The Manitoba Child Care Association Inc.

Retirees

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?

- This booklet is a summary of your benefit details effective September 30, 2014.
- 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-Retirees**	
	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 (Chiropractor*, Dietician/Nutrician Councellor, Massage Therapist, Naturopath, Osteopath*, Physiotherapist, Speech Therapist, Chiropodist/Podiatrist*, Psychologist). *(includes X-Rays, up to $50 per calendar year)
	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.
	Termination of Benefit	Age 99
Prescription Drug Benefit	Plan Type	Generic Drug Plan
	Percentage Reimbursed	80%
	Dispensing fee max	$9.00
	Ingredient Cost Mark Up	20%
	Calendar Year Maximum	$5,000 per calendar year
	Termination of Benefit	Age 99
Dental Care Benefit	Fee Guide	Current Year Provincial Dental Association Fee Guide – Specialist Fee Guide covered

Schedule of Benefits		
Benefit	**Coverage Details All Employees-Retirees**	
	Calendar Year Deductible	$25 single, $50 family
	Percentage Reimbursed	Levels 1 and 2 - Minor Services 70%
	Maximum Per Calendar Year	Levels 1, 2 and 3 combined - Minor and Major Services: Single: $1,500 Family: $4,000 per certificate
	Termination of Benefit	Age 99

General Provisions

Eligibility for Insurance

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

- a retired employee of a participating employer covered under this policy.

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.

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 no longer meet the eligibility conditions stipulated in the provision Eligibility for Insurance;
- You reach the age limit specified in the Schedule of Benefits;

- 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.

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

- 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.

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.

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.

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.

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.

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
Chiropodist/Podiatrist	Combined Maximum Benefit $300 per calendar year per covered person.
Chiropractor	Maximum Benefit $300 per calendar year per covered person.
Dietician/Nutrician Councellor	Combined 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 $300 per calendar year per covered person.
Psychologist	Maximum Benefit $300 per calendar year per covered person.
Registered Massage Therapist (Physicians Referral is Required)	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 $5,000 per calendar year per covered person. (covered at 80%) **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. A Physician's referral is required.
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.

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

Equipment or Supplies	Coverage
Orthopaedic Equipment	• Braces **Note**: Braces are wearable, orthopaedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body of the correct position. **Exclusions**: Elastic supports and foot orthotics and dental braces are not considered as an orthopaedic appliance. • Splints: including splints attached to a brace Exclusions: Intra-oral splints are not covered. • Casts • Cervical Collars
Prosthetic Equipment	• External Breast Prosthesis Maximum Benefit 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

Equipment or Supplies	Coverage
	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 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.

Equipment or Supplies	Coverage
Custom Made Orthopaedic Shoes	• Custom Fitted Orthopaedic Shoes Maximum Benefit of $300 every calendar year 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 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.

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 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

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.

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

1403 Kenaston Blvd.

Winnipeg, MB R3P 2T5