Welcome to HealthSource Plus!

This is an important document. Please keep this Employee Health Handbook in a safe place as it contains personal information just for you.

Your employer and HealthSource Plus have worked together to develop a package of benefits to meet your needs. These benefits are an important part of the total compensation package from your employer.

Why is this booklet important?

This booklet is a summary of your benefit details and your effective date.

What is included in your Employee Health Handbook?

- Your Personalized Statement of Coverage
  - Your Statement of Coverage indicates how you have been enrolled on the system. If you notice any discrepancy, please contact your Plan Administrator
  - Your Statement of Coverage illustrates the level of coverage for you and your dependents (if any)
  - Your Statement of Coverage also includes your Travel Insurance Card, if applicable (detach and keep in your wallet when you travel)

- Claims Forms
  - Your Employee Health Handbook includes two pre-filled Claims Forms with your personal information
    - Dental Claim Form
    - Health Claim Form
  - Additional forms are available at **www.healthsourceplus.com/forms**

- Pay Direct Card (if applicable)
  - Your Pay Direct Card is attached. Keep this card in your wallet and present it to your pharmacist and dentist at time of claim.

- Your Schedule of Benefits
  - A detailed description of each of your benefits

Should you have any questions regarding your health and/or dental claims, please contact ClaimSecure's Client Service Line at:

1.888.513.4464

Yours in good health,
HEALTHSOURCE PLUS

TABLE OF CONTENTS

Employee Customer Service

At HealthSource Plus, we take employee customer service very seriously.

That's why we're always introducing new ways to help you.

There are so many ways for you to get information on your Employee Benefits Plan. The first place to look always is your Employee Benefits Booklet. If you don't have one, ask your plan administrator. If you can't find what you need there, you also have these alternatives:

1. **eProfile – Online Claims Information**
2. **Online Customer Service (Q&A)**
3. **1-800 Customer Service Line**
4. **Online Forms**

1. HealthSource Plus eProfile™ - access your claims information online

You can access your personal **claims information online 24/7** with HealthSource Plus eProfile™ a secure and interactive online service.

What can eProfile do for me?

With eProfile you can;

- View your personal claims history
- Access dependent claims information
- Obtain details on the reason for a particular claims adjustment or rejection
- Submit coverage queries online "Ask the Expert"
- Print individual claims for Coordination of Benefits
- Run consolidated statements for tax purposes, and
- Access other important health information

eProfile™ – making it easier to keep track of your benefits

How Do I Register for eProfile?

Register online to view your benefit plan detail, your claims history, print reports and more – all online 24/7.

Go to www.healthsourceplus.com

Click on the **eProfile** tab at the top of every page

The eProfile screen with appear. Register to use eProfile by clicking "Register Now."

Follow along the prompts. You'll need your Group Number and Certificate Number which can be found on your **Pay Direct Card** or **Statement of Coverage**.

2. Online Customer Service

With HealthSource Plus eProfile you can submit your detailed questions anytime – all online. It's easy. Just login to your eProfile User Name and Password and then click on the **"request coverage information".**

What Kind of Questions Can I ask?

You can ask any question regarding your health & dental plan. Questions like;

- How much coverage is left on my dental plan?
- Have I satisfied my deductible?
- How much vision care coverage do I have left?
- Will my pay direct dental card work at this dentist?

3. Toll Free 800 Number

If you encounter difficulties and require additional support, please direct your call to the appropriate department:

Health & Dental Claim Inquiries
1.888.513.4464

Technical inquiries concerning registration and PIN issuance:
1.888.513.4464 ext 2621

HOURS OF OPERATION:

8am – 8pm Eastern

If the attendant is unavailable, please leave a detailed message including your name, certificate number, date, time, nature of your call, and a contact number where you can be reached. The Help Desk will return calls in priority sequence normally on the same business day.

4. Online Forms

All forms are available online. You can print the forms you require in Adobe Acrobat format on demand from our website at www.healthsourceplus.com then go to the "Forms" section after clicking on the Employer or Employee tab.

SCHEDULE OF BENEFITS

(Refer to the Benefit description for more details)

Benefits underwritten by SSQ Financial Group, Group Policy #38U80

Participant Basic Life Insurance

Unit(s)	Basic Amount of Insurance
001 & 002	200% of your annual salary*, rounded to the next higher multiple of $1,000, if not already such a multiple, up to a maximum of $300,000.

Notes:

This benefit reduces by 50% on your 65th birthday and ceases on your 70th birthday or on your retirement date, if earlier.

***Salary means :**

Division 041 – Family Child Care Providers: Your total gross earnings reported on your T1 from the last calendar year less 15% of childcare expenses deductible for income tax purposes.

All Other Divisions: Your regular annual salary, excluding bonuses, payments for overtime, fees, accommodation and meal allowances, as well as amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payments

Participant's Optional Life Insurance

Unit(s)	Optional Amount of Insurance
001 & 002	Units of $10,000, up to a maximum of $200,000

Any request for an Optional Life Insurance Amount or any increase in such coverage is subject to submission of satisfactory evidence of insurability. A suicidal clause which is shown in the description of benefit applies.
The Optional Life Insurance amount ceases on your 65th birthday or on your retirement date, if earlier.

Spouse's Life Insurance

Unit(s)	Optional Amount of Insurance
001 & 002	Spouse: Units of $10,000, up to a maximum of $200,000

Notes:

Any request for an Optional Life Amount or any increase in such coverage is subject to submission of satisfactory evidence of insurability. A suicidal clause which is shown in the description of benefit applies.
The Optional Spouse Life Insurance amount ceases on your 65th birthday or on your retirement date, if earlier.

SCHEDULE OF BENEFITS (Cont'd)

(**Refer to the Benefit Description for details)**

Benefit underwritten by American Home Assurance Company, Group Policy #9125976

Employee Accidental Death and Dismemberment Insurance

Unit(s)	**Amount of Insurance**
001 & 002	200% of your annual salary*, rounded to the next higher $1,000, if not already such a multiple, up to a maximum of $300,000.

Notes:
This benefit reduces by 50% on your 65th birthday and ceases on your 70th birthday or on your retirement date, if earlier.

***Salary means:**

Division 041 – Family Child Care Providers: Your total gross earnings reported on your T1 from the last calendar year less 15% of childcare expenses deductible for income tax purposes.

All Other Divisions: Your regular annual salary, excluding bonuses, payments for overtime, fees, accommodation and meal allowances, as well as amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payments

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SCHEDULE OF BENEFITS (Cont'd)

(Refer to the Benefit description for details)

Benefits underwritten by SSQ Financial Group, Group Policy #38U80

Short Term Disability Insurance

Unit(s)	001 & 002
- **Weekly Benefit Amount:** EI maximum, whichever is higher	66.67% of your gross salary*, up to $1,000, or to the
- **Waiting Benefit Period (calendar days):**	
In the event of accident	0 days
In the event of hospitalization	0 days
In the event of an illness	7 days
- **Duration of Benefit:**	17 weeks
- **Taxability of Benefit:**	Non-taxable Benefits
- **Termination of Coverage**	Age 70 or retirement

Long Term Disability Insurance

Unit(s)	001 & 002
- **Monthly Benefit Amount:**	60% of your gross salary*, up to a Maximum of $5,000
- **Elimination Period (calendar days):**	119 days
- **Taxability of Benefit:**	Non-taxable Benefits
- **Maximum Duration of Benefit Payment:**	Age 65 or earlier retirement
- **Termination of Coverage:**	Age 65 or earlier retirement

Notes:

*If at any time your amount of monthly Long Term Disability Insurance should exceed $4, 500, you will be required to submit evidence of insurability satisfactory to the insurer. The excess amount will become effective upon written approval from the insurer. This provision also applies to subsequent increases.

***Salary means:**

Division 041 – Family Child Care Providers: Your total gross earnings reported on your T1 from the last calendar year less 15% of childcare expenses deductible for income tax purposes.

All Other Divisions: Your regular annual salary, excluding bonuses, payments for overtime, fees, accommodation and meal allowances, as well as amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payments

.

SCHEDULE OF BENEFITS (Cont'd)

(Refer to the Benefit Description for details)

Health Care Benefits	Amounts
Underwritten by SSQ Financial Group – Group Policy #38U80	
Emergency Travel Insurance, Travel Assistance	$5,000,000 per trip
Trip Cancellation	$5,000 per trip
Benefits Administered by ClaimSecure - Group Policy #9707	
Extended Health Care Benefits	
Calendar Year Deductible* *(does not apply Basic Hospital, nor to Out of Province Expenses)	Nil
Percentage	80%
Basic Hospital	100%, Semi-Private Room
Convalescent Hospital	$20 per day for up to 120 days per disability
Paramedical Services – Practitioners (Chiropractor*, Registered Massage Therapist, Naturopath, Osteopath*, Speech Therapist, Chiropodist/Podiatrist*, Psychologist) *(plus $50 maximum for X-Rays)	$300 per type of practitioner per Calendar Year (Limit of 1 visit per day, per type of practitioner)
Physiotherapist	Unlimited
Dietician	$350 per calendar year
Prescription Drugs	**Pay Direct**
Deductible	Nil
Percentage	80%
Dispensing Fee Maximum	$9.00
Dental Care Benefit	
Fee Guide	Current Provincial Dental Association
Calendar Year Deductible	$25 single, $50 family
Percentages:	
Levels 1 and 2 Minor Restorative	100%
Level 3 - Major Restorative	50%
Level 4 - Orthodontics	50%
Maximum per Calendar Year Levels 1 and 2 Minor Restorative & Level 3 - Major Restorative	$1,500
Lifetime Maximum Level 4 - Orthodontics (Children under age 18 only)	$1,500

The above Benefits terminate at age 70 or on your retirement date, if earlier.

GENERAL PROVISIONS

Eligibility for Insurance

To be eligible for Coverage under the Group Benefit Plan, you must be:

- a permanent full-time employee working regularly for at least twenty (20) hours per week for a participating employer covered under this policy, and a Professional, Child Care Assistant or Family Child Care Provider member in good standing with the Manitoba Child Care Association .

Your Group Benefit Plan becomes effective on the date you have completed:

- Unit 001 three (3) months
- Unit 002 six (6) months

Please check with your Plan Administrator for the waiting period for your center.

of continuous full-time employment provided you are actively at work on that date, with full pay and on your regular work schedule. Otherwise, your Group Benefit Plan will become effective on the date you return to work with full pay and on your regular work schedule.

Employees actively at work on the date this Group Benefit Plan comes into force, whose insurance under another group policy terminates on the same date, are considered eligible for coverage on the date this policy comes into force.

Eligibility of your dependents (spouse and children)

Your spouse and children will become eligible for the Group Insurance Plan on the same date that you become eligible, or at a subsequent date on which they may later become your dependents.

If you already have family or single-parent coverage, protection for an additional child will become effective automatically on the date the child meets the definition of a dependent child. However, your plan administrator must be notified in writing of any additional dependents to be covered.

At no time may coverage for your spouse and dependent children become effective before your own insurance comes into force.

Participation in the Insurance

Participation in the Group Benefit Plan is mandatory except for Drugs, Extended Health and Dental Care Benefits which may be waived if you are covered under your spouse plan for these benefits.

Your spouse and children, if applicable, are also required to participate in this Group Benefit Plan, unless they are covered under another Group Benefit Plan which remains a mandatory coverage.

Effective date of Insurance

If you and/or your spouse and children are eligible for coverage as described above under the “Eligibility” provisions above, you must complete and submit the Group Enrollment form within 31 days following the date you become eligible for coverage, otherwise satisfactory evidence of insurability will be required for yourself and each of your dependents, at your expense. The Group Benefit Program will only become effective on the date the evidence is approved by the insurer and provided you are actively at work with full pay and on your regular work schedule on that date.

Effective date of Insurance for your dependents (spouse and children) and changes to your family or employment situation

Any change to your family or employment situation may have an impact on your coverage; therefore, the insurer/administrator must be notified in writing within 31 days following the date of the event motivating such change.

Increase in coverage

Any increase in coverage becomes effective on the date requested by your plan administrator if notification is received within 31 days following the date of the event motivating the change. If this change requires you to provide evidence of insurability, the increase in coverage will become effective on the date this evidence is accepted by the insurer.

If notification is not received within the time specified, you may be required to provide evidence of insurability at your expense and if this is the case, your change in coverage will become effective on the date this evidence is accepted by the insurer.

If you are not actively at work on the date your benefits are scheduled to change or increase or on the date evidence of insurability is approved, such increase or change will become effective on the date you return to work with full pay, on your regular work schedule.

Reduction in coverage

Any reduction in coverage becomes effective on the date requested by your plan administrator if notification is received within 31 days following the date of such reduction, otherwise the reduction in coverage will become effective on the date it is received by the administrator.

Definition of Dependents (For purpose of this Group Benefit Plan)

Spouse means the person who:

- is married to you through a civil union or other legally recognized marriage; or
- is living common-law with you, and has a child with you, and whom you have designated in writing to your Plan Administrator as your spouse; or
- has been living common-law with you, and whom you have designated to your Plan Administrator as your spouse.

The status of spouse ends when:

- you and this person divorce or your marriage or civil union is annulled or dissolved; or
- in the case of a common-law union, you and this person have been separated for more than 3 months.

When this person is designated in writing as your spouse, coverage of any person previously designated as your spouse will automatically become void.

Dependent Child means:

Your child, your spouse's child, or a child born of your union. This definition also includes a legally adopted child or a child from whom you or your spouse exercise parental authority, or would exercise if a minor, and whom you or your spouse support. The child must be unmarried and:

- under age twenty-one (21);
- or age twenty-one (21) or over and a full-time student in an accredited educational institution, subject to proof deemed satisfactory to SSQ or plan administrator;
- any age, if suffering from a severe, incurable and chronic physical or mental disability. The disability must occur while the child still meets the requirements of a dependent child indicated above. This disability renders the child incapable of pursuing gainful employment. Satisfactory medical evidence must be provided to the insurer.

Termination of your Group Benefit Plan

Your Group Benefit Plan terminates:

- On the date you cease to be eligible for benefits for any of the following reasons:
  - You are no longer an employee of the Group Participant Employer;
  - You no longer meet the eligibility conditions stipulated in the provision *Eligibility for insurance;*
  - You reach the age limit specified in the Schedule of Benefits;
  - You retire;
  - You are no longer actively at work*;*
  - You are no longer actively at work, except if your coverage was maintained in force, in accordance with the provisions specified hereafter under Section *Maintaining coverage in the event of a temporary interruption of work*.
- On the date when premiums are due, if such premiums are not paid to the insurer prior to the expiration of the grace period.
- On the termination date of this insurance policy.
- If you have been exempted from payment of premiums for one or more benefits, and on the termination date of the premium waiver you have not resumed premium payment as a regular employee with full pay and on your regular work schedule.
- On the date you collect any benefits that you are not entitled to under this policy, as a result of false claims or misrepresentations you or a third party make, irrespective of the compulsory nature of any coverage or any other action the insurer may take.

Termination of the Group Benefit Plan for your spouse and children

Unless specified otherwise in the policy your spouse's and children's benefits will terminate upon the earliest of the following occurrences:

- The date your insurance ends;
- The date your spouse and/or children cease to be considered as dependents in the context of this policy;
- The date you, your spouse and/or dependent children collect any benefits that you are not entitled to under this policy, as a result of false claims or misrepresentations you or a third party make, irrespective of the compulsory nature of any coverage or any other action the insurer may take.

Maintaining coverage in the event of a temporary interruption of work

In the event of a temporary interruption of work meeting the conditions specified in the following sections, your benefits may be maintained as described below, provided your premiums continue to be paid.

Within thirty-one (31) days following the start date, or end date, of your absence from work, your plan administrator must provide the administrator/insurer with the information needed to determine the dates your benefits are to be suspended or reinstated. Your plan administrator must also specify if and which benefits are to be maintained for participants on temporary interruption of work leave.

If you are disabled, you may continue to be covered until the final date of your employment in an employee class eligible for benefits**.**

Parental leave, maternity leave and compassionate leave
If you are on Parental leave, maternity leave or compassionate leave, you may continue to be covered for the duration of the statutory period of leave;
If you do not maintain your coverage for the whole or part of the duration of your leave, then coverage may not be reinstated at a later time during your leave. If you return to work and meet the definition of an eligible employee, as specified in the *Schedule of Benefits*, within 12 months following the start date of your leave, your coverage may be reinstated on the date you return to work.

Leave without pay, suspension
If you are on leave without pay or are suspended from your duties, you may be eligible to maintain your coverage for the duration of your leave. To find out if you are eligible, contact your employer.

If benefits are not maintained for the whole or part of the duration of your leave, coverage may not be reinstated at a later time during your leave. If you return to work on a full-time, full-pay basis within twelve (12) months following the start of your leave, your coverage may be reinstated on the date you return to work.

Temporary layoff
If you are laid off temporarily, you may continue to be insured for a maximum period of six (6) months; however, or for as long as your seniority rights provided for under a collective agreement allow.

You may continue to be insured for the duration of your layoff.
If you are laid off for less than seven (7) consecutive days, the total premium amount is payable for the premium period during which you are laid off and for the premium period during which you return to work;

If you do not maintain your coverage for the whole or in part of the duration of your leave, then coverage may not be reinstated later. If you return to work on a full-time, full-pay basis within twelve (12) months following the start date of your leave, your coverage may be reinstated on the date you return to work;

Any Disability Insurance coverage provided for in the policy terminates on the date you are laid off and will resume on the date you return to work on a full-time, full-pay basis.

Strike, lock-out **or temporary collective work stoppage** - your Health, Extended Health and Drug benefits will remain in force for a period of thirty (30) days.

Extension of coverage for your spouse and dependent children following your death
In the event of your death, Health and Dental Care Benefits in force for your spouse and dependent children will be maintained without premium payment until the earliest of the following:

- the end of a period of twenty-four (24) months immediately following your death;
- the date when insurance for your spouse and dependent children would have terminated, if your death had not occurred;
- the date when your spouse and dependent children become eligible for similar coverage under another insurance contract;
- the date this policy terminates.

DEFINITIONS

You
You is used interchangeably with the participant, as an employee eligible for insurance, as defined in the policy. The present brochure is addressed to you, the participant.

Participant
An employee eligible for insurance whose application for coverage has been approved by SSQ.

Accident
An unintentional, sudden, accidental and unforeseeable event, caused exclusively by an external, violent cause, resulting in bodily injury, directly and independently of any other cause.

Actively at work
An employee is deemed to be "actively at work" when present at his or her place of work and capable of carrying out normal duties in accordance with the regular work schedule. An employee able to work who is on vacation or leave approved by the employer is also considered to be actively at work.

Customary and reasonable expenses
Fees usually charged to an individual who does not have insurance, i.e. the amount of which must not exceed that normally charged for a particular service in the region where the service was rendered. This amount is based on the various provincial or national professional association fee guides.

Day
For the purposes of this policy, "day" shall mean "calendar day", unless specified otherwise.

Dentist
A qualified and specialized professional, licensed by competent government authorities to practise dentistry. This person provides oral and dental care, including oral and dental surgery, as authorized under the individual's licence to practise. This definition includes dental surgeons.

Disability period

A continuous absence from work due to disability.

Disability
During the Long Term Disability Insurance elimination period and the following 24 months:
A total and continuous incapacity caused by an accident or illness that prevents you from carrying out the main duties of your usual employment.

After the above-mentioned period:
A total and continuous incapacity caused by an accident or illness that prevents you from pursuing any gainful occupation for which you are reasonably suited by education, training or experience, regardless of the availability of employment.

Recurring disability

If you are entitled to benefits for an initial, continuous disability period and then you enter a subsequent disability period, SSQ will consider these two disability periods to be one and the same when:

- they are due to the same causes and are separated by less than [thirty-one (31)] consecutive days during which you are actively back at work on full pay and on your regular schedule.

When your disability period exceeds six (6) months, a subsequent disability period due to the same causes is considered as a recurring disability if separated by less than one hundred and eighty (180) consecutive days during which you are actively back at work in your usual duties on full pay and on your regular work schedule;

- they are due to entirely different causes and are separated by less than one full day during which you are actively back at work in your usual duties on full pay and on your regular work schedule.

In such cases, the elimination period will not apply a second time.

Upon termination of this policy, all applicable legislation and regulations in force shall take precedence in their application.

Elimination period
The period that begins at the onset of a disability, and must elapse before you are entitled to Income Insurance benefits.

Employee
Any salaried individual who works on a regular basis for the employer, and is a Professional, Child Care Assistant or Family Child Care Provider member in good standing with the Manitoba Child Care Association

Employer

The group policyholder, or any employer whose employees, or a class of employees, are represented by the group policyholder.

Hospital
A hospital as defined under applicable federal or provincial laws.

Hospitalization
Admission to hospital for a minimum duration of twenty-four (24) hours or a minor operation performed in a hospital centre, excluding all minor surgery that could be carried out in a doctor's office.

Illness
Any disease, deterioration of health or bodily disorder diagnosed by a physician. Organ donation and any related complications are also considered as an illness for the purposes of this policy.

Insured
You, as the participant, and your spouse and any dependent children, if applicable, to whom insurance has been granted.

Medical specialist
Any physician holding a specialist licence duly authorized to practise in any of the specialist fields related to the benefits provided for in this policy.

Physician
A duly qualified medical professional who is legally authorized to practise medicine.

Salary

Division 041 – Family Child Care Providers: Your total gross earnings reported on your T1 from the last calendar year less 15% of childcare expenses deductible for income tax purposes.

All Other Divisions: Your regular annual salary, excluding bonuses, payments for overtime, fees, accommodation and meal allowances, as well as amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payments

Your Income Insurance benefits will be calculated based on either your salary, as defined above, or your insurable earnings, as specified under the *Employment Insurance Act*, whichever is highest.

Net Salary
Your salary at the onset of disability, after deduction of Provincial and Federal Income Tax.

Business partner
An individual with whom the insured is associated for business purposes, as part of a corporation comprised of four (4) co-shareholders or less, or a commercial or non-commercial corporation comprised of four (4) partners or less.

Commercial activity
An assembly, conference, convention, exhibition or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legislation, regulations and policies of the region where it will be held. The activity must be the sole reason for the planned trip.

Family member
Spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

Host at destination
The person with whom the insured shares accommodation arranged in advance, provided the accommodation is at the principal residence of the host at destination.

Travel Companion
The person with whom the insured shares accommodation at the travel destination, or whose transport expenses were paid with those of the insured.

Prepaid travel expenses
Expenses incurred by the insured to purchase a package trip, a ticket from a public carrier, or to rent a motor vehicle from an accredited firm. The following amounts are also considered as prepaid travel expenses:

- Amounts paid by the insured for ground arrangements usually included in a package trip;
- Amounts paid by the insured in relation to registration fees for a commercial activity.

Relative
See Family member above.

Proof
Evidence or proof deemed satisfactory by SSQ.

Trip
A trip, as a tourist or for pleasure, or for a commercial activity, which entails:

- the insured's absence from the place of residence for a period of at least two (2) consecutive nights; and
- travelling at least 400 kilometres (round trip) from the insured's place of residence.

A cruise lasting at least two (2) consecutive nights, under the responsibility of an accredited firm, is also considered to be a trip.

PARTICIPANT'S LIFE INSURANCE (Details)
(SSQ Financial Group)

Scope

Under the Employee Life Insurance benefit, in the event of your death, SSQ pay the amount of your life insurance coverage to your beneficiary, in accordance with the provisions of this contract.

Amount of Life Insurance

The basic amount of life insurance that will be paid is specified in the Schedule of Benefits.

This amount will include any optional life insurance coverage you may take out, if applicable.

The amount of life insurance payable is subject to any applicable reductions in coverage, as specified in the Schedule of Benefits.

If you are disabled, the amount of your life insurance coverage will be equal to the amount in force at the onset of your disability. Coverage will not change throughout your disability period, except with regard to the reductions specified in the *Schedule of Benefits,* and will end when you reach age 65.

Evidence of Insurability

You must provide evidence of insurability deemed satisfactory by SSQ in the following situations:

- When the amount of your life insurance exceeds the maximum amount that may be underwritten without evidence of insurability. This amount is specified in the *Schedule of Benefits*;
- When you apply for optional life insurance coverage;
- If you apply for insurance more than thirty-one (31) days after the date you become eligible.

If SSQ determines that you constitute a higher than normal risk, your application may be refused, or approved on condition of payment of additional premiums.

Premium Waiver

If you are disabled, you may be exempted from paying life insurance premiums if you meet the following criteria:

- Your disability period exceeds a duration of six (6) months;
- Your disability began while you were covered under the Life Insurance benefit, and prior to the termination of your permanent employment position;
- You are under the continuous care of a physician, except if your condition is declared stable by your attending physician, to the satisfaction of SSQ
- Your condition meets the definition of a disability specified in the policy.

In such case, your coverage will be maintained and premium payments will be waived, in accordance with the policy provisions in force at the onset of your disability. Your premium waiver will continue for the duration of your disability, but will not exceed the date of your 65th birthday, regardless whether or not this benefit remains in force.

To benefit from the premium waiver privilege, you must provide proof of your disability to SSQ within ninety (90) days of the beginning of your right to waiver. If you do not provide proof of your disability within the time limit specified, you will not be exempted from premium payments for the period preceding the date SSQ receives such proof.

You must also submit proof of your continued disability within ninety (90) days of the request by SSQ. Failure to do so will result in the termination of your premium waiver and insurance coverage as of the date of the request by SSQ.

In addition, you must also agree to undergo any examination or treatment likely to be beneficial to your recovery. Failure to do so will result in your premium waiver and insurance coverage being terminated by SSQ.

Special provisions in the event of cancellation of coverage

If you become disabled while covered under this benefit and you are still disabled at the time this benefit is cancelled, your coverage will be extended until the earliest of the following

- The date on which you become covered by an other insurer;
- The date you return to full-time employment, unless you complete less than thirty (30) calendar days of full-time work.

To benefit from the premium waiver privilege, you must provide SSQ with proof of your disability within six (6) months of the onset of your disability. If you do not, your disability will not be recognized under this benefit.

The terms and conditions stipulated under the *Insurance Act* with regard to a relapse or recurrence of a disability take precedence over those contained in the definition of recurring disability, as specified in the policy.

Prepayment entitlement (within lifetime)

If you are disabled and your life expectancy is less than twelve (12) months, you may request advance payment of a portion of the amount of life insurance that would be payable upon your death. Your request must be approved by SSQ. To apply for the prepayment entitlement, you must:

- send a written request to SSQ's Head Office;
- be exempt from payment of your Life Insurance premiums under the waiver of premiums provision;
- provide proof that your life expectancy is less than twelve (12) months at the time of your request;

If the beneficiary of your insurance is designated as irrevocable, you must:

- obtain the consent of the designated beneficiary of your Life Insurance benefit.

The prepayment entitlement is equal to fifty percent (50%) of the amount of your life insurance coverage, without however exceeding $25,000. The prepaid amount is subject to any reduction in coverage planned to come into effect during the 24-month period following the date of your request.

Upon your death, the amount payable to the designated beneficiary of your life insurance will be reduced by the amount of the prepayment entitlement plus interest calculated at an annual rate of ten percent (10%).

Suicide limitation

If you commit suicide before being covered under a group optional life insurance benefit for twelve (12) months, SSQ will reimburse the optional life insurance premiums you have paid to SSQ in lieu of the amount of insurance. This provision is applicable, regardless of whether you are deemed to have been sane or insane at the time of suicide.

If you increase the amount of your optional life insurance coverage, this period of twelve (12) months will apply once again, starting on the effective date of the additional amount of optional life insurance. This provision is applicable to the additional amount only.

This limitation also applies to any life insurance coverage:

- in which your participation is optional;
- the amount of which is variable and may be determined by you;
- for which SSQ received your application after the deadline stipulated under the *Eligibility and Effective Date of Insurance* section under the General Provisions.

Claims and Proof

The form required for making a Life Insurance claim is available from your plan administrator. Claims must be submitted, along with written proof of the death which has occurred, within twelve (12) months of death. SSQ reserves the right to request additional information when processing the claim. If the claim, proof and additional information, if applicable, are not submitted within the specified time, benefits will still be payable, provided the required documents are submitted to SSQ as soon as is reasonably possible. However, no benefits will be payable if a claim proof or additional information are submitted more than three (3) years after the date of death.

Exclusions

Your Life Insurance benefit is not payable in the event of your death in any of the following situations:

- While committing or attempting to commit a criminal act;
- While actively participating in a riot or insurrection;
- Directly or indirectly due to war or civil war, whether declared or undeclared;
- While an active member of the armed forces of a country.

Termination of coverage

Your life insurance coverage will terminate on the date you reach age 70 as shown in Schedule of Benefits or on the earliest of the dates specified in the *Termination of your Group Benefit Plan* section under the General Provisions Section.

Conversion privilege

If you are no longer eligible for your group life insurance plan, you are entitled to apply to convert your group life insurance to individual life insurance, without evidence of insurability being required.

General provisions

If you stop working or no longer belong to the group insured under this policy, you may convert your group life insurance to “whole life” or “term-to-65” individual life insurance.

Amount

You are entitled to convert an amount equal to, or less than, the amount specified in your group life insurance benefit. However, any amount of life insurance provided for under any other group insurance policy that you are eligible for at the time you exercise your conversion privilege will be deducted from this amount.

You may convert up to a maximum of $200,000 of life insurance if you are under age 65 on the date your individual life insurance policy comes into force. If you are age 65 or over, the maximum conversion amount is $25,000.

Premium

Your individual life insurance premium is based on the rates in force, in accordance with your age, gender, occupation and place of residence. The premium payable for the first year of insurance is equal to that of a temporary one-year insurance contract.

How to convert your group life insurance

To convert your group life insurance to individual life insurance, you must complete the two following steps within thirty-one (31) days of the termination of your insurance:

- Submit your request in writing to SSQ's Head Office; and
- Make the first premium payment to Head Office.

Effective date

Your individual life insurance coverage will become effective at the end of the above-mentioned 31-day period.

If you should die within the thirty-one (31) days following the termination of your group life insurance coverage, the amount payable is the amount that would have been eligible for conversion.

Limitations

Individual life insurance does not provide for a premium waiver in case of disability.

If you are no longer eligible for insurance because your group policy is terminated or modified and the policy is not replaced, you will not be eligible for the conversion privilege unless you have been covered under this benefit for at least five (5) years.

If the terminated policy is replaced by another group policy within a period of one hundred and eighty (180) days, the individual policy issued will terminate on the date you become eligible for coverage under the new group policy.

If you are no longer eligible for coverage because you have enlisted in the armed forces of a country, your life insurance coverage may not be converted.

If you have already exercised your conversion privilege, you may convert the difference between the amount eligible for conversion under this benefit and the amount of individual life insurance resulting from any previous exercise of conversion privileges.

OPTIONAL LIFE INSURANCE
(PARTICIPANT & SPOUSE'S OPTIONAL LIFE INSURANCE) (Details)
(SSQ Financial Group)

This benefit allows you and your spouse to increase your level of protection with additional insurance coverage.

Amount of Protection

Coverage is available as follows:

Participant's Optional Life Insurance: Units of $10,000 to a maximum of $200,000

Spouse's Optional Life Insurance: Units of $10,000 to a maximum of $200,000

Optional Life Insurance Monthly Rates
(per $1,000 of protection)

	Male		Female	
Age Group	Smoker	Non-Smoker	Smoker	Non-Smoker
Less than 19	$0.07	$0.06	$0.04	$0.02
20 to 24	$0.07	$0.06	$0.04	$0.02
25 to 29	$0.07	$0.06	$0.04	$0.02
30 to 34	$0.09	$0.06	$0.06	$0.03
35 to 39	$0.13	$0.07	$0.10	$0.06
40 to 44	$0.22	$0.11	$0.18	$0.09
45 to 49	$0.46	$0.20	$0.32	$0.14
50 to 54	$0.90	$0.35	$0.57	$0.22
55 to 59	$1.69	$0.62	$0.98	$0.41
60 to 64	$2.40	$0.90	$1.20	$0.55

Rates are based on the participant's age, and the smoking status of the person insured (participant or spouse).

Optional Life Insurance coverage is subject to SSQ Financial Group's approval of the required evidence of insurability.

The participant's and spouse's Optional Life Insurance terminates on the participant's 65th birthday.

Suicide Restriction

If an insured commits suicide, while sane or insane, after being covered for less than 12 months, no Optional Life Insurance benefit will be payable. SSQ will refund the premiums paid.

Optional Life Waiver of Premium In the Event of Total Disability

If you become totally disabled (according to SSQ's definition of total disability) while insured, your Optional Life Insurance coverage will continue without payment of premium until the participant's 65th birthday. The waiver of premium takes effect after you have been continuously disabled for 6 months. Please see your Plan Administrator for assistance if you wish to apply for the premium waiver.

If your Participant's Life Insurance premium is waived because you are totally disabled (according to SSQ's definition of total disability) while insured, your Optional Life Insurance premium will also be waived until age 65. Please refer to the Participant's Life Insurance section for more details.

Conversion Privilege

If your Optional Life Insurance benefit is terminated or reduced, you are entitled to convert your coverage to an individual policy without providing medical evidence. However, SSQ must receive your application and your first monthly premium within 31 days of the loss of Optional Life Insurance. Please see your Plan Administrator for details.

ACCIDENTAL DEATH & DISMEMBERMENT (Details)

(American Home Assurance Company)

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Table of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Amount of Insurance

The amount of Insurance is shown in the **Schedule of Benefits**.

Principal Sum means the amount of Insurance.

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	Three-Quarters of The Principal Sum
Loss of One Leg	Three-Quarters of The Principal Sum
Loss of One Hand	Two-Thirds of The Principal Sum
Loss of One Foot	Two-Thirds of The Principal Sum
Loss of The Entire Sight of One Eye	Two-Thirds of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	Two-Thirds of The Principal Sum
Loss of Hearing in One Ear	One-Sixth of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	Two-Thirds of The Principal Sum
Loss of Use of One Arm or One Leg	Three-Quarters of The Principal Sum
Loss of Four Fingers of One Hand	One-Third of The Principal Sum
Loss of All Toes of One Foot	One-Eighth of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means, complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing in one ear means complete and irrecoverable loss of hearing in one ear and with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licenced practicing physician appointed by the Policyholder and a licenced practicing physician appointed by the Company, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licenced practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Policyholder and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Person has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Person shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Policyholder's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

ADDITIONAL BENEFITS

Repatriation

If accidental death, covered by the plan, occurs more than 50 kilometres away from your permanent place of residence, the plan will reimburse the actual expenses up to $15,000 which are incurred for the preparation and shipment of the deceased's body to the place of residence.

Rehabilitation

If you suffer an injury listed in the loss schedule, this plan will pay up to $15,000 for special training, provided such training is required because of the covered injury and in order to qualify you for an occupation in which you would not be engaged except for the accident. All such expenses must be incurred within two years from the date of the accident and are limited to the cost of the training and materials needed for such training.

Family Transportation

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100 Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Person's hotel accommodation in the vicinity of the hospital, and transportation to and from the hospital but not to exceed the amount of $15,000.00.

The term "member of the immediate family" means the spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Conversion Privilege

On the date of termination of employment or during the 90 day period following termination of employment, you may change your insurance to the American Home Assurance Company's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the policy ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the American Home Assurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Home Alteration and Vehicle Modification

If an Insured Person receives a payment under the Table of Losses herein and was subsequently required (due to the cause for which payment under the Table of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

A. The one-time cost of alterations to the injured person's residence to make it wheel-chair accessible and habitable; and
B. The one-time cost of modifications necessary to a motor vehicle, owned by the injured person, tomake the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
ii) Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both Items A and B combined will not exceed $15,000.00.

Day Care Benefit

If indemnity becomes payable under the policy for accidental loss of life of an Insured Employee, the Company will pay an amount equal to the lessor of the following amounts:

(1) The actual cost charged by such day care center per year, or
(2) 5% of the Insured's Principal Sum, or
(3) $5,000.00 per year,

On behalf of any child who was an Insured's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care center.

Seat Belt

Benefits under the policy shall be increased by 10% for a covered accident as regards Insured Persons, if the covered person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

The maximum amount payable for this benefit is fifty thousand dollars ($50,000.00) per Insured Person.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Policyholder's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

(a) The date the Insured Person attains age 65.
(b) The date of the death or recovery of the Insured Person.
(c) The date the Master Policy is terminated.

Educational Benefit

If indemnity becomes payable for the accidental loss of life of an Insured Employee of the Holder, under the policy, the Company shall:

1.Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident,
was enrolled as a full time student in any institution of higher learning beyond the l2th grade level:

(a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.
(b) $5,000.00 per school year.
(c) 5% of the Insured Employee's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the dependent child continues his education.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Employee for at least 50% of his maintenance and support.

"Institution of higher learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

2. Pay to or on behalf of the surviving spouse the actual cost incurred within 30 months from the date of death of the Insured Employee as payment for any professional or trades training program in which suchspouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of $15,000.00.

Continuation of Coverage

In the case of employees of the Policyholder who are (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 a period of twelve (12) months, subject to payment of premium.

If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

In-Hospital Indemnity Benefit

If an Insured suffers a loss under the Table of Losses as a result of a covered accident and requires that an Insured be confined to a hospital for more than five (5) consecutive days, We will pay:

(a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
(b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.

This benefit is limited to:

(a) a monthly amount not to exceed $2,500.00; and
(b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

The term **"Hospital"** is defined as an establishment which meets all of the following requirements:

(1) holds a license as a hospital (if licensing is required in the province);
(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in patients;
(3) provides 24-hour a day nursing service by registered or graduate nurses;
(4) has a staff of one or more licensed physicians available at all times;
(5) provides organized facilities for diagnosis, and major medical surgical facilities; and
(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Identification Benefit

In the event accidental Loss of Life is sustained by an Insured Person, whose body requires identification, and subsequently indemnity for such Loss becomes payable in accordance with the terms of this policy, the Insurer will pay the reasonably and necessary expenses actually incurred by a Member of the Immediate Family for:

(1) lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three (3) consecutive nights);

(2) transportation by the most direct route to such location.

Provided the body is located not less than one hundred and fifty (150) kilometers from the said family member's normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of twenty cents ($0.20) per kilometer travelled.

The maximum amount payable under this section will not exceed in the aggregate the amount of five thousand dollars ($5,000.00), nor will this benefit be payable under more than one (1) of the policies issued to the Policyholder by the Insurer.

"Member of the Immediate Family" means a person at least eighteen (18) years of age, who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Bereavement Benefit

If an Insured Employee suffers Injury which results in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay the reasonable and necessary expenses actually incurred for grief counseling provided that:

(a) the counseling is for the Spouse/Insured Employee and/or Dependent Children;

(b) such expenses are incurred within 365 days of the date of the accident causing Loss of Life; and

(c) such grief counseling is provided by a therapist or counselor who is licensed, registered or certified to provide such treatment and who is not a member of the Immediate Family of the Insured Employee.

The Company will pay the person who has incurred the actual expense.
The maximum amount payable for this benefit is one thousand dollars ($1,000.00).

Exclusions

The accident insurance plan does not cover any loss resulting from:

(a) suicide or any attempt thereat by the Insured Employee while sane;

(b) self inflicted injury or any attempt thereat by the Insured Employee while sane or insane;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, mental incapacity or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

(e) Injury sustained while the Insured Employee is undergoing the medical or surgical treatment of sickness, disease, or mental infirmity;

(f) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis; aneurysm;

(g) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Employee is:

I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or

II. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

III. riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder or the Insured Employee's Employer.

(h) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(i) Injury sustained while the Insured Employee is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Employee is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

(j) any attempt at self-asphyxiation whether with intent to harm oneself or not.

This description is a summary of the principal features of the Plan which is covered by the terms of the insurance contract with the American Home Assurance Company.

SHORT TERM DISABILITY INSURANCE (Details)
(SSQ Financial Group)

NOTE
For greater clarity, many terms that are used in the text, including disability, recurring disability and salary, are explained in the Definitions section provided at the beginning of this document.

Scope

If you become disabled, SSQ will pay you a weekly benefit. To be eligible for this benefit, your Short Term Disability (STD) Insurance must be in force at the onset of your disability.

Only one elimination period and one maximum duration of benefit payments are applicable to the same disability.

SSQ will make the first weekly benefit payment one (1) week following the end of the elimination period. Subsequent payments are made on a weekly basis, provided your disability continues.

Calculation of weekly benefit

The amount of the weekly benefit is determined in accordance with the *Schedule of Benefits* in force on the start date of your disability and the provisions contained under the section below entitled *Benefits and income from other sources*.

If, during your disability period, your salary or employee class changes, or modifications are made to your group insurance policy, the amount of the benefit remains unchanged.

Benefits and income from other sources

Your benefit will be reduced by 100% of any income and other benefits payable to you from the sources listed below:

- Any compensation received from your employer;
- Benefits payable under any applicable legislation respecting industrial accident or occupational illnesses;
- Benefits payable under any applicable legislation respecting automobile accidents;
- Disability benefits payable under the Quebec or Canada Pension Plan;
- Maternity, parental or compassionate care benefits payable under the *Employment insurance act*.

In addition, if the total amount of income and benefits payable to you from the sources listed below exceeds 85% of the net weekly salary at the onset of disability, benefits will be reduced by the excess amount.

Income and benefits from the following sources are taken into account.

- Benefits payable under this STD coverage;
- Any compensation received from your employer;

- Benefits payable under any applicable legislation respecting industrial accidents or occupational illnesses, automobile accidents or similar coverage, applicable social legislation other than the *Employment Insurance Act*, the Canada or Quebec Pension Plan, any retirement plan offered by your employer, or any group insurance policy;
- Maternity, parental or compassionate care benefits payable under the *Employment Insurance Act*;
- Retirement income benefits from the Canada or Quebec Pension Plan;
- Retirement income from your employer's pension plan.

The calculation of benefits does not take into account any indexation of benefits or pension income payable under the above-mentioned sources or under this benefit due to an increase in the cost of living.
All income and benefits used in the calculation are amounts payable before deduction of any applicable taxes.
If such income or benefits are normally payable in a lump sum, SSQ calculates the weekly equivalent of the lump sum amount.
If you do not receive income or benefits from any of the above-mentioned sources, you must provide SSQ with proof that you are not entitled to claim such income or benefits. Otherwise, SSQ will take into account any income and benefits that it deems you should be entitled to. This provision does not apply to retirement benefits payable under the Canada or Quebec Pension Plan, and your employer's pension plan.

Disability management

Gradual return to work

If you are disabled, you may begin a gradual return to work if:

- your condition meets the definition of disability specified in the *Definitions* section;
- the duration of the disability period preceding your gradual return to work is thirty (30) days or more; and
- your gradual return to work is approved by SSQ.

In this case, your Short Term Disability Insurance benefit payments will be reduced by an amount corresponding to the percentage of the time worked in relation to your normal work schedule.

Refusal to undergo medical examination or treatment

To be eligible for benefits, you must agree to undergo any medical examination or treatment likely to favour recovery of your health, to the satisfaction of SSQ.

Failure to do so will result in suspension or termination of benefit payments until you provide satisfactory proof that you have undergone the appropriate examination or treatment requested.

Rehabilitation

If considered justified by SSQ and its medical advisors, you will be required to participate in an SSQ-supervised rehabilitation program designed to favour your return to work.

If SSQ and its medical advisors deem it necessary and justified, a rehabilitation program may be modified or interrupted.

SSQ will review your case file to determine what kind of rehabilitation program, if any, would be best for you. If your case file indicates rehabilitation would be beneficial, SSQ will provide the necessary resources and support to help you recover your health and functional autonomy to a level enabling you to return to work.

The rehabilitation program resources may include, among others:

- Psychological consultation;
- Employment counselling;
- Changes to your workstation, job description or schedule.

Remuneration you receive during the rehabilitation period will not reduce your STD benefit unless that remuneration, together with other income or benefits specified under *Benefits and income from other sources,* exceeds 100% of your weekly pre-disability net income.

Limitations

In the case of a recurring disability, you will have ninety (90) days following the date of recurrence to provide SSQ with satisfactory proof of such. If you do not provide such proof within 90 days you will not be entitled to benefits for the period prior to the date of receipt of such proof by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the date of recurrence, no benefits will be payable.

In the case your claim is declined or benefit payments are terminated, you will have ninety (90) days following the date of written notice of the above by SSQ in which to provide supplementary proof justifying the continuation of your disability or to have your file reviewed. If you do not provide such proof within 90 days you will not be entitled to benefits for the period prior to the date of receipt of such proof by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the date of written notice by SSQ, no benefits will be payable.

In the case that your STD coverage ends, you must forward to SSQ's Head Office, no later than six (6) months after the date of the onset of your disability, written proof of:

- the accident you were a victim of or the illness you are afflicted with; and
- continuation of your disability.

If you do not provide satisfactory proof within the time specified, no benefits will be payable.

Claims, proof and medical examinations

You must submit your claim and forward written proof of your disability to the Head Office of SSQ within ninety (90) days following the end of the elimination period. If you do not submit a claim or provide such proof within the time specified, you will not be entitled to benefits for the period prior to the date such proof is received by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the end of the elimination period, no benefits will be payable.

You must submit your claim and forward written proof of your disability to the Head Office of SSQ within 90 days following the end of the elimination period. The elimination period begins on the first day that you are incapable of carrying out the main functions of your usual employment.

You must been seen and treated by your doctor within 7 days following your first day of absence due to disability otherwise, the benefit waiting period will commence on the date you are first seen and treated by your doctor.

Your must be treated Subsequently, during the processing of your claim or while you are receiving benefits, you must provide all further proof of your disability requested by SSQ. If you do not provide satisfactory proof or do not undergo a medical examination within ninety (90) days of a request by SSQ, your claim will be declined or benefit payments will be suspended or terminated.

Interruption of work

Leave without pay, suspension, maternity leave, parental leave, compassionate leave
If you become disabled during a period of leave without pay, suspension, maternity leave, parental leave or compassionate leave, you will be eligible for benefits according to the policy terms and conditions in force at the onset of your disability. You must also have kept your Short Term Disability Insurance coverage in force. The elimination period will begin only on the date of your return to work.

Temporary layoff
If you become disabled **before** the date you receive a notice of temporary layoff, you will be eligible for benefits. However, if you become disabled **after** the date the notice of temporary layoff was issued, benefits will no longer be payable as of the date of the layoff.

If you become disabled **during** the layoff period, you are not eligible for benefits.

Dismissal
If you become disabled after the date you receive a notice of dismissal, benefits will stop on the date of the dismissal.

Strike or lock-out
If you are disabled at the time a strike or lock-out begins, you will remain eligible for benefits in accordance with the terms and conditions in force at the onset of your disability.

If you become disabled during a strike or lock-out, you will be eligible for benefits according to the policy terms and conditions in force at the onset of your disability, provided you have kept your Short Term Disability Insurance coverage in force during the strike or lock-out. The elimination period will begin only on the date you are called back to work.

Employment contract of fixed duration
If you become disabled during the period of employment, you will be eligible for benefits according to the terms and conditions in force. However, benefits will cease as of the date the employment contract ends.

Termination of Short Term Disability benefits does not prevent you from being entitled to Long Term Disability benefits, if applicable.

Exclusions

You will not be covered if you become disabled:

- While you are committing or attempting to commit a criminal act;
- While you are actively participating in a riot or insurrection;
- Directly or indirectly as a result of war or civil war, whether declared or undeclared;
- While you are an active member of the armed forces of a country;
- And you are not under the continuous care of a physician, except when your condition is declared stable by a physician, to the satisfaction of SSQ;
- As a result of intentional self-inflicted injuries, regardless of whether or not you were conscious of your acts;
- As a result of aesthetic treatments;
- And you refuse to undergo a medical examination upon request by SSQ;
- And you hold a position or perform work, for which you earn any salary or profit (except as stipulated in the sections *Gradual return to work* and *Rehabilitation*);
- And you refuse to participate in a rehabilitation program recommended by SSQ.

How to Claim – Short Term Disability Insurance

You may file a claim by completing the «Application for Disability Insurance Benefit» claim form, which may be obtained from your group plan administrator or HealthSource Plus. Please indicate the certificate number as well as telephone numbers of claims forms and submit to HealthSource Plus at the following address:

Toronto	Montreal
240 Duncan Mill Road Suite 801 Toronto, Ontario M3B 3S6	100 bd. Alexis Nihon Suite 955 Saint. Laurent (Quebec) H4M 2P5

For more information or if you have any questions, please telephone or fax at the following numbers:

Telephone:

	416-445-0000	514-331-7728
(Toll free)	1-800-753-0110	1-877-331-7728

Fax:

416-445-2222	514-331-6486

LONG TERM DISABILITY INSURANCE (Details)
(SSQ Financial Group)

NOTE

For greater clarity, many terms that are used in the text, including disability, recurring disability and salary, are explained in the Definitions section provided at the beginning of this document.

Scope

If you are disabled, SSQ will pay you a monthly benefit. To be eligible for this benefit, your Long Term Disability (LTD) Insurance must be in force at the onset of your disability.

These monthly benefits will continue to be paid for the duration of your disability, without however exceeding the date of your 65th birthday.

Only one elimination period and one maximum duration of benefit payments are applicable to the same disability.

SSQ will make the first monthly benefit payment one (1) month following the end of the elimination period. Subsequent payments are made on a monthly basis, provided your disability continues.

Calculation of monthly benefit

The amount of the monthly benefit is determined in accordance with the *Schedule of Benefits* on the start date of your disability and the provisions contained under the section below entitled *Benefits and income from other sources.*

If, during your disability period, your salary or employee class changes, or modifications are made to your group insurance policy, the amount of the benefit remains unchanged.

Benefits and income from other sources

Your benefit will be reduced by 100% of any income and other benefits payable to you from the sources listed below:

- Any compensation received from your employer;
- Benefits payable under any applicable legislation respecting industrial accident or occupational illnesses;
- Benefits payable under any applicable legislation respecting automobile accidents;
- Disability benefits payable under the Quebec or Canada Pension Plan;
- Maternity, parental or compassionate care benefits payable under the *Employment insurance act.*

In addition, if the total amount of income and benefits payable to you from the sources listed below exceeds 85% of the net monthly salary payable at the onset of disability, benefits will be reduced by the excess amount.

Income and benefits from the following sources are taken into account:

- Benefits payable under this LTD coverage;
- Any compensation received from your employer;

- Benefits payable under any applicable legislation respecting industrial accidents or occupational illnesses, automobile accidents or similar coverage, applicable social legislation other than the *Employment Insurance Act*, the Canada or Quebec Pension Plan, any retirement plan offered by your employer, or any group insurance policy;
- Maternity, parental or compassionate care benefits payable under the *Employment Insurance Act*;
- Retirement income benefits from the Canada or Quebec Pension Plan;
- Retirement income from your employer's pension plan.

The calculation of benefits does not take into account any indexation of benefits or pension income payable under the above-mentioned sources or under this benefit due to an increase in the cost of living.

All income and benefits used in the calculation are amounts payable before deduction of any applicable taxes.

If such income or benefits are normally payable in a lump sum, SSQ calculates the monthly equivalent of the lump sum amount.

If you do not receive income or benefits from any of the above-mentioned sources, you must provide SSQ with proof that you are not entitled to claim such income or benefits. Otherwise, SSQ will take into account any income and benefits that it deems you should be entitled to. This provision does not apply to retirement benefits payable under the Canada or Quebec Pension Plan, and your employer's pension plan.

Disability management

Problem-solving service

Note: Your spouse and dependent children, if applicable, are also covered for this service.

If personal problems are affecting your psychological wellbeing and day-to-day activities, SSQ will provide you with access to consultation, counselling and support services for:

- Relationship or family difficulties;
- Work-related difficulties;
- Personal problems, such as loss of interest, fatigue, stress, insomnia and communication difficulties;
- Alcohol, drug or medication abuse.

These services are subject to an overall yearly maximum of twelve (12) hours of consultation for you, your spouse and any dependent children, if applicable.

Special Provisions in the case of the participant's death

In the case of your death, the services provided for under this benefit will be available to your spouse and any dependent children until the end of the third month following the date of your death, up to the limit provided for under this benefit.

Claims, proof and medical examinations

You must submit your claim and forward written proof of your disability within ninety (90) days following the end of the elimination period. If you do not submit a claim or provide such proof within the time specified, you will not be entitled to benefits for the period prior to the date such proof is received by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the end of the elimination period, no benefits will be payable.

You must submit your claim and forward written proof of your disability to the Head Office of SSQ within 90 days following the end of the elimination period. The elimination period begins on the first day that you are incapable of carrying out the main functions of your usual employment.

Subsequently, during the processing of your claim or while you are receiving benefits, you must provide all further proof of your disability requested by SSQ. If you do not provide satisfactory proof or do not undergo a medical examination within ninety (90) days of a request by SSQ, your claim will be declined or benefit payments will be suspended or terminated.

Limitations

In the case of a recurring disability, you will have ninety (90) days following the date of recurrence to provide SSQ with satisfactory proof as such. If you do not provide such proof within 90 days you will not be entitled to benefits for the period prior to the date of receipt of such proof by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the date of recurrence, no benefits will be payable.

In the case your claim is declined or benefit payments are terminated, you will have ninety (90) days following the date of written notice of the above by SSQ in which to provide supplementary proof justifying the continuation of your disability or to have your file reviewed. If you do not provide such proof within 90 days you will not be entitled to benefits for the period prior to the date of receipt of such proof by SSQ. Furthermore, if proof is submitted to SSQ later than twelve (12) months following the date of written notice by SSQ, no benefits will be payable.

In the case that your LTD coverage ends, you must submit, no later than six (6) months after the date of the onset of your disability, written proof of:

- the accident you were a victim of or the illness you are afflicted with; and
- continuation of your disability.

If you do not provide satisfactory proof within the time specified, no benefits will be payable.

Gradual return to work

If you are disabled, you may begin a gradual return to work if:

- your condition meets the definition of disability specified in the Definitions section;
- the duration of the disability period preceding your gradual return to work is thirty (30) days or more; and
- your gradual return to work is approved by SSQ.

In this case, your Income Insurance benefit payments will be reduced by an amount equal to the percentage of the period of work actually effectuated in relation to your normal work schedule.

Refusal to undergo examination or treatment

To be eligible for benefits, you must agree to undergo any medical examination or treatment likely to favour recovery of your health, to the satisfaction of SSQ.

Failure to do so will result in suspension of benefit payments until you provide satisfactory *proof* that you have undergone the appropriate examination or treatment requested.

Rehabilitation

If considered by SSQ and its medical advisors, you will be required to participate in an SSQ supervised rehabilitation program designed to favour your return to work. If SSQ and its medical advisors deem it necessary and justified, a rehabilitation program may be modified or interrupted.

SSQ will review your case file to determine what kind of rehabilitation program, if any, would be best for you. If your case file indicates rehabilitation would be beneficial, SSQ will provide the necessary resources and support to help you recover your health and functional autonomy to a level enabling you to return to work.

The rehabilitation program resources may include, among others:

- Psychological consultation;
- Employment counselling;
- Changes to your workstation, job description or schedule.

Remuneration you receive during the rehabilitation period will not reduce your LTD benefit unless that remuneration, together with other income or benefits specified under *Benefits and income from other sources,* exceeds 100% of your monthly net pre-disability income

Interruption of work

Leave without pay, suspension, maternity leave, parental leave, compassionate leave

If you become disabled during a period of leave without pay, suspension, maternity leave, parental leave or compassionate leave, you will be eligible for benefits according to the policy terms and conditions in force at the onset of your disability. You must also have maintained your Income Insurance coverage in force. The elimination period will begin only on the date of your return to work.

Temporary layoff

If you become disabled **before** the date you receive a notice of temporary layoff, you will be eligible for benefits. However, if you become disabled **after** the date the notice of temporary layoff was issued, benefits will no longer be payable as of the date of the layoff.
If you become disabled **during** the layoff period, you are not eligible for benefits.

Dismissal

If you become disabled after the date you receive a notice of dismissal, benefits will stop on the date of the dismissal.

Strike or lock-out

If you are disabled at the time a strike or lock-out begins, you will remain eligible for benefits in accordance with the terms and conditions in force at the onset of your disability.
If you become disabled during a strike or lock-out, you will be eligible for benefits according to the policy terms and conditions in force at the onset of your disability, provided you have maintained your Income Insurance coverage in force during the strike or lock-out. The elimination period will begin only on the date you are called back to work.

Waiver of premiums

Once you have been disabled for 6 months, you may be exempted from paying your Long Term Disability Insurance premiums, effective retroactively to your disability start date, for as long as your disability lasts.
To benefit from this exemption privilege, you must submit a claim or apply to SSQ in writing for a premium waiver. You must apply within ninety (90) days following the date you become eligible for the waiver of premiums.
If you do not apply within the deadline, you will not be exempted from paying premiums for the eligible period prior to the date SSQ receives your application.

Overlapping income insurance coverage

You may be insured for both Short Term Disability and Long Term Disability coverage at the same time. In this case, no benefits are payable under LTD coverage while you are still entitled to benefits under your STD coverage.

Lump sum benefit payable upon death

In the event of your death while disabled, a lump sum benefit payment equivalent to three (3) month's benefits will be made to your estate. The lump sum is calculated based on the amount of the last payment made.

Exclusions

You will not be covered if you become disabled:

- while you are committing or attempting to commit a criminal act;
- while you are actively participating in a riot or insurrection;
- directly or indirectly as a result of war or civil war, whether declared or undeclared;
- while you are an active member of the armed forces of a country;
- and you are not under the continuous care of a physician, except when your condition is declared stable by a physician, to the satisfaction of SSQ;
- as a result of intentional self-inflicted injuries, regardless of whether or not you were conscious of your acts;
- as a result of aesthetic treatments;
- and you refuse to undergo a medical examination upon request by SSQ;
- and you hold a position or perform work, for which you earn any salary or profit (except as stipulated in the sections Gradual return to work and Rehabilitation);
- and you refuse to participate in the Rehabilitation Program at SSQ’s request.

How to Claim - Long Term Disability Insurance

You may file a claim by completing the «Application for Disability Insurance Benefit» claim form, which may be obtained from your group plan administrator or HealthSource Plus. Please indicate the certificate number and telephone number on all claim forms and submit to HealthSource Plus at the following address:

Toronto	Montreal
240 Duncan Mill Road Suite 801 Toronto, Ontario M3B 3S6	100 blvd. Alexis Nihon Suite 955 Saint. Laurent (Quebec) H4M 2P5

For more information or if you have any questions, please telephone or fax at the following numbers:

Telephone:

	416-445-0000	514-331-7728
(Toll free)	1-800-753-0110	1-877-331-7728

Fax:

416-445-2222	514-331-6486

TRAVEL INSURANCE AND ASSISTANCE (HEALTH INSURANCE)

(SSQ Financial)

For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, contact SSQ's travel assistance service at one of the numbers below:

From Canada or the United States: 1 866 438-5498
From elsewhere in the world: (418) 651-2266 (collect call)

You must provide the Contract Number specified on your SSQ Card when calling.

1. Expenses covered

The percentage of reimbursement applicable to the following eligible expenses is specified in the *Schedule of Insurance*.

In the event of the insured's death during a trip outside the province of residence, or in the event that the insured suffers accidental injury or a sudden and unexpected illness during such trip, emergency expenses incurred by the insured as described below are eligible, up to a maximum reimbursement of $5,000,000 per insured per trip.

Travel Insurance only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the insured's province of residence. Insureds planning a trip scheduled to last more than 180 days must contact SSQ in advance for information about applicable conditions.

In the following cases, approval must be requested as soon as possible from SSQ's travel assistance service, either by the insured or by any other adult able to do so: hospitalization, medical care, transportation by ambulance.

In the following cases, insureds must obtain prior approval from SSQ's travel assistance service: treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist; repatriation; medical escort; living expenses and transportation of a close relative of the insured; transportation of the insured's body if deceased; return of a vehicle; expenses described under the *Services, products and articles* section.

For the expenses described below to be considered eligible, insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, services must be obtained from an individual who does not reside with the insured and is neither a close relative nor a travel companion of the insured.

Insureds who already have a known disease or illness before the trip must ensure before departure that:

- Their health condition is good, and stable. The insured's state of health is considered unstable, and its effects are not considered to be those of a sudden and unexpected illness, in the following cases:
  - Symptoms worsen
  - A relapse is suffered
  - The disease or illness is in its terminal phase
  - The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip

- They are able to carry out usual daily activities
  and
- They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the trip outside the province of residence

SSQ's travel assistance service can clarify the term "sudden and unexpected illness" and confirm whether coverage may be limited in any way by the insured's condition.

Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

Physician fees

Professional fees of a physician for medical, surgical or anaesthetic care, other than fees for dental care.

Nursing fees

When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $5,000 per insured per trip.

Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees

Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $1,000 per insured per trip.

Prescription drugs

Expenses for the purchase of drugs available only on prescription from a health care professional legally authorized to do so.

Transportation by ambulance

The cost of transportation by ambulance to the nearest hospital by a licensed ambulance service.

Repatriation of the insured

The cost of returning the insured to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the insured's health condition into account.

Transportation by plane of a medical escort

The cost of economy class return air fare for a medical escort who is neither a member of the insured's family nor a travel companion, when required by the air carrier or the attending physician of the insured.

Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class return transportation for a close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days. Eligible expenses, including transportation costs incurred in order to identify the deceased insured's body prior to return, are subject to the following limits:

- Transportation: $2,500 per trip for all insured family members
- Accommodation and meals: $200 per day for all insured family members, up to a maximum of $1,600 per trip

Eligible transportation expenses are limited to the cost of making the trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

Transportation of the insured's body if deceased

The expenses of preparing and returning the remains of the insured by the most direct route home, excluding expenses incurred for a coffin or casket. Eligible expenses are limited to a total maximum of $5,000 for preparation of the body and transportation.

Return of vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $1,000 per trip.

The vehicle must be returned by a recognized commercial agency. The insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the insured's travel companions, if applicable, must also be unable to return the vehicle.

Services, products and articles

Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator
- X-rays and laboratory analyses
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices

Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home due to hospitalization of the insured, a family member or a travel companion.

The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of $200 per day, or $1,600 per trip abroad, for all individuals covered.

Travel assistance services

Your insurance provides access to certain travel assistance services when you need them. These services may not be available in all countries and are subject to change by SSQ without notice.

The following services are available:

a) Directing the insured to an appropriate clinic or hospital
b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front
c) Ensuring the proper follow-up of the insured's medical file
d) Coordinating the return and transport of the insured as soon as medically possible
e) Providing emergency support and coordinating settlement applications
f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured
g) Arranging for the return of insured persons to their home (return expenses not included)
h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident
i) Communicating with the insured's family or employer
j) Acting as an interpreter for emergency calls
k) Recommending a lawyer in the event of legal difficulties

Medical and hospitalization expenses for care not available in the province of residence

For expenses to be eligible for reimbursement, you, your spouse or any dependent children, if applicable, must be covered by the health and hospitalization insurance plan of your province of residence.

Expenses incurred outside the province of residence are covered up to a maximum of $10,000. However, to be eligible for reimbursement, expenses must be incurred for treatment that is:

- unavailable in the insured's province of residence;
- prescribed by a physician.

Treatment must be pre-approved by the insured's provincial health and hospitalization insurance plan and by SSQ.

SSQ will reimburse the difference between the expenses incurred and the benefits payable under the insured's provincial health and hospitalization insurance plan in Canada or by any other public plan that has an agreement with the insured's province of residence in Canada.

Your insurance covers:

- Hospitalization in a hospital where the insured receives curative treatment;
- Professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care;
- Transportation and accommodation expenses incurred by the insured when obtaining the medical treatment covered under this section;
- Expenses incurred for medications, X-rays and laboratory analyses.

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel Insurance.

The following expenses are not eligible for reimbursement under the Travel Insurance benefit of this plan:

a) Expenses incurred as a result of the insured's refusal to be repatriated to the province of residence, upon SSQ's request

b) Expenses incurred by the insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the insured's life or health

c) Expenses incurred in a location for which the Government of Canada issued a travel advisory not to stay in or not to travel to. This exclusion does not apply to insureds already present at the location in question at the time the Government of Canada issues the travel advisory, provided they then take the necessary measures to comply with the advisory as soon as possible

d) Expenses payable under any public plan

e) Expenses related to elective or non-emergency surgery or treatment

f) In the case of a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the trip is taken, whether or not the trip is taken upon the recommendation of a physician

g) Expenses for chronic care incurred in a facility treating chronic illnesses

h) Expenses incurred for insureds in thermal spa facilities or extended care homes

i) Expenses incurred due to injury or death as a result of practising any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, mountaineering, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to.

j) Expenses related to an event occurring during the trip, or shortly thereafter, that insureds may reasonably have predicted due to their state of health at the start of the trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter

k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the public health or hospitalization plan of the insured's province of residence

TRIP CANCELLATION INSURANCE (HEALTH INSURANCE)

(SSQ Financial)

1. Reasons for cancellation

For cancellation expenses to be considered eligible, the trip must be cancelled, extended or interrupted due to one of the following causes:

a) An illness or accident suffered by the insured, a travel companion, a business partner of the insured, or a member of the insured's family. The illness or accident must prevent the patient from performing his or her usual activities and must be sufficiently serious to justify or force the cancellation or interruption of the insured's trip

b) Death of: the insured; the insured's spouse; the insured's or spouse's child; the insured's travel companion; or the insured's business partner

c) Death of a family member of any of the following individuals: the insured; the insured's spouse; the insured's child; the insured's travel companion. The funeral must be scheduled to take place during the planned trip or the preceding 14 days

d) Death, illness or accident suffered by a person for whom the insured is the legal guardian

e) Notwithstanding any other provision of the contract, suicide or attempted suicide of the insured's travel companion or a member of the insured's family

f) Death of a person for whom the insured is the testamentary executor

g) Death or emergency hospitalization of the host at destination

h) The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or is a police officer and has been subpoenaed as part of his or her regular duties

i) Quarantine of the insured, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the trip.

j) Hijacking of the airplane on which the insured is travelling

k) Damage rendering the principal residence of the insured or of the host at destination uninhabitable. The residence must remain uninhabitable 7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the trip

l) Transfer of the insured, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required by the employer within the 30 days preceding the scheduled date of departure

m) Notwithstanding any other provision of the contract, terrorism, war, whether declared or undeclared, or an epidemic in the location which the insured plans to travel to or leave, provided the Government of Canada issues an advisory not to travel to such location or one to leave such location. The advisory must be in force for the period of the planned trip or stay and have been issued after the insured has already finalized the travel arrangements or when the insured was already staying in such location.

n) Delay of the transportation used by the insured to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report

o) Weather conditions such that:

the departure of the public carrier used by the insured, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip

or

the insured is unable to make a scheduled connection after departure with another carrier, provided the scheduled connection after departure is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip

p) Damage occurring to the physical location where a commercial activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity

q) Death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation

2. Expenses covered

To be eligible, expenses must be incurred by the insured following the cancellation, extension or interruption of a trip, provided such expenses are related to amounts paid in advance by the insured and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation. Expenses are reimbursed in accordance with the provisions hereafter and with the provisions specified in the *Schedule of Insurance*.

Eligible cancellation expenses may not exceed $5,000 per insured per trip.

In the event of cancellation prior to departure

In the event of cancellation prior to departure, the trip must be cancelled through the travel agent or carrier within 48 hours of the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable portion of prepaid travel expenses

b) Additional expenses incurred by the insured if the travel companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation and the insured decides to proceed with the trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel

c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the insured decides not to proceed with the trip

In the event of missed departure or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the mostdirect route to the initially-planned trip destination. Departure must be missed due to a delay in the means of transportation used by the insured, subject to the conditions specified in the eligible reasons for cancellation. In the event of interruption of a trip, the interruption must be due to an illness or accident suffered by the insured or travel companion, subject to the conditions specified under the eligible reasons for cancellation.

If the return is earlier or later than planned

a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure. These expenses must be pre-approved by SSQ's travel assistance service

b) The unused and non-refundable portion of the ground portion of prepaid travel expenses

Restriction

If the return is delayed by more than 7 days, the expenses incurred are eligible, provided the person in question was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

If travel expenses were not paid in advance, the expenses incurred by the insured are covered provided that before the scheduled date of departure, the insured was not aware of any event that could reasonably lead to the interruption of the planned trip.

Round-trip transportation

The cost of transportation by the most economical means, following approval by SSQ's travel assistance service, for the insured to return to the province of residence and then back to the trip destination, provided the return is due to one of the following reasons:

a) Death or hospitalization of a member of the insured's family, a person for whom the insured is the legal guardian or a person for whom the insured is the testamentary executor

b) A disaster that has made the principal residence of the insured uninhabitable or has caused significant damage to the insured's business establishment

3. Exclusions, limitations and restrictions

In addition to the exclusions, restrictions and limitations applicable to all benefits of the Health Insurance plan, the following exclusions apply to Trip Cancellation Insurance.

Trip Cancellation Insurance does not cover losses due to the following causes or to which such causes have contributed:

a) War, whether declared or not, an epidemic or an act of war or of terrorism, it being understood that this exclusion does not apply to the insured already present in a place at the time a war or an epidemic breaks out, or an act of war or of terrorism occurs, provided the insured takes the necessary measures to leave such place as soon as the Government of Canada issues an advisory to do so. This exclusion does not apply to insureds whose travel plans are finalized on the same day the government advisory is issued or before.

b) Active participation of the insured in a riot or insurrection or perpetration or attempted perpetration of a criminal act by the insured or the insured's travel companion

c) Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences

d) Intentional self-inflicted injury by the insured or travel companion; suicide or attempted suicide, whether the individual is sane or insane

e) Participation in any the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, mountaineering, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to.

f) The reason for which the trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician

g) In the event that the trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person

h) A cause which, beyond any possible doubt, does not prevent the insured from proceeding with the trip.

If notice of cancellation of a trip prior to departure is not provided within the time specified, SSQ's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and any adult accompanying the insured on the planned trip provide proof deemed satisfactory by SSQ that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and SSQ's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation

EXTENDED HEALTH BENEFIT (Details)
(Benefits administered by Claims Secure)

Please refer to the Schedule of Benefits for deductibles and percentages

The Client shall pay reasonable and customary charges in the geographic area where the claim occurs, for the services, supplies and equipment set out below when the services, supplies and equipment are:

- ordered by a physician or other health care provider. A physician means a doctor of medicine who is legally qualified to practice medicine or surgery and is licensed by the appropriate board in the jurisdiction where his or her services are rendered. A health care provider is defined as a licensed, certified, registered or chartered practitioner licensed to practice in the jurisdiction where the services are provided.
- medically necessary services defined as services, equipment or supplies consistent with the diagnosis and treatment of the condition and in accordance with the standards of good medical practice. The order, recommendation or approval of a physician does not make the service medically necessary
- not covered or eligible for coverage by any government program or plan.
- subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance specified in the Master Application.
- must be incurred while you are eligible under this benefit.

As used under this section and unless mentioned otherwise, Benefit period means per calendar year.

PARAMEDICAL SERVICES

Services provided by the following licensed, certified or registered professional Paramedical Practitioners, providing the services are within the scope of their profession.

Notes: Eligible expenses are limited to one professional visit per day for each type of practitioner. Payment can be issued on first dollar claims excluding provinces where the Provincial Health Insurance Plan prohibits this by law. X-ray examinations provided by a licensed chiropractor, osteopath practitioner, chiropodist and podiatrist are eligible and included in the benefit maximum.

- **Dietician**
  Maximum Benefit $350 per calendar year per covered person.
- **Chiropodist/Podiatrist**
  Combined Maximum Benefit $300 per calendar year per covered person. $50 for x-rays
- **Chiropractor**
  Maximum benefit $300 per calendar year per covered person. $50 for x-rays
- **Naturopath**
  Maximum Benefit $300 per calendar year per covered person. $50 for x-rays
  Exclusions: Homeopathy is not covered. Supplements and remedies are not covered.
- **Osteopath**
  Maximum Benefit $300 per calendar year per covered person. $50 for x-rays
- **Physiotherapist**
  Unlimited benefit per calendar year per covered person.
- **Psychologist**
  Maximum Benefit $300 per calendar year per covered person.
- **Registered Massage Therapist**
  Maximum Benefit $300 per calendar year per covered person.
- **Speech Therapist**
  Maximum Benefit $300 per calendar year per covered person.

ACCIDENTAL DENTAL

Charges for the services of a licensed dental provider for the repair or replacement of sound natural teeth when caused by an external force or blow to the face. Services rendered must be within twelve (12) consecutive months of the date of the accident.
Note: Pre-approval by ClaimSecure is required.

AMBULANCE SERVICE

Charges for Ground Ambulance Service to the nearest Hospital or other medical facility capable of providing the required care.
Note: Emergency transportation by air, rail or water may be considered.
Limitations may apply. Only charges for uninsured amounts will be considered.

CONVALESCENT CARE

Convalescent facility room charges provided to a covered person who is receiving active treatment or rehabilitation for a condition that will significantly improve as a result of convalescent care.
Maximum Benefit is $20 per day up to one-hundred-twenty (120) days per covered person per disability and immediately follows three (3) or more days of hospital confinement of acute care
.**Exclusions:** Room charges for chronic care, custodial care, home for the aged, alcohol and substance abuse, mental health.

DIAGNOSTIC SERVICES

Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the provincial government plan.

EYE EXAMS

Maximum Benefit is one (1) eye exam per covered person every twenty-four (24) consecutive months.
Note: Provided by a licensed ophthalmologist or optometrist.

HEARING AIDS

The purchase of a new hearing aid(s) or repair of an existing hearing aid(s).
Maximum Benefit $400 every sixty (60) consecutive months per covered person.
Note: A Physician or Audiologist's referral is required for the purchase of a hearing aid. Provincial assistive device program maximums will be taken into consideration where applicable.
Exclusions: Hearing tests, batteries and ear moulds are not covered.

MEDICAL EQUIPMENT/SUPPLIES

The following medical equipment and supplies are covered when prescribed by a physician. Such equipment must be required for therapeutic use. Coverage is for supplies and equipment available on a rental basis, however at the discretion of ClaimSecure we may consider the cost of purchase for the equipment or supply.
Pre-approval may be required for specific medical equipment.

Note: Provincial assistive device program maximums will be taken into consideration where applicable.

Exclusions: The medical equipment benefit does not include charges for the maintenance of medical equipment rented or purchased. Rental costs may not exceed the purchase price.

- **Breathing Equipment**
  - Continuous Positive Airway Pressure Machine (CPAP)
    Maximum Benefit one (1) per lifetime per covered person.
    Exclusions: Supplies are excluded.
  - intermittent Positive Pressure Breathing Machine (IPPB)
    Maximum Benefit one (1) per lifetime per covered person.
    Exclusions: Supplies are excluded.
  - Apnea Monitors for respiratory dysrhythmias
  - Mist Tents and Nebulizers
  - Oxygen and the equipment needed for it's administration
  - Tracheostoma tubes
- **Orthopaedic Equipment**
  - Braces
    Note: Braces are wearable, orthopaedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body of the correct position.
    Exclusions: Elastic supports and foot orthotics and dental braces are not considered as an orthopaedic appliance.
  - Splints: including splints attached to a brace
    Exclusions: Intra-oral splints are not covered.
  - Casts
  - Cervical Collars
- **Prosthetic Equipment**
  - External Breast Prosthesis
    Maximum Benefit is one (1) per calendar year per covered person.
    Note: Required because of a total or radical mastectomy.
  - Standard Artificial Limbs
    Exclusions: Myoelectric limbs.
  - Artificial Eyes including repair and replacement
  - Stump Socks
  - Shoulder Harnesses

- **Mobility Aids**
  - Standard Wheelchair, or where medically required electric wheelchairs.
    Maximum Benefit of $3,000 every sixty (60) consecutive months per covered person.
    Note: Pre-approval required from ClaimSecure.
  - Canes
  - Crutches
  - Walkers

- **Other Medical Equipment**
  - Blood Glucose Monitoring Machines
    Maximum Benefit is once every forty-eight (48) consecutive months per covered person.
  - Insulin Infusion Sets
    Exclusions: Insulin Infusion Pump.
  - Intra-uterine Contraceptive Devices
    Note: must inserted by a doctor.
  - Standard Hospital Beds
    Exclusions: Electric hospital beds.
  - Surgical Brassieres
    Maximum benefit of two (2) per calendar year per covered person.
    Note: Following a mastectomy.
  - Support Hose and Compression Stockings.
    Maximum Benefit of four (4) pairs per calendar year per covered person.
  - Transcutaneous Nerve Stimulators for the control of chronic pain (Tens machine).
    Maximum benefit is $700 in a person's lifetime per covered person.
  - Wigs
    Maximum Benefit of $200 in a person's lifetime per covered person.
    Note: For cancer patients undergoing chemotherapy.
  - Bed Rails
  - Colostomy and Ileostomy Supplies
  - Custom-Made Burn Garments
  - Custom-Made Pressure Supports for lymphedema
  - Head Halters
  - Traction Apparatus
  - Trapeze Bars
  - Urethral Catheters

ORTHOTICS
Custom Moulded Orthotics
Maximum Benefit of $400 per calendar year per covered person.

CUSTOM MADE ORTHOPAEDIC SHOES
Custom Fitted Orthopaedic Shoes.
Maximum Benefit of $400 every thirty-six (36) consecutive months per covered person

OFF THE SHELF ORTHOPAEDIC SHOES AND ORTHOPAEDIC MODIFICATIONS
Orthopaedic Shoe(s) or the permanent modification of a regular shoe. Modifications may include sole buildups, lifts, wedges, steel plates, caliper plates, stirrups to accommodate braces and self-adhesive closures. Combined Maximum Benefit $150 per benefit period per covered person.
Exclusions: The Orthopaedic Shoe Benefit does not include shoes purchased only to accommodate orthotics or comfortable walking shoes such as Berkenstock, Nike, Brooks, Rockport, etc.

****Important information regarding submission of claims for Orthotics, Custom Made Orthopaedic Shoes, Off the Shelf Orthopaedic Shoes and Orthopaedic Modifications****

Orthotics, Custom Made Orthopaedic Shoes, Off the Shelf Orthopaedic Shoes and Orthopaedic Modifications may be obtained on the written recommendation of a Physician (MD), Podiatrist (DPM) or Chiropodist (D CH or D Pod M), accompanied by a diagnosis of the conditions and symptoms and a gait analysis/biomechanical exam. All Orthotics, Custom Made Orthopaedic Shoes, Off the Shelf Orthopaedic Shoes and Orthopaedic Modifications must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (CPed(c) or CPed(MC)), Podiatrist (DPM), Chiropodist (D CH or D Pd M) or Orthésistes du Pied (member of CCCOP). The dispenser must be a different provider than the prescriber.

A description of how the orthotics or orthopaedic shoes were constructed, or of the modifications made to an off the shelf shoe, and the raw materials used, plus a breakdown of the costs must accompany the claim. The name and license number of the dispenser must also be provided

PRIVATE DUTY NURSING
Services of a Registered Nurse, Licensed Practical Nurse, or Registered Nursing Assistant
Maximum Benefit $10,000 per calendar year per covered person.

Note: The Nursing Provider may not be a resident of the Participant's home or related to the Participant's family.

Services must be determined to be medically necessary and must be provided in a Participant's home. Services rendered must require the skill of a Registered Nurse, Licensed Practical Nurse or Registered Nursing Assistant. Services must be pre-approved by ClaimSecure with such approval being subject to periodic reassessment.

SPECIAL VISION BENEFIT AFTER SURGERY
An initial pair of frames and one (1) corrective lens, contact lens or prosthetic lens after cataract surgery
Maximum Benefit is one (1) per eye per lifetime per covered person.
Note: This benefit is ***in lieu*** of the frames and prescription lenses, or prescription contact lenses benefit.

HOSPITAL CARE
Standard semi-private room charges provided to a covered person in a public, licensed hospital.
Note: The hospital stay must be for acute care as a result of illness, injury and/or pregnancy.
Exclusions: Room charges for outpatient care, day surgery, private hospital, nursing home, chronic care facilities, home for the aged, rest home.

VISION CARE SERVICES

Frames and prescription lenses, or prescription contact lenses

Maximum Benefit: $120 every twenty-four (24) consecutive months per covered person.

Exclusions

- Refractions required by a Client, government body or other third party.
- Safety glasses or safety goggles.
- Replacement of lost, stolen or broken lenses or frames.
- Duplicate or spare eye glasses.
- Intra-ocular lens implants.
- Non-prescription sunglasses.

General Limitations & Exclusions for Extended Health Benefits

In addition to the limitations and exclusions of this benefit plan, and those limitations and exclusions contained in the description of the benefits, the Extended Health Benefits do not cover services, supplies or equipment that are primarily intended to facilitate:

- expenses that private insurers are not permitted to cover by law
- services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance
- service and supplies that do not represent reasonable treatment
- services or supplies associated with: services rendered for cosmetic reasons, exercise, weight loss, physical fitness or sports, environmental or atmospheric control in the home or workplace
- the diagnosis or treatment of infertility
- services or supplies associated with covered items, unless specifically listed as a covered expense
- extra medical supplies that function as spares or alternates
- services or supplies received outside Canada except as provided under the out-of-country emergency care
- services covered by any Workplace Safety and Insurance Board unless prohibited by any Government legislation
- services and supplies not shown in the included list of benefits
- expenses for services, treatment or supplies, which are considered experimental in nature
- any claim expense or service provided by an immediate family member are not eligible for coverage/payment
- health care services or supplies required as a result of war, terrorism rebellion or hostilities of any kind, whether or not the covered person is a participant
- health care services or supplies required as a result of participation in a riot or civil disturbance
- health care services or supplies due to intentional self-inflicted injury

PRESCRIPTION DRUG BENEFIT (Details)

PLAN AG - GENERIC PRESCRIPTION DRUG PLAN

Please refer to the Schedule of Benefits for deductibles and percentages

This plan covers the cost of the following drugs:

- All drugs which by law or convention* requires a physician's or dentist's prescription
- Insulin supplies which includes needles, lancets, syringes and diagnostic tests. This excludes swabs, rubbing alcohol, control solution, etc.
- All injectibles including serums and injectible vitamins
- Extemporaneous compounds prepared by a pharmacist

Exclusions

- Any drug or medication which may be purchased without a prescription. This further excludes over-the-counter (O.T.C.) products whether prescribed or not.
- Fertility drugs are not covered even if prescribed for therapeutic use
- Anabolic steroids are not covered even if prescribed for therapeutic use
- Anti-Smoking agents are not covered even if prescribed for therapeutic use
- Items deemed cosmetic even if a prescription is legally required

As a further guide, the plan excludes in part:

- Vitamins (except injectible vitamins)
- Vaccines
- Patented Medicines and G.P. Products
- First aid and surgical supplies
- Atomizers, vaporizers
- Salt and sugar substitutes
- Infant formula, dietary foods and aids
- Contact lens care products
- Diagnostic aids and laboratory tests
- Contraceptives other than oral
- Lozenges, mouthwash, toothpaste and cosmetics
- Non-medicated shampoos, skin cleansers, skin protectors, emollients and soaps
- Any benefit provided by a Government plan

NOTE: In the case of a Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.

The above exclusions apply unless by law such expenses are to be covered. In such cases, they will be reimbursed on the same basis as required by the law.

DENTAL CARE BENEFIT (Details)

(Administered by ClaimSecure)

Please refer to the Schedule of Benefits for deductibles, maximum and percentages

ClaimSecure shall pay the lesser of the reasonable and customary charge of the Dentist or Dentist Specialist and the charges specified in the suggested provincial Fee Schedule for the dental services when the dental services are:

- necessary Dental Services defined as dental services that are consistent with the diagnosis and treatment of the condition and in accordance with standards of good dental practice;
- not covered or eligible for coverage by a government program or plan;
- subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance specified in the Master Application;
- incurred while you are eligible under this benefit;
- provided by a dental provider licensed to practice in the province where the services are performed. A dental provider may be a licensed dentist, dentist specialist or denturist.

If the specialist dental fee schedule option is not included, services rendered by a Dentist Specialist will be paid in accordance with the suggested provincial fee schedule for general practice Dentists.

Fee schedule means the schedule of fees approved and published by a provincial dental association and stipulated for use under this Benefit Plan in the Master Application. When treatment outside Canada is necessary, the approved fee schedule used will be the fee schedule of the province of residence in which the covered person resides.

When a planned course of dental treatment is expected to exceed $500 or more, it is highly recommended that ClaimSecure receive a predetermination of benefits from the attending dental provider. This predetermination will include a description of the proposed treatment, an estimate of the charges for services and dental radiographs where applicable. ClaimSecure will determine and confirm the amount of approved benefits.

LEVEL 1

Level 1 services include Diagnostic, Preventive, Minor Restorative, Minor Oral Surgical, Maintenance only of Prosthetic Denture and Denture Maintenance, and Adjunctive Services.

Diagnostic Services are services to diagnose a dental condition.
The following diagnostic services are covered:

- complete examination.
  Limitation: one (1) complete examination every thirty-six (36) consecutive months.
- recall examination.
  Limitation: one (1) recall examination every six (6) months.
- specific examination.
  Limitation: two (2) specific examinations every twelve (12) consecutive months.
- emergency examination.
  Limitation: two (2) emergency examinations every twelve (12) consecutive months.

- complete series of radiographs or panoramic radiograph.
  Limitation: one (1) complete series or panoramic radiograph every twenty-four (24) consecutive months.
- bite-wing radiographs.
  Limitation: one (1) every six (6) consecutive months.
- bacteriological tests/analyses.
- histopathological tests/analyses.
- microbiological tests/analyses.
- occlusal radiographs.
- periapical radiographs.

Preventive Services are services to prevent future dental problems.
The following preventive services are covered:

- fluoride.
  Limitation: one (1) fluoride treatment every six (6) months
- oral hygiene instruction.
  Limitation: one (1) occurrence per lifetime.
- polishing.
  Limitation: one (1) unit of polishing every six (6) months.
- scaling/root planing.
  Limitation: ten (10) units per calendar year.
- interproximal disking.
- pit & fissure sealants
- space maintainers & maintenance of space maintainers

Minor Restorative services are services to repair teeth.
The following minor restorative services are covered:

- amalgam restorations.
  Limitation: non-bonded amalgam restorations. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations.
- prefabricated restorations (prefabricated crowns).
  Limitation: Primary Teeth only.
- tooth coloured restorations..
- caries/trauma/pain control.
- prefabricated posts.
- retentive pins.

Minor Oral Surgical services include oral surgery services.
The following minor oral surgical services are covered:

- alveoloplasty – simple.
- antral surgery.
- extractions & residual root removal.
- fractures.
- frenectomy.
- hemorrhage control.
- surgical excision.
- surgical exposure.
- surgical incision.
- treatment of salivary glands.
- vestibuloplasty.

Crown/Bridge/Denture Maintenance services include services for the repair of prosthetic appliances.
The following maintenance services are covered:

- denture rebase.
  Limitation: one (1) per arch every thirty-six (36) consecutive months.
- denture reline.
  Limitation: one (1) per arch every thirty-six (36) consecutive months.
- denture repair.
- recementation of crowns/bridgework.
- repair of crowns/bridgework.

Adjunctive services include services that are not classified elsewhere.
The following adjunctive services are covered:

- deep sedation.
- general anaesthesia.
- nitrous oxide.
- nitrous oxide with oral sedation.
- parenteral conscious sedation.
- therapeutic injections.

LEVEL 2
Level 2 Services include Endodontics and Periodontics.

Endodontic services include services to treat the pulp chamber of the tooth
the following endodontic services are covered:

- root canal therapy.
  Limitation: routine initial root canal therapy. Complicated root canal therapy reduced to cost of routine root canal therapy. Retreatment of root canal is covered only if at least thirty-six (36) consecutive months have elapsed from the date of the initial root canal therapy. No coverage for primary teeth.
- apexification.
- apicoectomy.
- bleaching of endodontically treated teeth.
- hemisection.
- intentional removal and implantation.
- isolation of endodontic tooth.
- open & drain.
- pulpectomy.
- pulpotomy.
- retrofilling.
- root amputation.

Periodontic services include services to treat the tissue supporting the teeth.
The following periodontic services are covered:

- periodontal appliances and maintenance.
  Limitation: one (1) appliance per arch every thirty-six (36) consecutive months.
- management of oral disease.
- occlusal equilibration.
- periodontal abscess or periocoronitis.
- periodontal surgery – flap approach – osteoplasty.
- periodontal surgery – flap approach – osseous defect.
- periodontal surgery – gingival curettage.
- periodontal surgery – gingivoplasty.
- periodontal surgery – gingivectomy.
- periodontal surgery – grafts – soft tissue.
- proximal wedge.

LEVEL 3

Level 3 services include Major Restorative and Major Oral Surgical Services.

Major Restorative

The following major restorative services are covered:

- INLAYS/ONLAYS/CROWN
  - inlays – metal, composite, porcelain.
  - onlays – metal composite, porcelain.
  - prosthodontic examinations.
  - acrylic crowns.
  - porcelain/ceramic crowns.
  - ¾ porcelain/ceramic crowns.
  - cast metal crowns.
  - ¾ cast metal crowns.
  - gold foil restorations.
  - cores – amalgam and tooth coloured.
  - equilibration casts.
  - posts, cores and posts & cores.
  - retentive pins for inlays, onlays & crowns.
- DENTURES
  - complete dentures.
    Limitation: standard complete dentures.
  - cast partial dentures including partial dentures with clasps and/or rests.
  - overdentures and complicated dentures reduced to the cost of standard dentures.
  - partial acrylic dentures including partial dentures with clasps and/or rests.
- BRIDGEWORK
  - cast metal pontics.
  - porcelain/ceramic pontics.
  - acrylic retainers.
  - porcelain/ceramic retainers.
  - cast metal retainers.
  - ¾ cast metal retainers.
  - metal, composite and porcelain inlay retainers.
  - metal, composite and porcelain onlay retainers.
  - retentive pins for inlay/onlay retainers.

  NOTE: replacement frequency for inlays, onlays, crowns, bridgework and dentures every 60 months.

Major Surgery
The following major oral surgery services are covered:

- alveoloplasty (not performed in conjunction with extractions).
- crown lengthening.
- mandibulectomy.
- maxillectomy.
- reconstruction.
- remodelling floor of mouth.
- sequestrectomy.
- surgical movement of teeth.

LEVEL 4

Level 4 Services include Orthodontics, for children under age 18

Orthodontics
The following orthodontic services are covered:

- cephalometric radiographs.
- diagnostic photographs.
- enucleation.
- full orthodontic treatment.
- hand & wrist radiographs.
- interpretation from other source.
- monthly payments.
- oral surgery performed in conjunction with orthodontics. These services will be evaluated on a case by case basis.
- orthodontic examinations.
- orthodontic casts.
- surgical exposure.
- tracing & interpretation.

General Limitations & Exclusions for Dental Benefits

In addition to the limitations and exclusions of this Benefit Plan, and those limitations and exclusions contained in the description of the benefits, the dental benefits do not cover the following:

- charges for services provided for cosmetic reasons only, except for orthodontic services when such services are included in the orthodontic services benefit in the schedule of dental benefits and orthodontic services are included under this benefit plan.
- charges for missed or cancelled appointments, completion of forms, communications, or any other non-treatment services.
- charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice.
- under this benefit charges which are covered under any other benefit in this benefit plan.
- professional fees for an anaesthetist.
- replacement of lost, stolen or broken prostheses or appliances.
- protective appliances for athletic purposes.
- implants and any dental service associated with implants.
- services covered by any Workplace Safety and Insurance Board unless prohibited by any Government legislation.
- services and supplies not shown in the included list of benefits.
- any claim expense or service provided by an immediate family member are not eligible for coverage/payment.
- dental services or supplies required as a result of war, terrorism, rebellion or hostilities of any kind, whether or not the covered person is a participant.
- dental services or supplies required as a result of participation in a riot or civil disturbance.
- dental services or supplies due to intentional self-inflicted injury.

Applicable to Health Care Benefits, Prescription Drug Benefits and Dental Care Benefits

Coordination of Benefits

The Canadian Life and Health Insurance Association (CLHIA) has set guidelines to determine who is the first payer when both spouses have Health Care coverage through their respective employers.

If you and your spouse are each covered by a benefit program, you may co-ordinate reimbursement of your claim payments. Co-ordination of Benefits (COB) enables you to submit your claims to both plans and obtain reimbursement for up to 100% of total claim costs.

You and your spouse should first submit your claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earliest birthday in the calendar year.

Today's technology has enabled some pharmacists to submit a secondary COB claim electronically, at point of service. Please ask your pharmacist if this feature is available.

Deadline for filing claims

We suggest you file your claims at regular intervals, once every three (3) months. Claims incurred while individual is covered but filed later than twelve (12) months following the date expenses were incurred will not be reimbursed. In case of termination of benefit this limit is restricted to six (6) months or three (3) months in case of contract cancellation.

As receipts and paid invoices submitted will not be returned to you, we recommend that you keep a copy of all documents sent to us.

How to Claim

Drug and Dental: Can be paid by pay direct card or submitted manually with completed claim form and original receipts.

Extended Health Care: Can be submitted manually only, with completed claim form and original receipts.

Claim Forms are available with your employer or on our Web site, www.healthsourceplus.com. Please complete the appropriate form, indicating the following: group number, certificate number, address and telephone number. Forward the completed form, along with the appropriate receipts, paid invoices and medical prescriptions if required, to the following address:

ClaimSecure
43 Elm St, Suite 200
Sudbury (Ontario)
P3C 1S4

For more information, or if you have any questions, you may call one of the following numbers:

HealthSource Plus	416-445-0000 or 1-800-753-0110
ClaimSecure	1-888-513-4464

Why is this booklet important?

This booklet is a summary of your benefit details effective February 1, 2009.

This booklet outlines the benefits that are available under your employer's policy with HealthSource Plus. The section called "General Provisions" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides.

IMPORTANT

This booklet is meant to provide information about your Group Insurance Plan. It is not a legal contract. The Master Policy itself determines the benefits, amounts, and effective dates that apply to you. If there is a discrepancy between this booklet and the Group Policy, then the terms and provisions of the Group Policy shall always prevail.

THIS GROUP INSURANCE PLAN HAS BEEN ARRANGED BY

HealthSource Plus
240 Duncan Mill Road, Suite 801
Toronto ON M3B 3S6