must be made by a Medical Specialist.

    For purposes of this policy, neurological deficits must be detectable by a Medical Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

    (a) transient ischemic attacks;

    (b) intracerebral vascular events due to trauma;

    (c) ischemic disorders of the vestibular system;

    (d) death of tissue of the optic nerve or retina without total loss of vision of that eye; or

    (e) lacunar infarcts which do not meet the definition of stroke as described above.

Covered Critical Illness Conditions for Partial Payment

A benefit of 10% to a maximum of $25,000 is payable with any of the following non-life-threatening Covered Critical Illnesses Conditions. The Participant is eligible for one partial payment per non-life-threatening Covered Critical Illnesses Conditions.

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

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

1. *Coronary Angioplasty:* The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

   The procedure must be determined to be medically necessary by a Medical Specialist.

2. *Ductal Carcinoma In Situ Of The Breast*: Ductal carcinoma in situ of the breast is a non-invasive cancer and must be confirmed by biopsy.

   The diagnosis of ductal carcinoma in situ of the breast must be made by a Medical Specialist.

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

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

   (b) a diagnosis of Cancer (covered or excluded under this policy).

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

   The diagnosis of Stage 1A malignant melanoma must be made by a Medical Specialist.

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

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

   (b) a diagnosis of Cancer (covered or excluded under this policy).

4. *Stage A (T1a or T1b) Prostate Cancer:* Stage A (T1a or T1b) prostate cancer must be confirmed by pathological examination of prostate tissue.

   The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a Medical Specialist.

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

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

   (b) a diagnosis of Cancer (covered or excluded under this policy).

Covered Childhood Conditions

A full benefit amount will be paid for one Covered Childhood Condition. Once a benefit has become payable for a Covered Childhood Condition, the Participant will no longer be covered under this benefit.

The following Childhood Conditions are eligible for a full benefit payment:

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

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

   (a) total anomalous pulmonary venous connection
   (b) transposition of the great vessels
   (c) atresia of any heart valve
   (d) coarctation of the aorta
   (e) single ventricle
   (f) hypoplastic left heart syndrome
   (g) double outlet left ventricle
   (h) truncus arteriosus
   (i) tetralogy of fallot
   (j) Eisenmenger syndrome
   (k) double inlet ventricle
   (l) hypoplastic right ventricle
   (m) Ebstein's anomaly

The above conditions are covered after a 30 day Waiting Period, beginning from the later of the date of diagnosis or birth.

The diagnosis of any of the conditions in must be made by a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

(a) pulmonary stenosis
(b) aortic stenosis
(c) discrete subvalvular aortic stenosis
(d) ventricular septal defect
(e) atrial septal defect

The above conditions are covered only when open heart surgery is performed for correction of the condition after a 30 day Waiting Period from the later of the date of diagnosis or birth.

The diagnosis of any of the conditions must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada.

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

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

5. *Type 1 Diabetes Mellitus*: The definitive diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival.

   The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of three months.

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

7. *Down Syndrome*: The definitive diagnosis of Down's Syndrome supported by a qualified pediatrician.

Exclusions and Limitations

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

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

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

1. an accident except for severe burns, or
2. self-inflicted injury or sickness, or
3. insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion, or
4. any accident or injury occurring while operating a motor vehicle under the influence of Drugs, including but not limited to marijuana; and/or with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred.

Pre-Existing Conditions

A Pre-Existing Condition means any Covered Critical Illness Condition for which, during the 24 months immediately prior to the effective date of the Critical Illness coverage, the Participant has been prescribed medication or has received medical Treatment, consultation, care or services by a Physician, including diagnostic measures for any symptom or medical problem which leads to a diagnosis of, or Treatment for, a Covered Critical Illness.

Critical Illness benefits are not payable as a result of any Pre-Existing Condition unless the Covered Critical Illness occurs after 24 consecutive months of coverage.

General Provisions

Employee

A person who is an active and permanent or temporary Employee of the Policyholder. An Employee must belong at all times to the class or classes of Employees covered by this Contract as specified in the Benefit Summary. All Employees must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

In order to be eligible for benefits an Employee is required to work at least 17.5 hours per week for the Policyholder.

All eligible Employees must apply for coverage within 31 days of becoming eligible for coverage and maintain coverage, except Employees covered under another group plan through a spouse or other employer.

Once approved for coverage an Employee is referred to as a Member.

Dependent

The Member's eligible Spouse and Children as defined below.

1. Spouse shall mean a person who is legally married to the Member, or who is not legally married to the Member but has continuously resided with the Member for not less than 12 consecutive months having been represented as members of a conjugal relationship (common-law).

   The Member requesting coverage for a common-law spouse must give written notice to Blue Cross. Unless such written request is made, the person legally married to the Member shall be considered to be the covered spouse. Discontinuance of cohabitation with the Member shall terminate coverage of the common-law spouse.

   The Member cannot claim a status of legally married and common-law at the same time. Only 1 spouse, as defined above, can be covered during any 1 period of time.

2. Children shall mean the Member's natural, adopted or stepchildren of the Member or Member's Spouse; or any other children for whom the Member or Member's Spouse has been appointed guardian. Such children must:
   (a) be dependent on the Member for financial care and support,
   (b) not be legally married or in a common law relationship that is 12 months or more in duration; and
   (c) be less than 21 years of age; or, if 21 years of age but less than 26 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

   Unmarried and unemployed children over 21 years of age shall qualify, if they are dependent upon the Member by reason of a mental or physical disability, and have been continuously disabled prior to attaining age 21. Unmarried children who become totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 26, and have been continuously disabled since that time shall also qualify as a Dependent.

   A child is considered to be mentally or physically disabled if they are incapable of engaging in any substantially gainful activity and is dependent on the Member for support, maintenance and care due to this disability. Blue Cross may require written proof of the Dependent's condition as often as may reasonably be necessary.

   The children of the Member's common-law spouse shall be covered provided the children are dependent upon the Member for financial care and support.

   All changes to add or delete eligible Dependents must be made in writing to Blue Cross.

Conversion Privilege

Health and Dental

Conversion Privilege

If a Member's coverage ceases because of termination of employment, or termination of membership in the class of Employees eligible for coverage under this Contract, then the Member may apply within 31 days of the termination date of this Contract to convert to one of the programs available to individuals through Blue Cross at that time.

The conversion option is also extended to Dependents. In the event of loss of coverage due to a change in status, or the Member's death, a spouse or dependent child may apply within 31 days of the change to convert to one of the programs available to individuals through Blue Cross at that time.

Survivor Benefit

In the event of a Member's death, Blue Cross will waive the monthly Member rates and continue benefits for the surviving Dependent(s) commencing the first day of the month following death and will be effective for a period not exceeding 24 months.

Employee Life Insurance

Conversion Privilege

If your Employee Life Insurance coverage ceases on or before attaining 65 years of age because of retirement, termination of employment or termination of membership in the class of Members eligible for insurance under this plan, then the Member may purchase an individual policy of the type then being offered by Blue Cross in an amount not to exceed the amount of Employee Life Insurance for which the Member was covered on the date of termination, or $200,000.

This conversion option also applies to scheduled reductions or termination of coverage which become effective at specified ages.

Limited conversion rights are available on termination of the Group Policy in accordance with applicable provincial legislation. If the Employee Life Insurance policy is not being replaced, all Members who had been insured for at least five continuous years may convert their Employee Life Insurance coverage in the same manner as terminating Members.

Critical Illness

Conversion Privilege

If a Member's Enhanced Critical Illness Insurance coverage ceases on or before attaining 65 years of age because of retirement, termination of employment or termination of membership in the class of Members, then the Member may purchase a conversion Critical Illness Insurance policy.

To be eligible for the Conversion Option, the Enhanced Critical Illness coverage or prior carrier's equivalent Critical Illness coverage must have been in effect for an uninterrupted 24 months, the conversion application must be made within 31 days of termination, the Member must be 65 years of age or younger to apply for individual coverage, the individual plan terminates at age 70 and the individual plan maximum coverage amount is the lesser of the Member's previous group CI coverage maximum or $100,000.

Claiming Provisions

Claiming Benefits

1. * Prescription Drug benefits are provided on a direct payment basis. Upon presenting your Blue Cross identification number, most pharmacies will bill Blue Cross directly.
2. * Hospital benefits are provided on a direct payment basis. Upon presenting your Blue Cross identification number, most hospitals will bill Blue Cross directly.
3. * Extended Health benefits are covered on a reimbursement basis. The Participant must complete a claim form approved and supplied by Blue Cross and submit an official paid receipt in support of the amount claimed, as required.

   Note: Some Extended Health service providers are eligible to bill Blue Cross directly for payment.
4. * Out of Province Emergency Travel benefits should be claimed on a Travel claim form.
5. * Vision Services are covered on a reimbursement basis. The Participant must complete a claim form approved and supplied by Blue Cross and submit an official paid receipt in support of the amount claimed, as required.

   Note: Some Vision Service providers are eligible to bill Blue Cross directly for payment.
6. * Dental Claim Forms must be completed by the dental office at the time the dental treatment is provided. The provider may elect to bill Blue Cross directly for payment, or may choose to collect the cost of services from the patient. It is then the patient's responsibility to forward the completed Dental Claim Form to Blue Cross for reimbursement.
7. In reference to Employee Life Insurance, Accidental Death & Dismemberment, Dependent Life Insurance, Critical Illness, Short Term Disability or Long Term Disability claims, please obtain the necessary form from your Employer. Certain portions must be completed by the Employer, the claimant and/or the attending physician. Once the claim forms are completed, they should be submitted to the insurer for processing. Written notice of claim must be given to the insurer within 31 days of loss. Claims for disability benefits should be reported within 90 days immediately following the end of the Elimination Period; or, if this is not reasonably possible, at least within six months of the commencement of disability.

* NOTE: Payment of allowable expenses will be made providing a claim is submitted within 12 months of the date such expense was incurred.

Claim forms may be obtained from any pharmacy, dental office or any Blue Cross office.

Claim forms can also be obtained from the Alberta Blue Cross website at www.ab.bluecross.ca/forms.php

Claims may also be submitted to Alberta Blue Cross online via the Alberta Blue Cross secure website for plan members. Sign in at www.ab.bluecross.ca and follow the instructions to submit your eligible claim online.

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, you may obtain copies of the following documents; your enrollment form or application for insurance, and any written statements or other records, not otherwise part of the application, provided to Blue Cross as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies. All requests for copies of documents should be requested in writing to Blue Cross.

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.

Beneficiary

If this policy is replacing a Previous Policy, then the beneficiary designations made under the Previous Policy are continued under this policy.

All employees may appoint or update their beneficiary designation with Blue Cross online through our member site or by completing a beneficiary designation form available on our public site at: https://www.ab.bluecross.ca/pdfs/beneficiary-form.pdf

Misrepresentation/Fraud

Coverage for Participants may be suspended or terminated by Blue Cross immediately, without notice, if a Participant:

- assists a person to obtain, or attempt to obtain, Benefits for which such person is not eligible;
- assists or knowingly participates in any act with a Provider that has the purpose or effect of enabling the Provider or a Participant to submit false, misleading or fraudulent claims; or
- makes any false statements, knowingly provides false information or withholds material information to obtain benefits for which they were not eligible.

The Member must reimburse Blue Cross for any amounts received from Blue Cross in such circumstances.

Blue Cross may, in its discretion, from time to time, review the qualifications, practices and claims of Providers and deem certain Providers ineligible. In such case, Blue Cross reserves the right, in its sole discretion, to refuse to accept claims submitted to it by or on behalf of a Participant in relation to that Provider.

Disclaimer

This material summarizes the important features of your group program. It is prepared as information only; and does not, in itself constitute an Agreement. The exact terms and conditions of your group benefits program are described in the Group Benefits Contract held by your employer. In the event of a discrepancy between this booklet and the Group Benefits Contract, the Group Benefits Contract will be deemed accurate.

Confidentiality, Security & Privacy

Personal information is the foundation of Blue Cross' business. Without specific, individual information about plan Members and their Dependents Blue Cross cannot administer their health, dental and life and disability benefits. As a health-information based organization, Blue Cross has always operated within a culture of confidentiality; respecting and maintaining the privacy and security of all of the personal information it holds. Blue Cross has developed information privacy and security policies and procedures to guide the actions of anyone working for us, from the moment we begin receiving customers' personal information to enroll them to disposing of it when no longer needed. These are summarized on our web site at: www.ab.bluecross.ca or are available upon request by calling Blue Cross.