The Manitoba Child Care Association Inc.

All Employees
Class 022

In force on February 1st 2009
Last updated March 22, 2018

This booklet contains important information.
Please keep it for future reference.

Table of Contents

Why is this booklet important? 1
Employee Customer Service 2
Schedule of Benefits 3
General Provisions 6
Benefit Provisions 9
Definitions 10
Participant's Basic Life Insurance Details 13
Optional Life Insurance Details 16
Accidental Death & Dismemberment Details 19
Long Term Disability Benefit Details 24
Travel Insurance and Assistance Details 27
Extended Health Care Benefit Details 39
Prescription Drug Benefit Details 46
Dental Care Benefits 48
Employee Assistance Program Details 54
Coordination of Benefits (COB) 55
Deadline for Filing Health, Dental and Drug Claims 56

Why is this booklet important?

- This booklet is a summary of your benefit details effective May 1, 2011.
- 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.
- This booklet is meant to provide information about your Group Benefit Plan. It is not a legal contract. The Group 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.

Employee Customer Service

Who do I call to obtain health, drug or dental care claims information?

Call the ClaimSecure Customer Response Centre at 1 (855) 885-8188 from 7am to 11pm, Eastern time, Monday through Friday. Please have your Certificate and Group numbers on hand. You can find these numbers on your HealthSource Plus pay direct card or on your Statement of Coverage.

How do I use the Internet to view my benefit booklet or access health, drug or dental care claims information?

Have your Certificate and Group numbers handy. You can find these numbers on your HealthSource Plus pay direct card or on your Statement of Coverage.

1. Go to www.healthsourceplus.com
2. Select the eProfile™ tab that appears at the top of every page. If you are visiting the site for the first time, you will be required to click "Register now" and follow the prompts. If you have already registered simply log on.

What are the benefits of using eProfile™?

eProfile™ is a secure, on-line way to manage your personal health, dental and drug claim information. Register to take advantage of these features:

- See the status of your claims:
- View your benefit booklet;
- View or print your personal claims history;
- Speed up payment of your claims – enrol in direct deposit to have your claims deposited directly to your bank account;
- Make claims submission easier – access pre-populated claims forms;
- Clarify plan details – submit coverage questions on-line.

Where can I find the forms I need?

Most of the forms that you need are available on our website www.healthsourceplus.com or from your Group Plan Administrator.

IMPORTANT PHONE NUMBERS		
ClaimSecure Health and Dental Claim Inquiries	1 (855) 885-8188	7am to 11pm, Eastern time
ClaimSecure Technical inquiries concerning eProfile™ registration and PIN issuance	1(855) 885-8188	8am to 8pm, Eastern time

If a representative 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. Calls will be returned in priority sequence normally on the same business day.

Schedule of Benefits

The table below summarizes the benefits available to eligible employees. Please refer to the individual benefit sections for further information, as well as limitations and exclusions that may apply.

Schedule of Benefits		
Benefit	**Coverage Details All Employees - Class 022**	
	Extended Health, Dental and Prescription Drug Benefits Administered by ClaimSecure Group Policy #9707	
Extended Health Care Benefit	Percentage Reimbursed	Medical 80% Hospital 100%
	Basic Hospital	Semi-Private Room
	Convalescent Hospital	$20 per day for up to 120 days per disability
	Paramedical Services	Practitioners: $300 per type of practitioner per calendar year, limit of 1 visit per day per type of practitioner (Athletic Therapist*, Chiropractor*, Dietician, Massage Therapist, Naturopath, Osteopath*, Speech Therapist, Chiropodist/Podiatrist*, Psychologist). *(includes X-Rays, up to $50 per calendar year) Physiotherapist: unlimited coverage
	Vision Care Services	Eye Exams Maximum Benefit of one (1) eye exam every 24 consecutive months, per covered person – payable at 100%. Note: Eye exams must be performed by an Ophthalmologist or licensed Optometrist. Frames & Prescription Lenses $120 every 24 consecutive months – payable at 100%.
	Termination of Benefit	Age 70 or retirement, whichever is earliest
Prescription Drug Benefit	Plan Type	Generic Drug Plan
	Percentage Reimbursed	80%
	Dispensing fee max	$9.00
	Ingredient Cost Mark Up	20%
	Calendar Year Maximum	$25,000 per calendar year
	Termination of Benefit	Age 70 or retirement, whichever is earliest

Schedule of Benefits		
Benefit	**Coverage Details All Employees - Class 022**	
Dental Care Benefit	Fee Guide	Current Year Provincial Dental Association Fee Guide – Specialist Fee Guide covered
	Calendar Year Deductible	$25 single, $50 family
	Percentage Reimbursed	Levels 1 and 2 - Minor Services 100% Level 3 - Major Services 50% Level 4 - Orthodontics 50%
	Maximum Per Calendar Year	Levels 1, 2 and 3 combined - Minor and Major Services: Single: $1,500 Family: $4,000 per certificate
	Maximum per Lifetime	Level 4 - Orthodontics $1,500 (Children under age 18 only)
	Termination of Benefit	Age 70 or retirement, whichever is earliest
Travel Insurance and Assistance & Travel Cancellation Insurance	Benefits underwritten by RSA Insurance of Canada, Group Policy #1166997 Travel Insurance and Assistance: Maximum $5,000,000 per stay per insured Travel Cancellation Insurance: Maximum $5,000 per trip per insured Duration 60 days	
Long Term Disability Insurance	Benefit underwritten by Fenchurch General Insurance Company, Group Policy #FGHO004L001	
	Monthly Benefit Amount	60% of your gross salary, up to a maximum of $5,000
	Elimination Period (calendar days)	119 days
	Non-evidence Maximum	$4,500
	Occupation Definition	2 years
	Maximum Duration of Benefit Payment	Age 65
	Taxability of Benefit	Non-taxable Benefit
	Termination of Benefit	Age 65 or retirement, whichever is earliest
	Notes: If at any time your amount of monthly Long Term Disability Insurance should exceed the non-evidence maximum, 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 in benefit amount exceeding the non-evidence maximum.	

Schedule of Benefits		
Benefit	**Coverage Details All Employees - Class 022**	
Participant's Basic Life Insurance	Benefit underwritten by SSQ Financial Group, Group Policy #38U80	
	Basic Amount of Insurance	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
	Reduction of Benefit	Benefit reduces by 50% of the amount in force on your 65th birthday.
	Termination of Benefit	Age 70 or retirement, whichever is earliest
Participant's and Spouse's Optional Life Insurance	Benefit underwritten by SSQ Financial Group, Group Policy #38U80	
	Optional Amount of Insurance	Participant: Units of $10,000 to a maximum of $200,000 Spouse: Units of $10,000 to a maximum of $200,000
	Termination of Benefit	Participant's Optional Life terminates at age 65 or retirement, whichever is earliest Spouse's Optional Life Insurance terminates on the earliest of your 65th birthday, your retirement date or your spouse's 65th birthday
	Note: Any request for an Optional Life Insurance Amount or any increase in such coverage is subject to submission of satisfactory evidence of insurability. Coverage will become effective upon written approval from the insurer. A suicide limitation, shown in the description of benefit, applies.	
Employee Accidental Death & Dismemberment Insurance	Benefit underwritten by, AIG Insurance Company of Canada, Group Policy #9125976	
	Amount of Insurance	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
	Reduction of Benefit	This benefit reduces by 50% on your 65th birthday
	Termination of Benefit	Age 70 or retirement, whichever is earliest
Employee Assistance Program	Services provided by Ceridian Corporation. See Employee Assistance Plan Details for more information.	

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.

Your Group Benefit Plan becomes effective on the date you have completed six (6) months of continuous full-time employment provided you are actively at work on that date, with full pay and according to your regular work schedule. Otherwise, your Group Benefit Plan will become effective on the date you return to work with full pay and according to 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 Group Benefit Plan comes into force.

Eligibility of Your Dependents (Spouse and Children)

Your spouse and children will become eligible for the Group Benefit 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 Group 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 Group Benefit Plan

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's plan for these benefits.

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

Effective Date of Insurance

If you and/or your spouse and children are eligible for coverage as described above under the "Eligibility" provisions, you must complete and submit the Group Enrolment 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 according to 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 Group Plan 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 Group 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 not become effective until the date this evidence is approved 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 and according to your regular work schedule.

Reduction in Coverage

Any reduction in coverage becomes effective on the date requested by your Group 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 HealthSource Plus.

Insurance that Cannot be Modified

During any period where you are retired or disabled, amounts of insurance cannot be increased and the provisions used to establish these amounts cannot be modified. Such modifications shall only become effective once you have actively returned to work and provided you are not disabled at this time.

No waiver of premiums shall apply to the premiums payable if you were not already insured prior to a change in coverage status if such change must occur after the date of retirement or the start of a period of disability.

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 Plan Sponsor;
- 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 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 the 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 the Group Benefit Plan;
- 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 the Group Benefit Plan, 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 Dependents (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 the Group Benefit Plan;
- The date you, your spouse and/or dependent children collect any benefits that you are not entitled to under the Group Benefit Plan, 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 Group Plan Administrator must provide HealthSource Plus/the insurer with the information needed to determine the dates your benefits are to be suspended or reinstated. Your Group 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.

Maternity Leave, Parental Leave and Compassionate Leave

If you are on maternity leave, parental 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 within 12 months following the start date of your leave and you meet the definition of an eligible employee, as specified in the Schedule of Benefits, 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; or, if applicable, 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 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 with full pay and according to your regular work schedule 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 with full pay and according to your regular work schedule.

Strike, Lock-out or Temporary Collective Work Stoppage

Your Extended Health Care, Dental and Prescription Drug benefits will remain in force for a period of thirty (30) days.

Seasonal Workers

Any specific provisions regarding seasonal workers premiums and benefits and the possibility of maintaining their participation in insurance appear in the Schedule of Benefits.

Extension of Coverage for Your Dependents (Spouse and Children) Following Your Death

In the event of your death,

i) Health Care, Prescription Drug and Dental Care Benefits in force for your spouse and dependent children will be maintained without premium payment and

ii) Travel Insurance and Assistance and Travel Cancellation Insurance in force for your spouse and dependent children can be maintained with 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 the group insurance policy terminates.

Benefit Provisions

Payment of Benefits

All benefits are payable to you. Any insurance amount that is payable upon your death will be paid to your estate or designated beneficiary, whichever is applicable in your case.

Beneficiary

You have the right to designate or revoke one or more beneficiaries of your insurance at any time. To designate or revoke a beneficiary, you must give notice in writing to the insurer or Group Plan Administrator. The designation or revocation of a beneficiary will be effective on the date the insurer or Group Plan Administrator receives your written notice.

If you do not designate a beneficiary, your estate will be considered as your beneficiary. If more than one beneficiary is designated, and there is no mention of respective interests, benefits will be shared equally between the beneficiaries.

The rights of a beneficiary who dies before you are not transferable to the beneficiary's estate and therefore revert back to you. You may then designate another beneficiary.

Proof, Medical Records and Examinations

When you file a benefit claim, the insurer may request certain proof, which it must deem as satisfactory. Therefore, you must provide the insurer with, at your expense, any information and supporting documents necessary to establish your eligibility for benefits and, if applicable, the amount payable.

During a period of disability or while a claim is being assessed, the insurer may require the insured to undergo examination, at reasonable intervals, by one or more physicians selected and compensated by the insurer. If the insured refuses to be examined within thirty (30) days of the insurer's request, the insurer may decline the claim or suspend or terminate benefits.

In addition, the insurer may also request that an autopsy be performed in accordance with applicable legislation.

No notice may be served or actions taken to recover benefits until thirty (30) days have lapsed following the date of receipt of the proof required by the insurer.

Premium Amount

The amount of the premiums you pay determines the amount of coverage for which you, your spouse and any dependent children, if any, are covered. In no case may a covered person obtain benefits in excess of those payable in accordance with the premiums paid to the insurer or HealthSource Plus.

Third-party Liability (Subrogation)

If you, your spouse or dependent children have the right to recover damages from any person or organization with respect to which benefits are payable by the insurer, you will be required to reimburse the insurer in the amount of any benefits paid out of the damages recovered.

You must notify the insurer of any legal action taken against a third party and of any judgment or settlement related to a claim filed with the insurer.

Limitation of Contractual Liability

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in employee working conditions or to an employer retirement plan has the effect of increasing liability under the contract, then the provisions of this contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the insurer by the Group Plan Sponsor. This additional premium shall be equal to the value of the increase in contractual liability.

Definitions

Accident

An unintentional, sudden, accidental and unforeseeable event, due exclusively to 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.

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.

Dependent Child

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 but under age twenty-six (26) and a full-time student in an accredited educational institution, subject to proof deemed satisfactory to SSQ or Group Plan Administrator; or
- 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.

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.

Disability Period

A continuous absence from work due to disability.

Elimination Period

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

Employee

Any salaried individual who works on a regular basis for the employer, and is a professional member in good standing with the Manitoba Childcare Association.

Employer

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

Group Benefit Plan

Refers to an employer or an association sponsored benefit plan providing coverage to a group of employees or association members.

Group Plan Administrator

The employee benefit contact person at the plan member’s workplace or association.

Group Plan Sponsor
The party that establishes the group benefit plan, usually the employer.

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 Group Benefit Plan.

Insured

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

Net Salary

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

Participant

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

Physician

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.

Plan Member

An employee or association member of the policyholder or affiliated company who has met the eligibility requirements for participation in the group benefit plan.

Proof

Evidence or proof deemed satisfactory by SSQ.

Reasonable and Customary 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.

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;
-
- 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.

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. 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.

Salary

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..

Spouse

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 Group Plan Administrator as your spouse; or
- is living common-law with you, and whom you have designated in writing to your Group Plan Administrator as your spouse.

The status of spouse ends when:

- in the case of marriage or civil union, you and this person have been separated for more than 3 months or have obtained a divorce or annulment of your marriage or civil union; 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.

SSQ, SSQ Financial Group

Refers to SSQ, Life Insurance Company Inc.

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's Basic Life Insurance Details

(SSQ Financial Group)

Scope of Coverage

Under the Participant's Basic Life Insurance benefit, in the event of your death, SSQ will 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.

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 70.

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;
- 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.

Prepayment Entitlement (within your 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 HealthSource Plus;
- be exempt from payment of your Basic 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 the average return rate of a one (1) year Treasury Bill plus 2%.

Waiver of Premiums

To qualify for the premium waiver privilege, you must meet the following conditions:

- Your disability must begin while you are covered under the Group Benefit Plan, and prior to the termination of your permanent employment position;
- You must be 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 must meet the definition of a disability that was in force at the time you became disabled.

Start and End of Waiver of Premiums

The start and end dates for the waiver of premiums are specified below:

Start date:

- As of the first day of the premium period following 6 months of disability.

End date (the earliest of the following):

- The date you retire, or reach age 70;
- The date of your death;
- The date your disability no longer meets the definition of disability;
- The date you are no longer under the continuous care of a physician, except if your condition is declared stable by a physician, to the satisfaction of SSQ;
- The date you do not submit proof of your disability as required. This proof must be submitted to SSQ within 90 days of request by SSQ. If proof is not submitted within this time, your premium waiver will be terminated as of the date of SSQ's request;
- The date you do not participate in a SSQ-supervised rehabilitation program designed to favour your return to work;
- The date you do not undergo any examination by a health care professional or do not participate in any treatment likely to be beneficial to your recovery.

Application, Proof and Medical Examinations

Your application for waiver of premiums must be submitted to SSQ, along with proof of your disability, within 90 days of the beginning of the right to waiver, unless you are unable to act during this period. 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.

All documents must be submitted to SSQ no later than 12 months following the beginning of your right to waiver; otherwise you will forfeit your right to apply for a waiver of premiums.

Your application for waiver of premiums should be submitted using the appropriate form. SSQ may require certain proof and supporting documents to be submitted with your claim.

If you are filing a disability claim with SSQ, the form that you submit for your disability claim will also serve as your application for waiver of premiums. You may be required to submit proof and supporting documents with your claim.

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.

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

Your Individual life insurance will not provide for a waiver of premium 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.

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.

How to Claim

File a claim by completing the Life Insurance Benefit Claim form, which may be obtained from the Group Plan Administrator or from HealthSource Plus. Please indicate the group and certificate numbers as well as telephone numbers on claim forms and submit to the servicing HealthSource Plus office at the following address:

> **Winnipeg**
>
> 1800 - 360 Main Street
>
> Winnipeg Manitoba
>
> R3C 3Z3

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

> **Winnipeg**
>
> (204) 940-3978
>
> Toll Free 1 (866) 940-3950
>
> Fax: (204) 940-3901

Optional Life Insurance Details

(Participant & Spouse's Optional Life Insurance)

(SSQ Financial Group)

Scope of Coverage

This benefit allows you and your spouse to increase your level of protection with additional insurance coverage. Upon the death of an insured under this benefit, SSQ will pay the applicable beneficiary an amount in accordance with the provisions of the group insurance policy and for which premiums are being paid.

Amount of Optional Life Insurance

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 Rate* (per $1,000 of protection)

	Male		Female	
Age Group	Smoker	Non-Smoker	Smoker	Non-Smoker
19 and Under	$0.072	$0.056	$0.040	$0.024
20 to 24	$0.072	$0.056	$0.040	$0.024
25 to 29	$0.072	$0.056	$0.040	$0.024
30 to 34	$0.088	$0.064	$0.056	$0.032
35 to 39	$0.128	$0.072	$0.104	$0.056
40 to 44	$0.216	$0.112	$0.184	$0.088
45 to 49	$0.456	$0.200	$0.320	$0.136
50 to 54	$0.904	$0.352	$0.568	$0.224
55 to 59	$1.688	$0.624	$0.976	$0.408
60 to 64	$2.400	$0.896	$1.200	$0.552

*Rates are subject to change without notice.

Rates are based on the insured's age, gender and smoking status and will increase accordingly on the date the insured reaches the next age group.

Evidence of Insurability

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

Suicide Limitation

If the insured commits suicide before being covered under the Optional Life Insurance benefit for twelve (12) months, SSQ will reimburse the premiums paid for this benefit in lieu of the amount of insurance. This provision is applicable, regardless of whether the insured is deemed to have been sane or insane at the time of suicide.

If the insured increases the amount of 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.

Waiver of Premiums

To qualify for the premium waiver privilege, you must meet the following conditions:

- Your disability must begin while you are covered under the present contract, and prior to the termination of your permanent employment position;
- You must be 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 must meet the definition of a disability that was in force at the time you became disabled.

Start and End of Waiver of Premiums

The start and end dates for waiver of premiums are specified below.

Start date:

- As of the first day of the premium period following 6 months of disability.

End date:

- The date that your premium waiver for Participant's Basic Life Insurance terminates.

Application, Proof and Medical Examinations

Your application for waiver of premiums must be submitted to SSQ, along with proof of your disability, within 90 days of the beginning of the right to waiver, unless you are unable to act during this period. 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.

All documents must be submitted to SSQ no later than 12 months following the beginning of your right to waiver; otherwise you will forfeit your right to apply for a waiver of premiums.

Your application for waiver of premiums should be submitted using the appropriate form. SSQ may require certain proof and supporting documents to be submitted with your claim.

If you are filing a disability claim with SSQ, the form that you submit for your disability claim will also serve as your application for waiver of premiums. You may be required to submit proof and supporting documents with your claim.

Exclusions

This Life Insurance benefit does not cover an insured who dies:

- 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.

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 Group Plan Administrator for details.

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 SSQ.

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.

Claims and Proof

The form required for making a Life Insurance claim is available from your Group 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.

How to Claim

You may file a claim by completing the Life Insurance Benefit Claim form, which may be obtained from your Group Plan Administrator or from HealthSource Plus. Please indicate your group and certificate numbers as well as telephone numbers on claim forms and submit to your servicing HealthSource Plus at the following address:

Winnipeg

1800 - 360 Main Street

Winnipeg Manitoba

R3C 3Z3

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

Winnipeg

(204) 940-3978

Toll Free 1 (866) 940-3950

Fax: (204) 940-3901

Accidental Death & Dismemberment Details

(AIG Insurance Company of Canada)

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer has provided for you Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum amount of 2 times your annual earnings to a maximum benefit of $300,000

Coverage reduces by 50% at age 65 and terminates at age 70.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

Insured Employee means you, if you are a permanent, active full-time employee of the Policyholder who is under the age of 70.

Spouse means a person who is under the age of seventy (70) and who is either:

- legally married to you, or if there is no such person;
- a person who, although not legally married to you, has cohabited with the you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

Dependent Child means a person who is either your natural child (legitimate or illegitimate), adopted child, step-child, or an infant to which you are "*in loco parentis*", and who is:

- under 21 years of age, unmarried and dependent upon you for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss;
- under 25 years of age and unmarried and in attendance at an Institution of Higher Learning and dependent upon you for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss; or
- by reason of mental or physical infirmity, incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses	
Loss of:	**% of Principal Sum**
Life	Principal Sum
Both hands	Principal Sum
Both feet	Principal Sum
Entire sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and entire sight of one eye	Principal Sum
One foot and entire sight of one eye	Principal Sum
Speech and hearing	Principal Sum
One arm	Three quarters Principal Sum
One leg	Three quarters Principal Sum
Speech or hearing	Two-thirds Principal Sum
One hand	Two thirds Principal Sum
One foot	Two thirds Principal Sum
Entire sight of one eye	Two thirds Principal Sum
Thumb and index finger on same hand	One third Principal Sum
Four fingers of same hand	One third Principal Sum
Hearing in one ear	One-sixth Principal Sum
All toes of the same foot	One-eighth Principal Sum
Loss of Use:	**% of Principal Sum**
Use of both arms or both hands	Principal Sum
Use of one hand or one foot	Two thirds Principal Sum
Use of one arm or one leg	Three quarters Principal Sum

Paralysis	% of Principal Sum
Quadriplegia (complete and irreversible paralysis of both upper and lower limbs)	Twice Principal Sum
Paraplegia (complete and irreversible paralysis of both lower limbs)	Twice Principal Sum
Hemiplegia (complete and irreversible paralysis of both upper and lower limbs on one side of the body)	Twice Principal Sum

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "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. “Loss” when used herein may also include “Loss of Life”.

Disappearance

If your body has not been found within one year of the forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then, for the purposes of this contract you shall, in the absence of any evidence to the contrary, be deemed to have suffered Loss of Life.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit

Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to $15,000 for your Spouse’s expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Serious Illness Benefit (Non-Cancer)
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson’s Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt thereat by you while sane;
- self inflicted injury or any attempt thereat by you while sane or insane;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
- injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in an aircraft owned or leased by the Policyholder;
- 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;
- injury or Loss sustained if you are 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 you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded); or
- any attempt at self-asphyxiation whether with intent to harm oneself or not.

Aggregate Limit per Accident

The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Employee”.

Termination Date

Coverage ends on the earliest of:

- the date the policy is terminated;
- the premium due date if premiums are not paid when due;
- the date you no longer satisfy the definition of an Insured Employee; or
- the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This section provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Long Term Disability Benefit Details

(Fenchurch General Insurance)

Definitions

Definition of Disability

For the Own Occupation Period, specified in the Schedule of Benefits, an illness or injury that prevents you from undertaking your own occupation. You are not considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete

Thereafter, LTD benefits will only continue if you are prevented from being gainfully employed in any occupation which provides you with an income of at least 50% of your pre-disability income.

Earnings

Earnings are your gross salary paid by your employer including any overtime or bonus earnings if earned on a regular basis.

Payment of Benefit

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 65, whichever comes first. Check the **Schedule of Benefits** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.
- -LTD benefits are payable following the waiting period if disease or injury prevents you from following your own occupation. You are not considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.
- -After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.
- If you, the employee, pay the entire cost of LTD coverage, benefits are not taxable.
- Your LTD insurance terminates when you reach age 65, or retirement if earlier.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- Disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts.
- Benefits under any Workers' Compensation Act or similar law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

- Your income under this plan
- Benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts.
- Loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law.
- Disability benefits under a plan of insurance available through membership in an association.
- Employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision).

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, including any increases in Canada or Quebec Pension Plan

benefits that take effect after the benefit period starts, would exceed your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.
- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.
- Depending on the severity of the condition, you may be required to be under the care of a specialist.
- If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- The scheduled duration of a lay-off or leave of absence. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.
- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any 12-month period in which you do not live in Canada for at least 6 months.
- Any period of confinement in a prison or similar institution.
- Disability arising from war, insurrection, or voluntary participation in a riot.

Waiver of Premium

Premiums are waived while you are receiving Long Term Disability benefits

Claims

All claims are managed on behalf of Fenchurch General by Crawford. All information provided to Crawford or Fenchurch General remains confidential and is not shared with your employer.

To submit a claim, obtain a Long Term Disability Benefits application package from your Plan Administrator, as soon as possible after you become totally disabled. The package will contain the appropriate claim and authorization forms required to administer your claim and Instructions on how to submit your claim.

It is important to note that Fenchurch General must receive written notice of claim within **30 days** of the date disability begins, and satisfactory proof of claim within **90 days** following the end of the Elimination period.

Fenchurch General may request supplementary reports to update the medical or vocational information on file. Any cost for completion of reports will be your responsibility.

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

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 your group and certificate numbers and telephone number on all claim forms and submit to your servicing HealthSource Plus office at the following address:

> **Winnipeg**
>
> 1800 - 360 Main Street
>
> Winnipeg Manitoba
>
> R3C 3Z3

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

> **Winnipeg**
>
> (204) 940-3978
>
> Toll Free 1 (866) 940-3950
>
> Fax: (204) 940-3901

Travel Insurance and Assistance Details

(RSA Insurance)

BENEFIT SUMMARY

Overall maximum for all benefits: $5 million CAD

Benefit	Coverage
Medical Referral	Up to $75,000 per lifetime
Hospital	Reasonable & Customary Costs
Incidental Hospital Expenses	Up to $250
Physician	Reasonable & Customary Costs
Prescriptions	30-day supply per prescription Up to $250 for lost prescriptions
Diagnostic Services	Reasonable & Customary Costs
Medical Appliances	Reasonable & Customary Costs
Ambulance Services	Reasonable & Customary Costs
Paramedical Practitioners	$500 per practitioner, per emergency
Nursing Care	Up to $5,000 per emergency
Treatment of Dental Accidents	Up to $2,000
Treatment of Dental Pain	Up to $300
Medical Evacuation	Reasonable & Customary Costs
Return of Travel Companion	One way economy airfare
Family/Friend Hospital Visit	Single round-trip economy airfare plus Up to $150 per day, $3,000 per trip
Child Care	Up to $5,000 per trip
Return of Vehicle	Up to $5,000
Meals & Accommodation	Up to $150 per day, $3,000 per trip
Return of Deceased	Up to $5,000

EMERGENCY INCIDENTAL BENEFITS

Benefit	Coverage
Alternate Transportation	Up to $5,000
Trip Cancellation	Up to $5,000 per trip
Baggage Insurance	Up to $1,000 per trip
Business Expenses	Up to $1,000 per trip

Viator Group Travel Advantage
Medical Emergency Insurance & Assistance Program

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Travel insurance is designed to cover losses arising from sudden and unforeseen circumstances occurring while temporarily travelling outside your province or territory of residence. It is important to read and understand this plan before travelling.

This booklet includes information on your eligibility, qualifications for eligible dependents, effective and termination dates, and details about your benefits. If you have any questions or need more information, please contact the plan administrator at your place of employment.

The information provided here is a summary of your benefits program and does not in itself constitute an agreement. If there is any discrepancy between this information and the plan master policy and governing documents, the terms of the latter take precedence.

Global Excel Management, Inc. (called "Global Excel") provides medical assistance and claims services under the policy.

IN THE EVENT OF A MEDICAL EMERGENCY,
IT IS EXTREMELY IMPORTANT THAT YOU CONTACT GLOBAL EXCEL:

The emergency telephone numbers are listed in this booklet under Contact Information (page 39) and on the back of the medical assistance card provided.

Global Excel must be contacted before seeking medical treatment or as soon as possible after being admitted to a hospital. Upon verification, Global Excel will confirm eligibility for coverage to the hospital. If a condition renders you unable to contact Global Excel, someone else must advise Global Excel of the situation immediately. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as is reasonably possible.

ELIGIBILITY

1. You must be a permanent resident of Canada;
2. You must be employed in Canada;
3. You must be covered under the Government Health Insurance Plan of your province or territory of residence;
4. You must qualify for coverage under your employer's basic group extended health care plan;
5. You must be younger than the termination age specified in the Schedule of Benefits;
6. (a) If you are covered as an employee, you must:
    1. work the minimum number of hours per week specified by your employer in the master application; and
    2. satisfy the waiting period specified by your employer in the master application; or

   (b) If you are covered as a member of the policyholder who is other than an employer, you must:
    1. be a member in good standing of the policyholder; and
    2. be on the monthly list of members entitled to coverage provided by the policyholder.

Coverage will become effective on the later of:

1. the date the policy becomes effective; or
2. the date you qualify for coverage under the policyholder's basic group extended health care plan.

Eligible Dependents

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must be eligible for coverage in order for your dependents to be eligible. Dependents must have their primary residence with you, and:

1. be covered under the Government Health Insurance Plan of their province or territory of residence;
2. qualify for coverage as a dependent under the policyholder's basic group extended health care plan.

Spouse

The person to whom you are legally married, or a person with whom you have been residing with for the cohabitation period specified by your employer in the master application.

Dependent Child

Your unmarried child, or the unmarried child of your spouse, who is:

1. under the age limit specified by your employer in the master application; and
2. primarily dependent on you for support; and
3. not employed on a full-time basis; or
4. any age and physically or mentally disabled and totally dependent on you for support.

TERMINATION

Coverage will terminate immediately upon the first to occur of:

1. the date you or a dependent cease to meet the above eligibility requirements for coverage;
2. the date employment terminates (voluntary or not);
3. the date the premium is due if the policyholder does not remit your premium, except where this is the result of clerical error; or
4. the date the policy is terminated.

***Note:** Coverage for disabled employees or employees who are not actively at work (as indicated in the master application) on the date their coverage would normally become effective will become effective on the date the employee resumes active work, or immediately if the required premiums are paid (except for employees on leave of absence).*

***Note:** You may only provide coverage for one spouse at a time.*

***Note:** Dependents registered for full-time school at an accredited institute of learning outside of Canada are **only** eligible for benefits that result from an emergency. As such, during an emergency, students may be required to return to their province or territory of residence (see Limitations page 11). Proof of school attendance must be provided at time of claim.*

***Note:** In the event of your death, coverage for dependents will continue for the length of time specified by your employer's basic group extended health care plan or to the date a dependent ceases to be eligible or remarries (whichever occurs first), provided the policyholder continues to make the required premium payments.*

BENEFITS

Referral Benefit

1. Reasonable and customary medical and transportation expenses in excess of those expenses covered by the insured person's Government Health Plan for the insured person and an approved escort, to a lifetime maximum of $75,000, for pre-approved medical referral, subject to the following conditions:
   a) The treatment must not be available within five hundred (500) kilometres from your residence;
   b) All referral services must be obtained in Canada, if available, regardless of any waiting lists;
   c) Your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment;
   d) All referral services must be eligible for reimbursement by your Government Health Insurance Plan whether reimbursement is in whole or in part;
   e) Medical services and travel must take place within thirty (30) days of receiving approval from your Government Health Insurance Plan, unless the earliest possible treatment date exceeds thirty (30) days from the date of approval; and
   f) All Medical Referrals must be pre-approved and submitted in writing to Global Excel, along with supporting documentation.

Out-of-Province Medical Benefits

An emergency is described as an acute sickness or accidental injury that requires immediate treatment. The emergency treatment must be **medically necessary** and prescribed by a physician. The emergency must occur while the insured person is travelling outside of their province or territory of residence. Such emergency no longer exists when, in the opinion of Global Excel, the insured person is able to return to his province or territory of residence.

The maximum amount payable for all benefits listed will not exceed five (5) million in Canadian funds per insured person.

The following benefits are payable up to the maximum amounts specified. Reasonable and customary costs are those that do not exceed the standard reimbursement of other providers of similar standing in the same geographical area. Only legally insurable expenses incurred as a result of an emergency in excess of the amount paid by any other insurance will be considered. However, certain expenses, as specified below, are covered only if the prior approval of Global Excel is obtained.

1. Hospital
   a) Room and board costs up to the private room rate charged by a general public active treatment hospital.
   b) The reasonable and customary cost of services provided on an out-patient basis by a general public active treatment hospital.
   c) Up to $250 per hospital stay for out-of-pocket expenses such as telephone charges, television rental and parking.

If coverage terminates for any reason during the hospital stay, benefits continue until discharge.

2. Physician

   Charges for treatment by a physician.
3. Doctor Prescribed Treatments/Services/Appliances

   The prescription benefits are limited to a 30-day supply per prescription, unless the insured person is hospitalized.
   a) Prescriptions: Drugs, including injectable drugs and sera, that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment.
   b) Lost Prescriptions: The replacement of lost prescription medication when approved in advance by Global Excel, to a maximum of $250.
   c) Diagnostic Services: Laboratory tests and x-rays prescribed by the attending physician that are part of the emergency treatment. Magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies must be authorized in advance by Global Excel.
   d) Medical Appliances: The reasonable and customary cost of splints, casts, crutches, canes, slings, trusses, walkers or the temporary rental of a wheelchair when authorized in advance by Global Excel.

Note:"Medically Necessary", *in reference to a given service or supply, means such service or supply:*

a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;

b) is not experimental or investigative in nature;

c) cannot be omitted without adversely affecting the insured person's condition or quality of medical care; and

d) cannot be delayed until the insured person returns to his province or territory of residence.

Note: "Hospital", *means an institution which is designated as a hospital by law; which is continuously staffed by one or more physicians available at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of sickness and/or injury in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and in-patient care. The term hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.*

Note: *A doctor visit to have the replacement prescription prescribed is eligible if arranged and approved in advance by Global Excel.*

4. Ambulance Services

   When reasonable and medically necessary, licensed ground ambulance service to the nearest medical facility.

5. Paramedical Practitioners

   The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to a maximum of $500 per practitioner listed above, per emergency, when approved in advance by Global Excel.

6. Nursing Care

   The services of a nurse, when prescribed by a physician and while hospitalized, to a maximum of $5,000 per insured person, per emergency, when approved in advance by Global Excel.

7. Dental Treatment

   a) Treatment of Dental Accidents: Up to $2,000 per insured person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the injury was caused by an external, accidental blow to the mouth or face. The insured person must consult a physician or dentist immediately following the injury. An accident report is required from a physician or dentist for claims purposes.

   b) Treatment of Dental Pain: Up to $300 per insured person for the relief of acute dental pain, excluding services related to crowns, root canals or temporomandibular joint dysfunction (TMJ), when treatment is rendered at least five hundred (500) kilometres outside the insured person's province or territory of residence.

8. Medical Evacuation

   When approved and arranged in advance by Global Excel:

   a) air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment; or

   b) transport on a licensed airline with an attendant (where required) to return the insured person to his province or territory of residence for immediate emergency treatment.

9. Return of Travel Companion

   If an insured person is returned to his province or territory of residence under the Medical Evacuation benefit or the Return of Deceased benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travel companion to return to Canada, when approved in advance by Global Excel.

10. Family/Friend Hospital Visit

    When approved in advance by Global Excel, a single round-trip economy airfare from Canada, plus up to $150 per day to a maximum of $3,000, for the cost of meals and commercial accommodation for one person to:

    a) be with the insured person if the insured person is travelling alone and has been hospitalized as the result of an emergency. To be payable, this benefit requires that the insured person eventually be hospitalized as an in-patient for at least three (3) consecutive days outside his province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or

    b) identify the deceased insured person prior to the release of the body, where necessary.

The insurer will only reimburse covered expenses evidenced by original receipts.

11. Child Care

    When approved in advance by Global Excel, to a maximum of $5,000 per trip for one of the following child care assistance benefits:

    a) Economy class airfare for the return of dependent children who are under sixteen (16) years of age in the event you or your spouse is hospitalized as a result of an emergency. Where necessary, arrangements will include provision for an escort for the children; or

    b) The cost of caregiver services (other than a relative) for dependent children who are under sixteen (16) years of age in the same location where you or your spouse is hospitalized as a result of an emergency; or

    c) The cost of caregiver services (other than a relative) for dependent children who are under sixteen (16) years of age in their home province or territory of residence when left unattended due to an emergency involving you or your spouse while travelling.

Note: *A professional nurse is a graduate registered nurse, licensed practical nurse, or registered nursing assistant.*

Note: *Dental treatment must begin during the coverage period and be completed prior to the return to the province or territory of residence.*

Note: *A travel companion is any person who accompanies the insured person on the trip, who shares accommodation or transportation with the insured person and who has paid such accommodation and transportation in advance of departure.*

12. Return of Vehicle

    Up to $5,000, if neither the insured person, nor someone travelling with him, is able to operate the insured person's vehicle, whether owned or rented, during the trip, due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to the home of the insured person in his province or territory of residence or the nearest appropriate rental agency when approved and/or arranged in advance by Global Excel. The insurer will only reimburse covered expenses evidenced by original receipts.

Exclusion: Benefits will only be payable for a single person to return the vehicle. This benefit does not cover wages lost by the person driving your vehicle.

13. Meals and Accommodation

    Up to $150 per day, to an overall maximum of $3,000 per trip, per insured person, for the cost of commercial accommodation and meals when a trip is extended beyond the last day of the scheduled trip due to sickness and/or injury suffered by an insured person or a travel companion. This benefit must be authorized in advance by Global Excel. The fact that an insured person or a travel companion is unable to travel must be certified by the attending physician and the claim must be supported with original receipts from commercial organizations.

Note: A travel companion is any person who accompanies the insured person on the trip, who shares accommodation or transportation with the insured person and who has paid such accommodation and transportation in advance of departure.

14. Return of Deceased

    Up to $5,000 towards the cost of preparation and transportation of the deceased insured person to his province or territory of residence, in the event of death due to a sickness and/or injury. In the case of cremation and/or burial at the place of death of the insured person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

Emergency Incidental Benefits

1. Alternate Transportation

   When approved in advance by Global Excel, to a maximum of $5,000, if, while travelling, the insured person's private vehicle is stolen or rendered inoperable due to an accident, the cost of one way economy airfare(s) will be provided to the insured person(s) to return to their province or territory of residence. To file a claim, the insured person must supply an official police report of the loss or accident.

Note: To claim, please contact Global Excel as soon as the event occurs and submit original receipts and all supporting documentation.

2. Trip Cancellation

   The cost of trip cancellation to a maximum of $5,000 per insured person per trip for any of the following occurrences that prevent an insured person from departing on a scheduled trip. To be payable, the prepaid travel arrangements must be cancelled prior to the scheduled departure date. Only the expenses that are non-refundable on the date of the event forcing cancellation shall be considered for the purpose of the claim. The insured person must contact Global Excel and the supplier of his travel services on the day the event occurs or the next business day to advise of the cancellation. A trip may be cancelled due to one of the following:

   a) Death, emergency hospitalization due to sickness or injury, or quarantine of an insured person, a travel companion, an immediate family member, a travel companion's immediate family member, a business partner, a key employee, a caregiver or the host at trip destination. To file a claim, the insured person must supply supporting medical records, or a death certificate.
   b) A new formal notice issued by the Canadian Government prior to the date of departure, warning Canadian residents not to travel to a specific region of any country that is part of the trip.
   c) The insured person is summoned to perform jury duty or subpoenaed as a witness in a case. This applies only when the trial is scheduled to be heard during the scheduled trip dates and the summons or subpoena is received after the travel arrangements were purchased. This must be substantiated by court documents.

Note: Immediate family members are limited to: spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather, or grandmother.

3. Baggage Insurance

   The cost of replacement of an insured person's luggage to a maximum of $1,000 per insured person per trip due to theft, damage or loss by a bus, taxi, train, boat, airplane or other vehicle which is licensed, intended and used to transport paying passengers. Reimbursement will be limited to the actual cash value or the maximum specified, whichever is less, with respect to any one item or set of items.

Exclusion: Baggage insurance does not cover: animals, cash, securities, credit cards and any other negotiable instruments, luggage not checked, luggage held seized, quarantined or destroyed by customs or any other government agency.

4. Business Expenses

   Business expenses to a maximum of $1,000 per insured person per trip for the temporary use or rental of a computer or portable phone in the event of theft provided such use or rental is required in connection with the business, trade or professional occupation of the insured person. Original receipts and a police report are required for reimbursement.

TRAVEL ASSISTANCE BENEFITS

Global Excel is available to take your calls 24 hours a day, 7 days a week. No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Medical Assistance Services

Global Excel will:

1. Assist in locating an appropriate physician, clinic or hospital;
2. Confirm coverage and arrange direct billing with the hospital or physician;
3. Monitor and supervise medical treatment and keep the family informed;
4. Arrange for approved transportation of a family member to the patient's bedside;
5. Arrange to transport the patient home, if medically permissible.

__Note:__ Whenever possible, Global Excel will instruct the hospital, clinic or physician to bill the insurer directly and arrange direct payment of covered expenses.

General Assistance Services

Global Excel will:

1. Provide emergency response in most major languages;
2. Assist in contacting your family, business partner or family physician;
3. Arrange for the transmission of urgent messages to family members or business partners;
4. Assist in the event of lost passports or airline tickets;
5. Coordinate claims submission and negotiate health care provider discounts;
6. Coordinate claims processing with government health plans.

__Note:__ Global Excel will ensure you receive the necessary claim forms and will answer any questions regarding your claim, the standard verification procedures and/or the way the policy benefits are administered.

EXTENSION OF COVERAGE

An automatic seventy-two hour (72-hour) extension of coverage will be granted to insured persons who have not reached the termination age, if scheduled return is delayed due to:

1. a medical emergency or the insured person being hospitalized on the last day of coverage. The coverage of the insured person will remain in force for as long as the insured person is hospitalized and the 72-hour extension commences upon release from hospital;
2. a late train, boat, bus, plane or other vehicle in which an insured person is a passenger (including by reason of inclement weather);
3. the private vehicle in which the insured person is travelling is involved in a traffic accident or mechanical breakdown.

   To file a claim incurred after your original scheduled return date, you must supply proof of the event resulting in your delayed return.

LIMITATIONS

1. Benefits are payable for expenses incurred only during the period the contract is in force.
2. You must contact Global Excel and your supplier of travel services on the day the event forcing trip cancellation occurs or the next business day to advise them of the cancellation. Failure to notify Global Excel may limit the benefits payable to you.
3. If you incur expenses without prior approval from Global Excel, reimbursement may be limited to the reasonable and customary costs for any treatment received. You will be responsible for paying any difference between the amount incurred and the reasonable and customary costs.
4. Global Excel reserves the right to limit the benefits payable, or may not accept liability for hospitalization and related services if the assistance centre is not contacted within twenty-four (24) hours of admission. Failure to contact the assistance centre may result in the payment of medical expenses being denied or delayed.
5. During an emergency, whether prior to admission or during a covered hospitalization, Global Excel reserves the right to transfer the insured person to another hospital or return the insured person to their province or territory of residence. Refusal to comply with the transfer request will absolve the insurer of any further liability related to the emergency.
6. Once the insured person is deemed medically stable to return to Canada (with or without medical escort) either in the opinion of Global Excel or by virtue of discharge from a medical facility, the emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under this policy.
7. Neither Global Excel nor the insurer shall be responsible for the availability, quality or results of any medical treatment or transportation or the failure of the insured person to obtain medical treatment.

__Note:__ A medical condition is considered stable if:

- *There has been no new diagnosis, treatment or prescribed medication;*
- *There has been no change in treatment or change in medication, including the amount of medication to be taken or how often it is taken.*
- *There have been no new symptoms, more frequent symptoms or more severe symptoms;*
- *There have been no test results showing deterioration;*
- *There has been no hospitalization or referral to a specialist (made or recommended) and test results or further investigations for the medical condition must not be pending.*

__Exceptions:__ the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic medication (provided that the dosage is not modified).

EXCLUSIONS

This policy does not cover losses or expenses caused directly or indirectly, in whole or in part, by any of the following:

1. A trip cancelled due to quarantine, death or hospitalization for a pre-existing medical condition if at any time in the ninety (90) days prior to the purchase of the travel arrangements the medical condition was not stable.
2. Any trip booked or commenced contrary to medical advice or after receipt of a terminal prognosis.
3. Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance the insured person may have.
4. Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a physician (except under the terms of the Referral Benefit).
5. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that the insured person elects to have provided outside his province or territory of residence when medical evidence indicates that the insured person could return to his province or territory of residence to receive such treatment. The delay to receive treatment in the province or territory of residence has no bearing on the application of this exclusion.
6. Treatment not performed by or under the supervision of a physician, licensed dentist, or a paramedical practitioner.
7. Services or supplies related to any of the following:
   a) a general health examination for "check-up" purposes, or routine ongoing care, or related care of a medical condition when the initial emergency has ended (as determined by Global Excel);
   b) home health care, chronic care, or the chronic unit of a general hospital, Long Term Care Facility, or nursing home;
   c) care in a psychiatric hospital;
   d) rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse; or non-compliance with any prescribed medical therapy or treatment;
   e) a rest cure, health spa, exercise program, weight reduction clinic or travel for health purposes;
   f) experimental drugs (not formally approved by the regulatory bodies in Canada or the U.S.) or investigative services;
   g) vitamins, food supplements and over-the-counter drugs or medicines, whether prescribed or not; or
   h) cosmetic or elective services.
8. Services or supplies related to any of the following:
   a) a disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless the insured person is hospitalized;
   b) suicide (including any attempt thereat) or self-inflicted injury, whether or not the insured person is sane;
   c) Medication, drugs or toxic substance abuse or overdose (whether or not you are sane); alcohol abuse, alcoholism or an accident while being impaired by drugs or alcohol or having an alcohol concentration that exceeds 80 milligrams per 100 milliliters of blood.
   d) driving a motorized vehicle while impaired by drugs, toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood; or
   e) commission of or attempt to commit, directly or indirectly, an illegal act or a criminal act.
9. Participation in and/or voluntary exposure to any risk from: war or act of war, whether declared or undeclared; invasion or act of foreign enemy; declared or undeclared hostilities; civil war, riot, rebellion; revolution or insurrection; act of military power; or any service in the armed forces.

10. Sickness, injury or medical condition suffered or contracted by the insured person in a specific country, region or area for which the Department of Foreign Affairs and International Trade of the Canadian Government has issued a travel advisory or formal notice, **before the insured person's departure date**, advising Canadians not to travel to that specific country, region or area.

    If the Canadian Government issues a travel advisory or formal notice to leave that specific country, region or area, **after the insured person's departure date**, coverage for sickness, injury or a medical condition is limited to a period of 10 days from the date the advisory was issued, or to a period that is reasonably necessary to safely evacuate the country, region or area. In this exclusion, "sickness, injury or medical condition" means any sickness, injury or medical condition that is **attributable** to the reason for which the travel advisory or formal notice was issued or any complications arising therefrom.
11. Treatment, hospitalization or expenses caused by:
    a) participation in any sport as a professional athlete (person who engages in an activity as one's main paid occupation);
    b) participation in any competitive motorized sporting events, racing or speed contests;
    c) scuba diving (unless you hold a basic SCUBA designation from a Canadian certified school), hanggliding, rock climbing, paragliding, skydiving, parachuting, bungee jumping or mountaineering; or
    d) a flight accident unless the insured person is riding as a fare paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more.
12. Treatment or hospitalization of mother or child as a result of:
    a) pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the eight (8) weeks before or after the expected delivery date; or
    b) a pregnancy being deemed a high risk pregnancy by a physician, at any time; or
    c) induced abortion.
13. Dental Services related to crowns, root canals or temporomandibular joint dysfunction (TMJ).
14. Any service, treatment or supply related to locating organ donors for transplants, nor any service, treatment or supply in connection with the use of artificial organs.
15. Baggage insurance does not cover: animals, cash, securities, credit cards and any other negotiable instruments, luggage not checked, luggage held seized, quarantined or destroyed by customs or any other government agency.

__Note: A high risk__ pregnancy is one in which any cause places the mother, the developing fetus, or both at risk and the mother is on leave from her regular employment in order to reduce or avoid such risk.

GENERAL PROVISIONS

1. Co-ordination of Benefits and Other Insurance

This insurance is a second payer plan. For any loss or damage insured by, or for any claim payable under any other liability, group or individual basic or extended health insurance plan, or contracts including any private or provincial or territorial auto insurance plan providing hospital, medical, or therapeutic coverage, or any other insurance in force concurrently herewith, amounts payable hereunder are limited to those covered benefits incurred outside the province of residence that are in excess of the amounts for which an insured person is insured under such other coverage.

All coordination with employee related plans follows Canadian Life and Health Insurance Association Inc. guidelines. In no case will the Insurer seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is $50,000 or less. If the lifetime maximum for all in-country and out-of-country benefits is over $50,000, the Insurer will coordinate benefits only above this amount.

__Note:__ All coordination follows the Canadian Life and Health Insurance Association guidelines.

2. Subrogation

   If an insured person suffers a loss covered under this policy, the insurer is granted the right from the insured person to take action to enforce all the insured person's rights, powers, privileges, and remedies, to the extent of benefits paid under this policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to the insured person, regardless of fault, the insurer is granted the right to make demand for, and recover, those benefits. If the insurer institutes an action it may do so at its own expense, in the name of the insured person, and the insured person will attend at the place of loss to assist in the action, in addition to providing the insurer all information, cooperation and assistance as the insurer may reasonably require. If the insured person institutes a demand or action for a covered loss, the insured person shall immediately notify the insurer so that the insurer may safeguard its rights.

   The insured person shall take no action after a loss that will impair the rights of the insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.
3. Examination of the Policy

   The policy, including any endorsements, will be kept at the office of the policyholder. You may request to consult the policy during the regular business hours of the policyholder.
4. Evidence of age

   The insurer reserves the right to request proof of age of any insured person.

CLAIMS

Your benefit plan provides for direct payment to providers in order to reduce your out-of-pocket expenses. Whenever possible Global Excel will arrange for direct billing with providers, and you may choose to assign benefits to the provider of the service (hospital, clinic, physician). To facilitate direct billing be sure to present your medical assistance card to the provider.

Claims you pay out-of-pocket must be submitted directly with all original receipts and a completed claim form including the following information:

1. Your name and complete address;
2. Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
3. Claimant's date of birth, name and, if applicable, relationship to you;
4. Proof of the departure date(s) and return date(s);
5. All original prescription drug receipts (not cash register receipts), and/or itemized bills from the medical provider(s) stating the date(s) of the service(s) provided, the diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician;
6. For trip cancellation claims, the original airline tickets, electronic copy of your airline booking if applicable, and/or proof of all requested applicable refunds;
7. For baggage insurance, a report by the police and one of either the hotel manager, tour guide or transportation authorities in whose custody the insured property was at the time of loss, and adequate proof of loss, ownership and itemized value along with a detailed statement.
8. For medical evacuation claims, the unused portion of the insured person’s air ticket must be returned to Global Excel.

Note: *You must sign and return the authorization form to allow Global Excel to recover payment from the Canadian provincial or territorial Government Health Insurance Plan.*

Currency

All sums in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Note: *Covered expenses are the lesser of actual expenses or reasonable and customary charges for the covered services or supplies.*

Processing and Submission Timeframes

Settling a medical emergency claim involves several steps. Due to the complexity of travel claims, please allow a minimum of 4-6 weeks for the submission of medical records, itemized invoices, and documentation review. Additional information pertinent to your claim may be required by Global Excel, and it is very important for you to provide requested information in a timely manner.

To facilitate the process, submit claims as soon as possible after the date of service. This significantly increases our ability to obtain any required additional information, and allows us to maximize cost containment attempts. On termination of coverage (for any reason), claims for services incurred prior to the termination date must be submitted within 90 days of the termination date.

Note: *Claims must be submitted within 12 months from the date of service to be reimbursed under this plan.*

CONTACT INFORMATION

In the event of an emergency, call:
Canada/USA, toll free: **1-866-870-1898**
Collect: **+819-566-1898**

Trip Cancellation/Baggage Insurance Desk, call:
Canada/USA, toll free: **1-877-644-4215**
Collect: **+819-566-4215**

To purchase Top-Up coverage, call:
Canada/USA, toll free: **1-866-254-8573**
Collect: **+819-566-8573**

__Note:__ Your policy number is required to waive the top-up administration fee.

For claims, submit documentation to:

Global Excel Management, Inc.
73 Queen Street
Sherbrooke, Quebec
J1M 0C9

For verification of claim status, call during regular business hours:
Canada, toll free**: 1-866-870-1898**
Collect: **+819-566-1898**

All other inquiries should be directed to your plan administrator.

PROTECTING YOUR PRIVACY

For privacy information, please see www.rsagroup.ca, or call 1-800-716-4339.

We at RSA recognize and respect every individual's right to privacy. When you apply for benefits, we establish a confidential file of your personal information. We use the information to administer the benefit plan under which you are covered. This includes many tasks, such as:

- Determining your eligibility for coverage under the plan;
- Assessing your claims and providing you with payment;
- Managing your claims;
- Verifying and auditing eligibility and claims; and
- Underwriting activities, such as determining the cost of the plan and analyzing the design options of the plan.

We limit access to information in your file to staff, to persons authorized by us who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We may also exchange information, when necessary to administer the benefit plan, with your health care provider, other insurance and reinsurance companies, and your plan administrator.

IDENTIFICATION OF INSURER

Viator™ Out-of-Province/Canada Group Travel Advantage Medical Emergency Insurance and Assistance Program is underwritten by Royal & Sun Alliance Insurance Company of Canada.

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Extended Health Care Benefit Details

(Administered by ClaimSecure)

Please Refer to the Schedule of Benefits for Deductibles, Maximums and Percentages Reimbursed

General Description of the Coverage

The Group Plan Sponsor, The Manitoba Child Care Association Inc., has the sole legal and financial liability for this benefit. ClaimSecure only acts as administrator on behalf of the Group Plan Sponsor.

Your Group Plan may reimburse you for 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 percentage reimbursed specified in the Group Policy;
- 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 athletic therapist, chiropractor, osteopath, chiropodist and podiatrist are eligible up to a maximum or $50 per calendar year per covered person.

Paramedical Practitioner	Coverage
Athletic Therapist	Maximum Benefit $300 per calendar year per covered person.
Chiropodist/Podiatrist	Combined Maximum Benefit $300 per calendar year per covered person.
Chiropractor	Maximum Benefit $300 per calendar year per covered person.
Dietician	Maximum Benefit $300 per calendar year per covered person.
Naturopath	Maximum Benefit $300 per calendar year per covered person. Exclusions: Homeopathy is not covered. Supplements and remedies are not covered.
Osteopath	Maximum Benefit $300 per calendar year per covered person.

Paramedical Practitioner	Coverage
Physiotherapist	Maximum Benefit is unlimited.
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.

Other Medical Expenses

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.
Hearing Aids	The purchase of new hearing aid(s) or repair of existing hearing aid(s). Maximum Benefit of $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.
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, administrative or incidental fees charged to the patient by the hospital and fees charged by an establishment for long-term accommodation or care that the patient is responsible for paying.
Private Duty Nursing	Services of a Registered Nurse, Licensed Practical Nurse, or Registered Nursing Assistant. Maximum Benefit of $10,000 per calendar year per covered person. **Note**: 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 of 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.

Medical Equipment and 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.

Equipment or Supplies	Coverage
Breathing Equipment	• Continuous Positive Airway Pressure Machine (CPAP & APAP) Maximum Benefit of one (1) per lifetime per covered person. Exclusions: Supplies are excluded. • Intermittent Positive Pressure Breathing Machine (IPPB) Maximum Benefit of 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

Equipment or Supplies	Coverage
	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 of 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 of one (1) every forty-eight (48) consecutive months per covered person. • Intra-uterine Contraceptive Device (must be 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 20 mmhg and over 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 of $700 in a person's lifetime per covered

Equipment or Supplies	Coverage
	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
Out-of-Province Medical Referral	**Coverage**
(administered by SSQ Financial Group)	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 per calendar year. 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.
Foot Care	**Coverage**
Custom Moulded Orthotics	Maximum Benefit of $400 per calendar year per covered person. Note: A physician's, Physiotherapist's or Chiropodist/Podiatrist's referral is required.
Custom Made Orthopaedic Shoes	• Custom Fitted Orthopaedic Shoes Maximum Benefit of $400 every thirty-six (36) consecutive months per covered person. Note: A physician's or Chiropodist/Podiatrist's referral is required.
Off The Shelf Orthopaedic Shoes and Orthopaedic Modifications	• Orthopaedic shoe(s) or the permanent modification of a regular shoe Combined Maximum Benefit of $150 per calendar year per covered person. Note: A physician's or Chiropodist/Podiatrist's referral is required.
• **Exclusion**: Shoes purchased only to accommodate orthotics or comfortable walking shoes, such as	

Equipment or Supplies	Coverage
Birkenstock, Nike, Brooks, Rockport, etc. are not covered. Deep shoes and sandals are not covered.	

Important information regarding submission of claims for Orthotics,Custom Made Orthopaedic Shoes, Off-the- Shelf Orthopaedic Shoes or Orthopaedic Modifications:

- Orthotics, Custom Made Orthopaedic Shoes, Off-the-Shelf Orthopaedic Shoes and Orthopaedic Modifications may be obtained on the written recommendation of the prescribers listed below, 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 provided by the dispensers listed below.
- A description of how the Orthotics or Custom Made Orthopaedic Shoes were constructed, or of the modifications made to an Off the Shelf Orthopaedic 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.

Approved Prescribers:		**Approved Dispensers:**	
Physician	**M.D.**	**Podiatrist**	**D.P.M.**
Podiatrist	**D.P.M.**	**Pedorthist**	**C.Ped. (C) or C Ped MC**
Chiropodist	**D.Ch. or D Pod M**	**Orthotist**	**C.O. (c) or CPO (c)**
Physiotherapists	**P.T, Pht, CPTA, MCPA, RPT**	**Physiotherapists**	**P.T, Pht, CPTA, MCPA, RPT**

Note: The dispenser must be a different provider than the prescriber.

Vision Services	Coverage
Frames, Prescription Lenses, Contact Lenses	Frames and prescription lenses, prescription sunglasses, prescription contact lenses Maximum Benefit of $120 every twenty-four (24) consecutive months per covered person. Prescription eyeglasses or contact lenses must be dispensed by an on-site, licensed Optometrist, Registered Optician or Ophthalmologist. **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

The Extended Health Care Benefits do not cover services:

- 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 Travel Insurance and Assistance and Out-of-Province Medical Referral;
- 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;
- 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;
- Expenses as a result of a criminal act the insured commits or attempts to commit;
- Expenses incurred due to the insured's active service in the armed forces;
- Expenses payable by another insurer;
- Expenses for which a third party is liable, except in the case of subrogation;
- Expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract;
- Expenses for products or services related to the treatment of cellulite or obesity;
- Expenses for products or services designed to treat sexual dysfunction;
- Expenses for products or services designed to stimulate hair growth or prevent hair loss;
- Expenses that you are unable to prove were incurred by the insured;
- Expenses incurred for products or treatments of an experimental nature or obtained under a federal program providing special access to health products;
- Expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes or incurred further to a request by a third party;
- Expenses incurred in relation to eye refraction examinations or for the purchase of eyeglasses or contact lenses not explicitly insured under the contract;
- Expenses incurred in relation to services that are not provided while the individual is insured;
- Expenses incurred for service contracts or maintenance fees;
- Expenses for surgically-implanted prostheses;
- Expenses for delivery or mailing costs.

Prescription Drug Benefit Details

(Administered by ClaimSecure)

Plan AG - Generic Prescription Drug Plan

Please Refer to the Schedule of Benefits for Deductibles, Maximums and Percentages Reimbursed

General Description of the Coverage

The Group Plan Sponsor, The Manitoba Child Care Association Inc., has the sole legal and financial liability for this benefit. ClaimSecure only acts as administrator on behalf of the Group Plan Sponsor.

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, infusion sets/reservoirs and their supplies 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;
- Vaccines
- Anabolic steroids are not covered even if prescribed for therapeutic use;
- Anti-Smoking agents are not covered even if prescribed for therapeutic use;
- Products used for aesthetic, cosmetic or personal hygiene purposes;
- Substances or drugs used or administered for preventative purpose, except preventive vaccines;
- Experimental drugs or those obtained under the federal Emergency Drug Release Program;
- Homeopathic or natural products;
- Dietary supplements intended as a meal supplement or replacement;

  However, dietary supplements prescribed as a treatment for a clearly diagnosed metabolic disease are covered, provided they are used in compliance with applicable legislation. A complete medical report detailing all conditions justifying prescription of the product must be provided to ClaimSecure;
- Sunscreens;

  However, sunscreens meeting the conditions provided for under this clause that are necessary for individual afflicted with an illness requiring treatment with such products may be covered. A complete medical report detailing all conditions justifying the prescription of such products must be presented to ClaimSecure;
- Drugs used for infertility, artificial insemination, in vitro fertilization or any other related procedures even if prescribed for therapeutic use;
- Growth hormones;

  However, growth hormones prescribed for treatment of hypophysial dwarfism may be covered. A complete medical report confirming the diagnosis of hypophysial dwarfism and justifying the prescription of such products must be provided toClaimSecure;
- Drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital;
- The patient’s contribution required for an insured who is eligible for a public prescription drug insurance plan;
- Drugs used to treat erectile dysfunction (Viagra and other similar drugs);
- Vitamins (except injectible vitamins);
- Patented Medicines and G.P. Products;
- First aid and surgical supplies;
- Atomizers, vaporizers;

- Salt and sugar substitutes;
- Infant formula;
- 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 Benefits

(Administered by ClaimSecure)

Please refer to the Schedule of Benefits for Deductibles, Maximums and Percentages Reimbursed

General Description of the Coverage

The Group Plan Sponsor, The Manitoba Child Care Association Inc., has the sole legal and financial liability for this benefit. ClaimSecure only acts as administrator on behalf of the Group Plan Sponsor.

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 he 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 percentage reimbursed specified in the Group Policy;
- 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.

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 Group Policy. 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 Minor Services

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

Diagnostic Services (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 nine (9) consecutive 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 (services to prevent future dental problems)

The following preventive services are covered:

- fluoride

  Limitation: one (1) fluoride treatment every nine (9) consecutive months
- oral hygiene instruction

  Limitation: one (1) occurrence per lifetime.
- polishing

  Limitation: one (1) unit of polishing every nine (9) consecutive months.
- scaling/root planing

  Limitation: 10 units per calendar year.
- interproximal disking
- pit & fissure sealants
- space maintainers & maintenance of space maintainers

Minor Restorative (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.
- pre-fabricated restorations (prefabricated crowns)

  Limitation: Primary Teeth only.
- tooth coloured restorations

  Limitation: Limited to anterior and bi-cuspid teeth only. Tooth coloured restorations performed on molar teeth are reduced to the cost of non-bonded amalgam 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 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 (services 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 Minor Services include Endodontics and Periodontics.

Endodontic Services (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 (services to treat 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.
- periodontal evaluation and re-evaluation

  Limitation: must be provided by a specialist (Periodontist).
- 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 Services - Restorative and Oral Surgical Services.

Major Restorative

The following major restorative services are covered:

Inlays/Onlays/Crown

- inlays – metal, composite, porcelain
- onlays – metal composite, porcelain
- removal of crowns, veneers, inlays, onlays, posts
- 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. (Applicable for children up to 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 (to be evaluated on a case by case basis)
- orthodontic examinations
- orthodontic casts
- surgical exposure
- tracing & interpretation

General Limitations and Exclusions

The Dental Care benefit does 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;
- Dental services or supplies required as a result of war whether declared or undeclared, 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, whether the sane or not;
- Expenses as a result of a criminal act the insured commits or attempts to commit;
- Expenses incurred due to the insured’s active service in the armed forces;
- Services, supplies, examinations or treatments that do not comply with reasonable and customary standards of current practice in the healthcare profession in question;
- Services, supplies, examinations or treatments required by a third party or received collectively;
- Aesthetic care, including transformation, extraction or replacement of healthy teeth to modify their appearance;
- For any drugs, products, devices, services or supplies used for experimental purpose or at the medical research stage;
- For an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction and vertical dimension correction;
- For expenses that the insured would not have had to assume in uninsured, that the insured is not obliged to pay or that the insured would not be obliged to pay if covered under the provisions of a public insurance or social security plan, government program, applicable legislation, or any regulation or decree adopted with regard to such plans, programs or legislation;
- For the services of a professional who normally lives in the insured’s home, or who is a relative of the insured;
- For a dental appliance for treatment of snoring and sleep apnea;
- For transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort;
- For transitional pontics or abutments made during healing;
- For treatment or services in relation to microbiological tests or analyses;
- For diagnostic photographs.

Employee Assistance Program Details

(Services provided by Ceridian Corporation)

Being together. It's what life is all about. And it's why we offer LifeWorks® – to help you manage your work and personal life so you can focus on what's important to you. Lifework is fast, easy to use and completely confidential. It's available to you and your immediate family at no cost to you. And best of all, it's there for you any time of the day or night, wherever you are.

Be empowered every day. A healthy balance between your work and personal life is important to us. LifeWorks can help you to lead a healthier, happier and more productive life.

LifeWorks can provide you with support, advice and information on a wide range of every day issues including:

- Parenting & child care
- Education
- Older adults
- Midlife & retirement
- Disability
- Financial
- Legal
- Everyday issues
- Work
- Managing people
- Health
- Emotional well-being
- Grief & loss
- Addiction & recovery

Lifeworks offers you:

- Free service to you and your immediate family
- Confidential, personal support available in more than 140 languages
- English and French counsellors available through a toll free number 24 hours a day, seven days a week, 365 days a year
- LifeWorks Online – an informative Web site that gives you direct access to required information and resources
- Abundance of resources and tools including booklets, recordings and Life Articles
- Referrals to resources, services and support in your community
- A commitment to always being there when you have a question or need help

To find out more about how LifeWorks can help, call to speak with a LifeWorks consultant anytime at 877-207-8833, or visit the LifeWorks Web site at www.lifeworks.com (User ID: mcca; Password: wellness).

Coordination of Benefits (COB)

Do you have coverage under more than one group benefit plan?

Many people have coverage under more than one benefit plan – for example, their own plan and their spouse's plan or a plan offered through a professional association or a retiree plan. If this is your situation, you can use both plans when claiming your expenses. This is referred to as coordinating your benefits and it's a great way to cover more of your health, dental and drug costs.

How does coordination of benefits work?

The insurance industry has rules for how coordination of benefits works. This ensures that claims are charged to the correct benefit plan. You can never receive more than the actual cost of a product or service. This means you cannot be reimbursed for more than 100% of the expense under both plans. Under the second plan, you can only claim the amount that the first plan did not cover.

How to claim?

Every time you submit a claim, check the 'yes' box on your claim form to show that you have other coverage. Remember to make copies of your receipts before you submit a claim.

If you are submitting an expense for yourself, you need to send it to your own benefit plan first and then to your spouse's plan. Your spouse should submit their claims to their benefit plan first and then to your benefit plan if there is any unpaid amount.

If you have children, the parent whose birthday falls earliest in the year sends the child's claims to their plan first. The birthday rule uses the day and month only. It doesn't matter who is older.

For children whose parents have the same birthday, claims should be sent first to the plan of the parent whose first name begins with the earlier letter in the alphabet.

Who is the claim for:	**And**	1. **Submit the claim to**:	2. **Submit the claim to*:**
You	You are covered as a dependent with your spouse's plan	Your plan with HealthSource Plus	Your spouse's plan
Your spouse	Your spouse is an eligible dependent under your HealthSource Plus plan	Your spouse's plan with their insurance company	Your plan with HealthSource Plus
A dependent child	The children are listed as eligible dependents under both plans	The plan of the parent whose birth month and date is earliest in the calendar year	The plan of the parent whose birth month and date is later in the calendar year
You	You have coverage as a plan member under another group benefits plan in addition to your HealthSource Plus plan	To the plan with the earlier effective date	To the plan with the later effective date

** When submitting your claim form, please ensure that you include the original Explanation of Benefits (EOB received from the first payer as well as copies of the claim and receipts.*

Important Notes

Be sure to let your Group Plan Administrator know about any life changes or changes to your covered dependents (e.g. if you get married, you have a child, your spouse loses or gains a benefits plan).

Your pharmacist can often coordinate your benefits right at the counter if both you and your spouse have drug cards under your plans.

Where benefits are being coordinated, plan deductibles, maximums or coverage limitations are applied before claim payments are issued.

Deadline for Filing Health, Dental and Drug 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 website, 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

P.O. Box 6500, Station A

Sudbury, ON

P3A 5N5

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

HealthSource Plus	(204) 940-3978 or Toll Free: 1-866-940-3950 ext. 3978
ClaimSecure	1(855) 885-8188

Respecting Your Privacy

In order to maintain the confidentiality of information concerning the persons it insures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to any other person you may authorize. SSQ keeps these insurance files in its offices.

All persons insured with SSQ have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of SSQ's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

SSQ may exchange information of a personal and confidential nature with its legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned. SSQ's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When you enrol in a group insurance plan, and also when you make a claim, you are actually giving your consent that the insurer and its legal agents and service providers may use your personal information for the above-mentioned purposes. It is understood that not giving this consent would compromise the management of your insurance coverage and the quality of the services SSQ can offer you. For more information, consult the SSQ Personal Information Protection Policy available at www.ssq.ca.

This Group Benefit Plan Has Been Arranged By

HealthSource Plus

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