Group Name and Number(s)

Burnaby Association for Community Inclusion
– Community Living Unionized Employees: BCGEU –

Employee Classification
Community Living Unionized Employees - BCGEU

Group Number(s)
PBC & BC Life..... 24162
ACE INA Life Insurance..... CC50058301
Acclaim Ability..... 23654

September 2014

Introduction

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

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

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

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and British Columbia Life & Casualty Company (BC Life) are referred to as "we", "us", or "our" in this booklet, ACE INA Life Insurance is referred to as ACE and Benefits by Design is referred to as "we", "our", or "us" in this booklet. We will refer to you, the employee/member, as "you" or "your" in this booklet.

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

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

BC Life
Group Term Life
Long Term Disability (LTD)

ACE INA Life Insurance
Basic Accidental Death & Dismemberment (AD&D)

ACCLAIM Ability Management Inc.
Early Intervention Program

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

Table of Contents

Our Commitment to Privacy

Our Privacy Code balances the privacy rights of our group and benefit plan participants, and our employees, with the legitimate information requirements to provide customer service and to meet our human resource requirements. It consists of the following key principles:

1) We ask for your personal information for the following purposes:
   - To establish your identification
   - To provide you and/or your dependents with the applicable benefit coverage
   - To protect you and us from error and fraud
   - To provide ongoing services

2) Consent
   When you enrolled in your group benefit plan as a plan participant, your personal information was obtained and used only with your consent. We obtained your consent before we:
   - Provided benefit coverage
   - Obtained, used or disclosed to other persons, information about you unless we were obliged to do so by law or to protect our interests
   - Used your personal information in any way we did not tell you about previously

   Your consent can be either express or implied. Express consent can be verbal or written. Consent can be implied or inferred from certain actions. For our existing group and benefit plan participants, we will continue to use and disclose your personal information previously collected in accordance with our current privacy code, unless you inform us otherwise and will infer that consent has been obtained by your continued use.

3) Withdrawal of Consent
   You can withdraw your consent any time after you've given it to us, provided there are no legal or regulatory requirements to prevent this. If you don't consent to certain uses of personal information, or if you withdraw your consent, we will no longer be able to administer your benefit coverage. If so, we will explain the situation to you to help you with your decision.

For further information on our privacy policies and procedures, please refer to the BBD web site at www.bbd.ca.

Schedule of Benefits

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

Extended Health Care - *Underwritten by PBC*		
Deductible	$45 per person or family each calendar year.	
	If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.	
Reimbursement	**In-Province/Territory Eligible Expenses**	
	Hospital Rooms	100%
	All Other Eligible Expenses	80%
	Out-of-Province/Territory Eligible Expenses	
	Emergency	100%
	Non-Emergency	Same as In-Province/Territory
	After $1,000 has been paid for a person in a calendar year, further Eligible expenses for that person within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract.	
Termination	Retirement	
Dependent Children	See definition of Dependent.	

Dental Care - *Underwritten by PBC*			
Deductible	No Deductible		
Reimbursement	**Plan A**	**Plan B**	**Plan C**
	Basic Services	Major Restorative Services	Orthodontics
	100%	60%	60%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Life Time**
Financial Limit Per Dependent Child	Not Applicable	Not Applicable	$2,750
Financial Limit Per Member or Spouse	Not Applicable	Not Applicable	$2,750
Financial Limit for Late Applicants	$250 per person for all dental services for first 12 months of coverage		
Termination	Retirement		
Dependent Children	See definition of Dependent.		

Group Term Life – *Underwritten by BC Life*	
Benefit Amount	$50,000
Living Benefit Amount	50% of the Group Term Life Benefit Amount, to a maximum of $50,000
No Evidence Limit	$50,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 70 or earlier retirement

Long Term Disability – *Underwritten by BC Life*	
Benefit Amount	70% of monthly basic earnings rounded to the next higher $1, if not already a multiple of $1, to a maximum of $6,000
Non Evidence Limit	$6,000
Elimination Period	180 Days
Maximum Benefit Period	Age 65 or earlier retirement with the following exception: If you reach termination age while receiving benefits and have been receiving payments for less than 12 months, benefit payments will continue during disability until you have received 12 months of benefits.
Termination	Age 65 less the elimination period or earlier retirement

Basic Accidental Death & Dismemberment (AD&D) - *Underwritten by ACE Life*	
Principal Sum	An amount equal to the amount payable under your current group term life insurance.
Aggregate Limit	$1,000,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 70 or earlier retirement

PBC/BC Life

This section includes a description of the benefits underwritten by PBC/BC Life under Group Number 24162.

General Information

Definitions

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

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

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

Dependent
means any of the following persons for whom coverage is provided under this Plan:
1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 19 and financially dependent on you or your Spouse, and
3) under age 26 if the unmarried child is also in full-time attendance at a recognized educational institute, and
4) any unmarried handicapped child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Handicap status is subject to approval by Us. The Dependent must become handicapped while covered as a Dependent under Clause 2 or 3 above.

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

Enrolment grace period
means,
1) within 4 months (for Pacific Blue Cross benefits), or
2) within 31 days (for BC Life benefits)
from the coverage effective date.

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

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

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

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

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

Member Information/Access to Records

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.
2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other

fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.

3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy
   c) any written statement or other record provided to us as evidence of insurability of the Member.
6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

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

Effective Date of Coverage and Enrolment

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

You should apply for Dependent coverage (when applicable):

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

Limitations:

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

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

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

Late Applicants

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

Beneficiary

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

Identification (ID) Cards

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

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

Claims

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.

3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.
4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

General Exclusions

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

Legal Action

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

Continuation of Coverage

Your coverage will continue if you are on maternity or parental leave (as defined by the Employment Standards Act). Coverage will also continue during an unpaid leave of absence or while your are receiving sick pay for the first 20 work shifts in any calendar year.

Coverage may continue beyond the first 20 work shifts if you pay 100% of the contributions during a leave of absence or while receiving sick pay.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, age limitation or retirement, if you terminate your employment, or if the group plan terminates, etc.

For further details on termination of coverage, please contact your Plan Administrator.

Right of Recovery

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

Conversion to an Individual Plan

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

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

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

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

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

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

Individual Travel Benefits

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

CARESnet

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

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

All dollar limits included in the benefit descriptions are **eligible** unless specifically shown as **payable**.

To determine the benefit amount **eligible**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- applies the eligible limits
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the EHC plan maximum.

To determine the benefit amount **payable**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the payment limits
- applies the EHC plan maximum.

Definitions

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

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

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging), which represents an amount in

excess of the schedule of costs prescribed by the government plan. PharmaCare's low cost alternative and reference daily price policies will not be applied unless specified in this booklet.

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

Practitioner
means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided, but excludes a psychologist or counsellor employed by your employer.

In-Province/Territory Eligible Expenses

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

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

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

3) Drugs and medicines
   Charges for drugs and medicines in a quantity we consider reasonable, and
   a) which are dispensed by a pharmacist, Physician, or a Dentist, including:
      i) insulin preparations, testing supplies, needles, and syringes for diabetics
      ii) vitamin B12 for the treatment of pernicious anemia
      iii) allergy serums when administered by a Physician, or
   b) which legally require a prescription from a medical provider legally authorized to do so.

   Only those drugs and medicines covered by PharmaCare will be considered Eligible expenses under your EHC plan.

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician.* For certain Practitioners (chiropractor, massage practitioner, naturopath, physiotherapist, and podiatrist), we will pay a visit fee to a maximum of $10 per visit per Practitioner for the first 12 visits (under age 65), first 15 visits (age 65 and over), subject to your plan's maximum benefit amount and reimbursement percentage. We will pay the full amount of any further visits to these Practitioners, subject to the reimbursement percentage and any remaining benefit.

a) acupuncturist $500
b) chiropractor $500
c) massage practitioner $500
d) naturopath $500
e) physiotherapist $500
f) podiatrist $500
g) psychologist/social worker/clinical counsellor combined $500
h) speech language pathologist $500
i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province/territory of residence.

5) Dental Accident

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

Accidental

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

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

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

Charges for the following services and supplies:

a) oxygen
b) ostomy and ileostomy supplies
c) walkers, canes and cane tips, crutches, casts, and trusses
d) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, or chiropractor as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
e) mastectomy brassieres to a maximum of 1 brassiere per calendar year when required as a result of medical treatment for injury or illness

f) charges for the following items to the limitations or maximum amounts indicated per calendar year:
   i) stump socks .....no maximum
   ii) surgical stocking .....2 pairs

g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500

h) when prescribed by a Physician, podiatrist, or chiropractor (including a physiotherapist for orthotics) as medically necessary after diagnosis of the patient (including an in person biomechanical assessment for orthotics):
   i) custom made orthopaedic shoes (including repairs) and modifications to stock item footwear, and
   ii) custom made orthotics

   to a combined calendar year maximum of $500 per adult and $300 per Dependent Child. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

i) hearing aids and repairs to a maximum of
   i) $1,000 in a 48 month period for adults, and
   ii) $1,000 in a 24 month period for dependent children.

   Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

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

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

8) Insulin Infusion Pump
When prescribed by a Physician and upon our approval, charges for the reasonable and customary cost of an insulin infusion pump. Charges for repairs or replacements for the insulin infusion pump, whichever is most appropriate, shall be considered after the warranty expiration date.

9) Vision Care and Laser Eye Surgery
Charges for the following when prescribed by a Physician or legally authorized optical provider (as applicable)
a) purchase and/or repair of eyewear and charges for contact lens fittings, and
b) laser eye surgery
to a combined maximum of $225 in a 24 month period. Charges for non-prescription eyewear are not covered.

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

Extended Health Benefit – Second Opinion™

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

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

1) AIDS
2) Alzheimer's disease
3) Any disease requiring amputation
4) Any life threatening illness
5) Benign brain tumor
6) Cancer (all types)
7) Cardiovascular conditions, including heart attack (myocardial infarction), coronary bypass surgery, or aortic surgery
8) Coma
9) Deafness
10) Emphysema
11) Hip and/or knee replacement
12) Loss of speech

13) Loss of eyesight
14) Major lung and bone disorders
15) Major trauma
16) Neuro-degenerative diseases (e.g. Multiple sclerosis)
17) Paralysis
18) Parkinson's disease
19) Renal insufficiency or kidney failure
20) Severe burns
21) Stroke (Cerebrovascular accident)
22) Thrombophlebitis and embolism
23) Vital organ transplants

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

In the event that the medical specialist proposes a course of treatment outside of Canada and the patient wishes to pursue this treatment, the benefit will include coordination between the patient, their Physician and the treatment centre, and assistance, to facilitate timely transportation, accommodation and treatment. However, this benefit does not cover the cost of the travel, accommodation and treatment costs; these are the responsibility of the patient.

If you or your Dependents have been diagnosed with one of the conditions listed above, you can seek Second Opinion by calling 1-866-895-1371 (toll-free) between 9:00 am and 4:00 pm (Eastern or Pacific time). You will be asked for your Pacific Blue Cross policy number, as shown on your ID card.

This benefit terminates:
1) for you and your Dependents when your employment is terminated, on your retirement, on termination of the EHC benefit, or when you reach age 70, whichever occurs first, and
2) for any Dependent who reaches age 70, provided your coverage has not terminated as indicated above.

Disease Support Programs

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

Services available, including but not limited to:
1) Support groups.
2) Tools for patient to take charge of their health.
3) Natural approaches to prevention and treatment.
4) Multidisciplinary team of Physicians and health care practitioners.
5) Individualized cancer survivorship plan.

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

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

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

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

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory of residence, benefits are payable for the following Eligible expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.
1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.
   If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.

4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.
6) Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to his or her place of residence in Canada in the event you and/or your Spouse is hospitalized and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.
7) Charges, limited to the cost of one-way economy fare air transportation, for the delay of the return trip of you or your Spouse due to the hospitalization of another insured person with whom you or your Spouse are travelling.
8) Charges, limited to return economy fare air transportation, for one immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.
9) Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of $5,000 per family per medical emergency.
10) Charges for accommodation for convalescence following hospitalization to a maximum of $75 per day per patient for a maximum of 5 days per medical emergency.
11) Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized Member or Dependent to a maximum of $100 per day up to 7 days per family per medical emergency.
    Limitation:
    Expenses only apply if the immediate family member had to travel to visit the patient, or if the immediate family member had to extend his or her stay beyond the scheduled date of his or her return trip.
12) Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of $500 per medical emergency.
13) Charges for the repatriation of a deceased Member and/or Dependent to their place of residence to a maximum of $5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to $1,500.

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

Emergency Travel Assistance

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

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

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

Exclusions

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

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province/territory of residence
2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
3) except as specifically included in this booklet: contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
4) allergy testing unless rendered by a naturopath
5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests

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

Claims

Electronic Claims

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

after the **June 30th** deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.

5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

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

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

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.
2) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming PharmaCare expenses may be obtained from you pharmacist.
3) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet.
   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
   c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

   Example: We must receive your receipts for 2014 before June 30, 2015.

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

Helping You Live Better

My Good Health

CaresNet Health Resources
Small changes in our lifestyle can have a big impact on our health. But most of us find it difficult to make the time or we don't know where to start. With My Good Health from Blue Cross it's never been easier for you to take control of your health and well-being.

What is My Good Health?
My Good Health is a new resource site for plan members. Accessible to all Pacific Blue Cross members and their spouses, it contains everything you need to get on the road to better health.

Build Your Health Profile
When you first sign in to My Good Health, you'll want to build your personal health profile*. It takes about 10 – 15 minutes to build your profile by answering a few questions. The questions are easy and help you understand your health risks. You get an easy to understand report that shows you where you're doing well, how ready you are for a change, and where you can take action. My Good Health even helps you create a plan to get you where you want to go.

Some of the other great things you can do at My Good Health

- Discover new prevention and treatment options
- Learn the details of drugs prescribed to you
- Find out more about natural products and remedies
- Calculate your risks
- Count calories
- Test your health knowledge
- Check your symptoms
- Watch health videos
- Sign up for our new health e-newsletter
- Access community support

We want you to be as healthy as you can be

My Good Health provides easy to understand information you can trust and puts you in control of your health. And with user-friendly tools, you can make informed health decisions for you and your family.

Dental Care

Payment of Benefits

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

Plan A – Basic Preventive & Restorative Services

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

1) Diagnostic services
   a) examinations:
      i) complete – provided we have not paid for any other exam in the past 9 months for adults and in the past 6 months for Dependent children under age 19 – 1 per 3 year period
      ii) recall – 1 per 9 month period for adults and 2 per calendar year for Dependent children under age 19
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment)

b) x-rays
   i) diagnostic
   ii) panoramic – 1 per 2 year period
   iii) complete mouth series – 1 per 3 year period
   All x-rays combined shall not exceed the dollar limit for a complete mouth series.
c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing – 1 per 9 month period for adults and 2 per calendar year for Dependent children under age 19
   c) topical application of fluoride – 1 per 9 month period for adults and 2 per calendar year for Dependent children under age 19
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

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

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

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

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

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances

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

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

Plan B – Major Restorative Services

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

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

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

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

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

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

Limitations
1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed after you have been eligible for benefits under the collective agreement for a 12 consecutive month period. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

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

Emergency Treatment Outside Your Province/Territory of Residence

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

Exclusions

The following are not Eligible expenses under your dental plan:

1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
2) any item not specifically included as a benefit
3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
4) procedures performed for congenital malformations or for purely cosmetic reasons
5) charges for drugs, medicines, pantographic tracings, and grafts
6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule

7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
9) incomplete or temporary procedures
10) recent duplication of services by the same or different Dentist
11) any extra procedure which would normally be included in the basic service performed
12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
13) travel expenses incurred to obtain dental treatment.

Claims

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

the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when We receive:
   i) a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or
   ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

5) Orthodontic Claims Procedures

a) Receipts

Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.

b) Claiming deadlines
   i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
   ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.

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

d) Monthly or quarterly fees
   i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 1 year old will not be reimbursed.
   ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
   iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

Group Term Life

Payment of Benefit

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

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

Living Benefit

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

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

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

Waiver of Premium

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

Conversion Option

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

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

You may purchase less than the maximum amount of life insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy. You will have a choice of two policies:
1) a term life insurance policy for one year, or
2) a term life insurance policy to age 65.

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

For employees 65 to 69 years of age
You will be able to convert your group life insurance as above to a maximum of $25,000.

Claims

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

Long Term Disability

Definitions

Disability
means that during the Elimination period and the subsequent 12 months of disability you are:

1) prevented, by injury or sickness, from performing each of the essential duties of your own occupation
2) have a 20% or more loss of your indexed pre-disability earnings due to the same sickness or injury.

After that you are prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

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

Elimination period
means a period of time, when you are continuously disabled, which must be completed before your claim will be considered. It will be calculated from the date disability begins. If you are working while disabled, the days you are disabled will count towards the Elimination Period.

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

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

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

Availability of work is not considered when assessing disability.

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

Benefit

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

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

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

Rehabilitation and Return to Work Assistance Program

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

While the you are participating in the Rehabilitation and Return to Work Assistance program, We will pay an additional disability benefit of 10% of the gross disability payment to a maximum benefit of $1,000 per month. This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as deductible sources of income. However, the total benefit cap will apply.

In addition, We will make monthly payments to you for 3 months following the date the disability ends if We determine you are no longer disabled while:
1) you are participating in the Rehabilitation and Return to Work Assistance Program; and
2) you are not able to find employment.

This benefit payment may be paid in a lump sum.

We may continue to send monthly payments if you have been disabled and satisfies the following:
1) you have satisfied the elimination period for that disability,
2) you have successfully completed an approved Rehabilitation and Return to Work Assistance program/plan, but are unable to return to your regular occupation full time with the employer; and
3) you are actively seeking employment with another employer.

Recovery income protection benefit payments will end on the earliest of the following:
1) the date 6 months recovery income protection benefits have been paid; or
2) the date you secure employment with another employer.

Dependent Care Expense Benefit

While participating in BC Life's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain Dependent care expenses.

We will pay a Dependent Care Expense Benefit when you are disabled and:
1) are incurring expenses to provide care for a child under the age of 15; and/or
2) start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start BC Life's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent care Expense Benefit will:
1) be $350 per month, per Dependent; and
2) not exceed $1,000 per month for all eligible Dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitles you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:
1) the date the you are no longer incurring expenses for your Dependent;
2) the date you are no longer participating in BC Life's Rehabilitation and Return to Work Assistance program; or
3) any other date payments would stop in accordance with this plan.

Total Benefit Cap

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in BC Life's Rehabilitation and Return to Work Assistance Program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

Recurrent Disability

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

Extended Benefit

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

Survivor Benefit

If you die after being disabled for 180 or more consecutive days and while receiving a monthly benefit amount, a payment equal to 3 times your gross monthly benefit amount will be made to your Eligible survivor. If you have no eligible survivors, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on the claim.

You may receive their 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay a lump sum amount equal to 3 months of the gross disability payment if:
1) you have been diagnosed with a terminal illness or condition;
2) your life expectancy has been reduced to less than 12 months; and
3) you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

1) you must make this election in writing to BC Life; and
2) your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

Coordination with other Income Sources

Your monthly LTD benefit may be reduced by any amount of disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of:
1) your monthly basic earnings, if benefits are taxable
2) your take-home pay, if benefits are nontaxable.
For details of other income sources and how your monthly benefit is calculated, contact your Plan Administrator.

Waiver of Premium

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

Third Party Liability

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

Are Benefits Taxable?

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

Termination of Benefit

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

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

Exclusions

Benefits are not payable for any period of disability:

1) arising from any of the following:
    a) self-inflicted injury or sickness
    b) participation in an assault or criminal offense, or an act incident thereto
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
    d) a pregnancy related sickness
        i) during any period of formal maternity leave and/or parental leave
        ii) during any period in which Employment Insurance (EI) benefits are being paid
    e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are confined in a public general hospital or you are satisfactorily participating in a withdrawal program approved by us
    f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
    g) The loss of a professional or occupational license or certification.
2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
    a) in a jail or penitentiary
    b) on leave of absence
    c) involved in a strike or lockout, if the disability commenced after notice of strike or lockout was given
    d) receiving sick pay, vacation pay, or any other salary or wage from your normal or any occupation (except as provided under the rehabilitation program).

Claims

1) We must receive written notice of claim within **30 days** of the date disability begins. On receipt of written notice of claim, we will provide you with a claim form.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your physician complete and sign the medical portions of the form.
5) Forward the claim form (satisfactory proof of claim) to us within **90 days** following the end of the Elimination period.
6) We may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

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

Rehabilitation Review Committee

1) Employees who do not agree with the recommended rehabilitation plan or feel they are medically unable to participate must demonstrate reasonable grounds for their lack of participation or appeal the dispute to the Rehabilitation Review Committee.
2) The Rehabilitation Review Committee is composed of 3 qualified individuals who, by education, training and experience are recognized specialists in the rehabilitation of disabled employees.
3) Committee members are composed of one employer nominee, one union nominee and a neutral chair appointed by the nominees.
4) If the employee does not accept the Committee's decision, LTD benefits are suspended until the employee is willing to participate.

Claims Review Committee

1) The employer/provider will assume administrative responsibility for setting up the Claims Review Committee.
2) An employee may request Us to coordinate a Claims Review Committee if their LTD claim is denied or terminated by the carrier.
3) The Committee is comprised of 3 medical doctors: one designated by the employee; one by the employer; and one (chairperson) who has no relationship to the employee and agreed upon by the first two doctors.
4) The Committee is responsible for reviewing the medical and vocational information with respect to the employee

5) The Committee may interview and/or examine the claimant and may establish medical procedures and tests to determine if the employee is disabled as defined in the collective agreement.
6) The majority decision of the committee is final and binding.
7) The final report is signed by all members of the Committee and forwarded in writing to Us who is then responsible for forwarding a copy to the employee, employer and the union.
8) Expenses of the chairperson are shared equally between the employee (or union) and Us; expenses of the two nominees are the responsibility of each appointing party; expenses for medical procedures requested by the committee, and travel expenses of the employee are the responsibility of the employee (or union).

ACE INA Life Insurance

Basic Accidental Death & Dismemberment

Coverage

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

Eligibility

All active, permanent full-time employees of the Policyholder, under age 70.

Benefit Amount

An amount equal to the amount payable under your current group term life insurance. Benefit reduces at 50% at age 65 and terminates at age 70 or earlier retirement.
In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by ACE INA Life Insurance *(not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).*

Schedule of Losses

Accidental Death & Dismemberment
If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, ACE INA Life Insurance will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then ACE INA Life Insurance will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and

lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to ACE INA Life Insurance to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to ACE INA Life Insurance to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Quadriplegia, Paraplegia, Hemiplegia and Loss of Use losses are subject to an all policies combined maximum Benefit Amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, ACE INA Life Insurance will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by ACE INA Life Insurance under any benefit excluding the Loss of Life Benefit, ACE INA Life Insurance will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

a. such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within 2 years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 150 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of an "Immediate Family Member" as recommended by the attending physician, in writing, ACE INA Life Insurance will pay

for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

"Immediate Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law

Spousal Occupational Training Benefit

When injuries result in a payment being made by ACE INA Life Insurance under the Loss of Life Benefit, ACE INA Life Insurance will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or operable for an Insured Person.

Benefit payments herein will not be paid unless:

(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's spouse for financial support

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.
"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, ACE INA Life Insurance will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If an Insured Person suffers a third degree burn due to an accident, ACE INA Life Insurance will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	**% of Principal Sum Payable**
Face, Neck, Head	100%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.
"Seat Belt" means those belts that form a restraint system.

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by an "Immediate Family Member" has been requested by the police or a similar governmental authority, ACE INA Life Insurance will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Immediate Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while the policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, ACE INA Life Insurance will pay 10% of the Principal Sum up to a maximum of $40,000. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person.

Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

Covered Disease
Whenever used in the policy means Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type 1 Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy (excluding the Critical Illness Rider) of ACE INA Life Insurance. The individual policy will be effective either as of the date that the application is received by ACE INA Life Insurance or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of ACE INA Life Insurance. The amount of insurance benefit converted shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for 6 consecutive months and an Insured Employee provides evidence of total disability satisfactory to ACE INA Life Insurance, ACE INA Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, ACE INA Life Insurance will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and ACE INA Life Insurance will waive the 6 month qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one 1 day.

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

a) the date an Insured Employee ceases to meet the policy's definition of totally disabled;
b) the date an Insured Employee does not supply ACE INA Life Insurance with appropriate medical evidence as deemed necessary by ACE INA Life Insurance;
c) the date an Insured Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by ACE INA Life Insurance;
d) the date an Insured Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by ACE INA Life Insurance;
e) the date the policy terminates;
f) the date an Insured Employee turns 65; or
g) the date an Insured Employee dies.

Coverage During Waiver of Premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Employee will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for 6 consecutive months.

Continuance of Coverage

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person.

If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Exclusions

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by ACE INA Life Insurance pro-rata for any such period of full-time active duty);
5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

Cancer Critical Illness Benefit

If, while coverage is in effect but only after coverage has been in effect on an Insured Person for a period of 90 days, an Insured Person is then diagnosed with Cancer and an Insured person survives for a period of 30 days thereafter and is under age 65, ACE INA Life Insurance will pay 5% of the Principal Sum up to a maximum of $10,000.
ACE INA Life Insurance shall only be obligated to pay the Cancer Critical Illness Benefit once.

30 Day Survival

If, while coverage is in effect, an Insured Person suffers a Cancer and an Insured Person survives for a period of 30 days thereafter, ACE INA Life Insurance will pay the benefit amount as outlined above.

Pre-Existing Medical Conditions Provision: means a sickness suffered from or injury sustained by an Insured Person for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a physician during the 24 months immediately prior to the Insured Person's effective date of insurance or any increased amount of insurance, in which directly or indirectly causes the condition to occur within the first 24 months from the Insured Person's effective date of insurance or any increased amount of insurance. (Except for increases caused by annual salary changes.)

Definition

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV)
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth
- Prostate cancer diagnosed as TI N0 M0 or equivalent staging
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage

A Physician certified as an Oncologist must confirm diagnosis in writing.

90 Day Cancer Exclusion

The Cancer exclusion period is 90 days from the later of:

a) the Effective Date, or;
b) the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for cancer if a diagnosis of any type of cancer, whether included or excluded under the policy, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of

cancer. In the event of any such diagnosis the policy will remain in force but cancer will no longer be considered an Insured Condition, except for a subsequent diagnosis of an unrelated cancer.

Cancer Critical Illness Benefit Exclusions

1. for injury or sickness, other than the covered illness;
2. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
3. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
4. intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane;
5. declared or undeclared war or any act thereof;
6. the commission or attempted commission by an Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;
7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-Existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following an Insured Person's effective date of coverage.

How To Claim

In the event of a claim, claim forms can be obtained from the Plan Administrator. Notice of claim must be given to ACE INA Life Insurance within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to ACE INA Life Insurance within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will ACE INA Life Insurance accept notice of claim beyond one (1) year.

General Provisions

Beneficiary
An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: 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. For residents of Manitoba: 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. For residents of Ontario: 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 Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

Effective Date: November 2013

ACCLAIM Ability Management Inc.

Early Intervention Program

The Early Intervention Program (EIP) is a collaborative and consensus-based program that is included in collective agreements to assist employees who are ill or injured return to work in an early and safe manner.

The Early Intervention Program (EIP) will help assist employees off work due to work related injuries (WCB) and non-related work injuries.

Once a referral is received by the independent service provider, ACCLAIM Ability Management Inc., ACCLAIM's Early Intervention Coordinator (EIC) will contact the employee to discuss the EIP and determine how the program can help. After receiving medical documentation, the EIC will review the information and consult with the members of the employee's EIP team who include the employee and their employer, union, physician and/or health care team, and the EIC. This team works together collaboratively to design a customized and individualized return to work plan for the employee based on their medical condition, the requirements of their job, abilities and employer's ability to accommodate any applicable limitations. Only capabilities and limitations with respect to performing the employee's job tasks or alternative work is shared.

Once the return to work plan is implemented, the EIC will monitor the progress and make adjustments to the plan as needed to ensure that the employee's return to work is successful.

ACCLAIM
Ability Management Inc.

Federation Association Benefit Plan Broker

Schmunk, Gatt, Smith & Associates

Suite 204 - 20334, 56th Ave., Langley, BC V3A 3Y7
Phone: (604) 533-9813 Fax: (604) 533-9814

Website: www.schmunkgattsmith.com

Federation Association Benefit Plan Administrator

BBD

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Phone: (604) 464-0313 Fax: (604) 464-7997
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