First Nations Health Authority
Health through wellness

CSBT
Community Services Benefits Trust

Employee Benefits Handbook

Plan Effective Date

July 1, 2013

(amended January 1, 2015)

Employee Class

Non-Union Employees

For the Employees of

First Nations Health Authority

Introduction

This handbook contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contracts/Policies. Defined terms are capitalized (e.g. Dependent). GroupHEALTH Global Benefit Systems Inc. ("GroupHEALTH Benefit Solutions") is referred to as "we", "us", or "our" in this handbook. We will refer to you, the employee/member, as "you" or "your" in this handbook. For the purposes of this handbook, the masculine form includes the feminine unless a different meaning is required from the context. In addition, the singular shall include the plural where required.

Possession of this handbook alone does not mean that you or your dependents are insured under your employer's group benefits program. Coverage must be in effect and you must satisfy all the enrolment requirements included in the Group Contracts/Policies. Please refer to the Table of Contents to help you locate the appropriate section in this handbook. If you require additional information, please contact your Plan Administrator.

In this document, "SSQ" refers to SSQ, Life Insurance Company Inc.

Employee Eligibility

Eligible Employees *(amended January 1, 2015)*	An employee must be employed by the employer on a permanent, full-time basis and be regularly scheduled to work for the employer for a minimum of 18 hours per week at the employer's place of business in Canada
Waiting Period	**Permanent Full-Time:** - 3 months of continuous employment for Extended Health care and Dental Insurance benefits - no waiting period for all other benefits **Term Over 6 Months:** - 6 months of continuous employment for Extended Health care and Dental Insurance benefits - 3 months of continuous employment for all other benefits **Term Over 3 Months:** - 6 months of continuous employment for Extended Health care , Dental Insurance benefits and MSP - 3 months of continuous employment for all other benefits
Effective Date of Insurance	Immediately upon completion of the waiting period

Your Insurers, Service Providers and Policy Numbers

Benefit	Insurance Company (hereinafter called the Insurer) *Service Provider*	Policy Number
Group Life Insurance	SSQ, Life Insurance Company Inc.	54509
Accident & Serious Illness	Industrial Alliance	100005649-1358
Dependent Life Insurance	SSQ, Life Insurance Company Inc.	54509
Short Term Disability*	SSQ, Life Insurance Company Inc. *Disability Management Institute (DMI)*	54509
Long Term Disability*	SSQ, Life Insurance Company Inc. *Disability Management Institute (DMI)*	54509
Group Critical Illness	SSQ Insurance Company Inc.	1JZ65-155
Extended Health Care	SSQ, Life Insurance Company Inc. *ClaimSecure*	54509
Travel Insurance and Assistance (Extended Health Care)	SSQ, Life Insurance Company Inc. *CanAssistance*	54509
Travel Cancellation Insurance (Extended Health Care)	SSQ, Life Insurance Company Inc. *CanAssistance*	54509
Dental Care	SSQ, Life Insurance Company Inc. *ClaimSecure*	54509
Diagnosis +	SSQ, Life Insurance Company Inc. *Diagnosis +*	54509
Employee & Family Assistance Program (EFAP)	*Ceridian LifeWorks®*	—
Protector Series™ Optional Life Insurance	The Co-operators	6521
Protector Series™ Optional Accident & Serious Illness (ASI)	Industrial Alliance	100005650
Protector Series™ Optional Critical Illness	SSQ Insurance Company Inc.	1JZ75

* *These benefits are insured by SSQ, Life Insurance Company Inc. and, acting on behalf of you and your employer, the Disability Management Institute (DMI) provides additional support and services.*

Who To Contact

Your group benefits program is developed and administered by GroupHEALTH Benefit Solutions. The provision of insured benefits and support services is a fundamental element of this exclusive program for Canadian organizations and their employees. Insurance companies and other service providers are both involved in the delivery of your benefits plan. They are listed above along with the policy numbers pertaining to their benefits. For claims concerns or inquiries please call the telephone numbers indicated below for assistance.

For Extended Health Care and Dental Care Claims
ClaimSecure Inc.
Toll Free: **1.855.324.2444**

To Contact Ceridian LifeWorks®
Toll Free: **1.866.331.6851**

To Contact Diagnosis+
Toll Free: **1.866.622.4775**

To Contact CanAssistance
Toll Free: **1.866.438.5498**
Outside Canada / USA (collect): **1.418.651.2266**

For Disability Claims
Disability Management Institute (DMI)

BC, Alberta, Saskatchewan
Toll Free: **1.866.963.9995**

Manitoba, Ontario, Atlantic Provinces
Toll Free: **1.866.459.3066**

Inquiries for all Other Claims
Please contact your Plan Administrator

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: www.grouphealth.ca. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

Table of Contents

Schedule of Benefits

In this section you will find a brief summary of the benefits included in your benefit plan.

This information includes, where applicable:

***coverage amounts** – or formulas for how they are calculated;*

***covered expenses** – what expenses are covered under the plan;*

***plan deductibles** – how much you must pay before the plan pays;*

***benefit percentages** – what percentage of a specific expense will be paid by the plan;*

***benefit limits** – how much of a particular expense will be paid by the plan; and*

***benefit maximums** – how much can be claimed in a calendar year or in your lifetime.*

*For detailed information regarding a particular benefit, please refer to the **Description of Benefits** section of this handbook.*

Group Life Insurance

Benefit Amount	2.0 times annual salary, rounded to the next higher $1,000 if not already a multiple thereof
Maximum Benefit	$500,000
Minimum Benefit	$20,000
Non-Evidence Maximum	$300,000
Benefit Reduction	The amount of insurance reduces by 50% at age 65
Waiver of Premium	The elimination period for waiver of premium matches the elimination period for Long Term Disability if the insured is eligible to receive LTD benefits. Otherwise the elimination period for waiver is 6 months of continuous total disability
Definition of Total Disability	As defined under the Long Term Disability benefit, or if not covered for LTD then; Totally disabled for purposes of the Waiver of Premium benefit under the Group Life Insurance plan means a restriction or lack of ability due to illness or injury which prevents an employee from performing the essential duties of any occupation for which they are qualified, or may reasonably become qualified, by training, education or experience
Conversion Privilege	Included
Living Benefit	Employees who suffer a terminal illness may be eligible to receive 50% of their group life insurance amount ▪ the maximum benefit payable under this section is $50,000
Termination Age	An employee's insurance terminates at age 75 or earlier retirement

Accident & Serious Illness (ASI)

Employee's Principal Sum

Equal to the group life insurance amount for all employees

Benefit Reduction

Same as group life insurance

Enhanced Schedule of Losses

If, within 12 months of the date of the accident, Injury results in any of the following losses, the insurer will pay as follows:

Loss or Loss of Use of:	% of Principal Sum
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	100%
One Leg	100%
One Hand	66⅔%
One Foot	66⅔%
Entire Sight of One Eye	66⅔%
Speech or Hearing in Both Ears	66⅔%
Thumb and Index Finger of Either Hand	33⅓%
Four Fingers of Either Hand	33⅓%
Hearing in One Ear	33⅓%
All Toes of One Foot	25%

Paralysis Benefits

Included at 200% of Principal Sum for

- quadriplegia (complete paralysis of both upper and lower limbs)
- paraplegia (complete paralysis of both lower limbs)
- hemiplegia (complete paralysis of upper and lower limbs of one side of body)

Critical Disease Benefit

Employees under age 65 who are totally disabled from a covered critical disease may be eligible to receive a benefit as follows:

- a lump sum payment equal to 10% of their Principal Sum
- the maximum benefit payable under this section is $50,000
- covered critical diseases include Polio, Parkinson's, MS, ALS, Alzheimer's, Huntington's Chorea, Type 1 Diabetes, Peripheral Vascular Disease, Necrotizing Fasciitis

Serious Illness Benefit

Employees under age 65 may be eligible to receive a benefit if they suffer a covered serious illness as follows:

- a lump sum payment equal to 10% of their Principal Sum
- the maximum benefit payable under this section is $10,000
- covered serious illnesses are Cancer, Heart Attack, Stroke and Kidney Failure

	Pre-Existing Conditions Applicable to the Serious Illness Benefit An exclusion applies to a serious illness which commences within 24 months of becoming insured, and which results from a pre-existing condition for which the employee sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately prior to becoming insured
Day Care Benefit	Included ▪ maximum 5% of Principal Sum or $5,000 ▪ payable per year for 4 years for each child
Disability Fitness Benefit	Included ▪ maximum $5,000
Education Benefit	Included ▪ maximum 5% of Principal Sum or $5,000 ▪ payable per year for 4 years for each child
Eyeglass & Hearing Aid Benefit	Included ▪ maximum $1,000
Family Transportation Benefit	Included ▪ maximum $15,000
Funeral Expense Benefit	Included ▪ maximum $5,000
Home Alteration Benefit	Included ▪ also includes Vehicle Modification Benefit ▪ combined maximum $25,000
Parental Care Benefit	Included ▪ maximum 5% of Principal Sum or $5,000
Psychological Therapy Benefit	Included ▪ maximum $1,000
Rehabilitation Benefit	Included ▪ maximum $15,000
Repatriation Benefit	Included ▪ maximum $15,000
Seat Belt Benefit	Included ▪ benefit payable in the event of a loss is increased by 10% if the insured person was wearing a seat belt
Spousal Retraining Benefit	Included ▪ maximum $15,000
Exposure and Disappearance	Included
Waiver of Premium	Premiums are waived during the period that premiums are waived for group life insurance
Conversion Privilege	Employees have the right to convert to individual coverage without health evidence when their employment terminates ▪ any individual policy issued under the conversion privilege does not include the Critical Disease and Serious Illness Benefit
Termination Age	An employee's insurance terminates at age 75 or earlier retirement

Dependent Life Insurance

Benefit Amount for Spouse	$7,500
Benefit Amount for Each Child	$2,500
Dependent Children Eligibility	Dependent children are eligible from birth to: ▪ age 22, or ▪ age 26 if in full time attendance as a student at a recognized educational institute
Conversion Privilege	Included
Stillbirth Benefit	In the event of a stillbirth the plan will pay the child benefit amount
Waiver of Premium	Premiums are waived during the period that premiums are waived for group life insurance
Termination Age	Insurance terminates at the employee's age 75 or earlier retirement

Short Term Disability

Benefit Amount	60% of weekly salary
Maximum Benefit	$3,500 per week
Non-Evidence Maximum	$1,900
Elimination Period	0 day (s) for Accident 0 day (s) for Hospitalization 7 day (s) for illness
Maximum Benefit Period	17 weeks If an employee reaches the termination age while receiving benefits and has then received payments for less than 15 weeks, benefit payments will continue during disability until at least 15 weeks of benefits have been paid
Taxability of Benefits	non-taxable for Status Employees taxable for Non-Status Employees
Work Re-entry Program	Included
Waiver of Premium	Included
Disability Management	Disability Management Institute (DMI) provides early intervention support after the 5th day of absence from work. Services include employee and employer support, assistance with claim forms, and return to work planning
Termination Age	An employee's insurance terminates at age 75 or earlier retirement

Long Term Disability

Benefit Amount	66.67% of monthly salary
Maximum Benefit	$15,000 per month
Maximum From All Sources	The overall maximum from all sources must not exceed 85% of the pre-disability “net” monthly salary if benefits are non-taxable or 85% of the pre-disability “gross” monthly salary if benefits are taxable
Non-Evidence Maximum	$9,000
Elimination Period	119 days
Maximum Benefit Period	To age 65
Definition of Total Disability	2 year own occupation
Taxability of Benefits	non-taxable for Status Employees taxable for Non-Status Employees
Cost of Living Adjustment (COLA)	Not included
Work Re-entry Program	Included
Survivor Benefit	Included ▪ Lump sum payment equal to 3 monthly benefit payments
Waiver of Premium	Premiums are waived while receiving LTD benefits
Pre-Existing Conditions	An exclusion applies to a disability which commences within 12 months of becoming insured and which results from a pre-existing condition that was contracted, incurred, treated or for which medication prescribed by a physician was being taken during the 3 month period prior to becoming insured
Disability Management	Disability Management Institute (DMI) provides early intervention support after the 5th day of absence from work. Services include employee and employer support, assistance with claim forms, and return to work planning
Termination Age	An employee’s insurance terminates at age 65 or earlier retirement

Group Critical Illness

Employee Only Plan

Benefit Amount	$25,000
Guaranteed Issue Limit	$25,000
29 Insured Illnesses	Includes coverage for the following illnesses: ■ Alzheimer's Disease ■ Aortic Surgery ■ Aplastic Anemia ■ Bacterial Meningitis ■ Benign Brain Tumor ■ Blindness ■ Cancer (Life – Threatening) ■ Coma ■ Coronary Artery Bypass Surgery ■ Deafness ■ Dilated Cardiomyopathy ■ Fulminant Viral Hepatitis ■ Heart Attack ■ Heart Valve Replacement ■ Kidney Failure ■ Loss of Independent Existence ■ Loss of Limbs ■ Loss of Speech ■ Major Organ Failure on Waiting List ■ Motor Neuron Disease ■ Major Organ Transplant ■ Multiple Sclerosis ■ Muscular Dystrophy ■ Occupational HIV Infection ■ Paralysis ■ Parkinson's Disease ■ Primary Pulmonary Hypertension ■ Severe Burns ■ Stroke (cerebrovascular accident)
Multiple Event Coverage	When diagnosed with a covered critical illness for which a benefit has been paid and then diagnosed with another covered critical illness, another benefit is paid, subject to the limitations specified in the "Re-entry exclusions"
Complementary Benefit	A one-time payment equivalent to 10% of the principal benefit amount to a maximum of $25,000 subject to policy limitations will be paid if diagnosed with one of the following illness: ■ Coronary angioplasty ■ Ductal carcinoma in situ of the breast ■ Stage A (T1a or T1b) prostate cancer ■ Stage 1A malignant melanoma Payment of the Complementary Benefit is paid in addition to the principal benefit and can only be paid once in a lifetime

Re-Entry Exclusions

If a claim has been made for a critical illness indicated in the left column of the Re-Entry Exclusions table below, no claim can be made for the critical illnesses listed in the right column of the table

Critical illnesses claimed for	**Re-Entry exclusions** (Critical illnesses for which the insured person cannot claim)
Alzheimer's Disease	Alzheimer's Disease, Loss of Independent Existence
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Aplastic Anemia	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Bacterial Meningitis	Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Benign Brain Tumour	Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Blindness	Blindness, Loss of Independent Existence
Cancer (life-threatening)	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Coma	Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Coronary Artery Bypass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Deafness	Deafness, Loss of Independent Existence
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Fulminant Viral Hepatitis	Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Heart Valve Replacement	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Kidney Failure	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Loss of Independent Existence	Following a Loss of Independent Existence claim, the insured person cannot claim anymore. Insurance coverage terminates.

Critical illnesses claimed for	Re-Entry exclusions (Critical illnesses for which the insured person cannot claim)
Loss of Limbs	Loss of Independent Existence, Loss of Limbs
Loss of Speech	Loss of Independent Existence, Loss of Speech
Major Organ Failure on Waiting List	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Major Organ Transplant	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Motor Neuron Disease	Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis, Stroke
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis, Stroke
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke
Occupational HIV Infection	Blindness, Cancer (Life-Threatening), Coma, Deafness, Ductal Carcinoma in Situ of the Breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Paralysis	Coma, Loss of Independent Existence, Loss of Speech, Paralysis
Parkinson's Disease	Coma, Loss of Independent Existence, Loss of Speech, Paralysis, Parkinson's Disease
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, Stroke
Severe Burns	Loss of Independent Existence, Paralysis, Severe Burns
Stroke (Cerebrovascular Accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Cancer Recurrence Benefit

A payment equivalent to the principal benefit amount if diagnosed a subsequent time with cancer if:

- Over 60 months have passed since the previous cancer diagnosis; and
- No treatment relating directly or indirectly to cancer has been received within that 60-month period

Waiver of Premium

The insurer will waive the premium for insured persons in the following circumstances:

- If the insured person has Long Term Disability (LTD) Insurance:
  - From the first day of the month following the date this person begins to receive monthly disability benefit payments through his LTD Insurance
- If the insured person does not have Long Term Disability (LTD) Insurance:
  - When injury or sickness totally disables and prevents the insured person from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience, for a period of at least 6 consecutive months
  - Premiums will be waived on the first day of the month following the 6 consecutive month period

Note: other conditions may apply.

Limitations

The program does not cover a critical illness that results directly or indirectly from any one or more of the following causes or situations:

1. Within 90 days following the effective date of the insured person's coverage:
   - diagnosis of cancer is made; or
   - any signs, symptoms or investigations that lead to a diagnosis of cancer, regardless of when the diagnosis is made.
2. Within 90 days following the effective date of the insured person's coverage:
   - diagnosis of benign brain tumour is made; or
   - any signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made.
3. The insured person does not satisfy the survival period limitations.
4. An intentionally self-inflicted injury or sickness, whether the insured person is sane or insane.
5. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
6. Any cancer that manifests itself prior to the effective date of the insured person's insurance when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
7. From a Pre-existing Condition except if such Critical Illness is diagnosed 24 months after the Insured Person's effective date of coverage.

Pre-Existing Condition Definition	A pre-existing condition means: ■ the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period preceding the insured person's effective date of coverage; or ■ an illness or condition for which the insured person, during 24 months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician. This pre-existing condition exclusion applies only to amounts equal to or below the Guaranteed Issue Limit
Guaranteed Issue	No medical questions asked and no medical testing required for amounts of Critical Illness insurance up to and including $50,000
Tax Status	Benefit payments are non-taxable
Conversion Privilege	If, with the exception of policy termination, an insured employee's insurance is terminated due to: ■ termination of the insured employee's employment; or ■ cessation of eligibility for insurance under this policy; or ■ cessation of a period of total disability after which the insured employee did not return to work for the policyholder, and prior to attainment of age of seventy, the insured employee makes a written application to the insurer within 31 days of said termination, the insurer will, without evidence of insurability, issue on the life of such insured person an individual critical illness policy. The amount of insurance that may be converted will not exceed the insured person's amount of insurance then in effect on the date of termination or a total aggregate of $150,000 for all such conversions with the insurer. Premiums for such an individual critical illness policy being issued in compliance with the aforementioned condition will be calculated at the insurer's manual rates then in force for the attained age of the insured person at the date of conversion. Premiums will be payable annually in advance and the individual critical illness policy will be issued on an annually renewable basis.
Second Medical Opinion Service	Any insured person who is diagnosed with a covered critical illness while enrolled in the insurance program is offered access to SSQ Assistance's **Second Medical Opinion** program. This program allows the insured person to obtain second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the insured person's file to confirm the initial diagnosis and make recommendations on appropriate treatment.
Termination Age	An employee's insurance terminates at age 70 or earlier retirement

Extended Health Care

Reasonable and Customary

Claims for all expenses under the Extended Health Care benefit are paid on a reasonable and customary basis, unless a specific financial limit and/or claiming frequency is indicated for a particular expense.

Reasonable and customary is defined as the costs incurred for eligible, covered medical services or supplies that do not exceed the standard costs of other providers of similar standing in the same geographic areas for the same treatment of a similar illness or injury.

Calendar Year Deductible

No Deductible

% Reimbursement of Eligible Expenses

Prescription Drugs	100%
Hospital	100%
Health Care Practitioners	100%
Vision Care	100%
Other Medical Expenses	100%
Out-of-Province Medical Referral	100%
Travel Insurance and Assistance (Out of Province Emergency)	100%
Travel Cancellation Insurance	100%

Note: If the insured is a resident of Quebec, the percentage of reimbursement for prescription drug coverage in any calendar year will change to 100% once he has attained the out-of-pocket maximum set under Quebec's Basic Prescription Drug Insurance Plan (BPDIP) for that calendar year.

Prescription Drugs – Included

Prescription Drug Plan

Pay Direct Drug Card
- covers the lowest cost generic equivalent product

Limited to drugs that can only be:
- obtained with the written prescription of a healthcare provider who is legally licensed to prescribe drugs; and
- dispensed by a licensed pharmacist

Includes the following:
- insulin supplies for diabetics
- lancets
- oral contraceptives, contraceptive patches, Nuvaring and intrauterine device (IUD)
- preventive vaccines – no annual limit
- *anti-smoking drugs – lifetime maximum $300
  (amended January 1, 2015)

** If the insured is a resident of Quebec, the maximum for anti-smoking drugs is equal to the annual limit for smoking cessation products under Quebec's BPDIP*

Hospital – Included

Hospital Room

Semi-private room

Hospital Indemnity

Included
- Cash payment of $40 per day with a combined maximum of 180 days per calendar year commencing on the 5th consecutive day in hospital

Convalescent Care

Included
- $40 per day with a combined maximum of 90 days per calendar year per disability

Health Care Practitioners – Included

Maximums shown are per person per calendar year. Where certain practitioners are combined below, the fees of these practitioners are combined for purposes of satisfying the maximum indicated.

Practitioner	Maximum
Acupuncturist	$300
Audiologist	$500
Chiropractor (includes x-rays)	$500
Dietician	$300
Massage Therapist/Orthotherapist	$300
Naturopath	$300
Occupational Therapist	$500
Osteopath (includes x-rays)	$300
Physiotherapist/Physical Rehabilitation Therapist	$500
Podiatrist/Chiropodist (includes x-rays)	$500
Psychologist/Social Worker/Registered Clinical Counsellor	$500
Speech Therapist	$500

Vision Care – Included

Vision Care

Eyeglasses, contact lenses and laser vision correction:
- adults – maximum $250 every 24 months
- dependent children – maximum $250 every 12 months

Other Medical Expenses

** Requires a referral or prescription from a physician*

External Breast Prostheses

1 per breast per calendar year

**Artificial Limbs*

$10,000 per prosthesis per limb

Eye Examinations

One examination maximum of $100
- adults – every 24 months
- dependent children – every 24 months

**Off-the-shelf Orthopedic Shoes and Orthopaedic Modifications*

Stock-item orthopedic shoes, including modifications and adjustments
- $300 per calendar year

**Orthopedic Shoes*

Custom-made orthopedic shoes
- 1 pair per calendar year

**Foot Orthotics*

Casted, custom-made orthotics
- $300 per calendar year

**Hearing Aids*

$500 every 36 consecutive months

**Magnetic Resonance Imaging (MRI)*

$1,000 per calendar year
(provided that it is not prohibited by provincial legislation)

**Nursing*

$10,000 per calendar year

Sclerosing Agents

$15 per visit

Special Vision Benefit after Cataract Surgery	Lifetime maximum $300
**Support Hose*	4 pairs per calendar year
Surgical Brassiere	4 per calendar year
**Wig Following Chemotherapy (Including Hair Pieces)*	$500 per lifetime

Out-of-Province Medical Referral – Included

Non-Emergency Treatment	$10,000 per calendar year

Travel Insurance and Assistance (Out of Province Emergency) – Included

Travel Insurance and Assistance	$5,000,000 per event

Travel Cancellation Insurance - Included

Travel Insurance and Assistance	$5,000 per event

Diagnosis +

Diagnosis+	Allows an insured person under age 65 to obtain a medical second opinion

Ceridian® Employee and Family Assistance Program

Employee & Family Assistance

CERIDIAN LifeWorks®

LifeWorks® is the Ceridian Employee and Family Assistance Program (EFAP) integrated with Work-Life Services. It is a full-service, bilingual program that combines confidential counseling and comprehensive work-life services to assist employees and their immediate families with personal problems and concerns.

Ceridian Full-Service EFAP includes:

- In-person confidential counseling during the day, evening and on weekends, with no fixed limit on the number of short term counseling sessions
- Bilingual expert counselors available 24 hours a day, seven days a week via a toll-free number
- Referrals to a network of community resources
- Management and supervisor consultation

Ceridian Work-Life Services include:

- Access to an extensive library of tip sheets, educational articles, DVD's, CD's, audiotapes and booklets that address a wide range of topics
- Referrals to community resources including childcare, eldercare, financial and legal support and educational resources
- Convenient access to thousands of pages of work-life information on English and French Web sites

General Plan Provisions

Dependent Children Eligibility

Dependent children are eligible from birth to:

- age 22, or

	▪ age 26 if in full time attendance as a student at a recognized educational institute

Survivor Benefit	If an employee dies while insured, insurance will continue for his or her dependents who were covered under this benefit at the time of the employee's death
	▪ without premium payment
	▪ until the earliest of the following dates
	  ▪ 24 months from the date of the employee's death;
	  ▪ the date when insurance for the dependents would have terminated if the employee's death had not occurred;
	  ▪ the date when the dependents become eligible for similar coverage under another insurance contract;
	  ▪ the date the contract terminates

Termination Age	An employee's insurance terminates at age 75 or earlier retirement

Dental Care

Calendar Year Deductible	No Deductible
Rates Based on Dental Procedure Fee Guide:	Current fee guide for general practitioners in the province where the expenses were incurred
% Payment of Eligible Expenses	Basic Dental Care ..... 90% ▪ Diagnostic Services ▪ Preventive Dental Care Examinations and Diagnoses – recall or periodic oral examination: twice per calendar year – complete oral examination: once every 24 months – complete periodontal examination: once every 24 months Preventive Services – polishing of coronal portion of teeth – 2 units per calendar year – scaling and root planing – 15 units of time per calendar year – topical application of fluoride twice per calendar year Routine Dental Care ..... 90% ▪ Minor Restorative Services ▪ Endodontics ▪ Periodontics ▪ Rebase, Reline, Adjustment and Repair of Removable Dentures ▪ Repair of Fixed Bridges and Crowns ▪ Oral Surgery ▪ Additional Services Dental Restorative Services ..... 50% ▪ Major Restorative Services and Fixed Prosthodontics ▪ Removable Dentures ▪ Fixed Bridges Orthodontic Care ..... 50% ▪ Orthodontics (for dependent children under age 19 only)
Maximum Amount Covered	Basic Dental Care, Routine Dental Care and Dental Restorative Services ▪ combined maximum of $2,000 per insured per calendar year Orthodontic Care ▪ $2,500 per insured per lifetime

General Benefit Provisions

Dental Specialists	Limited to the normal rate suggested for general practitioners, plus 20%
Dependent Children Eligibility	Dependent children are eligible from birth to: ▪ age 22, or ▪ age 26 if in full time attendance as a student at a recognized educational institute

Survivor Benefit	If an employee dies while insured, insurance will continue for his or her dependents who were covered under this benefit at the time of the employee's death
	▪ without premium payment
	▪ until the earliest of the following dates:
	  ▪ 24 months from the date of the employee's death;
	  ▪ the date when insurance for the dependents would have terminated if the employee's death had not occurred;
	  ▪ the date when the dependents become eligible for similar coverage under another insurance contract;
	  ▪ the date the contract terminates

Termination Age	An employee's insurance terminates at age 75 or earlier retirement

Protector Series™ Optional Life Insurance

Benefit Amount	Employee and/or Spouse ■ units of $5,000 ■ minimum benefit $10,000 ■ maximum benefit $500,000 Dependent Child Benefit ■ flat $5,000
Medical Evidence Requirements	For the Employee and Spouse ■ up to $50,000 of insurance is available without medical evidence ■ medical evidence is required for all amounts of insurance in excess of $50,000 Dependent Child Benefit ■ medical evidence of insurability is not required
Benefit Limitation	In the event where insurance is issued without providing medical evidence of insurability: ■ no death benefit is payable during the first 12 months of being insured unless the death is caused by an accident ■ if death occurs in the first 12 months and is not caused by an accident, the premiums will be refunded ■ after being insured for 12 months or more a death benefit will be paid for death from any cause In the event where insurance is issued upon approval of medical evidence of insurability submitted: ■ a death benefit will be paid for death from any cause
Dependent Children Eligibility	Your Dependent children are eligible from birth to age 21, or to age 25 if in full time attendance as a student at a recognized educational institute
Payment of Premium	Premiums are paid 100% by the employee by way of payroll deduction
Termination Age	Insurance terminates at age 70 or earlier retirement

Protector Series™ Optional Accident & Serious Illness (ASI)

Plan I	Employee Only Plan ▪ you may select any amount of benefit in units of $50,000 to a maximum of $400,000
Plan II	Family Plan ▪ you may select any amount of benefit in units of $50,000 to a maximum of $400,000 Your family will be insured for the following: ▪ your spouse will be insured for either 50% of the benefit if you have dependent children or 60% of the benefit if you do not have dependent children ▪ each dependent child will be insured for either 10% of the benefit if there is a spouse or 25% of the benefit if there is no spouse, subject to a maximum of $50,000 per child
Dependent Children Eligibility	Your Dependent children are eligible from birth to age 21, or to age 25 if in full time attendance as a student at a recognized educational institute
Eligibility Age	An employee who is under age 65
Medical Evidence Requirements	Medical evidence is not required
Payment of Premium	Premiums are paid 100% by the employee by way of payroll deduction
Termination Age	Insurance terminates at age 75 or earlier retirement

Protector Series™ Optional Critical Illness

Benefit Amount	Employee and/or Spouse ▪ units of $5,000 ▪ minimum benefit $10,000 ▪ maximum benefit $150,000 Dependent Children ▪ flat $5,000
Guaranteed Issue Limit	Up to $50,000 is available on a guaranteed issue basis – i.e. medical evidence is not required
29 Insured Illnesses	Includes coverage for the following critical illnesses: ▪ Alzheimer's Disease ▪ Aortic Surgery ▪ Aplastic Anemia ▪ Bacterial Meningitis ▪ Benign Brain Tumor ▪ Blindness ▪ Cancer (Life-Threatening) ▪ Coma ▪ Coronary Artery Bypass Surgery ▪ Deafness ▪ Dilated Cardiomyopathy ▪ Fulminant Viral Hepatitis ▪ Heart Attack ▪ Heart Valve Replacement ▪ Kidney Failure ▪ Loss of Independent Existence ▪ Loss of Limbs ▪ Loss of Speech ▪ Major Organ Failure on Waiting List ▪ Motor Neuron Disease ▪ Major Organ Transplant ▪ Multiple Sclerosis ▪ Muscular Dystrophy ▪ Occupational HIV Infection ▪ Paralysis ▪ Parkinson's Disease ▪ Primary Pulmonary Hypertension ▪ Severe Burns ▪ Stroke (Cerebrovascular Accident)
Dependent Children Eligibility	Your Dependent children are eligible from birth to age 21, or to age 25 if in full time attendance as a student at a recognized educational institute
Conversion	Available for Employee and/or Spouse
Waiver of Premium	Included for Employee and/or Spouse
Payment of Premium	Premiums are paid 100% by the employee by way of payroll deduction
Termination Age	Insurance terminates at age 70 or earlier retirement

General Information

In this section you will find information regarding defined terms used in your benefit plan, policy provisions, insuring provisions and claiming information.

This section may include references to benefits that are not included in your benefit plan.

*Please refer to the **Schedule of Benefits** section of this handbook to determine which benefits are included in your benefit plan.*

General Information

Definitions

Accident
A sudden, violent and unforeseeable occurrence which is external to the person.

Actively at work
If it is a scheduled work day, the participant will be considered actively at work if he reports for work at his usual place of employment in Canada or at some other location where his employer's business requires him to be and when he so reports he is able to perform all his usual and customary duties of his occupation on a regular, full-time basis.

If the participant is not at work due to it being a non-scheduled work day, holiday or vacation day, the participant will be considered to be actively at work if on such date he is neither (i) hospital confined nor (ii) disabled to a degree that he could not have reported to his usual place of employment in Canada or some other location where his employer's business requires him to be and performed all of the usual and customary duties of his occupation on a regular full-time basis.

Annual Salary
The participant's annual gross base earnings received from the employer and which the employer or policyholder has reported to the insurer including any additional income earned on a regular basis (overtime, bonuses, shift differentials) which is included in accordance with the standards of the Employment Insurance Act.

Where a participant's earnings are composed wholly or partially of commissions, his annual salary will be:

a) the total of his annual gross base earnings plus the average of the commissions received over the preceding two calendar years, as set forth on his T-4 Taxation form, if he has been employed by the employer for at least 2 calendar years, or

b) the total of his annual gross base earnings plus the average of the commissions received over the period he has been employed by the employer, if he has been employed by the employer for less than 2 calendar years.

Approval of Evidence of Insurability
The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.

Calendar Year
The period from any January 1st to the next December 31st, both inclusive.

Day
A calendar day, except if otherwise defined in this booklet.

Dependent
The participant's spouse or a child of the participant or of the spouse. If dependents are insured under the group policy, "spouse" and "child" shall have the following meanings for purposes of the Dependent Life Insurance, Extended Health Care and Dental Care benefits, if included in the Schedule of Benefits:

a) Spouse

The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to be his spouse and with whom he has been living on a permanent basis for at least one year.

A de facto separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

If according to this definition, the participant has had more than one spouse, spouse shall mean the person most recently qualified.

b) Child

An unmarried child (including any stepchild, legally adopted child or legal ward, but not a foster child) of the participant or of his spouse who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) is under the age limit stated in the Schedule of Benefits, for each applicable benefit; or

ii) if attending a recognized educational institution on a full-time basis, is under the age limit stated in the Schedule of Benefits, for each applicable benefit; or

iii) is mentally or physically handicapped and is incapable of earning his own living due to such handicap provided such handicap commenced while he was a child as defined in (i) or (ii).

Eligibility Period
The period, as specified in the *Employee Eligibility* section of the Introduction, during which an employee must be actively at work before being eligible for coverage under the group policy.

Employee
A person who is employed by his employer on a permanent full-time basis and works the minimum number of hours per week indicated in the *Employee Eligibility* section of the Introduction. The employee must work on a regular basis for such employer, except for periods of vacation.

Full-Time Resident of Canada
Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

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

Illness
Any deterioration in health requiring regular, continuous and curative care actively provided by a physician.

Insured Person
A participant who is insured under the group policy. This definition will also include a dependent of a participant for purposes of the Dependent Life Insurance, Extended Health Care and Dental Care Insurance benefits, if included in the Schedule of Benefits.

Monthly Salary
The participant's annual salary divided by 12.

Participant
An employee who is insured under the group policy.

Physician
A person who is legally licensed and authorized to practice medicine and who is operating within the scope of his license.

Plan Administrator
An individual, appointed by the Policyholder, responsible for the administration of this group insurance plan.

Province
The use of the term "province" refers to the provinces of Canada, as well as the Yukon, Northwest Territories and Nunavut.

Specialist
A physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Weekly Salary
The participant's annual salary divided by 52.

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 agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the Insurer by the participating employer. This additional premium shall be equal to the value of the increase in contractual liability.

Medical Services and/or Supplies Covered by a Government Sponsored Plan or Program

There will be no coverage under the group policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the insured person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

Incontestability

Whenever evidence of insurability is required to approve insurance for a participant or a dependent, or to approve one of the benefits, the statements made with respect to the evidence will be, except in the case of an error in age or fraud, accepted as true and incontestable after the participant's or dependent's insurance or benefit has been in force for 2 years. If the insurance is cancelled and then reinstated, the 2-year period will begin again as of the date the insurance has been reinstated.

Lawful Currency

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

Coverage Elsewhere

A participant who is eligible for Extended Health Care and/or Dental Care Insurance and whose spouse is covered for comparable insurance may decline coverage under the group policy for such insurance.

The refusal of insurance under the group policy may be in respect of the participant and his dependents or his dependents only.

If the insurance under the spouse’s policy ceases because of termination of such policy or because eligibility for the insurance ceases, then application may be made to insure under the group policy those persons whose insurance has terminated.

The application must be made within 31 days after cessation of the insurance under the spouse’s policy and the insurance under the group policy shall be effective on the day following the date of termination of the insurance under the spouse’s policy.

Eligibility

Employee
An employee will become eligible to be insured under the group policy as a participant on the date (his “eligibility date”) on which he satisfies the following conditions:

a) He satisfies the definition of employee in the group policy.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

d) He has satisfied the eligibility period specified in the Introduction.

Dependents
A person will become eligible to be insured as a dependent under the Dependent Life Insurance, Extended Health Care and Dental Care benefits included in the group policy on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of dependent in this booklet.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

d) The employee of whom he is a dependent has become eligible to be insured under the group policy.

Application for Group Insurance

An employee who is eligible to become insured under the group policy must complete and submit an application for himself and for each of his dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to, the insurer.

Effective Date of Insurance

Whether membership under the group policy is compulsory or voluntary, the employee's insurance and dependent's insurance, if any, will take effect on the person's eligibility date, if the application for group insurance has been received by the insurer on or prior to such date, or within 31 days after such date.

If the application for group insurance is not received within 31 days of the eligibility date, or within 31 days following the date the insured person can no longer be covered under another group insurance contract for Extended Health Care or Dental Care, the insurance will not take effect until the date on which the insurer receives and approves the person's evidence of insurability. The evidence of insurability will be provided at no expense to the insurer.

However, if

a) the employee was not actively at work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again actively at work; or

b) the dependent is hospitalized on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is no longer hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn child.)

If the employee is a resident of Quebec and the employee's application for Extended Health Care under this plan is not received within 31 days of him becoming eligible, or within 31 days following the date he can no longer be covered under another group insurance contract, coverage will not require evidence of insurability and will become effective:

a) retroactively to the date the employee became eligible for insurance under this group insurance contract or ceased to be eligible for coverage under the other group insurance contract, provided he pays the premiums owing since that date; or

b) on the date SSQ receives notice, should the employee choose not to pay the premiums retroactively as stated in item (a) above.

Any amount of insurance which is in excess of the non-evidence maximum(s) specified in the Schedule of Benefits will not take effect until the date the insurer receives and approves the participant's evidence of insurability. If the participant's evidence of insurability should not be approved by the insurer, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the participant's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the participant's insurance, if he submits evidence of his insurability and it is approved by the insurer.

Termination of Insurance

Participant
A participant's insurance automatically terminates on the earliest of the following dates:

a) The date the group policy is terminated;

b) The date on which the participant retires, unless otherwise specified in the Schedule of Benefits;

c) The date the participant reaches the age limit specified in the Schedule of Benefits if an age limit is indicated;

d) The date the participant is no longer a full-time resident of Canada;

e) The date the participant is no longer covered by his provincial health plan;

f) The date of the participant's death;

g) The later of the following dates:

   i) the date indicated on a written notice received from the policyholder;

   ii) the date this notice was received by the insurer;

h) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;

i) The date the participant ceases to qualify as an employee as defined in the group policy.

Insurance may be extended to a participant during periods the participant has ceased to be actively at work due to, but not limited to, illness, injury, temporary lay-off or a leave of absence. The participant should contact the policyholder for further information.

Dependents
A dependent's insurance terminates on the earliest of the following dates:

a) The date the participant of whom he is a dependent ceases to be covered under the group policy;

b) The date the dependent ceases to be a dependent as defined in this booklet;

c) The date the dependent reaches the age limit specified in the Schedule of Benefits, if an age limit is indicated;

d) The date the dependent is no longer a full-time resident of Canada;

e) The date the dependent is no longer covered by the provincial health plan;

f) The later of the following dates:

   i) the date indicated on a written notice received from the policyholder;

   ii) the date this notice was received by the insurer.

The above terms and conditions also apply in the case of the partial cancellation of insurance owing to the cancellation of one or more benefits.

Claims

All of the following benefits may not be included in your plan. Please refer to the Schedule of Benefits section of this handbook to determine which benefits are included in your benefit plan.

Extended Health Care and Dental Care
ClaimSecure must receive notice of any claim for Extended Health Care or Dental Care within 12 months of the date of the event which gives entitlement to the benefit.

However, if the group policy terminates, notice of claim for an Extended Health Care benefit or Dental Care Insurance benefit must be submitted to ClaimSecure within 90 days following the date of termination of the group policy.

Life Insurance
The insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

Short Term Disability Income Insurance
The insurer must receive notice of any claim for a Short Term Disability Income Insurance benefit within 90 days of the date of the commencement of the participant's total disability.

Long Term Disability Income Insurance
The insurer must receive notice of any claim for a Long Term Disability Income Insurance benefit within 90 days of the end of the participant's elimination period.

All notices of claims must be submitted to the insurer on the forms provided for that purpose by the insurer and must include all information that the insurer deems necessary for the assessment of the claim. If all information that is required by the insurer is not received, the insurer will have the right to deny the claim.

The insurer reserves the right to require additional proof or information regarding a claim whenever it deems necessary.

If notice of claim is not received by the insurer within the periods set out above or additional proof or information requested by the insurer is not provided, the insurer will have the right to deny the claim.

At the time of claim for a benefit which is based on the participant's salary, the amount of salary that will be used to determine the benefit will be the lesser of:

a) the salary that the policyholder had last reported to the insurer and which has been used in the calculation of the premium payable; and

b) the participant's actual salary at the time of the event for which a claim is being made, as determined in accordance with the definition of salary included in the group policy.

Beneficiary

A participant may designate a beneficiary or change a named beneficiary, subject to the provisions of the law, by a signed written declaration.

The insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

The rights of a beneficiary who dies before the participant revert to the participant.

If the participant does not designate a beneficiary, any death benefit that becomes payable under the group policy due to the death of the participant will be paid to the participant's estate.

Insurer's Right to Examination of a Claimant

The insurer, at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

The insurer, at its own expense and discretion, shall have the right and opportunity to conduct an examination under oath of any person who has submitted a claim or for whom a claim has been submitted under the group policy, whether or not a legal action has been commenced by the person under the group policy with respect to the claim.

Third-Party Liability and Subrogation

(This provision is not applicable to the Life Insurance Benefits.)

The participant must notify the Insurer of any notice served to, or legal action taken against a third party, or any judgment, claim or settlement related to an event which may result in entitlement to benefits under the insurance plan.

If the participant is entitled to receive financial compensation from a third party with respect to which benefits are payable under the contract, the participant will be required to reimburse the insurer of any benefits overpaid.

The Insurer is subrogated to all rights of the insured against a third party liable for damage that results in an entitlement to payment of benefits under the terms of the contract, up to the limitation of the amounts paid by the Insurer. Should the Insurer decide to exercise its right of subrogation, the insured may be required to sign a letter of subrogation drafted by the Insurer.

Description of Benefits

In this section you will find detailed information regarding benefits available in the benefit program and the specific provisions of these benefits.

This section may contain descriptions of benefits and benefit provisions that are not included in your benefit plan.

Please refer to the ***Schedule of Benefits*** *section of this handbook to determine which benefits and benefit provisions are included in your benefit plan.*

Group Life Insurance

Upon the death of the participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the group policy.

Definition(s)

As used in this benefit:

Total Disability and Totally Disabled
A state of total and continuous incapacity, resulting from illness or injury, which prevents the participant from performing any work for which he is reasonably qualified by education, training or experience.

However, if the participant should be covered by a Long Term Disability Income Insurance benefit under the group policy, the definitions of "total disability" and "totally disabled" shall be as defined under such benefit.

Conversion Privilege

If your insurance under this benefit ends because you cease to belong to the group insured while the contract is in force, you are entitled to convert all or part of your group life insurance coverage to individual life insurance without having to prove your insurability. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the day you cease to belong to the group insured.

If you cease to belong to the group on the day you reach age 65 or earlier, you can opt for one of the following types of individual insurance:

a) A life insurance that is comparable to your group insurance as to the amount and duration, but that does not exceed $200,000 for all of your group life insurance benefits combined, including the ones you were insured for as a spouse, where applicable;

b) A one-year term life insurance that can be converted into the insurance described in item a) above. Individual life insurance policies issued after having exercised the conversion privilege do not provide for a premium waiver.

If you should die during the 31-day period in which you could have exercised your conversion privilege and your group insurance coverage has not already been converted, the amount of life insurance you were eligible to convert shall be payable under the group insurance contract.

In all cases described above, the premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the rates in force for individual insurance, in accordance with your gender, age and smoking status on the date you cease to belong to the group insured, and in accordance with the particulars that applied to your group life insurance. SSQ must receive the first premium for individual life insurance within 31 days following the date you ceased to belong to the group insured.

Waiver of Premium

a) A participant who becomes totally disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long Term Disability Income Insurance benefit, if included in the group policy.

   If the participant is not eligible to receive a benefit under the Long Term Disability Income Insurance benefit or there is no Long Term Disability Income Insurance benefit included in the group policy, he will be eligible to have his premiums waived for this benefit provided:

   i) the participant was less than 65 years of age at the onset of total disability;

   ii) the participant became totally disabled as defined under this benefit, while insured under this benefit and before any termination of employment;

   iii) the participant has been totally disabled for at least 6 continuous months;

iv) proof of total disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the total disability. The evidence will be submitted at no expense to the insurer.

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the participant's life at the onset of the total disability, and will be subject to any reductions and termination indicated in the Schedule of Benefits which would have been applicable to the participant if he had been actively at work.

c) The participant's premiums will begin to be waived on:

i) the day following completion of the elimination period under the Long Term Disability Income Insurance benefit;

ii) if the participant is not eligible to receive a benefit under the Long Term Disability benefit or there is no Long Term Disability benefit included in the policy, then the day following a continuous period of total disability of 6 months.

d) The participant whose premiums are waived under this section must provide the insurer with proof of total disability, as often as the insurer may reasonably require. Such proof will be provided at no expense to the insurer.

e) The waiver of premiums will terminate on the earliest of the following dates:

i) the date on which the participant ceases to be totally disabled;

ii) the date on which the participant fails to submit to an examination by the physician designated by the insurer;

iii) the date on which the participant retires or reaches the normal retirement age under the employer's pension plan;

iv) the date on which the participant reaches the termination age for his life insurance benefit as indicated in the Schedule of Benefits, if applicable;

v) the date on which the participant fails to provide any proof of total disability required by the insurer;

vi) the date on which the participant is incarcerated after committing a criminal offence for which he was found guilty;

vii) the participant's 65th birthday.

f) If on the date the waiver of premiums terminates with respect to the participant, he is not eligible to be covered under the Participant's Life Insurance benefit, he will be eligible to exercise the conversion privilege as provided for under this benefit.

Living Benefit

Benefit

Upon request by the participant for the benefit and upon receipt by the insurer of due proof that the participant has incurred a terminal condition, the insurer will pay a Living Benefit to the participant provided the conditions set out below are satisfied. The amount of the Living Benefit will be determined in accordance with the Schedule of Benefits.

As used in this benefit, "terminal condition" shall mean an injury or illness that is expected to result in death within 12 months and from which there is no reasonable prospect of recovery as determined by the insurer.

Conditions
The Living Benefit will be subject to the following conditions, unless otherwise agreed to by the insurer and the policyholder.

1) The participant must provide all medical information requested by the insurer so as to allow the insurer to determine whether or not the participant is suffering a terminal condition as defined in this benefit.
2) The participant will be required to sign a “Living Benefit Agreement” prior to the benefit being payable.
3) The participant’s amount of life insurance under this policy will be reduced by the amount paid under this benefit and any interest on such amount which may be charged by the insurer.

Exclusion
No amount will be payable under this benefit if all or a portion of the participant’s life insurance under this policy is to be paid to his former spouse as part of a divorce or separation agreement.

Accident & Serious Illness (ASI)

Coverage

This plan provides coverage for accidents which occur anywhere, at any time, on or off the job. You will be covered whether you are at home or traveling, including air travel as a passenger (but not as a pilot or crew member) in any certified aircraft flown by a duly licensed pilot.

This plan does not cover any loss resulting from suicide or self-inflicted injury or war or any act of war. It also excludes any loss suffered while on active service in the armed forces or while you are piloting or acting as a member of a crew in an aircraft.

Definitions Applicable to the ASI Benefit

Whenever used in this policy:

Airworthiness Certificate
means "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of Canada or its foreign equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of its registry.

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

a) Carcinoma in situ;

b) Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of human immunodeficiency virus (HIV);

c) Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth;

d) Prostate cancer diagnosed as T1 N0 M0 or equivalent staging.

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

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

Date of Diagnosis
means the date on which the Insured Person is diagnosed with a Covered Disease by a Specialist.

Day Care Centre
means a facility which is operated according to law, including laws and regulations applicable to day care facilities and which provides care and supervision for children in a group setting on a regular basis. Day care centre will not include a Hospital, the child's home or care provided during normal school hours while a child is attending grades 1 through 12.

Dependent Child
means any natural child, step-child, or legally adopted child of the Insured Person, who receives support and maintenance from the Insured Person and is:

a) under 21 years of age and unmarried; or

b) 21 years of age but less than 25 years of age, unmarried, and is in full-time attendance at a School for Higher Learning; or

c) mentally or physically infirm.

Notwithstanding the above limitations, this definition will also include a child of the Insured Person's Spouse who is in the care, custody and control of the Insured Person and living in a parent-child relationship with the Insured Person.

Dependent Parent
means the Insured Person's parents or grandparents who are dependent upon the Insured Person for support, maintenance and care.

Flight Time
means the total time from the moment the aircraft first moves under its own power for the purpose of take-off until the moment it comes to rest at the end of the flight.

Heart Attack
means the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. Diagnosis must be confirmed in writing by a Physician who is a certified specialist in internal medicine or a cardiologist and should be based on new electrocardiograph changes consistent with heart attack and at least one of the following; elevation of cardiac biochemical markers or elevation of cardiac enzyme, to levels consistent with heart attack.

Heart attack does not include elevation of cardiac biochemical markers or elevation of cardiac enzymes due to coronary angioplasty unless accompanied by diagnostic changes of a new Q wave infarction of the ECG.

Hospital
means an institution operated pursuant to law for the care and treatment of sick and injured persons, with organized facilities for diagnosis, major surgery and 24 hour nursing service. This does not include a convalescent or nursing home, or home for the aged, health spa or a facility for the treatment of alcoholism, drug addiction or mental illness.

Injury
means bodily injury caused by an accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

Insured Person
means all eligible employees who are employed by a Participating Employer and are covered under the Participating Employer's Group Basic Life policy.

Kidney Failure
means end stage renal disease due to chronic irreversible failure of both kidneys' ability to function, requiring the Insured Person to undergo regular hemodialysis, peritoneal dialysis, or renal transplantation. A Physician who is certified in nephrology must confirm diagnosis in writing.

Leased Aircraft
means an aircraft whose possession is turned over to a firm or individual for a specified period of time, with the owner retaining full title to such aircraft.

Loss
with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Loss of Use
means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Member of the Crew
means a person assigned to duty in an aircraft during Flight Time, and whose occupation is related to the safety of passengers, the operation and/or the actual flying of the aircraft.

Member of the Immediate Family
means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the above include natural, adopted or step relationships), Spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Physician
means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practice medicine by (1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing organization, or (2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

Principal Sum
means the amount of insurance for which the Insured Person is covered, as shown in the records of the Company and/or the Policyholder.

Psychological Therapy
means the treatment or counselling by a therapist or counselor, who is licensed, registered, or certified to provide such treatment, whether on an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

Regular Care and Attendance
means medical treatment to the extent necessary under existing standards of medical practice for the condition causing disability, Hospital confinement or requiring such treatment.

Residence
means the primary dwelling of which the Insured Person is an occupant and the premises on which it is situated.

School for Higher Learning
includes any university, college, CEGEP {College D'Enseignement General et Professionel (community colleges in Quebec)} or trade school.

Sickness
means sickness or disease occurring while this policy is in force as to the Insured Person whose sickness is the basis of claim.

Specialist
means a Physician registered and licensed to practice in Canada whose practice is limited to the particular branch of medicine relating to the applicable Covered Disease.

Stroke
means an acute cerebral vascular accident (CVA) producing permanent neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 30 days following the occurrence of the stroke. Transient Ischemic Attacks (TIAs) are not covered.

Totally Disabled
means that the Insured Person (1) is unable to engage in any and every occupation or employment for compensation or profit and (2) requires the Regular Care and Attendance of a Specialist.

Vehicle
means a passenger car, station wagon, van, jeep-type automobile or truck.

Whenever a reference to the masculine gender appears in this policy, it will also be construed to include the feminine gender.

Benefits

Accidental Death, Dismemberment and Specific Loss Indemnity
If, within 12 months of the date of the accident, Injury results in any of the following losses, the Company will pay for Loss of or permanent and total Loss of Use of:

	% of Principal Sum
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	100%
One Leg	100%
One Hand	66 ⅔%
One Foot	66 ⅔%
Entire Sight of One Eye	66 ⅔%
Speech or Hearing in Both Ears	66 ⅔%
Thumb and Index Finger of Either Hand	33 ⅓%
Four Fingers of Either Hand	33 ⅓%
Hearing in One Ear	33 ⅓%
All Toes of One Foot	25%

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;

(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same accident.

Continuation of Coverage During Approved Leaves

Coverage under this policy may be continued for an Insured Person during any approved leave of absence, temporary lay-off, maternity leave or disability leave, provided payment of premium is continued.

Conversion Option

Upon termination of active employment with the Policyholder, an Insured Person may convert to an individual accident insurance plan, with no evidence of insurability required, at the individual rates in force with the Company at the time of such Insured Person's termination. The Insured Person may elect an amount of Principal Sum equal to or lower than the amount of Principal Sum, to a maximum of $200,000.00, in force at the time of termination. An application for conversion must be made within 31 days of the date of termination. Individual policies issued under this option do not include the Critical Disease and Serious Illness benefits.

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while this policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, the Company will pay 10% of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

Serious Illness Benefit

If an Insured Person is diagnosed by a Specialist with Cancer, Heart Attack, Kidney Failure or Stroke, and the Insured Person survives for a period of 30 days thereafter and is under 65, the Company will pay 10% of the Principal Sum up to a maximum of $10,000.00.

The Company shall only be obligated to pay the Critical Illness Benefit once notwithstanding that an Insured Person may be diagnosed with more than one of the covered illnesses.

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

Limitations and Exclusions
This policy does not provide benefits from any of the Insured Conditions caused directly or indirectly by or resulting from any of the following:

(a) Injury or Sickness, other than one of the covered illnesses, even though such Injury or Sickness may have been complicated by one of the covered illnesses;

(b) a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;

(c) the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;

(d) misuse of medication or the abuse of drugs or intoxicants;

(e) any Pre-existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following the Insured Person's effective date of coverage.

Day Care Benefit

If an Injury sustained by an Insured Person results in loss of life within 12 months of the date of accident, the Company will pay the Day Care Benefit stated below for each of the Insured Person's Dependent Children, under 13 years of age who:

(a) are enrolled in a legally licensed Day Care Centre on the date of such loss; or

(b) enroll in a legally licensed Day Care Centre within 12 months after the date of death of the Insured Person.

The Day Care Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of the Insured Person's Principal Sum to a maximum of $5,000.00, for each year the Dependent Child described above is enrolled in a legally licensed Day Care Centre, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled in a legally licensed Day Care Centre, but payment will not be made for expenses incurred prior to the death of the Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

If, at the time of loss, the Insured Person has no Dependent Children eligible for the Day Care Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Disability Fitness Benefit

If Injury results in a Loss payable to an Insured Person under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity” of this policy, the Company will pay the reasonable and necessary expenses actually incurred for the purposes of any specially designated fitness training or athletic equipment for disabled persons, which you would not have required except for such injury, but not to exceed an amount of $5,000.00. The expense must be incurred within 2 years of the date of accident.

The above benefit shall only be payable under one of the policies issued by the company and shall not duplicate any other benefits payable.

Education Benefit

If an Injury sustained by an Insured Person results in loss of life within 12 months of the date of accident, the Company will pay the Education Benefit stated below for each of the Insured Person's Dependent Children, who are enrolled as full-time students:

(a) in a School for Higher Learning above the secondary school level as defined, in the province, territory or country of Residence; or

(b) at the secondary school level but who enroll as full-time students in a School for Higher Learning within 12 months after the date of death of the Insured Person.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of the Insured Person's Principal Sum to a maximum of $5,000.00, for each year the Dependent Child described above continues his education on a full-time basis in a School for Higher Learning, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in a School for Higher Learning, but payment will not be made for expenses incurred prior to the death of the Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

If, at the time of loss, the Insured Person has no Dependent Children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If, as the result of an Injury, an Insured Person requires and receives treatment by a Physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00.

Family Transportation Benefit

If, following an Injury which results in a Loss payable under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity" of this policy, an Insured Person is confined as an inpatient in a Hospital located from a point of not less than 150 kilometers from his normal place of Residence and such Insured Person is under the Regular Care and Attendance of a Physician, the Company will pay the reasonable and necessary expenses actually incurred by any Member of the Immediate Family for accommodation/lodging in the vicinity of the Hospital where the Insured Person is confined and transportation by the most direct route from the normal place of Residence of the Member of the Immediate Family to the confined Insured Person and return to the normal place of Residence of such Member of the Immediate Family.

Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a Vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $.20 per kilometer travelled.

The maximum amount payable under this part is $15,000.00 for all such expenses.

Funeral Expense Benefit

If an Injury sustained by an Insured Person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.00.

Home Alteration and Vehicle Modification Benefit

If an Injury sustained by an Insured Person does not cause loss of life, but results in a Loss for which indemnity becomes payable under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity", and such Insured Person is subsequently required to use a wheelchair to be ambulatory, the Company will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such Loss for:

(a) the cost of alterations to the Insured Person's principal Residence; and/or

(b) the cost of modifications to one motor vehicle utilized by the Insured Person, when such modifications are approved by the provincial vehicle licensing authorities where required

for the purpose of making them wheelchair accessible.

Payment by the Company for the total of all expenses incurred by or for any Insured Person is subject to a maximum of $25,000.00 as the result of any one accident.

Parental Care Benefit

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance with the terms of this policy, the Company will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible for this benefit if, at the time of the accident:

1) is a resident in a licensed nursing care facility; or

2) is enrolled in a home health care program; or

3) is living in the Insured Person's Residence; or

4) is receiving support and care provided by the Insured Person as evidenced by:
   (a) cancelled cheques;
   (b) income tax returns showing the parent as a dependent; or
   (c) other similar forms of proof.

The amount of Parental Care Benefit will be 5% of the Insured Person's Principal Sum, subject to an overall maximum of $ 5,000.00.

Psychological Therapy Benefit

If Injury results in a Loss payable to an Insured Person under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity” of this policy, and results in the Insured Person requiring Psychological Therapy, as prescribed by a Physician, the Company will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00, until one of the following occurs:

(a) the total Psychological Therapy Benefit amount has been paid; or

(b) two years have elapsed from the date of the Injury; or

(c) the Insured Person dies.

Rehabilitation Benefit

If an Injury sustained by an Insured Person results in a Loss payable under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity”, and such Injury requires that the Insured Person undergo special training in order to be qualified to engage in a special occupation in which he would not have engaged except for such Injury, the Company will pay the reasonable and necessary expense incurred for such training by the Insured Person within two years of the date of the accident, subject to a maximum of $15,000.00 as the result of any one accident.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If an Injury sustained by an Insured Person results in loss of life (due to any cause) out of Canada, or if in Canada at least 150 kilometers from the Employee’s normal place of residence, and indemnity becomes payable in accordance with the terms of this policy, the Company will pay the reasonable and necessary expenses actually incurred for the transportation of the body to the city of Residence, including the preparation of the body for such transportation, subject to a maximum of $15,000.00.

Benefits will be reduced under this part by any amount paid or payable under any other policy providing similar expenses.

Seat Belt Benefit

If, due to a vehicular accident, Injury results in a loss payable to an Insured Person under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity”, the Insured Person's amount of Principal Sum will be increased by 10% if, at the time of the accident, the Insured Person was driving or riding in a Vehicle and wearing a properly fastened Seat Belt.

The driver of the Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the accident occurs.

Due proof of Seat Belt use must be provided as part of the written proof of Loss.

Spousal Retraining Benefit

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance with the terms of this policy, the Company will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the Spouse of the Insured Person who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, not to exceed in the aggregate $15,000.00 for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Waiver of Premium

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

(a) the date the Insured Person ceases to be totally disabled;

(b) the termination of this policy;

(c) the date the Insured Person reaches 65 years of age.

The Company reserves the right to request proof of total disability or any continuance thereof from time to time as the Company may reasonably require. Failure to provide proof satisfactory to the Company may result in termination of this Waiver of Premium benefit.

The coverage, which is continued under this benefit, will be subject to the terms and provisions of this policy in effect as of the date of commencement of disability, including any provision providing for reductions in Principal Sum.

Notwithstanding anything contained to the contrary in this policy, in no event will benefits payable for any Loss which occurs while coverage is being continued under this benefit exceed the Principal Sum that would have been payable to the Insured Person at the date of commencement of disability.

Limited Air Travel Coverage

Insurance provided under this policy includes Injury sustained in consequence of riding as a passenger, and not as a pilot or Member of the Crew, in, boarding or alighting from, or being struck by, or making a forced landing with or from (a) any aircraft having a current and valid Airworthiness Certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or (b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, this policy excludes Injury sustained while and in consequence of riding as a passenger, pilot, operator or Member of the Crew, in or on, boarding or alighting from, or being struck by, or making a forced landing with or from any aircraft owned, operated or Leased by the Policyholder.

Exposure and Disappearance

If, as the result of an accident, an Insured Person is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the Insured Person suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an Insured Person was riding, the Insured Person disappears, and if the body of the Insured Person is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the Insured Person suffered loss of life as a result of Injury.

Exclusions and Limitations

This policy does not cover loss, fatal or non-fatal, caused by or resulting from:

a) declared or undeclared war or any act thereof;

b) active full-time service in the armed forces of any country;

c) suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;

d) committing, attempting or provoking an assault or criminal offence including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood. A “vehicle” means a vehicle that is drawn, propelled or driven by any means or other than muscular power;

e) medical care or treatment of any kind including surgery;

f) any drug, poison, gas or intoxicant taken, administered, absorbed or inhaled, voluntarily or otherwise (occupation-related accidents excepted);

g) injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled “Limited Air Travel Coverage”.

Notice and Proof of Claim

The Insured Person or his agent, or a beneficiary entitled to make a claim or his agent, will

(a) give written notice of claim to the Company:

(i) by delivery thereof, or by sending it by registered mail to the Head Office or chief agency of the Company in the province, or

(ii) by delivery thereof to an authorized agent of the Company in the province,

not later than 30 days from the date of the accident or the Date of Diagnosis for the “Critical Disease Benefit” and “Critical Illness Benefit”;

(b) within 90 days from the date of the accident or the Date of Diagnosis for the “Critical Disease Benefit” and “Critical Illness Benefit” for which the claim is made, furnish to the Company such proof of claim as is reasonably possible in the circumstances of the happening of the accident or Sickness, and the loss occasioned thereby; and

(c) if so required by the Company, furnish a satisfactory certificate as to the cause or nature of the accident or Sickness for which the claim may be made under the contract.

Failure to give notice of claim or furnish proof of claim within the time prescribed does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than 12 months from the date of the accident, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

A claim form can be obtained from the benefits administrator.

Dependent Life Insurance

Upon the death of a dependent while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the group policy.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

Stillbirth Benefit

In case of a stillbirth, the insurer will pay the child benefit provided under the Dependent Life Insurance benefit, provided:

a) the fetus weighs a minimum of 500 grams, or

b) the body length is a minimum of 25 centimetres, or

c) the gestational age is at least 20 weeks.

Conversion Privilege

If life insurance coverage for your spouse ends because you cease to belong to the group insured, you are entitled to convert all or part of this group life insurance coverage to individual life insurance without having to provide any evidence of insurability. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the day you cease to belong to the group insured.

The conversion privilege applies only to those whose insurance terminates on or before their 65th birthday due to the fact that you cease to belong to the group on the day you reach age 65 or earlier. The following types of individual life insurance are available as a result of conversion:

a) A life insurance that is comparable to the group insurance of the insured person as to the amount and duration, but that does not exceed $200,000 for all of the group life insurance benefits combined you had for this person, whether the person is insured as a participant or spouse;

b) A one-year term life insurance that can be converted into the insurance described in item a) above.

Individual life insurance policies issued after having exercised the conversion privilege do not provide for a premium waiver.

If the insured person should die during the 31-day period in which you could have exercised this conversion privilege and the group insurance coverage has not already been converted, the amount of life insurance you were eligible to convert shall be payable under the group insurance contract.

In all cases described above, the premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the rates in force for individual insurance, in accordance with the gender, age and smoking status of the individuals to be insured on the date you ceased to belong to the group insured, and in accordance with the particulars that applied to their group life insurance. SSQ must receive the first premium for individual life insurance within 31 days following the date you ceased to belong to the group insured.

Short Term Disability

If a participant becomes totally disabled while insured under this benefit and while he is actively at work, the insurer will undertake to pay the participant the amount of weekly indemnity benefit specified herein for each week or part of a week during which such total disability lasts, subject to the terms and conditions of this benefit and the group policy.

Definitions

As used in this benefit:

Hospitalization
Occupancy of a hospital room as an admitted bedridden patient, where a room and board charge has been made in connection with the confinement, or admittance as an out-patient for a surgical procedure.

Total Disability and Totally Disabled
A disability caused by an accident or illness that renders you totally incapable of carrying out the main duties of your usual employment. A participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be totally disabled.

Pre-disability gross weekly salary
The weekly salary applicable to the participant immediately prior to the date his total disability commenced.

Pre-disability net weekly salary
The weekly salary applicable to the participant immediately prior to the date his total disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Elimination period
The period specified in the Schedule of Benefits during which the participant must be absent from work due to a total disability before he can begin to receive weekly indemnity benefit payments.

Beginning of Benefit Payments

Payment of the weekly indemnity benefit begins following completion of the elimination period specified in the Schedule of Benefits.

Amount of Benefit Payments

The amount of the weekly indemnity benefit payable is determined according to the formula set forth in the Schedule of Benefits and will not exceed the weekly maximum amount specified.

Reduction of Benefit Payments

The weekly indemnity benefit payments will be reduced by:

a) Any benefits which are payable or which would have been payable due to his disability had a satisfactory application been made under

   i) a Workers' Compensation Act;

   ii) a provincial automobile insurance law if the reduction is acceptable under the Employment Insurance Regulations;

   iii) the Quebec or Canada Pension Plan;

   iv) any similar law, act or plan to those listed in (i), (ii) and (iii);

   v) a provincial crime victims compensation act, except for the period during which employment insurance benefits would or could have been payable;

b) Any pension benefits that the participant receives on his or her own behalf from the Quebec or Canada Pension Plan;

c) Any payment received according to the employer's policy regarding continuation of salary, vacation, statutory holidays or sick leave;

d) Any damages for loss of income received from a third party which arise out of the same circumstances that caused the participant's disability.

Termination of Benefit Payments

The weekly indemnity benefit payments cease on the earliest of the following dates:

a) The date the maximum benefit period specified in the Schedule of Benefits has been reached;

b) The date on which the participant ceases to be totally disabled;

c) The date on which the totally disabled participant reaches the age of termination, if any, indicated in the Schedule of Benefits provided the participant has received at least 15 weeks of benefit payments; otherwise, on the date on which he has received 15 weeks of benefit payments;

d) The date on which the participant retires;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

g) The date on which the participant fails to provide any evidence of total disability required by the insurer;

h) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty;

i) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;

j) The date the participant is capable of earning at least 80% of his pre-disability gross weekly salary, if he is involved in a trial work, part-time work or modified work program or a rehabilitation program as provided under the Work Re-Entry provision.

Successive Periods of Total Disability

If a participant who had been totally disabled returns to full-time active work and again becomes totally disabled while this benefit is in force, such disability will be considered a continuation of the previous disability provided he has been back at full-time active work for less than 15 days and the disability results from the same or related cause or causes as the previous disability.

However, if the successive period of total disability is due to a cause or causes unrelated to the cause or causes of the previous period of total disability, it will be considered to be a new disability and a new elimination period will apply.

Exclusions and Limitations

a) The weekly indemnity benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

   ii) Attempted suicide or voluntarily self-inflicted injury, while sane or insane;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an accidental injury or illness;

   iv) Committing, attempting to commit a criminal offence, or provoking an assault.

   v) Active service in the armed forces.

b) The weekly indemnity benefit will not be payable:

i) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the employer;

ii) During any extension of such a leave, if the participant was entitled to and requested such extension.

However, if the participant's benefit was kept in force during the leave, the elimination period will begin on the date the disability commenced. The weekly indemnity benefit will be payable on the later of the date the elimination period is satisfied or the date the participant would have returned to work if not for his disability. No weekly indemnity benefit will be payable during the period the employee is absent from work due to the leave.

c) The weekly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

d) The weekly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant's entitlement to the weekly indemnity benefit will be restored only upon the participant's return to Canada or the United States, subject to all other provisions of this benefit.

e) The weekly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

Where the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period will begin on the date the disability commenced. The weekly indemnity benefit will be payable on the later of the date the elimination period is satisfied or the date the participant would have returned to work if not for his disability. No weekly indemnity benefit will be payable during the period the employee is absent from work due to the strike, lock-out or temporary lay-off.

f) The weekly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

g) The weekly indemnity benefit will not be payable to a participant during any period that the participant receives payment(s) in lieu of notice under a severance package from his employer. Where the payment is made to the participant in the form of a lump sum, this exclusion will apply to the period of notice for which the lump sum is attributed.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

However, the waiver of premiums will cease on the termination date of this benefit or the group policy.

Work Re-entry Program

Gradual return to work
SSQ must give prior approval to any period of gradual return to work, both with regard to duration and number of hours worked per week.

During the gradual return to work period, your Disability Insurance benefit payments will be reduced by an amount corresponding to the percentage of hours you normally work each week during this period in relation to the hours you normally worked each week before you became totally disabled.

Rehabilitation
In the event you become totally disabled, you must agree to participate in good faith in any rehabilitation program approved and supervised by SSQ.

Your benefits will be reduced by any remuneration you receive during the rehabilitation period that, when combined with other income from the sources specified under the REDUCTION OF BENEFIT PAYMENTS section, exceeds 100% of your pre-disability net weekly salary if the Short Term Disability benefit is non-taxable, or 100% of your pre-disability gross weekly salary if the Short Term Disability benefit is taxable.

Claims

Some Short Term Disability claims are handled directly with SSQ and others are handled by the Disability Management Institute (DMI). To determine how your STD claims are handled please refer to the Schedule of Benefits section of this handbook.

If your STD claims are handled by the Disability Management Institute (DMI)

To ensure you are supported while you are disabled your employer is providing additional services through the Disability Management Institute (DMI). DMI will provide assistance to you and your employer during the claiming process and during your return to work. All information provided to DMI remains confidential and is not shared with your employer. DMI may also work with the insurer of your disability benefits, SSQ

To submit a claim, obtain a Short 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 SSQ must receive satisfactory proof of claim within **90 days** following the end of the elimination period. Failure to submit a claim within the 90 day limit will not invalidate the claim if special circumstances prevail.

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

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

You can contact the Disability Management Institute (DMI) as follows:

BC, Alberta, Saskatchewan	**Manitoba, Ontario, Atlantic Provinces**
Toll Free: **1.866.963.9995**	Toll Free: **1.866.459.3066**

Long Term Disability

If a participant becomes totally disabled while insured under this benefit and while he is actively at work, the insurer will undertake to pay the participant the amount of the monthly indemnity benefit specified herein for each month or part of a month during which such disability lasts, subject to the terms and conditions of this benefit and the group policy.

Definitions

As used in this benefit:

Total Disability and Totally Disabled
During the participant's elimination period, and the period following the elimination period indicated in the Schedule of Benefits, the participant is not able to perform substantially all of the essential duties of his own occupation and earn at least 80% of his indexed pre-disability gross monthly salary due to an illness or injury, as determined by the insurer.

Thereafter the participant is not able to perform substantially all of the essential duties of his own or any other occupation for which he is reasonably qualified by training, education or experience and earn at least 70% of his indexed pre-disability gross monthly salary due to the illness or injury, as determined by the insurer.

However, a participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be totally disabled.

Indexed pre-disability gross monthly salary
The monthly salary applicable to the participant immediately prior to the date his total disability commenced, increased each March 1st coincident with or next following the anniversary of the date on which the participant became entitled to a monthly indemnity benefit by the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Pre-disability gross monthly salary
The monthly salary applicable to the participant immediately prior to the date his total disability commenced.

Pre-disability net monthly salary
The monthly salary applicable to the participant immediately prior to the date his total disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Elimination period
The period specified in the Schedule of Benefits during which the employee must be totally disabled before he can begin to receive monthly indemnity benefit payments.

Beginning of Benefit Payments

Payment of the monthly indemnity benefit begins following completion of the elimination period specified in the Schedule of Benefits.

Amount of Benefit Payments

The amount of the monthly indemnity benefit payable is determined according to the formula set forth in the Schedule of Benefits and will not exceed the monthly maximum amount specified.

Reduction of Benefit Payments

The monthly indemnity benefit will be reduced, after the application of the monthly maximum amount, by any disability benefits which are payable or which would have been payable to the participant had a satisfactory application been made under:

a) the Quebec or Canada Pension Plan, excluding benefits payable on behalf of dependent children;

b) a Workers' Compensation Act;

c) a provincial automobile insurance law;

d) a provincial crime victims compensation act.

Moreover, the amount of the monthly indemnity income benefit payable by the insurer will be adjusted so that the sum of all income, compensation, indemnity and benefits which the participant would or could receive, due to his disability, from: (a) the policyholder, (b) his employer (c) any government body, (d) a franchise or association insurance plan, (e) any group insurance or pension plan to which the policyholder or employer contributes, and (f) a third party in the form of damages for loss of income, will not exceed 85% of the participant's pre-disability net monthly salary if the monthly indemnity income benefit is non-taxable or 85% of the participant's pre-disability gross monthly salary if the monthly indemnity income benefit is taxable.

After the first reductions made for each of the sources listed in this provision, future cost of living adjustments made to amounts received from such sources will not bring about further reductions.

Termination of Benefit Payments

The monthly indemnity benefit payments cease on the earliest of the following dates:

a) The date the maximum benefit period specified in the Schedule of Benefits has been reached;

b) The date on which the participant ceases to be totally disabled;

c) The date on which the participant reaches the age of 65;

d) The date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Schedule of Benefits of the group policy;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

g) The date on which the participant fails to provide any evidence of total disability required by the insurer;

h) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;

i) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

Successive Periods of Total Disability

If the participant who had been totally disabled returns to full-time active work again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous total disability, provided:

a) it is due to the same cause or causes as the previous total disability;

b) during the elimination period, he has been back at full-time active work for less than 15 days; and

c) after the elimination period has been completed, he has been back at full-time active work for less than 6 months.

However, if the successive period of total disability is due to a cause or causes unrelated to the cause or causes of the previous period of total disability, it will be considered to be a new disability and a new elimination period will apply.

Exclusions and Limitations

a) The monthly indemnity benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

   ii) Attempted suicide or voluntarily self-inflicted injury, while sane or insane;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an accidental injury and commenced within 90 days of the accident;

   iv) Committing, attempting to commit a criminal offence, or provoking an assault or criminal offence.

   v) Active service in the armed forces.

b) The monthly indemnity benefit will not be payable:

   i) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the employer;

   ii) During any extension of such a leave, if the participant was entitled to and requested such extension.

   However, if the participant's benefit was kept in force during the leave, the elimination period will begin on the date the disability commenced. The monthly indemnity benefit will be payable on the later of the date the elimination period is satisfied or the date the participant would have returned to work if not for his disability. No monthly indemnity benefit will be payable during the period the employee is absent from work due to the leave.

c) The monthly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

d) The monthly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant's entitlement to the monthly indemnity benefit will be restored only upon the participant's return to Canada or the United States, subject to all other provisions of this benefit.

e) The monthly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

   Where the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period will begin on the date the disability commenced. The monthly indemnity benefit will be payable on the later of the date the elimination period is satisfied or the date the participant would have returned to work if not for his disability. No monthly indemnity benefit will be payable during the period the employee is absent from work due to the strike, lock-out or temporary lay-off.

f) The monthly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

g) The monthly indemnity benefit will not be payable to a participant during any period that the participant receives payment(s) in lieu of notice under a severance package from his employer. Where the payment is made to the participant in the form of a lump sum, this exclusion will apply to the period of notice for which the lump sum is attributed.

Cost of Living Adjustment

This is not a standard benefit provision and may not be included in your Long Term Disability benefit. Please refer to the Schedule of Benefits section of this handbook to determine if this benefit provision is included in your LTD benefit.

If included in your plan, the amount of monthly indemnity benefit payable will be adjusted on the first day of January of each year according to the Canadian Consumer Price Index, up to the maximum cost of living adjustment rate indicated in the Schedule of Benefits.

Pre-existing Condition Exclusion

As used in this provision, "pre-existing condition" means an illness or injury:

a) which was sustained or contracted, or

b) for the symptoms of which the participant was under treatment by a physician, or

c) for the symptoms of which a physician had undertaken an investigation or review of, or

d) for which the participant was taking medication as prescribed by a physician,

during the 3 months prior to the date on which the participant became covered under this benefit.

No monthly indemnity benefit will be payable for a disability that:

a) resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) which begins in the first 12 months after the participant became covered under this benefit.

However, if the group policy is a replacement group policy, a monthly indemnity benefit will be payable for a disability due to a pre-existing condition, provided the participant:

a) was covered under the previous policy on the date it was terminated; and

b) became covered under this benefit on the effective date of the group policy; and

c) was actively at work on the effective date of the group policy; and

d) satisfies the pre-existing condition exclusion period under the group policy, giving consideration towards continuous time covered under both policies, or the prior policy giving consideration towards continuous time covered under both policies.

The monthly indemnity benefit payable to the participant will be determined in accordance with this benefit, but in no case will it exceed the previous policy's maximum monthly indemnity benefit.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

Work Re-entry Program

Gradual return to work
SSQ must give prior approval to any period of gradual return to work, both with regard to duration and number of hours worked per week.

During the gradual return to work period, your Disability Insurance benefit payments will be reduced by an amount corresponding to the percentage of hours you normally work each week during this period in relation to the hours you normally worked each week before you became totally disabled.

Rehabilitation
In the event you become totally disabled, you must agree to participate in good faith in any rehabilitation program approved and supervised by SSQ.

Your benefits will be reduced by any remuneration you receive during the rehabilitation period that, when combined with other income from the sources specified under the REDUCTION OF BENEFIT PAYMENTS section, exceeds 100% of your indexed pre-disability net monthly salary if the Long Term Disability benefit is non-taxable, or 100% of your indexed pre-disability gross monthly salary if the Long Term Disability benefit is taxable.

Survivor Benefit

In the event of your death before the end of a period during which you are entitled to benefits under this insurance coverage, a lump-sum benefit payment equal to 3 full months' benefits will be made to your estate, or to your designated beneficiary, as applicable. The lump sum is calculated based on the amount of the last payment made.

Claims

To ensure you are supported while you are disabled your employer is providing additional services through the Disability Management Institute (DMI). DMI will provide assistance to you and your employer during the claiming process and during your return to work. All information provided to DMI remains confidential and is not shared with your employer. DMI may also work with the insurer of your disability benefits, SSQ.

If it is determined that you are going to be off work longer than the LTD elimination period, a Long Term Disability Benefits Application package will be provided to you by DMI 60 days prior to end of the elimination period. Complete instructions on how to submit the claim are included in this package. For confidentiality and privacy purposes, you can send these forms directly to DMI in the self addressed envelope.

It is important to note that SSQ must receive written notice of claim within **90 days** following the end of the elimination period.

SSQ 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.

You can contact the Disability Management Institute (DMI) as follows:

BC, Alberta, Saskatchewan
Toll Free: **1.866.963.9995**

Manitoba, Ontario, Atlantic Provinces
Toll Free: **1.866.459.3066**

Group Critical Illness Insurance

What is Critical Illness Insurance?

Critical illness insurance provides the funds and the means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

Critical·Choice·Care
is designed to provide the Insured person with a lump sum payment in the event this person is diagnosed with a critical illness covered and survives at least 30 days following this diagnosis. Among other advantages, the benefits are not limited by the person's ability to work or by full recovery. In the event you should receive such a diagnosis, the benefit is paid directly to you – and you are free to choose how to use it!

Why is Critical Illness Insurance important to you and your family?

Research has shown that a significant number of Canadians will face the challenge of critical illness:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- On average, 3,300 Canadians will be diagnosed with cancer every week.
- There are an estimated 70,000 heart attacks each year in Canada. One heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.
- 75% of stroke victims survive the initial event.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illness occurs everyday and, with the help of modern medicine, many survive such an illness. Unfortunately, along with this positive outcome sometimes comes a long recovery which can dramatically affect family income and introduces substantial costs.

How many of us are actually prepared financially for the event of a critical illness and to its repercussions? Most of us are not. Unfortunately, no one is immune; critical illness strikes people of all ages and backgrounds.

Critical Illness insurance benefits can help:

- obtain appropriate care where and when you decide
- cover your medical expenses not covered under your provincial health care plan
- take an unpaid vacation in order to help recovery or to take care of a sick family member
- replace reduced family earnings and face increased costs, by using the benefit to pay:
  - medical bills or nursing care at home
  - mortgage or rent
  - debt or financial liabilities
  - for help with the care of children
  - hired help for chores
  - for adapting the home to meet health need

Definitions for a better comprehension of the Group CI benefit in this booklet

Wherever used in this document:

"You", "Your"
means the insured Employee to whom this document was intended.

"Policyholder"
means the Employer named herein who is a Participating Client of GroupHEALTH Benefit Solutions.

“We”, “Us”, “Insurer”
means SSQ Insurance Company Inc.

“Insured person”
means you, while you are an insured active Employee of the Policyholder, and before the date of coverage termination.

“Policy”
means the Critical·Choice·Care™ 29 illnesses insurance program’s Master Policy, endorsements and attached papers, if any, and the entire contract of insurance, unless stated otherwise.

“Critical Illness”
means, with respect to the insured Employee, one of the illnesses, conditions or surgical operations listed under “*Covered Critical Illnesses (for Employee)*”.

“Diagnosis”
means the time when a specialist establishes, using tests or other diagnostic methods, that the insured person has a specific critical illness. The diagnosis of any covered critical illness must be made by a licensed specialist practising in Canada. Furthermore, his practice must be limited to the branch of medicine directly linked to the critical illness.

“Surgery”
means that the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The surgery must be performed by a Physician in Canada.

“Irreversible”
means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the insured person’s health.

“Physician”
means an individual who is legally licensed to practice medicine in Canada and provide treatment within the scope of his licence. The physician must not be the insured person, a relative of or business associate of the insured person.

“Specialist”
means a licensed physician who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified physician practising in Canada. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The specialist must not be the insured person, a relative of or business associate of the insured person.

“Claimant”
means the person who has requested or is in the process of requesting a settlement after being diagnosed with a covered critical illness.

“Pre-Existing Condition”
means :

- the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period preceding the insured person’s effective date of coverage; or
- an illness or condition for which the insured person, during 24 months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

"Survival period"
means 30 days following the date of the diagnosis or 30 days following the date of surgery if applicable, except where indicated otherwise. The survival period does not include the number of days on life support as defined below. For those conditions which have a longer qualification requirement, for example 90 days for bacterial meningitis and paralysis, the survival period runs concurrently with that requirement.

"Life support"
means being under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

When referring to a female person, male pronouns used in this document will be construed as the feminine.

Eligibility

You are eligible for coverage under the program if you are under age 70 and an active Employee of the Policyholder.

Coverage amounts

Refer to the Schedule of Benefits for your benefit amount (the principal sum) and the guaranteed issue limit.

Coverage Effective Date

Coverage is effective:

- on the Effective Date of the Policyholder's coverage under the Master Policy with respect to a person eligible on or before such date;
- on the date the eligible Employee returns to active full-time work if such Employee is absent from active full-time work for any reason other than bona fide vacation on the Effective Date of the Policyholder's coverage under the Master Policy;
- on the first of the month coincident with or following receipt of the completed Enrolment Card by the Policyholder with respect to an Employee who becomes insured under such program after the Effective Date of the Policyholder's coverage under the Master Policy.

Coverage Termination

Coverage terminates on the earliest of the following events:

- on the date the Master Policy is terminated;
- on the date the Policyholder's coverage under the Master Policy is terminated;
- on the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
- on the next premium due date following the date the Employee reaches seventy (70) years of age;
- on the next premium due date following the date the Employee ceases to be an active Employee of the Policyholder on account of resignation, dismissal or retirement;
- on the date the Employee dies;
- on the date the Principal Sum payment for Loss of independent existence claim has been paid.

Critical illness coverage

You will receive a payment equivalent to your principal sum if diagnosed with one of the following 29 illnesses while coverage is in force:

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)

- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dilated Cardiomyopathy
- Fulminant Viral Hepatitis
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Primary Pulmonary Hypertension
- Severe Burns
- Stroke (Cerebrovascular Accident)

Important:
The claimant's critical illness must meet one of the definitions presented under "Covered Critical Illnesses" and illnesses covered for "Complementary Benefit in Case of Certain Illnesses" – at the end of this document in order to be eligible under the Critical·Choice·Care program.

The payment is subject to Critical·Choice·Care program limitations of the survival period as referred to under the "Definitions" section and the exclusions presented in the "*Exclusions*" section.

When the insured has been paid any benefit under the Critical·Choice·Care program, the payment of benefits is then also subject to limitations referred to in the "*Multiple Event Coverage*" section below.

Multiple Event Coverage

When an insured Employee is diagnosed with one of the covered critical illnesses listed above for which a principal sum has been paid and is then diagnosed with another critical illness listed above, the claimant's principal sum will be paid, subject to the limitations presented in the "*Re-Entry Exclusions*" section.

To receive a benefit payment under the Multiple Event Coverage benefit, the critical illness diagnosed must meet one of the definitions presented at the end of this document and the diagnosis must be made at least 90 days after the principal sum payment.

Cancer Recurrence Benefit

You will receive a payment equivalent to your principal sum if diagnosed with one of the following illnesses while coverage is in force:

- over 60 months have passed since the previous cancer diagnosis; and
- no treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to doctor).

The claimant's critical illness must meet one of the definitions presented at the end of this document in order to be eligible under the Critical·Choice·Care program.

The payment is subject to Critical·Choice·Care program limitations of the Survival period as referred to under the "Definitions" section and the exclusions presented in the "Exclusions" section.

Cancer recurrence Benefits do not apply to insured children.

Complementary Benefit in Case of Certain Illnesses

You will receive a payment equivalent to 10% of your principal sum, subject to a maximum of $25,000, if diagnosed with one of the following illnesses while coverage is in force:

- Coronary angioplasty
- Ductal carcinoma in situ of the breast
- Stage A (T1a or T1b) prostate cancer
- Stage 1A malignant melanoma

Important: The claimant's critical illness must meet one of the definitions presented at the end of this document in order to be eligible under the Critical·Choice·Care program.

Sums for Complementary Benefit in Case of Certain Illnesses can only paid once in the insured's lifetime. These sums come in addition of other benefits to be paid *(the insurer will not deduct the sums of the payment from any previous or later principal sum payments)*.

The payment is subject to Critical·Choice·Care program limitations of the survival period as refered to under the "*Definitions*" section and the exclusions presented in the "*Exclusions*" section.

When the insured has been paid any benefit under the Critical·Choice·Care program, the payment of benefits is then also subject to exclusions presented in the "*Re-Entry Exclusions*" section.

Complementary Benefit in Case of Certain Illnesses does not apply to insured children.

Second Medical Opinion Service

Any insured person who is diagnosed with a covered critical illness while enrolled in the insurance program is offered access to SSQ Assistance's **Second Medical Opinion** program.

This program allows the insured person to obtain second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the insured person's file to confirm the initial diagnosis and make recommendations on appropriate treatment.

If you have been diagnosed with a covered critical illness, simply call: **1.877.266.6550** in order to benefit from SSQ Assistance's Second Medical Opinion program.

Exclusions

The program does not cover a critical illness that results directly or indirectly from any one or more of the following causes or situations:

1) Within 90 days following the effective date of the insured person's coverage:
    a. diagnosis of cancer is made; or
    b. any signs, symptoms or investigations that lead to a diagnosis of cancer, regardless of when the diagnosis is made.
2) Within 90 days following the effective date of the insured person's coverage:
    a. diagnosis of benign brain tumour is made; or
    b. any signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made.
3) The insured person does not satisfy the survival period limitations.
4) An intentionally self-inflicted injury or sickness, whether the insured person is sane or insane.

5) The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.

6) Any cancer that manifests itself prior to the effective date of the insured person's insurance when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.

7) From a Pre-existing Condition except if such Critical Illness is diagnosed 24 months after the Insured Person's effective date of coverage.

Re-Entry Exclusions

If an insured Employee has already received a principal sum for a covered critical illness, coverage will automatically continue. An insured person can claim a subsequent Principal Sum for another covered Critical Illness subject to the following restrictions:

If a claim has been made for a critical illness indicated in the left column of the Re-Entry Exclusions table below, no claim can be made for the critical illnesses listed in the right column of the table.

Critical illnesses claimed for	**Re-Entry exclusions** (Critical illnesses for which the insured person cannot claim)
Alzheimer's Disease	Alzheimer's Disease, Loss of Independent Existence
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Aplastic Anemia	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Bacterial Meningitis	Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Benign Brain Tumour	Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Blindness	Blindness, Loss of Independent Existence
Cancer (life-threatening)	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Coma	Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Coronary Artery Bypass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Deafness	Deafness, Loss of Independent Existence

Critical illnesses claimed for	Re-Entry exclusions (Critical illnesses for which the insured person cannot claim)
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Fulminant Viral Hepatitis	Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Heart Valve replacement	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Kidney Failure	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Loss of Independent Existence	Following a Loss of Independent Existence claim, the insured person cannot claim anymore. Insurance coverage terminates.
Loss of Limbs	Loss of Independent Existence, Loss of Limbs
Loss of Speech	Loss of Independent Existence, Loss of Speech
Major Organ Failure on Waiting List	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Major Organ Transplant	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Motor Neuron Disease	Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis, Stroke
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis, Stroke
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke

Critical illnesses claimed for	Re-Entry exclusions (Critical illnesses for which the insured person cannot claim)
Occupational HIV Infection	Blindness, Cancer (Life-Threatening), Coma, Deafness, Ductal Carcinoma in Situ of the Breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Paralysis	Coma, Loss of Independent Existence, Loss of Speech, Paralysis
Parkinson's Disease	Coma, Loss of Independent Existence, Loss of Speech, Paralysis, Parkinson's Disease
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, Stroke
Severe Burns	Loss of Independent Existence, Paralysis, Severe Burns
Stroke (Cerebrovascular Accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Waiver of Premium

The insurer will waive the premium for insured persons in the following circumstances:

a) If the insured person has Long Term Disability (LTD) Insurance:

From the first day of the month following the date this person begins to receive monthly disability benefit payments through his LTD Insurance.

b) If the insured person does not have Long Term Disability (LTD) Insurance:

When injury or sickness totally disables and prevents the insured person from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience, for a period of at least 6 consecutive months. Premiums will be waived on the first day of the month following the 6 consecutive month period.

The insurer must receive notice of disability within 12 months of the onset of total disability and due proof of such disability within 3 months following this notice.

Premiums will continue to be waived until the earliest of the following dates:

- on the date the Master Policy is terminated;
- on the date the Policyholder's coverage under the Master Policy is terminated;
- on the date the insured person reaches 65 years of age;
- on the date the insured person ceases to be totally disabled; or
- on the date the insured person fails to provide, within 90 days of request, proof satisfactory to the insurer of the continuance of total disability or refuses to submit to examination.

Coverage continued under the Waiver of premium benefit will be subject to the terms and provisions of the Policy in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the policy, in no event will benefits payable for any diagnosis which occurs while coverage is being continued under the Waiver of premium benefit exceed the amount of insurance that would have been payable to the insured person at the date of commencement of disability.

The insurer can request proof of the continuance of total disability, and may also require the disabled insured person to submit to examination by the insurer's medical advisor, from time to time as the insurer may reasonably require.

Conversion Option

If, with the exception of policy termination, an insured employee's insurance is terminated due to:

- termination of the insured employee's employment; or
- cessation of eligibility for insurance under this policy; or
- cessation of a period of total disability after which the insured employee did not return to work for the policyholder,

and prior to attainment of age of seventy (70), the insured employee makes a written application to the insurer within 31 days of said termination, the insurer will, without evidence of insurability, issue on the life of such insured person an individual critical illness policy.

The amount of insurance that may be converted will not exceed the insured person's amount of insurance then in effect on the date of termination or a total aggregate of one hundred and $150,000 for all such conversions with the insurer.

Premiums for such an individual critical illness policy being issued in compliance with the aforementioned condition will be calculated at the insurer's manual rates then in force for the attained age of the insured person at the date of conversion. Premiums will be payable annually in advance and the individual critical illness policy will be issued on an annually renewable basis.

Area of Diagnosis

Diagnosis and surgery must occur within Canada. Should a critical illness occur or be diagnosed outside of Canada, payment of the principal sum may be considered upon the insured person's return to Canada for medical assessment and confirmation of the diagnosis of a critical illness.

Notice of Claim and Proof of Critical Illness

In the event of a diagnosis of critical illness, a notice of this critical illness must be given to the policyholder, who will then give notice of the claim to the insurer in a timely manner.

The notice must be received by the insurer within 30 days of the diagnosis.

The insurer, upon receipt of such notice will furnish to the claimant such forms as are usually furnished by it for filing proofs of a critical illness. If such forms are not furnished by the insurer within 15 days after the receipt of such notice, the claimant will be deemed to have complied with the requirements of the insurance program as to proof of such critical illness upon submitting, within the 90 days time fixed for filing proofs of critical illness, written proof covering the occurrence, character and extent of the critical illness for which claim a notice has been given.

Written proof of critical illness must be furnished to the insurer within 90 days after the date of diagnosis.

Failure to furnish such proof within such time will not invalidate any claim, if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but **in no event not later than one year** after the date of the diagnosis.

The insurer reserves the right to confirm the diagnosis by appointing a medical practitioner to examine the insured person.

The benefit provided under the insurance program's coverage will be paid immediately after receipt of due proof.

All moneys payable under the insurance program are payable in the lawful money of Canada.

Benefit payment

With respect to an insured Employee, the principal sum payable in the event of a critical illness will be payable to the insured Employee.

With respect to an insured Employee, the Complementary Benefit in Case of Certain Illnesses payable under the terms specified in the "Complementary Benefit in Case of Certain Illnesses" section will be payable to the insured Employee.

Accrued benefits, if any, unpaid at the time of the insured Employee becoming unable to legally receive payment of benefits will be paid to the insured Employee.

NOTE: The payment of the benefit is subject to the limitations of the survival period as defined in this document under the "*Definitions*" section.

Legal recourse

To take any legal action in order to recover a benefit amount under this program, the claimant must wait 60 days after having submitted proof of claim to the insurer. Thereafter, the claimant will be limited to a one year period [3 years in the province of Quebec] during which legal action may be taken.

If any time limitation specified in this policy for giving notice of claim, or undertaking legal action is less than that permitted by law of the province in which the insured person is residing at the time of claim, then the time limitation will not be less than that provided for by provincial law.

Covered critical illnesses

With respect to the insured Employee, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Alzheimer's disease
A definite diagnosis of a progressive degenerative disease of the brain. The insured person must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The diagnosis of Alzheimer's disease must be made by a specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic surgery
The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

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

- marrow stimulating agents;
- immunosuppressive agents;
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist.

Bacterial meningitis
A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign brain tumour
A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the insured person has any of the following:
- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour.

This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for benign brain tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness
A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:
- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist.

Cancer (life-threatening)
A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:
- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the insured person has any of the following:
- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

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

Exclusion: No benefit will be payable under this condition for:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Coronary artery bypass surgery
The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a specialist.

Deafness
A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist.

Dilated cardiomyopathy
A condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of dilated cardiomyopathy must be made by a specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least 3 months.

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

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

Fulminant viral hepatitis
A definite diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:
- a rapidly decreasing liver size as confirmed by abdominal ultrasound;
- necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
- rapidly deteriorating liver function tests;
- deepening jaundice.

The diagnosis of fulminant viral hepatitis must be made by a specialist.

Exclusion: No benefit will be payable under this condition for:
- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

Heart attack
A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist.

Exclusion: No benefit will be payable under this condition for:
- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart valve replacement
The undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist.

Exclusion: No benefit will be payable under this condition for heart valve repair.

Kidney failure
A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist.

Loss of independent existence
A definite diagnosis of:
- A total inability to perform, by oneself, at least two of the following six Activities of Daily Living; or
- Cognitive Impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of loss of independent existence must be made by a specialist.

Activities of Daily Living are:
- Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting - the ability to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.
Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of limbs
A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist.

Loss of speech
A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist.

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

Major organ failure on waiting list
A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrollled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Major organ transplant
A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.

Motor neuron disease
A definitive diagnosis of one of the following:
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy,

and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist.

Multiple sclerosis
A definite diagnosis of at least one of the following:
- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of multiple sclerosis must be made by a specialist.

Muscular dystrophy
A definite diagnosis of all of the following:
- clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- characteristic electromyography changes;
- muscle biopsy confirming diagnosis of muscular dystrophy.

The diagnosis of muscular dystrophy must be made by a specialist.

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

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

- The accidental injury must be reported to the insurer within fourteen days of the accidental injury;
- A serum HIV test must be taken within fourteen days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist.

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

- the insured person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis

A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist.

Parkinson's disease

A definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations:

- muscle rigidity;
- tremor; or
- bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The diagnosis of Parkinson's disease must be made by a specialist.

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

Primary pulmonary hypertension

(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)

A definite diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of primary pulmonary hypertension must be made by a specialist.

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

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

Severe burns

A definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.

Stroke (cerebrovascular accident)
A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist.

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

- transient ischemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Illnesses Covered for Complementary Benefit in Case of Certain Illnesses

Under the Complementary Benefit in case of Certain Illnesses, only the four illnesses and surgical operations presented below are covered for an insured Employee:

Coronary angioplasty
The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist.

Ductal carcinoma in situ of the breast
The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

Stage A (T1a or T1b) prostate cancer
The diagnosis of this illness must be made by a specialist and must be confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma
A melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

Extended Health Care

Definitions

As used in all components of the Extended Health Care benefit:

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

Basic Daily Activities
Feeding oneself, dressing oneself, moving around and providing for one's own basic hygiene needs.

ClaimSecure
The adjudicator of the Extended Health Care and Dental Care benefits of this plan.

Deductible
The deductible is the amount you must assume before any expenses covered under a given benefit are reimbursed.

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

Hospitalization
Admission to hospital for a minimum duration of 24 hours, or day surgery.

Reasonable and Customary Expenses
The costs incurred for eligible, covered medical services or supplies that do not exceed the standard costs of other providers of similar standing in the same geographic area, for the same treatment of a similar illness or injury.

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

Scope of Coverage

Expenses for medical treatment, services, products or articles specified in the following sections are eligible for reimbursement by ClaimSecure in accordance with the provisions specified in the Schedule of Benefits, insofar as they are deemed reasonable and customary and provided such treatment, services, products or articles are:

- obtained while the insured is covered under this Extended Health Care benefit;
- administered in compliance with current health practice standards;
- used in compliance with the manufacturer's instructions, or, where no such instructions exist, in accordance with government-approved directives;
- prescribed by a physician, when such requirement is specified in the Schedule of Benefits;
- deemed necessary for the treatment of illness or injury.

Preapproval recommendation:
You are advised to contact ClaimSecure before obtaining treatment or medical services or purchasing costly medical products or articles to check if these expenses are covered.

Reimbursement of Covered Expenses

The amount of covered expenses reimbursed takes into account the deductible, coinsurance and maximums specified in the Schedule of Benefits

Expenses Related to a Workplace or Automobile Accident

Most medical and hospital expenses incurred due to an accident in the workplace may be reimbursed in full by the workplace safety board of the insured's province of residence.

Most medical and hospital expenses incurred due to an automobile accident may be reimbursed in full by the insured's provincial auto insurance plan, if applicable.

Before filing a claim with ClaimSecure, the insured should first submit expenses to these government agencies for reimbursement.

Medical Expenses Covered by Provincial and Federal Governments

Each province offers programs covering certain medical expenses. Contact your provincial authority for more information about the programs available before filing a claim with ClaimSecure. You may also contact ClaimSecure for more information.

Multiple Coverage and Coordination of Benefits (COB)

Effect on Benefits
If an insured is covered under this policy as an Employee and as a Dependent or as a Dependent of more than one Employee or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under this policy for allowable expenses shall be coordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual allowable expenses.

How the Plans Coordinate Benefits
The plan that determines the benefits first (hereinafter referred to as "primary plan") will calculate its benefits as though duplicate coverage does not exist.

The plan that determines the benefits second (hereinafter referred to as "secondary plan") will limit its benefits to the lesser of:

- the amount that would have been payable had it determined the benefits first; and
- 100% of all allowable expenses reduced by all other benefits payable for the same expenses by the primary plan.

Order of benefit determination with another plan

1. If the other plan does not contain a provision for coordination of benefits with this policy, such plan will be deemed to be the primary plan.
2. If the other plan contains a Coordination of Benefits provision, determination of primary plan and secondary plan will be made on the following basis:
    a) With respect to an Insured who is covered as an Employee and as a Dependent under more than one plan, the plan which covers the Insured, other than as a Dependent, shall be deemed to be the primary plan.
    b) With respect to an Insured who is covered as an Employee under more than one plan, the determination of which plan is the primary plan will be made in the following plan order:
        i) the plan under which the Insured is covered as a full-time Employee;
        ii) the plan which the Insured is covered as a part-time Employee;
        iii) the plan under which the Insured is covered as a retiree.

c) With respect to an Insured who is covered as a Dependent under more than one plan and the two people of whom he is a Dependent are neither separated or divorced, the determination of which plan is the primary plan will be made on the following basis:

i) The plan which covers the Insured as the Dependent of the person whose birthday comes first in the calendar year shall be considered the primary plan;

ii) The plan, which covers the Insured as the Dependent of the person whose first name begins with the earlier letter in the alphabet, shall be considered the primary plan, in the situation where the two individuals of whom he is a Dependent have the same birth date.

d) With respect to an Insured who is covered as a Dependent under more than one plan and the two people of whom he is a Dependent are either separated or divorced, the determination of which plan is the primary plan will be made in the following plan order:

i) The plan of the person who has custody of the Insured;

ii) The plan of the spouse of the person who has custody of the Insured;

iii) The plan of the person who does not have custody of the Insured;

iv) The plan of the spouse of the person who does not have custody of the Insured.

3. When clauses 1, and 2 do not serve to establish an order of benefit determination, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

Order of Benefit Determination Within the Same Plan
The rules outlined under the Order of Benefit Determination with another Plan will be applied to ensure that the total benefits payable under the plan shall not exceed 100% of the actual allowable expenses.

Order of Benefit Determination in the Case of a Dental Accident
If a benefit is payable due to allowable expenses incurred as a result of a dental accident, a supplementary health benefit which provides for dental accident coverage shall determine the benefits payable before a dental benefit.

Right to Receive and Release Information
For the purposes of determining the applicability of and implementing the terms of this section of this policy or any provision of similar purpose of any other plan, the Provider may, with proper authorization, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Provider deems to be necessary for such purposes. Any person claiming benefits under this policy shall furnish to the Provider such information as may be necessary to implement this section.

Facility of Payment
Whenever payments which should have been made under this policy in accordance with this section have been made under any other plans, the Provider shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this policy and, to the extent of such payments, the Provider shall be fully discharged from liability under this policy.

Right of recovery
Whenever payments have been made by the Provider with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Provider shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Provider shall determine: any person to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

Deadline for filing claims

ClaimSecure recommends that you file your claims at regular intervals, once every 3 months.

ClaimSecure must receive notice of any claim for an Extended Health Care benefit within 12 months of the date of the event which gives entitlement to the benefit.

However, if this policy should terminate, notice of claim must be received by ClaimSecure within 90 days of the date of termination of the policy.

Exclusions

This insurance does not cover any treatment, service, product or article related directly or indirectly, in whole or in part, to:

a) A criminal act that the insured commits or attempts to commit;

b) Active participation in a riot or insurrection;

c) War or civil war, whether declared or undeclared;

d) Active service in the armed forces of a country;

e) Attempted suicide;

f) Self-inflicted injuries, regardless of whether the insured is deemed to be sane or insane at the time.

Furthermore, no benefits will be paid for treatment, services, products or articles:

a) That are covered under any social legislation or law governing hospitalization or health insurance, industrial accidents and occupational illnesses, or legislation regarding automobile accidents in the insured's province of residence, regardless of whether or not the insured is eligible for coverage under such automobile insurance plan;

b) That are obtained through a municipal, provincial or federal clinic;

c) That are usually covered by government organizations;

d) That are required by a third party or received collectively;

e) Obtained for aesthetic or cosmetic treatments, unless otherwise specified;

f) For services, supplies, examination or treatments that do not comply with reasonable and customary standards of current practice in the health care profession in question.

Survivor Benefit

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

- The end of a period of months immediately following your death, as noted in the Schedule of Benefits;
- The date when insurance for your spouse and children would have terminated, if your death had not occurred;
- The date when your spouse and children become eligible for similar coverage under another insurance contract;
- The date the contract terminates.

Extended Health Care – Hospital

Hospital Room

If Hospital Room coverage is listed as a covered expense in the Schedule of Benefits, your Extended Health Care benefit will pay you the difference between the cost of hospital ward accommodation and a semi-private or private hospital room, whichever is indicated in the Schedule of Benefits.

Expenses will be eligible for reimbursement provided the insured is admitted to a hospital in Canada for the purpose of receiving curative treatment or care related to pregnancy.

Exclusions

The following expenses are not covered:

a) Administrative or incidental fees charged to the patient by the hospital;
b) Fees or room charges for outpatient care, day surgery, private hospital, nursing home, chronic care facilities, home for the aged, rest home.

Hospital Indemnity

If the Hospital Indemnity coverage is listed as a covered expense in the Schedule of Benefits, you may be eligible to receive a daily cash benefit as outlined in the Schedule of Benefits.

Convalescent Care

If Convalescent Care coverage is listed as a covered expense in the Schedule of Benefits, your Extended Health Care benefit will cover the daily cost of semi-private accommodation and meals for a stay in a convalescent home immediately following three (3) or more days of hospitalization is covered, up to the maximum specified in the Schedule of Benefits, including all related care and services, provided that the establishment is:

- Recognized by ClaimSecure (private establishments) or your provincial ministry governing health and social services (public establishments);
- Capable of providing the medical care of a registered nurse, a nursing assistant or a licensed physician 24 hours per day.

To be eligible for reimbursement, such care and services are subject to prior medical approval. To obtain medical approval, the insured must have the attending physician complete the Convalescent Home form. This form is available from GroupHEALTH Benefit Solutions or ClaimSecure.

Exclusions

Fees or room charges for private hospital, chronic care, custodial care, home for the aged, nursing home, rest home, alcohol and substance abuse, mental health.

How to Claim

Hospital Room

Present your oneCard™ at the hospital and the hospital will send your claim to ClaimSecure.

Hospital Indemnity and Convalescent Care

To file a claim, you must complete a health insurance claim form and send it to ClaimSecure along with the original receipts or paid invoices.

Extended Health Care – Drugs

Expenses Covered

If prescription Drugs coverage is listed as a covered expense in the Schedule of Benefits, your Extended Health Care benefit covers expenses incurred for prescription drugs that meet all of the following conditions:

a) Bear a valid DIN (Drug Identification Number) issued by the federal government;
b) Are prescribed by a health care professional legally authorized to do so (includes over-the-counter drugs up to the limit specified in the Schedule of Benefits;
c) Are only available in a pharmacy; and
d) Are dispensed by a pharmacist or health care professional legally authorized to do so.

"Exception" or "Prior approval" drugs
Certain prescription drugs are only covered under specific clinical criteria and directions for use determined by the appropriate government authorities. Special Authorization forms are available from ClaimSecure. You are responsible for any charges for completion of forms.

How to Claim

If you are using a direct payment system
Your group insurance plan includes access to a direct payment system for eligible prescription drug expenses, which means that your claim is sent electronically by your pharmacist directly to ClaimSecure, and the insured portion of your eligible prescription drug expenses is automatically reimbursed.

Present your oneCard™ to your pharmacist when purchasing prescribed medications, and you pay only the non-insured portion of the expenses. ClaimSecure pays the insured portion directly to your pharmacist.

You do not need to show your card each time you visit your local pharmacy, as the pharmacist's computer system records your card information the first time you present your card. However, if you change group insurance plan (if you change jobs, for example) or go to a different pharmacy, you will have to show your card.

If you do not show your oneCard™ to your pharmacist or if your pharmacist suggests you send your claim, you must complete a health insurance claim form and send it to ClaimSecure along with the original receipts or paid invoices.

If you are not using a direct payment system
You must complete a health insurance benefit form and send it to ClaimSecure along with the original receipts or paid invoices.

Exclusions

The following treatment, services, products or articles are not covered, regardless of whether or not they are considered medical drugs, unless they are specifically included in the list of covered prescription drugs in the Schedule of Benefits:

a) Products used for aesthetic, cosmetic or personal hygiene purposes;
b) Substances or drugs used or administered for preventive purposes,
c) Experimental drugs or those obtained under the federal Emergency Drug Release Program;
d) Drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital;
e) In the case of a medical drug injected by a health care professional in a private clinic, only the cost of the substance injected is covered, not the medical procedure;
f) The cost of services payable by an insured as a contribution to a public prescription drug insurance plan, which may consist of a premium, a deductible amount or a coinsurance payment;
g) Homeopathic or natural products;
h) Sunscreens; However, sunscreens meeting the conditions provided for under this clause that are necessary for individuals 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 provided to ClaimSecure;

i) Proteins, dietary supplements or amino acids, unless such products can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe them and are required to be dispensed by a pharmacist;
j) Growth hormones; However, growth hormones prescribed for the 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 to ClaimSecure;
k) Anabolic steroids;
l) Drugs used for the treatment of infertility, artificial insemination or in vitro fertilization;
m) Smoking cessation products;
n) Drugs used to treat erectile dysfunction (Viagra and other similar drugs);
o) Anti-obesity drugs, vitamin injections administered for the purpose of weight loss;
p) Alcohol swabs/pads for the treatment of diabetes.

For residents of Quebec, under no circumstances may the exclusions, limitation and restrictions that apply to the prescription drug coverage of this plan render the plan less generous than the Basic Prescription Drug Insurance Plan (BPDIP) of the Régie de l'assurance maladie du Québec (RAMQ).

Extended Health Care – Health Care Practitioners

Expenses Covered

If Health Care Practitioners coverage is listed as a covered expense in the Schedule of Benefits, your Extended Health Care benefit covers expenses incurred for treatment, services or supplies obtained from the health care practitioners specified in the Schedule of Benefits.

Only one treatment by the same practitioner is covered per day, per insured, regardless of the number of fields of specialization the professional is licensed to practice in.

Expenses paid are eligible for reimbursement, provided the health care practitioner is a member of a professional order governing the practice of the practitioner's activities and/or use of the professional title. In the absence of such an order, the health care practitioner must be a member of a professional association recognized by ClaimSecure.

For expenses paid to be eligible for reimbursement, the health care practitioner must not reside with the insured, nor be a relative.

How to Claim

To obtain reimbursement for services or supplies received from one of the health care professionals listed under the Schedule of Benefits. Expenses covered above, you must provide an original receipt or paid invoice.

The receipt or paid invoice must include the following information:

a) The health care professional's name, the association or professional order, and the professional's membership number;
b) The date when treatment or services were obtained or products or articles were purchased;
c) The cost of the treatment, services, products or articles;
d) The name of the insured for whom treatment, services, products or articles were obtained.

To file a claim for expenses related to the treatment or supplies, you must complete a health claim form and send to ClaimSecure for processing. Send the receipt or paid invoice issued by the health care professional who administered the treatment or provided the supplies along with the completed claim stub.

Treatment or supplies requiring a prescription
When filing a claim for treatments or supplies requiring a prescription, you must provide the physician's prescription and the original receipt or paid invoice with your claim.

Exclusions and Limitations

If Chiropractor X-rays are included in the list of Health Care Practitioners in the Schedule of Benefits, they are limited to those taken by a chiropractor to determine the necessity for corrections to the spinal column, pelvic bones or other articulations of the body.

If the treatment or services of a Naturopath are included in the list of Health Care Practitioners in the Schedule of Benefits, such treatment or services are limited to the fees for a consultation to obtain dietary advice, a health assessment or establish a diet based on natural products. Natural products, massages, baths, posturology, physical exercises or other products or services are not covered

Extended Health Care – Vision Care

Expenses Covered

If Vision Care coverage is listed as a covered expense in the Schedule of Benefits, your Extended Health Care benefit covers expenses paid for the following eye care services:

Eyeglasses
Purchase of glasses for correction of vision prescribed by an optometrist or ophthalmologist. Prescription safety glasses, prescription sunglasses or prescription safety goggles are also covered.

Contact lenses
Purchase of contact lenses for correction of vision prescribed by an optometrist or ophthalmologist.

Laser vision correction
Expenses for laser eye surgery to correct myopia, hypermetropia or astigmatism, when recommended by an ophthalmologist.

How to Claim

To be eligible for reimbursement, you must provide an original receipt or paid invoice for the treatment, services, products or articles obtained from an optometrist or ophthalmologist.

The receipt or paid invoice must include the following information:

a) The name and professional membership number of the optometrist or ophthalmologist;
b) The date when treatment or services were obtained or products or articles were purchased;
c) The cost of the treatment, services, products or articles;
d) The name of the insured for whom treatment, services, products or articles were obtained.

To file a claim, you must complete a health insurance claim form and send it to ClaimSecure along with the original receipts or paid invoices issued by the optometrist or the ophthalmologist who provided the treatment, services, products or articles.

Exclusions

The following products are not covered under Vision Care:

a) Non-prescription sunglasses;
b) Refractions required by a client, government body or other third party;
c) Intraocular lens implants, except after cataract surgery.

Extended Health Care – Other Medical Expenses

Expenses Covered

Expenses for medical equipment or supplies must be submitted to your provincial health plan first for their consideration as first payor. Any remaining balance may be eligible under this plan up to the maximum specified in the Schedule of Benefits. Equipment or supplies normally eligible through your provincial health plan that are deemed not eligible due to lack of medical necessity are not eligible under this plan. Equipment or supplies not eligible under your provincial health plan may be eligible under this plan.

Ambulance
Reasonable and customary charges for emergency transportation to the nearest hospital by a licensed ground ambulance service. In addition, when the circumstances dictate (as pre-approved by ClaimSecure), coverage may be considered for transportation by air or rail or water.

Artificial Eye
The cost of purchasing an artificial eye provided the insured is covered under this clause at the onset of the disability causing the loss of the eye. The cost of repair and replacement of the artificial eye is also covered. Eligible expenses are subject to a replacement period of once every 60 months.

Artificial Limbs
The cost of purchasing an artificial limb, including myoelectric and electric artificial prostheses, provided the insured is covered under this clause at the onset of the disability causing the loss of the natural limb. The cost of repair and replacement of the artificial limb is also covered.

Blood glucose monitor
Device used to measure blood sugar levels.

Breathing equipment
Rental, or purchase, whichever is more economical, of:

- Mist tents and nebulizers. Eligible expenses are subject to a replacement period of once every 60 months;
- Oxygen and the equipment needed for its administrations. Eligible expenses are subject to a replacement period of once every 60 months;
- Continuous positive airway pressure machine (CPAP & APAP). Eligible expenses are subject to a replacement period of once every 60 months;
- CPAP Supplies (Mask, Tubing, Battery Pack, Filters, Wipes for Mask and Nose Pillows). APAP supplies are excluded. Eligible expenses are subject to a replacement period of once every30 days;
- Bi-level Positive Airway Pressure Machine (Bi-PAP) - Maximum benefit of one (1) per lifetime per covered person. Supplies are excluded.
- Intermittent positive pressure breathing machine (IPPB) - Maximum benefit of one (1) per lifetime per covered person. Supplies are excluded.
- Apnea monitors for respiratory dysrhythmias. Eligible expenses are subject to a replacement period of once every 60 months;
- Tracheostoma tubes. Eligible expenses are subject to a replacement period of once every 60 months;
- Aerochambers for children under age seven. Eligible expenses are subject to a replacement period of once every 60 months;

Colostomy and ileostomy supplies
Colostomy and ileostomy supplies prescribed by a physician, in excess of the amount reimbursed by the government.

Custom-made burn garments
The purchase of custom-made burn garments when prescribed by a physician. Eligible expenses are subject to a replacement period of once every 60 months.

Custom-made pressure supports for lymphedema
The purchase of custom-made pressure supports when prescribed by a physician for treatment of lymphedema only. Eligible expenses are subject to a replacement period of once every 60 months.

Dental treatment following accidental injury to natural teeth
Professional fees of a dentist for treatment of damage to healthy, natural teeth sustained as the result of an accident.

For the purposes of this clause, a tooth is deemed to be healthy if it is not afflicted with any pathology, either in itself or the adjacent structures. A tooth that has been treated or restored to normal function is considered to be healthy.

These expenses are only covered if the following conditions are met:

- The insured was covered under this benefit at the time the accident occurred;
- Treatment is administered by a licensed dentist or denturist;
- Treatment or services are received within the 12 months following the date the accident occurred, provided you are still covered under this benefit.

Limitations
Expenses will be covered up to the amount specified in the official general practitioners' fee guide approved by your provincial dental association for the year during which treatment or services are received.

Exclusions
Any treatment, procedures, or prostheses related to dental implants are excluded. Damage to teeth occurring while eating, regardless of the nature or cause of such damage, is not covered.

Preapproval recommendation
Before incurring any expenses for this product or care, prior approval is required. Please forward all relevant medical information obtained from your attending medical physician to ClaimSecure for assessment.

External breast prosthesis
The cost of purchasing an external breast prosthesis is covered provided the loss is the result of a total or radical mastectomy.

Eye examination
Eye examination by an optometrist or ophthalmologist.

Foot orthotics
Foot orthotics may be obtained on the written recommendation of a Physician (MD), Podiatrist (DPM), Chiropodist (D CH or D Pod M) or Chiropractor, accompanied by a diagnosis of the conditions and symptoms and a gait analysis/biomechanical exam. The orthoses must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (CPed(c) or CPed(MC)), Podiatrist (DPM), Chiropodist (D CH or D Pod M), Chiropractor or Orthésistes du Pied (member of CCCOP). The dispenser must be a different provider than the prescriber.

A description of how the orthotic was constructed 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.

Head halters
Purchase of head halters when prescribed by a physician. Eligible expenses are subject to a replacement period of once every 60 months.

Hearing aids
Purchase, adjustment, replacement or repair of a hearing aid. Batteries and ear moulds are included.

Hospital bed
Rental or purchase, whichever is most economical, of a hospital bed of the type normally used in a hospital centre. Bed rails and electric hospital beds are also covered. Eligible expenses are subject to a replacement period of once every 60 months.

Insulin infusion sets and reservoir sets
Purchase of insulin infusion sets and reservoir sets.

Insulin infusion pumps
Purchase of insulin infusion pumps. Eligible expenses are subject to a replacement period of once every 60 months.

Laboratory analyses and x-rays
Analyses of tissues and body fluids (e.g. blood, urine) of the same type as those available in a hospital, administered in a private laboratory for purposes of prevention or diagnosis and x-rays taken outside a hospital centre in a private clinic for the purpose of prevention or diagnosis.

Exclusion
Magnetic resonance and computed axial tomography (CAT) are excluded from this coverage.

Mobility aids
Rental or purchase, whichever is most economical, of a scooter, standard wheelchair or an electric wheelchair if medically necessary. Purchase and rental for crutches, canes and walkers are subject to a replacement period of once every 60 months.

Wheelchair and scooter repairs are considered eligible expenses as are supplies such as cushions, foot rests, foot plates, head rests, tires, parts and labour when under repair and when there is a need to replace.

Replacement of cane tips is considered an eligible expense subject to a replacement period of once every 60 months.

Preapproval recommendation
Before incurring any expenses for wheelchairs or walkers, prior approval is required. Please forward all relevant medical information obtained from your attending medical physician to ClaimSecure for assessment.

Nurse
Continuous and exclusive care provided to the insured, at home, by a registered nurse (RN), registered practical nurse (RPN) or licensed practical nurse (LPN), or Registered Nursing Assistant (RNA) who is not a relative of the insured. To be eligible for reimbursement, expenses must be incurred for care that requires the specific skills of one of the aforementioned nurses.

Preapproval recommendation
Before incurring any expenses for this product or care, prior approval is required. Please forward all relevant medical information obtained from your attending medical physician to ClaimSecure for assessment.

Orthopaedic apparatus
Purchase, adjustment, rental, replacement or repair of corsets, splints, casts, trusses, collars, leg orthoses or braces (other than foot braces). Eligible expenses are subject to a replacement period of once every 60 months.

For any other orthopaedic apparatus necessary to perform basic daily activities, expenses may be considered eligible for reimbursement up to an amount deemed reasonable by ClaimSecure.

Exclusion
Orthopaedic shoes and foot orthotics are not covered under Orthopaedic Apparatus. Intra-oral splints are not covered.

Orthopaedic shoes
Purchase or repair of custom-made orthopaedic shoes.

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

A description of how the orthopaedic shoe was constructed 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.

Off-the-shelf orthopaedic shoes and orthopaedic modifications to regular shoes
Orthopaedic shoe(s) or the permanent modification of a regular shoe on the written recommendation of a Physician (MD), Podiatrist (DPM) or Chiropodist (D CH or D Pod M), accompanied by a diagnosis of the conditions and symptoms and a gait analysis/biomechanical exam. The orthopaedic shoes must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (CPed(c) or CPed (MC)), Podiatrist (DPM), Chiropodist (D CH or D Pod M) or Orthésistes du Pied (member of CCCOP). The dispenser must be a different provider than the prescriber. Modifications may include sole build-ups, lifts, wedges, steel plates, stirrups to accommodate braces and self-adhesive closures.

A description of the modifications made to the shoes including a breakdown of the costs and the brand name of the shoe must accompany the claim. The name and license number of the dispenser must also be provided.

Exclusion
Off-the-shelf shoes purchased only to accommodate orthotics or as comfortable walking shoes, including but not limited to Birkenstocks, Nike, Brooks, Rockport, are not covered. Sandals are also not covered.

Sclerosing agents
Purchase of sclerosing agents. The professional fees charged by the physician are not considered to be expenses for sclerosing agents.

Special vision benefit after cataract surgery
An initial pair of frames and 1 corrective lens, contact lens, prosthetic lens or intraocular lens after cataract surgery.

Stump socks and shoulder harnesses
The cost of purchasing stump socks and shoulder harnesses are covered. Eligible expenses are subject to a replacement period of once every 60 months.

Support hose
Purchase of graduated compression stockings, 20mmHG or more, from a pharmacy or medical facility for the treatment of a venous or lymphatic system deficiency.

Surgical brassiere
Purchase of a brassiere to support an external breast prosthesis worn by mastectomy patients.

Traction apparatus
Purchase of traction apparatus when prescribed by a physician. Eligible expenses are subject to a replacement period of once every 60 months.

Transcutaneous electrical nerve stimulator
Purchase, rental, adjustment, replacement or repair of a transcutaneous electrical nerve stimulator. Eligible expenses are subject to a replacement period of once every 60 months.

Trapeze bars
Purchase of trapeze bars when prescribed by a physician. Eligible expenses are subject to a replacement period of once every 60 months.

Urethral catheters
Purchase of urethral catheters when prescribed by a physician.

Wig following chemotherapy
Purchase of a wig (capillary prosthesis) or hair piece necessary as a result of chemotherapy.

How to Claim

When filing a claim for expenses paid for the services or supplies listed above, you must submit original copies of receipts or paid invoices.

Receipts and invoices must include the following information:

a) The health care professional's name, association or professional order, and the professional's membership number, or the name and address of the supplier from whom products or articles were purchased;
b) The date when treatment or services were received or products or articles were purchased;
c) The cost of the treatment, services, products or articles;
d) The name of the insured for whom the treatment, services, products or articles were obtained.

To file a claim for expenses related to the treatment or supplies, you must complete a health claim form and send to ClaimSecure for processing. Send the receipt or paid invoice issued by the health care professional who administered the treatment or provided the supplies along with the completed claim form.

Treatment, services, products or articles requiring a prescription
When filing a claim for treatments or supplies requiring a prescription, you must provide the physician's prescription and the original receipt or paid invoice with your claim.

Extended Health Care – Out-of-Province Medical Referral

You are insured under this coverage only if Out-of-Province Medical Referral is listed as a covered expense in the Schedule of Benefits.

For insureds covered by the health and hospitalization insurance plan of their province of residence, expenses incurred outside the province of residence for the following treatment, services, products and articles are covered, provided that such expenses are pre-approved by the insured's provincial health and hospitalization insurance plan and by SSQ:

- hospitalization in a hospital where the insured receives curative treatment;
- professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care;
- transportation and accommodation expenses paid by the insured;
- expenses incurred for medications, x-rays and laboratory analysis.

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

Before incurring any expenses for this product or care, prior approval is required. Please forward all relevant medical information obtained from your attending medical physician to ClaimSecure for assessment.

Extended Health Care – Travel Insurance and Assistance (Out of Province Emergency)

You are insured under this coverage only if Travel Insurance and Assistance (Out of Province Emergency) is listed as “Included” in the Schedule of Benefits.

> For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, contact SSQ’s travel assistance service at one of the numbers below:
>
> From Canada or the United States: 1 866-438-5498
>
> From elsewhere in the world: (418) 651-2266 (collect call)
>
> You must provide the Policy Number specified on your Card when calling.

Definitions

As used in this benefit:

Close relative
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Family member
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

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

Expenses covered

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

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

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

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

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

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

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

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

- Their health condition is good, and stable. The insured's state of health is considered unstable, and its effects are not considered to be those of a sudden and unexpected illness, in the following cases:
  - Symptoms worsen;
  - A relapse is suffered;
  - The disease or illness is in its terminal phase;
  - The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip;
- They are able to carry out usual daily activities;
- They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the trip outside the province of residence.

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

Hospitalization
Hospitalization expenses incurred due to treatment in a hospital.

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

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

Chiropractor, podiatrist or physiotherapist fees
Professional fees of a chiropractor, podiatrist or physiotherapist.

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

Prescription drugs
Expenses for the purchase of drugs available only on prescription from a Health Care Provider legally authorized to do so.

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

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

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

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

- Transportation: $2,500 per trip for all insured family members;
- Accommodation and meals: $300 per day for all insured family members, up to a maximum of $2,400 per trip.

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

Transportation of the insured's body if deceased
The expenses of preparing and returning the remains of the insured by the most direct route home, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of $10,000 for preparation of the body and transportation.

Return of vehicle
The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per trip.

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

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

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

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

The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of $300 per day, or $2,400 per trip abroad, for all individuals covered.

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

The following services are available:

a) Directing the insured to an appropriate clinic or hospital;

b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front;

c) Ensuring the proper follow-up of the insured's medical file;

d) Coordinating the return and transport of the insured as soon as medically possible;

e) Providing emergency support and coordinating settlement applications;

f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured;

g) Arranging for the return of insured persons to their home (return expenses not included);

h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident;

i) Communicating with the insured's family or employer;

j) Acting as an interpreter for emergency calls;

k) Recommending a lawyer in the event of legal difficulties.

Exclusions, limitations and restrictions

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

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

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

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

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

d) Expenses payable under any public plan;

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

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

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

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

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

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

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

How to Claim

In the event of an emergency that occurs during an insured's stay outside the province of residence, all travel assistance services, and reimbursement for most expenses eligible under Travel Insurance, will be coordinated by SSQ's travel assistance service, provided the insured contacts one of its representatives.

When the insured returns home, SSQ's travel assistance service will send you:

- The documents you need to file your claim. Originals of all receipts and paid invoices for eligible expenses paid should be enclosed with your claim
- A form for you to sign, authorizing SSQ's travel assistance service to obtain reimbursement on your behalf for expenses eligible under your provincial health and hospitalization plan

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

From Canada or the United States: 1 866-438-5498

From elsewhere in the world: (418) 651-2266 (collect call)

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

Extended Health Care – Travel Cancellation Insurance

You are insured under this coverage only if Travel Cancellation Insurance is listed as “Included” in the Schedule of Benefits.

Definitions

As used in this benefit:

Business Partner
An individual with whom the insured is associated for business purposes as part of a corporation comprised of 4 shareholders or fewer, or a commercial or non-commercial corporation comprised of 4 partners or fewer.

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

Family Member
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

Host at Destination
An individual at whose principal residence the insured is planning to stay for at least part of the trip.

Prepaid Travel Expenses
Refers to the following:

- Expenses incurred by the insured to purchase a package trip, including tickets from a public carrier, rental of motor vehicles from an accredited firm and hotel room reservations;
- Amounts paid by the insured for travel arrangements usually included in a package trip;
- Amounts paid by the insured in relation to registration fees for a commercial activity.

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

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

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

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

Reasons for cancellation

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

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

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

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

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

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

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

g) Death or emergency hospitalization of the host at destination;

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

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

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

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

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

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

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

o) Weather conditions such that:

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

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

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

Expenses covered

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

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

In the event of cancellation prior to departure
In the event of cancellation prior to departure, the insured must notify the travel agent or carrier, as well as SSQ, at the latest 48 hours following the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable portion of prepaid travel expenses;

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

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

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

If the return is earlier or later than planned

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

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

Restriction
If the insured's return is delayed by more than 7 days, the expenses incurred are eligible, provided the insured or the insured's travel companion was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

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

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

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

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

Exclusions, limitations and restrictions

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

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

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

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

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

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

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

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

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

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

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

How to Claim

To file a claim, contact SSQ's travel assistance service at one of the numbers below:

From Canada or the United States: 1 866-438-5498

From elsewhere in the world: (418) 651-2266 (collect call)

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

Insureds must include the following supporting documents with their claim:

a) Unused travel tickets;
b) Official receipts for additional transportation expenses;
c) Receipts for travel arrangements. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation;
d) Written proof that you have requested a reimbursement of travel expenses from the travel agent or accredited firm, along with the reply you receive from the travel agent or accredited firm;

e) Official documents certifying the reason for cancellation. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip;

f) An official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure;

g) An official report pertaining to weather conditions;

h) Written proof issued by the official organizer of a commercial activity to the effect that an event is cancelled and the specific reasons why;

i) Any other report required by SSQ in support of the insured's claim.

Diagnosis +

You are insured under this coverage only if Diagnosis+ is listed as “Included” in the Schedule of Benefits.

Eligible Medical Conditions

This coverage applies to any Insured Person under age 65 who, at the time of request for Diagnosis+, is insured under the Extended Health Care Benefit or Long Term Disability benefit (whichever benefit shows the coverage as “Included”). Diagnosis + allows a person who is afflicted with one of the eligible medical conditions specified below to obtain a medical second opinion.

For medical conditions to be considered eligible, it must have been diagnosed previously and may be degenerative neurological disease, a severe affliction, or any other conditions seriously endangering life, including the following:

- AIDS
- Alzheimer’s disease
- Blindness
- Cancer
- Cardiovascular Disease
- Coma
- Deafness
- Heart Attack
- Kidney Failure
- Loss of language or vocal capacity
- Major bone and lung illnesses
- Major Burn
- Major Trauma
- Medical condition giving rise to possible amputation
- Motor neuron disease
- Multiple sclerosis
- Parkinson’s Disease
- Stroke and consequential conditions
- Vital organ transplant

Medical Second opinion

When an insured diagnosed with an eligible medical condition requests a medical second opinion from the service provider, a team of medical specialist reviews the medical file to determine the accuracy of the initial diagnosis and recommend the most appropriate treatment plan. This file revision is performed in cooperation with the insured’s attending physician.

Any costs related to file transfers or fees that may be charged by the attending physician are to be assumed by the insured.

Request for a medical second opinion

To request a medical second opinion, the insured must first contact the Diagnosis + provider at the telephone number indicated in the benefit brochure or the insurance booklet.

Availability of Services

Availability of Diagnosis + services is subject to continuation of an agreement between SSQ and the service provider, and the service provider’s capacity to offer such services.

Dental Care

Definitions

As used in this benefit:

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

ClaimSecure
The adjudicator of the Health and Dental Care benefits of this plan.

Deductible
The deductible is the amount you must assume before any expenses covered under a given benefit are reimbursed.

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

Reasonable and Customary Expenses
The costs incurred for eligible, covered medical services or supplies that do not exceed the standard costs of other providers of similar standing in the same geographic area, for the same treatment of a similar illness or injury.

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

Scope of coverage

Expenses for treatment, services, products or articles specified in the following sections are eligible for reimbursement by ClaimSecure in accordance with the provisions specified in the Schedule of Benefits, provided such treatment, services, products or articles have been paid for and are:

- Obtained while you are covered under this Dental Care benefit;
- Provided by an accredited dentist, dental specialist, denturist or dental hygienist, who neither resides with the insured, nor is a relative;
- Administered in compliance with current dental practice standards;
- Used in compliance with the manufacturer's instructions, or, where no such instructions exist, in accordance with government-approved directives.

Reimbursement of Covered Expenses

The amounts eligible for reimbursement are specified in the general practitioners' or specialists, if covered, fee guide approved by your provincial dental association.

Eligible laboratory expenses are limited to 60% of the fees specified for the dental treatment or service in question.

The amount of covered expenses reimbursed takes into account the deductible, coinsurance and maximums specified in the Schedule of Benefits

Expenses covered

Basic dental care

Diagnostic services

Clinical oral examination

- Recall or periodic oral examination: see Schedule of Benefits for frequency limits
- Complete oral examination: see Schedule of Benefits for frequency limits
- Complete periodontal examination: see Schedule of Benefits for frequency limits
- Emergency examination: 2 examinations per 12 months
- Specific oral examination: 2 examinations per 12 months

Radiographs (X-rays)

a) Intraoral films
- Periapical film
- Occlusal film
- Bitewing film: 1 per period of 12 months
- Complete series: 1 per period of 24 months

b) Extraoral films
- Extraoral film
- Sinus examination
- Sialography
- Use of radiopaque dyes to demonstrate lesions
- Temporomandibular joint
- Panoramic film: one film per period of 24 months
- Cephalometric film

c) Other
- Interpretation of radiographs from another source: one film per calendar year
- Duplicate radiograph: 2 times per calendar year

Laboratory tests and examinations

- Histological tests: Biopsy of soft tissue, biopsy of hard tissue
- Bacteriological tests
- Diagnostic casts (excluded if associated with restorative treatment or prosthodontics)
- Case presentation / treatment plan
- Consultation with patient
- Vitality test

Preventive services

Preventive Services

- Polishing of coronal portion of teeth: see Schedule of Benefits for frequency limits
- Scaling and root planing: see Schedule of Benefits for frequency limits
- Topical application of fluoride Plaque control program: 5 times per calendar year
- Finishing restorations
- Pit and fissure sealants, including prophylactic odontotomy and acid etch preparation **(**only on occlusal surfaces of premolar and permanent molar teeth): once per period of 36 months per tooth
- Removal of subgingival filling material requiring anaesthesia, without flap
- Interproximal discing
- Enameloplasty (recontouring of natural tooth for non-aesthetic reasons)
- Oral hygiene instruction: once per lifetime

Space maintainers for children under age 18

Routine dental care

Minor Restorative Services

- Sedative filling
- Smoothing of traumatized tooth
- Amalgam and composite restorations*
- Retentive pins
- Prefabricated restoration (Prefabricated crowns) for primary teeth only

* Treatment for the same surface or class of the same tooth is reimbursed once per period of 12 months, regardless of the material used and the treating dentist.

Endodontics

- Endodontic emergency: pulpotomy, pulpectomy, open and drain
- Endodontic trauma, treatment and surgery
- Apexification

Retreatment of previously completed root canal therapy is reimbursed if more than 36 months has elapsed since previous root canal therapy.

Periodontics

- Non-surgical treatment
- Periodontal surgery
- Gingival curettage
- Splinting
- Periodontal irrigation
- Periodontal appliances: 2 appliances combined per period of 60 months. Maintenance and repairs are excluded.
- Occlusal equilibration: 8 units of time per calendar year

Rebase (jump), reline, adjustment and repair of removable dentures

- Rebase, reline: one per visit per period of 24 months
- Repairs with or without impression
- Remount and equilibration of complete or partial dentures: one visit per period of 60 months

Repair of fixed bridges and crowns

- Repair of fixed bridges
- Repair of crowns
- Recementation, Immobilization, sectioning

Oral surgery

- Removal of erupted teeth, complex or uncomplicated
- Removal of impacted teeth, roots and tooth fragments
- Alveolectomy, alveoloplasty, osteoplasty, tuberoplasty, stomatoplasty, gingivoplasty
- Removal of hyperplasic tissue or excess mucosa, surgical excision of cysts or tumours
- Extension of mucosal folds
- Surgical incision and drainage
- Reduction of fracture
- Frenectomy
- Treatment of salivary glands
- Sinus treatment or surgery
- Hemorrhage control
- Post-surgical treatment
- Repair of soft tissue or through & through laceration

Additional services

- Local anaesthesia
- General anaesthesia (anaesthetic cost only)
- Conscious sedation
- Deep sedation
- Therapeutic injections
- Home, hospital or dental office visit outside normal office hours

Dental restorative services

Major restorative services and fixed prosthodontics (see gold foil, inlay and replacement denture limitation)

- Gold foil
- Inlays and retentive pins
- Metal cast retainer, Maryland type: once per period of 60 months for any one tooth
- Individual crown
- Coping crown (cap), precious metal or not
- Cast metal posts
- Prefabricated post
- Tooth reconstruction (core build up) in preparation for crown
- Supplement for restoration
- Post removal

Removable dentures (see limitation on replacement dentures)

- Complete dentures*
- Partial dentures*

* Equilibrated dentures are reimbursed on the basis of the equivalent standard dentures.

Fixed bridges (see limitation on replacement dentures)

- Pontics
- Butterfly bridge (Maryland, Rochette or other)
- Metal cast retainer (inlay) for Monarch bridge
- Retention bar for attachment to coping crowns
- Abutments, inlays or onlays: metal, porcelain, ceramic or resin
- Other prosthetic services: precision attachment
- Retentive pin for crowns and/or abutments
- Supplement for preparation of crown under existing partial denture clasp

Orthodontics

A specific treatment plan established by the dentist or orthodontist is required for the treatments listed below. The treatment plan must include details about the total estimated cost and duration of treatment. A maximum amount of **25%** of the total treatment cost shall be eligible for the initial reimbursement. ClaimSecure will determine the amount of subsequent reimbursements and spread these out over the duration of treatment, provided your insurance remains in force. No advance payments will be made.

- Specific orthodontic examination: once per period of 12 months
- Complete orthodontic examination
- Surgical exposure of tooth, including orthodontic attachment
- Transplantation of tooth
- Surgical repositioning of tooth
- Enucleation of an unerupted tooth and follicle
- Corrective orthodontics
- Repairs, alterations, recementation
- Retention appliances
- Orthodontic treatment
- Radiograph: hand and wrist (as diagnostic aid for dental treatment)
- Complete treatment of dental malocclusion

Limitations

a) The claims adjudicator will determine the benefits payable taking into account possible alternate procedures, services or courses or treatment based on accepted dental practice.

Payment will not be made for any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

b) All insureds are considered as being eligible for the public health insurance plan of their province of residence. If this is not the case, ClaimSecure shall not pay any amount greater than that payable if the insured were eligible for coverage under the public health insurance plan of the province of residence.

c) Where the general practitioners' fee guide approved by the dental association of the province mentioned in the Schedule of Benefits uses the word sextant or quadrant in the description of a treatment, the code or codes for services corresponding to such treatment are limited to 6 different sextants or 4 different quadrants, as the case may be, per calendar year, per insured.

d) Where the general practitioners' fee guide approved by the dental association of the province mentioned in the Schedule of Benefits stipulates a rate based on units of time for a treatment or service, the rate covering the maximum number of units of time for the treatment or service in question shall be eligible for reimbursement under the present contract. Any costs related to additional units are not covered under the present contract.

e) If Major Restorative Services is included in your Dental Care coverage, no benefits will be paid for gold foil, inlays or replacement dentures (individual crown, veneer (if covered), cast post, prefabricated post, removable dentures, fixed bridge) if installed within 60 months of the previous one. However, expenses for partial or complete permanent removable dentures are eligible for reimbursement when such replacement is carried out within 12 months of the date the transitional dentures were installed (only when waiting for completion of the healing process.

Preapproval of Treatment Costs

When expenses exceed five hundred dollars ($500), particularly in the case of major restorative services, a detailed written treatment plan and radiographs must be submitted to ClaimSecure prior to the start of treatment. This allows ClaimSecure to determine the eligibility of treatment and the amount of benefits payable.

Certain expenses are only eligible for reimbursement if pre-approved by ClaimSecure, following analysis of appropriate supporting documents, such as a copy of the patient's chart, radiograph(s), periodontal chart, diagnostic cast, etc.

How to claim

If your dentist uses electronic claim submission
When you, your spouse or children, if applicable, incur dental expenses, present your oneCard™ to your dentist and pay only the portion of the expenses not covered by your insurance. ClaimSecure will reimburse the insured portion of the expenses directly to your dentist.

If your dentist does not use electronic claim submission
You may file your claim by completing and returning to ClaimSecure the dental claim form provided by your dentist.

Multiple Coverage and Coordination of Benefits (COB)

Effect on benefits
If an insured is covered under this policy as an Employee and as a Dependent or as a Dependent of more than one Employee or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under this policy for allowable expenses shall be coordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual allowable expenses.

How the plans coordinate benefits
The plan that determines the benefits first (hereinafter referred to as "primary plan") will calculate its benefits as though duplicate coverage does not exist.

The plan that determines the benefits second (hereinafter referred to as "secondary plan") will limit its benefits to the lesser of:

- The amount that would have been payable had it determined the benefits first; and
- 100% of all allowable expenses reduced by all other benefits payable for the same expenses by the primary plan.

Order of benefit determination with another plan

1. If the other plan does not contain a provision for coordination of benefits with this policy, such plan will be deemed to be the primary plan.
2. If the other plan contains a Coordination of Benefits provision, determination of primary plan and secondary plan will be made on the following basis:
    a) With respect to an Insured who is covered as an Employee and as a Dependent under more than one plan, the plan which covers the Insured, other than as a Dependent, shall be deemed to be the primary plan;
    b) With respect to an Insured who is covered as an Employee under more than one plan, the determination of which plan is the primary plan will be made in the following plan order:
        i) The plan under which the Insured is covered as a full-time Employee;
        ii) The plan under which the Insured is covered as a part-time Employee;
        iii) The plan under which the Insured is covered as a retiree;
    c) With respect to an Insured who is covered as a Dependent under more than one plan and the two people of whom he is a Dependent are neither separated or divorced, the determination of which plan is the primary plan will be made on the following basis:
        i) The plan which covers the Insured as the Dependent of the person whose birthday comes first in the calendar year shall be considered the primary plan;
        ii) The plan, which covers the Insured as the Dependent of the person whose first name begins with the earlier letter in the alphabet, shall be considered the primary plan, in the situation where the two individuals of whom he is a Dependent have the same birth date;
    d) With respect to an Insured who is covered as a Dependent under more than one plan and the two people of whom he is a Dependent are either separated or divorced, the determination of which plan is the primary plan will be made in the following plan order:
        i) The plan of the person who has custody of the Insured;
        ii) The plan of the spouse of the person who has custody of the Insured;
        iii) The plan of the person who does not have custody of the Insured;
        iv) The plan of the spouse of the person who does not have custody of the Insured.
3. When clauses 1, and 2 do not serve to establish an order of benefit determination, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

Order of benefit determination within the same plan
The rules outlined under the Order of Benefit Determination with another Plan will be applied to ensure that the total benefits payable under the plan shall not exceed 100% of the actual allowable expenses.

Order of benefit determination in the case of a dental accident
If a benefit is payable due to allowable expenses incurred as a result of a dental accident, a supplementary health benefit which provides for dental accident coverage shall determine the benefits payable before a dental benefit.

Right to receive and release information
For the purposes of determining the applicability of and implementing the terms of this section of this policy or any provision of similar purpose of any other plan, the Provider may, with proper authorization, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Provider deems to be necessary for such purposes. Any person claiming benefits under this policy shall furnish to the Provider such information as may be necessary to implement this section.

Facility of payment
Whenever payments which should have been made under this policy in accordance with this section have been made under any other plans, the Provider shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this policy and, to the extent of such payments, the Provider shall be fully discharged from liability under this policy.

Right of recovery
Whenever payments have been made by the Provider with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Provider shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Provider shall determine: any person to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

Deadline for filing claims

ClaimSecure recommends that you file your claims at regular intervals, once every 3 months.

ClaimSecure must receive notice of any claim for a Dental Care benefit within 12 months of the date of the event which gives entitlement to the benefit.

However, if this policy should terminate, notice of claim must be received by ClaimSecure within 90 days of the date of termination of the policy.

Exclusions

This insurance does not cover any treatment, service, product or article related directly or indirectly, in whole or in part, to:

a) A criminal act the insured commits or attempts to commit;
b) Active participation in a riot or insurrection;
c) War or civil war, whether declared or not;
d) Active service in the armed forces of a country;
e) Attempted suicide;
f) Self-inflicted injuries, regardless of whether the insured is deemed to be sane or insane at the time.

Furthermore, no benefits will be paid for treatment, services, products or articles:

a) Required by a third party or received collectively;
b) Provided for aesthetic care, including transformation, extraction or replacement of healthy teeth to modify their appearance;
c) Used for experimental purposes or at the medical research stage;
d) Regarding implants and any implant-related treatment or prosthesis;
e) Regarding an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction and vertical dimension correction;

f) Regarding the replacement of removable appliances or dentures that are lost or stolen;
g) In relation to appointments not kept, filing claims, treatment plans, written reports, travelling expenses, correspondence expenses, legal identification, appearance in court as an expert witness or telephone consultations;
h) Regarding sports appliances, e.g. mouth guards;
i) That the insured would not have had to pay for if uninsured, that the insured is not obliged to pay for or that the insured would not be obliged to pay for 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;
j) Regarding a dental appliance for treatment of snoring or sleep apnea;
k) Regarding transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort;
l) Regarding transitional pontics or abutments;
m) Related to microbiological tests or analyses;
n) Regarding diagnostic photographs;
o) For services, supplies, examinations or treatments that do not comply with reasonable and customary standards of current practice in the dental / health care profession in question.

Survivor Benefit

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

- The end of a period of months immediately following your death as noted in the Schedule of Benefits;;
- The date when insurance for your spouse and children would have terminated, if your death had not occurred;
- The date when your spouse and children become eligible for similar coverage under another insurance contract;
- The date the contract terminates.

Employee & Family Assistance Program (EFAP)

The GroupHEALTH Benefit Solutions Employee & Family Assistance Program (EFAP) is a voluntary, confidential, Short Term counseling, advisory and information service for eligible employees and dependent family members of GroupHEALTH Benefit Solutions customers. The EFAP can help with personal problems that affect your family life, your work life, or your general well being. Dedicated professionals are available to provide you with assistance 24 hours a day.

What is LifeWorks®?

LifeWorks is the Ceridian Employee and Family Assistance Program (EFAP) integrated with Work-Life Services, and is available exclusively to eligible employees and their eligible dependents covered under GroupHEALTH Benefit Solutions benefit plans. It is a full-service, bilingual program that provides you and your immediate family with 24/7 access to the confidential support and resources you need to manage virtually any personal or professional issue, so you can lead a healthier, happier, more productive life. From face-to-face counselling to work-life balance and everyday issues, LifeWorks can help manage any issue, large or small.

Who provides the service?

The service is provided by Ceridian LifeWorks®, one of Canada's largest and most respected EFAP providers. Their staff consists of a diverse range of experienced professionals including psychologists, social workers, addictions and career counselors, childcare and elder specialists, legal and financial experts.

Why should I use the EFAP?

LifeWorks is designed to help you find the support, advice and resources you need – no question is too small, no issue is too big. In fact, if anything is troubling you or a member of your family, you should contact LifeWorks immediately. The program provides you with confidential counselling, personal support, referrals to community resources, Life Articles, booklets, DVD's, CD's, and LifeWorks Online – an informative Web site featuring thousands of online resources.

What kinds of problems or concerns can I get help with?

LifeWorks can help with a wide range of issues, on-line or by phone, including:

Parenting and Child Care	Pregnancy and birth, adoption, child development, step or single-parenting, adolescents, discipline issues, child care options, infertility
Education	Homework issues, study habits, colleges and universities, special needs programs, scholarships, kindergarten to high school, selecting a school
Older Adults	Long-distance care giving, care options, healthcare information, meal and transportation programs, elder care, home care services
Midlife & Retirement	Growing as a couple, midlife health, relationships in midlife, life planning/priorities in midlife, work and careers
Financial and Legal Issues	Budgeting, debt management, investing, taxes, retirement planning, credit and collections, home buying and renting, divorce, living wills, criminal, attorney selection, family matters
Everyday Issues	House sitting, appliance/home repair, buying big ticket items, pet sitter/pet care, healthy lifestyle, community information, time saving services
Work Issues	Co-worker relationships, change in the workplace, business travel, career planning, communication skills
Health & Wellness	Stress and overload, exercise and fitness, diet and nutrition, prenatal health, living with an illness or disability, depression and anxiety, addiction and recovery, living with a disability
Emotional Well-Being	Balancing work and life, violence and crisis, relationship conflicts, first-time events, depression, stress, marital concerns, grief and loss, divorce

Be well… Do more… Find balance. Whether you have a simple question or a complex concern, LifeWorks is here to help you and your family – every day.

What can I expect?

Your call will be answered by a professional Intake Counselor who will ask for some basic information, discuss your concerns, and match you to a Ceridian LifeWorks counselor in your community and/or a LifeWorks Specialist. This counselor will then contact you to arrange an appointment at a mutually convenient time.

How quickly can I expect to get a face-to-face appointment with a counselor?

In emergency situations, appointments will be arranged the same day. Appointments will be offered within three business days for non-emergencies.

What happens during a face-to-face counselling session?

When you attend a face-to-face counselling session, the counselor will:

- Establish an environment that makes you feel comfortable discussing problems and concerns
- Listen and ask questions in order to clearly understand the problem
- Explore the expectations that you have to resolve this problem
- Work with you to identify options and choices
- Develop strategies to reduce or resolve the problem

The counselor will also give some objective feedback and provide problem solving and support when needed. Together, you and the counselor will establish a helpful and effective action plan.

What qualifications do the counselors have?

The fully qualified, professional counselors have been carefully screened and credentialed by Ceridian, and only those with extensive experience are selected. Many of the counselors have PhDs, and MDs; minimally, they are required to have a Master's Degree in one of the following fields: Psychology, Social Work or Educational Counselling.

How many counselling sessions are available to me?

Shorter term, solution-focused counselling is provided. The service can be accessed for each problem or issue that you are experiencing. The number of sessions varies and is determined on a case-by-case basis. Where the problem may be longer term or ongoing in nature, the counselor will discuss the appropriateness of a referral to a community resource and will work with you to access such a resource.

If you are in a state of crisis, Ceridian will offer the necessary support to stabilize the situation regardless of whether your issues are shorter term, longer term or ongoing.

How much will it cost?

There is no charge to eligible individuals who use the program. This is a fully paid benefit included in your employer's group benefit plan.

If longer term or more specialized counselling is required, your counselor will assist you with a referral to an affordable community resource. You would at that time be responsible for any fees that your employer's benefit plan or provincial health insurance does not cover.

Is the EFAP confidential?

YES! Information is not given to or shared with anyone without the informed, voluntary and written consent of the individual. Unless you tell them, no one at your workplace will know if you have used the EFAP.

What kind of information about the use of the program is provided to my employer?

Employers never receive identifying information about individuals who have used the program. Only statistical and aggregate data is provided.

Is participation in the program mandatory?

No. Participation is voluntary.

In summary…

LifeWorks® offers you:

- Free service to you and your immediate family
- Confidential, personal support available in more than 140 languages
- In-person confidential counselling during the day, evening and on weekends, with no fixed limit on the number of counselling sessions
- English and French counselors 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
- An 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

How do I contact the EFAP?

To find out more about how LifeWorks can help – 24 hours a day, 7 days a week, 365 days a year – call to speak with a LifeWorks consultant or visit the LifeWorks Web site anytime.

Call a LifeWorks consultant: 1.866.331.6851

Visit the LifeWorks Web site: www.lifeworks.com

(refer to your wallet card for your User ID and Password)

Protector Series™ Optional Benefits

In this section you will find details regarding Protector Series™ Optional Benefits available to all employees (and their family members) insured under your benefit plans.

The following optional benefits are available to both you and your spouse:

Protector Series™ Optional Life Insurance
Protector Series™ Optional Critical Illness

It is not necessary for you to apply for coverage in order for your spouse to be eligible to apply.

Protector Series™ Optional Accident and Serious Illness
benefits are available in two plans:

Employee Only Plan (covers you only)
Family Plan (covers you, your spouse and your dependent children)

Premiums for all Protector Series™ optional benefits are outlined in separate brochures available from your Plan Administrator and are paid by you by way of payroll deduction.

Protector Series™ Optional Life Insurance

You may wish to apply for an additional amount of group life insurance for both you and your dependents by completing the application form provided by The Co-operators. If your applications are approved, coverage will take effect the first day of the next month. The Co-operators will be responsible for any medical fees incurred for information required in order to proceed with your application.

The amount of insurance shown below is available for your selection.

Classification	Amount of Optional Life Insurance
Each Employee and/or eligible Spouse	Units of $5,000 from a minimum of $10,000 to a maximum of $500,000.
Non-Evidence Maximum:	$ 50,000
Health Evidence Maximum:	$500,000
Dependent Child Benefit	Flat $5,000

Written application for any amount of insurance must be made on the forms provided by Co-operators Life and coverage shall not be effective until the first day of the month next following the date that Co-operators Life approves the application in writing.

Any amounts over the Non-Evidence Maximum are subject to approval by providing satisfactory health evidence of insurability. Co-operators Life will be responsible for the cost of medical fees incurred in obtaining any medical information that may be required in order to proceed with the application.

If you have ever been approved for an amount of Optional Life Insurance over the Non-Evidence Maximum you are not eligible to apply for any additional amount of insurance without providing health evidence of insurability. In addition if you have ever been declined for Optional Life Insurance you are not eligible for any amounts of insurance without providing health evidence of insurability.

Optional Life Insurance Conversion Privilege

Where your optional life insurance (and your spouse's optional life insurance if applicable) terminates before age 65, you (and/or your spouse) may obtain an individual policy with Co-operators Life without providing evidence of good health.

The individual Life Insurance policy is available in the following forms:

- a Permanent Traditional Plan,
- a Term to age 65 Plan, or
- a One Year non-renewable Term Plan.

At Co-operators Life's rates in effect at the date of conversion based on the class of risk applicable to you and/or your spouse and the new policy (determined by Co-operators Life's rules at the time of conversion) and you or your spouse's then attained age (nearest birthday).

At age 65, you (or your spouse, if your spouse has optional life insurance under this plan) may convert to a Permanent Traditional Plan allowed by Co-operators Group Insurance department for the purpose of conversion at that time at the rate class determined by Co-operators Life's then current rules.

The Individual Life Policy will not include any Total Disability Benefits or Accidental Death Benefits or any other special benefit.

Amount of Insurance
Where you or your spouse's insurance terminates and your employer's coverage under the master policy remains in force, the Amount of Insurance which you or your spouse may convert will be limited to the lesser of:

- $200,000, or
- the full amount of Optional Life Insurance at the time of termination less the full Amount of Insurance for which you (or your spouse) is eligible under a new group policy within 31 Days after termination of the insurance under this plan.

Premium
The premium for the Individual Life Insurance Policy will be based on the covered person's age (nearest birthday), sex, class of risk and on the type and amount of policy being issued at the time of conversion.

Termination of the master policy
If you or your spouse's insurance terminates due to termination of the master policy or termination of your employer's coverage under the master policy, the following will apply:

- the amount of insurance that may be converted will not exceed three times the year's Maximum Pensionable Earnings as established under the Canada Pension Plan, and
- the conversion right will be limited to persons who have been insured under the employer's group life policy for at least five continuous years, and
- the conversion privilege will apply only if the insurance is not being replaced within 31 days by another contract of group insurance or if the insurance is being replaced by an amount that is less than the amount for which you (or your spouse) is eligible under the first point above.

Application for conversion
The Individual Life Policy will be issued if a written application (including the required first premium) is completed and received by Co-operators Life at its Regina office within 31 Days from the date the insurance under the master policy terminates. The Individual Life Policy will become effective on the day following the expiration of the 31-day period.

Death during the Conversion Period
Where you (or your spouse, if your spouse has optional life insurance) have not converted insurance under this plan and where you (or your spouse, if insured) dies within the 31 days allowed for conversion, the total amount of Basic Life Insurance (and Optional Life Insurance if applicable) eligible for conversion, will be payable under this plan.

Subsequent Eligibility under the Master Policy
If you or your spouse obtains an Individual Policy through this provision and later becomes eligible for insurance under the master policy, the amount for which the person is eligible will be reduced by the amount of insurance remaining in force under the Individual Policy.

No Obligation to Advise
Co-operators Life is under no obligation to advise any person of their right to convert.

Limitations

No benefit shall be payable under this Provision where the cause of death is suicide occurring within 2 years from the date your Optional Life coverage became effective, and premiums will not be refunded.

In the event where you have been approved for an amount up to the Non-Evidence Maximum without providing health evidence of insurability, benefits will not be payable if you die due to Sickness within 12 months from the date your Optional Life coverage became effective, and premiums will be refunded.

In the event you have been approved for an amount up to the Non-Evidence Maximum without providing health evidence of insurability, benefits will not be payable and only premiums will be refunded under this Provision if you die within 12 months from the date your Optional Life coverage became effective unless the death is caused by an "Accident." Under this provision, "Accident" does **not** mean death which is caused by or results directly or indirectly from one or more of the following:

- self-inflicted Injury, while sane or insane, or
- committing, attempting or provoking an assault or criminal offense, or
- a situation where the Covered Loss results from Injuries sustained in, or directly or indirectly from, a Vehicle accident where the Employee was driving the Vehicle involved in the accident and had either:
  (a) alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred millilitres of blood; or
  (b) his or her capacity impaired as a result of drug or alcohol usage, or
- disease, or bodily or mental infirmity, or medical or surgical treatment of any kind, except surgical reattachment, or
- death where there is no visible contusion on the exterior of the body (except death by drowning), or
- any drug, poison, gas or fumes, voluntarily or otherwise taken administered, absorbed or inhaled, other than as a result of an accident arising from a hazard incident to the Employee's occupation, or
- insurrection or war (whether war be declared or not) or participation in any riot, or active service in the armed forces of any country, or
- travel or flight in any aircraft, or descent from such aircraft, if the Employee is a pilot or a member of the crew of the aircraft, or if such flight is made for the purpose of instruction, training or testing.

Termination Age

Optional group life insurance coverage terminates on the insured person's 70th birthday or when your dependent child is no longer eligible as a dependent.

When and How to Submit a Protector Series™ Optional Life Claim

The claim form must be submitted to Co-operators Life within **6 months** from the date of death.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than **12 months** after the date of death.

Protector Series™ Optional Accident & Serious Illness (ASI)

What Does It Cover?

Any accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

Who Is Eligible?

All Eligible Employees under the Termination Age, stated in the Schedule of Benefits, their Spouse and unmarried Dependent Children. Unmarried Children are those under age 21 or to age 25 if attending college or other school on a full-time basis and are dependent on your support.

Note: All Eligible Employees must be under the age of 65 to first enroll in this benefit.

Accidental Death, Dismemberment and Specific Loss Indemnity

The policy provides benefits for injury resulting in loss, **or permanent and total loss of use**, which occurs within **one year** after the date of the accident as follows:

	% of Principal Sum
Loss of Life	100%
Loss of Two Hands, Two Feet or Entire Sight of Both Eyes	100%
Loss of Speech and Hearing in Both Ears	100%
Loss of One Foot or One Hand and Entire Sight of One Eye	100%
Loss of One Hand and One Foot	100%
Loss of One Arm or One Leg	100%
Loss of One Hand, One Foot, the Entire Sight of One Eye, or Speech or Hearing	66 ⅔%
Loss of Four Fingers of Either Hand	33 ⅓%
Loss of Thumb and Index Finger of Either Hand	33 ⅓%
Loss of Hearing in One Ear	33 ⅓%
Loss of All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of both legs)	200%
Hemiplegia (total paralysis of one arm and leg on one side of body)	200%

“Injury” means bodily injury caused by an accident occurring while the policy is in force with respect to the Insured Person for whom a claim is presented and resulting in loss covered by the policy.

"Loss" as above used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; and as used with reference to hearing means the total and irrecoverable loss thereof.

Any indemnity payable for Loss of Use shall be paid only if such loss is permanent, total and irrecoverable and shall have been continuous for a period of twelve months from the date of the accident.

"Loss" as above used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Continuation of Coverage During Approved Leaves

Coverage under this policy may be continued for an Insured Person during any approved leave of absence, temporary lay-off, maternity leave or disability leave, provided payment of premium is continued.

Conversion Option

In the event of the termination of the insurance of an Insured Person for any reason, the Insured Person may, within 31 days following the date of such termination, make written application to the Company for an individual Accidental Death and Dismemberment policy not to exceed the amount of insurance in force or $400,000.00.

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while this policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, the Company will pay 10% of the Principal Sum up to a maximum of $40,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

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

Serious Illness Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Condition while the policy is in force and survives for 30 days following the Date of Diagnosis or such longer period, the Company will pay such Insured Person 10% of their Principal Sum to a maximum of $10,000.00, subject to all limitations and exclusions of the policy. If the Insured Person dies before the Serious Illness Benefit is paid, the Serious Illness Benefit will be paid to the estate of such Insured Person. Payment of the Serious Illness Benefit is limited to only the first Covered Condition to occur.

Covered Condition
Whenever used in this policy and for which a benefit is paid under the "Serious Illness Benefit" means Cancer, Heart Attack, Kidney Failure and Stroke.

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

90 Day Cancer Exclusion
The Cancer exclusion period is 90 days from the later of the effective date, or the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for cancer if a diagnosis of any type of cancer, whether included or excluded under this contract, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently result in an investigation leading to the diagnosis of cancer. In the event of any such diagnosis the coverage will remain in force but cancer will no longer be considered an Insured Condition, except for a subsequent diagnosis of an unrelated cancer.

Day Care Benefit

In the event accidental loss of life is sustained by an Insured Person the Company will pay the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of the Insured Person's Principal Sum or $5,000.00 for each year the Dependent Child described above is enrolled in a legally licensed Day Care Centre, but not to exceed four years which must run consecutively with respect to any one Dependent Child.

Dependent Child
Means a legitimate child, adopted, step child or any child who is in a parent-child relationship with the Insured Person and who is 12 years of age and under and dependent upon the Insured Person for maintenance and support. If at the time of accident, none of the dependent children qualify the Company will pay an additional benefit of $2,500 to the designated beneficiary.

Disability Fitness Benefit

If Injury results in a Loss payable to an Insured Person under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity” of this policy, the Company will pay the reasonable and necessary expenses actually incurred for the purposes of any specially designated fitness training or athletic equipment for disabled persons, which you would not have required except for such injury, but not to exceed an amount of $5,000.00. The expense must be incurred within 2 years of the date of accident.

The above benefit shall only be payable under one of the policies issued by the company and shall not duplicate any other benefits payable.

Education Benefit

If an Injury sustained by an Insured Person results in loss of life within 12 months of the date of accident, the Company will pay the Education Benefit stated below for each of the Insured Person's Dependent Children, who are enrolled as full-time students:

(a) in a School for Higher Learning above the secondary school level as defined, in the province, territory or country of Residence; or

(b) at the secondary school level but who enroll as full-time students in a School for Higher Learning within 12 months after the date of death of the Insured Person.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of the Insured Person's Principal Sum to a maximum of $5,000.00, for each year the Dependent Child described above continues his education on a full-time basis in a School for Higher Learning, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in a School for Higher Learning, but payment will not be made for expenses incurred prior to the death of the Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

The above benefit shall only be payable under one of the policies issued by the Company and shall not duplicate any other benefits payable.

If, at the time of loss, the Participant has no Dependent Children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If, as the result of an Injury, an Insured Person requires and receives treatment by a Physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00.

Family Transportation Benefit

When, as a result of loss covered by this policy, an Insured Person is confined as an inpatient in a hospital located from a point of not less than one hundred and fifty kilometers from his/her normal place of residence, the Company will pay the reasonable expenses actually incurred by all members of the immediate family of the Insured Person for hotel accommodation and transportation by the most direct route to the confined Insured Person, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Funeral Expense Benefit

If an Injury sustained by an Insured Person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.00.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustains accidental loss of or loss of use of both feet or both legs or becomes quadriplegic, paraplegic or hemiplegic and subsequently requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the Insured Person's principal residence and/or the cost of modifications to one motor vehicle utilized by the Insured Person, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $25,000.00.

Parental Care Benefit

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance with the terms of this policy, the Company will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible for this benefit if, at the time of the accident:

1) is a resident in a licensed nursing care facility; or
2) is enrolled in a home health care program; or
3) is living in the Insured Person’s Residence; or
4) is receiving support and care provided by the Insured Person as evidenced by:
    a) cancelled cheques;
    b) income tax returns showing the parent as a dependent; or
    c) other similar forms of proof.

The amount of Parental Care Benefit will be 5% of the Insured Person’s Principal Sum, subject to an overall maximum of $ 5,000.00.

Dependent Parent
Means the Insured Person’s parents or grandparents who are dependent upon the Insured Person for support, maintenance and care.

Psychological Therapy Benefit

If Injury results in a Loss payable to an Insured Person under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity” of this policy, and results in the Insured Person requiring Psychological Therapy, as prescribed by a Physician, the Company will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00, until one of the following occurs:

a) the total Psychological Therapy Benefit amount has been paid; or
b) two years have elapsed from the date of the Injury; or
c) the Insured Person dies.

Psychological Therapy
means the treatment or counselling by a therapist or counselor, who is licensed, registered, or certified to provide such treatment, whether on an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

Rehabilitation Benefit

If injury requires that the Insured Person undergo special training in order to be qualified to engage in a special occupation in which he/she would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training by the Insured Person within 3 years of the date of the accident, subject to a maximum amount of $15,000.00 as the result of any one accident.

Repatriation Benefit

If injury results in the loss of life of an Insured Person within 365 days of the date of the accident, the Company will pay the actual expense incurred for preparing the Deceased for burial or cremation and the shipment of the body of the Insured Person to the city of residence of the Deceased, subject to a maximum amount of $15,000.00.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a loss payable under Accidental Death and Dismemberment Benefits of the policy, the Insured Person's amount of Principal Sum will be increased by ten percent (10%) if, at the time of the accident, the Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit

In the event loss of life as the result of an injury is sustained by an Insured Person, the Company will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the Spouse of the Insured Person who engages in a formal occupational training programme in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Waiver of Premium

In the event an Insured Person becomes totally disabled and his/her waiver of premium claim is accepted and approved under the Policyholder's current Group Life policy, then premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Policy Underwriter.

Limited Air Travel Coverage

Insurance provided under this policy includes Injury sustained in consequence of riding as a passenger, and not as a pilot or Member of the Crew, in, boarding or alighting from, or being struck by, or making a forced landing with or from (a) any aircraft having a current and valid Airworthiness Certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or (b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, this policy excludes Injury sustained while and in consequence of riding as a passenger, pilot, operator or Member of the Crew, in or on, boarding or alighting from, or being struck by, or making a forced landing with or from any aircraft owned, operated or Leased by the Policyholder.

Exposure and Disappearance

If due to accident an Insured Employee, Insured Spouse or Insured Dependent Child is unavoidably exposed to the elements and if, as a result of such exposure and within 365 days after the date of the accident the Insured Employee, Insured Spouse or Insured Dependent Child suffers a loss for which indemnity would otherwise have been payable hereunder, such loss shall be deemed to be the result of injury as defined herein.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an Insured Employee, Insured Spouse or Insured Dependent Child is riding the Insured Employee, Insured Spouse or Insured Dependent Child disappears, and if the body of the Insured Employee, Insured Spouse or Insured Dependent Child is not found within 365 days after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the Insured Employee, Insured Spouse or Insured Dependent Child suffered loss of life as a result of injury.

What Amounts Are Available?

You may elect to insure yourself only or yourself and your family for one of these plans outlined herein:

A. EMPLOYEE ONLY PLAN

You may select any amount of benefit desired from a minimum of $50,000.00 to a maximum of $400,000.00 in units of $50,000.00.

B. FAMILY PLAN

You may select amounts of insurance from a minimum of $50,000.00 to a maximum of $400,000.00 in units of $50,000.00 AND your family will automatically be insured for the following:

Spouse - Your Spouse will be insured for 50% of the benefit you elect for yourself if you have Dependent Children, or 60% if you do not.

Children - Each Dependent Child will be insured for 10% of your benefit if you have a Spouse, or 25% if you do not, subject to a maximum of $50,000.00.

To Whom Are Benefits Paid?

Your Accidental Death benefit will be paid to the beneficiary designated on your Enrolment form/card. Any other benefits payable (which includes those payable for dependents) will be paid to you.

When Does This Insurance Not Apply?

a) declared or undeclared war or any act thereof;

b) active full-time service in the armed forces of any country;

c) suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;

d) committing, attempting or provoking an assault or criminal offence including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood. A “vehicle” means a vehicle that is drawn, propelled or driven by any means or other than muscular power;

e) medical care or treatment of any kind including surgery;

f) any drug, poison, gas or intoxicant taken, administered, absorbed or inhaled, voluntarily or otherwise (occupation-related accidents excepted);

g) injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled “Limited Air Travel Coverage”.

How May I Enroll?

You may enroll in the plan by completing the Group Enrolment form/card.

1) Select the type of Plan desired: EMPLOYEE ONLY PLAN or FAMILY PLAN.

2) Select the amount of insurance desired from the Schedule of Principal Sums which best suits your needs.

This brochure is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of an Insured Employee will be governed by the Group Master Policy, a copy of which is filed with the Plan Administrator.

Protector Series™ Optional Critical Illness

What is Critical Illness Insurance?

Critical illness insurance provides the funds and the means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

Critical·Choice·Care
is designed to provide the Insured person with a lump sum payment in the event this person is diagnosed with a critical illness covered and survives at least 30 days following this diagnosis. Among other advantages, the benefits are not limited by the person's ability to work or by full recovery. In the event you should receive such a diagnosis, the benefit is paid directly to you – and you are free to choose how to use it!

Why is Critical Illness Insurance important to you and your family?

Research has shown that a significant number of Canadians will face the challenge of critical illness:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- On average, 3,300 Canadians will be diagnosed with cancer every week.
- There are an estimated 70,000 heart attacks each year in Canada. One heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.
- 75% of stroke victims survive the initial event.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illness occurs everyday and, with the help of modern medicine, many survive such an illness. Unfortunately, along with this positive outcome sometimes comes a long recovery which can dramatically affect family income and introduces substantial costs.

How many of us are actually prepared financially for the event of a critical illness and to its repercussions? Most of us are not. Unfortunately, no one is immune; critical illness strikes people of all ages and backgrounds.

Critical Illness insurance benefits can help:

- obtain appropriate care where and when you decide
- cover your medical expenses not covered under your provincial health care plan
- take an unpaid vacation in order to help recovery or to take care of a sick family member
- replace reduced family earnings and face increased costs, by using the benefit to pay:
  - medical bills or nursing care at home
  - mortgage or rent
  - debt or financial liabilities
  - for help with the care of children
  - hired help for chores
  - for adapting the home to meet health needs

What are the advantages of your coverage?

With Critical·Choice·Care's group critical illness insurance program, you benefit from:

- protection up to $50,000 (guaranteed issue amount), tax-free, for you and your spouse without having to answer any medical questions or provide any evidence of insurability
- group cost savings; making your coverage more affordable
- payments made easy through automatic withdrawal from your paycheck
- continued coverage even if you have claimed a critical illness benefit under this coverage.

Definitions for a better comprehension of the Optional CI benefit in this booklet

Wherever used in this document:

"You", "Your"
means the insured employee to whom this document was intended.

"Policyholder"
means the Employer named herein who is a Participating Client of GroupHEALTH Benefit Solutions.

"We", "Us", "Insurer"
means SSQ Insurance Company Inc.

"Insured person"
means you, while you are an insured active employee of the Policyholder, or your insured spouse, while meeting the spouse definition criteria below or insured employee's dependent children, and before the date of coverage termination.

"Policy"
means the Critical·Choice·Care™ 29 illnesses insurance program's Master Policy, endorsements and attached papers, if any, and the entire contract of insurance, unless stated otherwise.

"Critical Illness"
means, with respect to the insured employee and to the insured spouse, one of the illnesses, conditions or surgical operations listed under "*Covered Critical Illnesses (for member or employee and insured spouse)*". With respect to insured children, "*Critical Ilness*" means one of the illnesses, conditions or surgical operations listed under "*Critical Illnesses Covered for Dependent Children*".

"Diagnosis"
means the time when a specialist establishes, using tests or other diagnostic methods, that the insured person has a specific critical illness. The diagnosis of any covered critical illness must be made by a licensed specialist practising in Canada. Furthermore, his practice must be limited to the branch of medicine directly linked to the critical illness.

"Surgery"
means that the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The surgery must be performed by a Physician in Canada.

"Irreversible"
means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the insured person's health.

"Physician"
means an individual who is legally licensed to practice medicine in Canada and provide treatment within the scope of his licence. The physician must not be the insured person, a relative of or business associate of the insured person.

"Specialist"
means a licensed physician who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified physician practising in Canada. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The specialist must not be the insured person, a relative of or business associate of the insured person.

"Claimant"
means the person who has requested or is in the process of requesting a settlement after being diagnosed with a covered critical illness.

"Pre-Existing Condition"
means :

- the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period preceding the insured person's effective date of coverage; or
- an illness or condition for which the insured person, during 24 months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

"Survival period"
means 30 days following the date of the diagnosis or 30 days following the date of surgery if applicable, except where indicated otherwise. The survival period does not include the number of days on life support as defined below. For those conditions which have a longer qualification requirement, for example 90 days for bacterial meningitis and paralysis, the survival period runs concurrently with that requirement.

"Life support"
means being under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

When referring to a female person, male pronouns used in this document will be construed as the feminine.

Coverage Options

The **Critical·Choice·Care** insurance program is made available for employee and dependents (spouse and dependent children).

Eligibility

You are eligible for coverage under the program if you are under age 70 and an active employee of the Policyholder. Your spouse and each of your children are covered while they meet the definition criteria below for spouse and for dependent child.

Spouse
The person considered to be your spouse under the Critical·Choice·Care program is:

A person to whom you are legally married or with whom you have been continuously cohabiting in a conjugal relationship for a minimum of one year immediately before this person receives a Critical Illness diagnosis while the coverage is in force.

When the person is the biological or adoptive mother or father of at least one of your children, the spouse shall be recognized as such from the date of the adoption or the date of birth of this child if that date precedes the end of the period of one year of cohabitation.

Only one individual qualifies as a spouse. If you are legally married but also cohabiting with an individual as described above, you may choose which person will qualify as the spouse under the policy: the spouse you are legally married to or the person you are cohabiting with. This choice must be made in writing, signed and filed with the Policyholder before the insured event. If there is no statement filed to that effect, the person to whom you are legally married will be deemed to be your spouse under the policy.

Dependent child
The person considered to be your dependent child under the Critical·Choice·Care coverage is:

A natural child, adopted child, stepchild or child with whom you are in a parent-child relationship. The child is unmarried and dependant upon you for maintenance and support and:

- is under 21 years of age; or
- is under 25 years of age (26 in the province of Quebec) and in attendance at an institution for higher learning on a full-time basis; or
- no matter his age, this person has been struck with a functional disability while satisfying the conditions above. Proof of existence of this functional disability must be presented to the insurer within 31 days after the child reaches the applicable limiting age indicated above. Thereafter, the insurer may periodically require that other proof be submitted establishing to its satisfaction that the functional disability still exists. If such proof is not presented to satisfaction, the person will no longer qualify as a dependent child under the policy.

Coverage Amounts

Employee:
Principal Sum Available:

- units of..... $5,000
- minimum benefit..... $10,000
- maximum benefit..... $150,000

Guaranteed Issue Amount:

- units of..... $5,000
- minimum benefit..... $10,000
- maximum benefit..... $50,000

Spouse:
Principal Sum Available:

- units of..... $5,000
- minimum benefit..... $10,000
- maximum benefit..... $150,000

Guaranteed Issue Amount:

- units of..... $5,000
- minimum benefit..... $10,000
- maximum benefit..... $50,000

You can enroll your dependent children for coverage of $5,000, without having to provide any evidence of insurability.

Coverage Effective Date

If you have chosen a Guaranteed Issue Amount and complete an enrolment card for this Critical·Choice·Care program, insurance for insured persons indicated on this enrolment card shall take effect:

- on the effective date of the program, if eligible on or before the effective date of the program.
- on the date the eligible employee returns to active full-time work if such employee is absent from active full-time work for any reason other than bona fide vacation on the effective date of the program.
- on the first of the month next following or coincident with the date the employee becomes eligible after the effective date of the program.

Each person who has completed an application for optional coverage under this Critical·Choice·Care program and has been approved by the insurer, will have their insurance take effect on the 1st day of the month next following or coincident with the date their coverage was approved by the insurer.

Coverage Termination

The coverage terminates on the earliest of the following events:

With respect to insured employees:

- on the date the Master Policy is terminated;
- on the date the Policyholder's coverage under the Master Policy is terminated;
- on the premium due date if the policyholder fails to pay the required premium, except as the result of an inadvertent error;
- on the next premium due date following the date the employee reaches seventy (70) years of age;
- on the next premium due date following the date the employee ceases to be an active employee of the policyholder on account of resignation, dismissal or retirement;
- on the date members or employees die;
- on the next premium due date following the date the employee gives notice of cancellation to the policyholder.

With respect to an insured spouse and an insured dependent child:

- on the date the person ceases to meet the definition criteria for spouse and for dependent child presented under the "Eligibility" section of this document;
- on the date the insured employee's insurance is terminated.

This policy may be cancelled by the Policyholder by mailing to the insurer written notice stating when thereafter such cancellation will be effective. This policy may be cancelled by the insurer not less than 30 days prior to the Anniversary Date of this policy. Cancellation stated in the notice will become the end of the policy.

Critical illness coverage

You or your spouse will receive a payment equivalent to their principal sum if diagnosed with one of the following illnesses while coverage is in force:

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dilated Cardiomyopathy
- Fulminant Viral Hepatitis
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Primary Pulmonary Hypertension
- Severe Burns
- Stroke (Cerebrovascular Accident)

Important:
The claimant's critical illness must meet one of the definitions presented under "Covered Critical Illnesses (for employee and insured spouse)" and "Illnesses covered for Complementary Benefit in Case of Certain Illnesses (for employee and insured spouse)" at the end of this document in order to be eligible under the Critical·Choice·Care program.

The payment is subject to Critical·Choice·Care program limitations of the survival period as referred to under the "Definitions" section and the exclusions presented in the "*Exclusions*" section.

When the insured has been paid any benefit under the Critical·Choice·Care program, the payment of benefits is then also subject to limitations referred to in the "*Multiple Event Coverage*" section below.

Multiple Event Coverage

When an insured employee or insured spouse is diagnosed with one of the covered critical illnesses listed above for which a principal sum has been paid and is then diagnosed with another critical illness listed above, the claimant's principal sum will be paid, subject to the limitations presented in the "*Re-Entry Exclusions*" section.

To receive a benefit payment under the Multiple Event Coverage benefit, the critical illness diagnosed must meet one of the definitions presented at the end of this document and the diagnosis must be made at least 90 days after the principal sum payment.

Cancer Recurrence Benefit

You or your spouse will receive a payment equivalent to their principal sum if diagnosed with one of the following illnesses while coverage is in force:

- over 60 months have passed since the previous cancer diagnosis; and
- no treatment relating directly or indirectly to cancer has been received within that 60-month period (treatment does not include preventive medications and follow up visits to doctor).

The claimant's critical illness must meet one of the definitions presented at the end of this document in order to be eligible under the Critical·Choice·Care program.

The payment is subject to Critical·Choice·Care program limitations of the Survival period as referred to under the "Definitions" section and the exclusions presented in the "Exclusions" section.

Complementary Benefit in Case of Certain Illnesses

You or your spouse will receive a payment equivalent to 10% of their principal sum, subject to a maximum of $25,000, if diagnosed with one of the following illnesses while coverage is in force:

- Coronary Angioplasty
- Ductal Carcinoma in Situ of the Breast
- Stage A (T1a or T1b) Prostate Cancer
- Stage 1A Malignant Melanoma

Important: The claimant's critical illness must meet one of the definitions presented at the end of this document in order to be eligible under the Critical·Choice·Care program.

Sums for Complementary Benefit in Case of Certain Illnesses can only paid once in the insured's lifetime. These sums come in addition of other benefits to be paid *(the insurer will not deduct the sums of the payment from any previous or later principal sum payments)*.

The payment is subject to Critical·Choice·Care program limitations of the survival period as refered to under the "*Definitions*" section and the exclusions presented in the "*Exclusions*" section.

When the insured has been paid any benefit under the Critical·Choice·Care program, the payment of benefits is then also subject to exclusions presented in the "*Re-Entry Exclusions*" section.

Children Coverage

You will receive a payment equivalent to your dependent child's principal sum if this child is diagnosed with one of the following illnesses while coverage is in force:

- Blindness
- Cancer (Life-Threatening)
- Cerebral Palsy
- Coma
- Congenital Heart Disease requiring surgery
- Cystic Fibrosis
- Deafness
- Down's Syndrome
- Loss of Speech
- Major Organ Transplant
- Mental Deficiency
- Muscular Dystrophy
- Paralysis
- Severe Burns
- Spina Bifida Cystica

The dependent child's critical illness must meet one of the definitions presented at the end of this document in order to be eligible under the Critical·Choice·Care program.

The payment is subject to Critical·Choice·Care program limitations of the survival period as referred to under the "*Definitions*" section and exclusions presented in the "Exclusions" section.

Second Medical Opinion Service

Any insured person who is diagnosed with a covered critical illness while enrolled in the insurance program is offered access to SSQ Assistance's **Second Medical Opinion** program.

This program allows the insured person to obtain second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the insured person's file to confirm the initial diagnosis and make recommendations on appropriate treatment.

If you have been diagnosed with a covered critical illness, simply call: **1.877.266.6550** in order to benefit from SSQ Assistance's Second Medical Opinion program.

Exclusions

The program does not cover a critical illness that results directly or indirectly from any one or more of the following causes or situations:

1. Within 90 days following the effective date of the insured person's coverage:
   - diagnosis of cancer is made; or
   - any signs, symptoms or investigations that lead to a diagnosis of cancer, regardless of when the diagnosis is made.
2. Within 90 days following the effective date of the insured person's coverage:
   - diagnosis of benign brain tumour is made; or
   - any signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made.
3. The insured person does not satisfy the survival period limitations.
4. An intentionally self-inflicted injury or sickness, whether the insured person is sane or insane.
5. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
6. Any cancer that manifests itself prior to the effective date of the insured person's insurance when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
7. From a Pre-existing Condition except if such Critical Illness is diagnosed 24 months after the Insured Person's effective date of coverage.

Re-Entry Exclusions

If an insured employee or insured spouse has already received a principal sum for a covered critical illness, coverage will automatically continue. An insured person can claim a subsequent Principal Sum for another covered Critical Illness subject to the following restrictions:

If a claim has been made for a critical illness indicated in the left column of the Re-Entry Exclusions table below, no claim can be made for the critical illnesses listed in the right column of the table.

Critical illnesses claimed for	Re-Entry exclusions (Critical illnesses for which the insured person cannot claim)
Alzheimer's Disease	Alzheimer's Disease, Loss of Independent Existence
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Aplastic Anemia	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Bacterial Meningitis	Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Benign Brain Tumour	Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Blindness	Blindness, Loss of Independent Existence
Cancer (life-threatening)	Aplastic Anemia, Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Coma	Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Coronary Artery Bypass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Deafness	Deafness, Loss of Independent Existence
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Fulminant Viral Hepatitis	Cancer (Life-Threatening), Ductal Carcinoma in Situ of the Breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Heart Valve Replacement	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Critical illnesses claimed for	Re-Entry exclusions (Critical illnesses for which the insured person cannot claim)
Kidney Failure	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Loss of Independent Existence	Following a Loss of Independent Existence claim, the insured person cannot claim anymore. Insurance coverage terminates.
Loss of Limbs	Loss of Independent Existence, Loss of Limbs
Loss of Speech	Loss of Independent Existence, Loss of Speech
Major Organ Failure on Waiting List	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Major Organ Transplant	Aplastic Anemia, Cancer (Life-Threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Motor Neuron Disease	Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis, Stroke
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis, Stroke
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke
Occupational HIV Infection	Blindness, Cancer (Life-Threatening), Coma, Deafness, Ductal Carcinoma in Situ of the Breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Paralysis	Coma, Loss of Independent Existence, Loss of Speech, Paralysis
Parkinson's Disease	Coma, Loss of Independent Existence, Loss of Speech, Paralysis, Parkinson's Disease
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, Stroke
Severe Burns	Loss of Independent Existence, Paralysis, Severe Burns
Stroke (Cerebrovascular Accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Waiver of Premium

(applicable to an Insured Employee and Insured Spouse)

The insurer will waive the premium for insured persons in the following circumstances:

a) If the insured person has Long Term Disability (LTD) Insurance:

From the first day of the month following the date this person begins to receive monthly disability benefit payments through his LTD Insurance.

b) If the insured person does not have Long Term Disability (LTD) Insurance:

When injury or sickness totally disables and prevents the insured person from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience, for a period of at least 6 consecutive months. Premiums will be waived on the first day of the month following the 6 consecutive month period.

The insurer must receive notice of disability within 12 months of the onset of total disability and due proof of such disability within 3 months following this notice.

Premiums will continue to be waived until the earliest of the following dates:

- on the date the Master Policy is terminated;
- on the date the Policyholder's coverage under the Master Policy is terminated;
- on the date the insured person reaches 65 years of age;
- on the date the insured person ceases to be totally disabled; or
- on the date the insured person fails to provide, within 90 days of request, proof satisfactory to the insurer of the continuance of total disability or refuses to submit to examination.

Coverage continued under the Waiver of premium benefit will be subject to the terms and provisions of the Policy in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the policy, in no event will benefits payable for any diagnosis which occurs while coverage is being continued under the Waiver of premium benefit exceed the amount of insurance that would have been payable to the insured person at the date of commencement of disability.

The insurer can request proof of the continuance of total disability, and may also require the disabled insured person to submit to examination by the insurer's medical advisor, from time to time as the insurer may reasonably require.

Conversion Option

(applicable to an Insured Employee and Insured Spouse)

If, with the exception of policy termination, an insured employee's or insured spouse's insurance is terminated due to:

- termination of the insured employee's employment; or
- cessation of eligibility for insurance under this policy; or
- cessation of a period of total disability after which the insured employee did not return to work for the policyholder,

and prior to attainment of age of seventy, the insured employee or insured spouse makes a written application to the insurer within 31 days of said termination, the insurer will, without evidence of insurability, issue on the life of such insured person an individual critical illness policy.

The amount of insurance that may be converted will not exceed the insured person's amount of insurance then in effect on the date of termination or a total aggregate of one hundred and fifty thousand ($150,000) for all such conversions with the insurer.

Premiums for such an individual critical illness policy being issued in compliance with the aforementioned condition will be calculated at the insurer's manual rates then in force for the attained age of the insured person at the date of conversion. Premiums will be payable annually in advance and the individual critical illness policy will be issued on an annually renewable basis.

Monthly Premium

Optional Plan
Monthly rates for each $1,000 of principal sum:

Age Band	Male		Female	
	Non-Smoker	Smoker	Non-Smoker	Smoker
<20	$0.116	$0.128	$0.102	$0.113
20-24	$0.122	$0.134	$0.095	$0.106
25-29	$0.166	$0.194	$0.158	$0.190
30-34	$0.177	$0.219	$0.205	$0.268
35-39	$0.203	$0.285	$0.243	$0.368
40-44	$0.286	$0.474	$0.312	$0.561
45-49	$0.478	$0.938	$0.454	$0.921
50-54	$0.747	$1.673	$0.621	$1.320
55-59	$1.283	$3.067	$0.838	$1.754
60-64	$2.184	$5.135	$1.244	$2.395
65	$2.401	$5.648	$1.368	$2.635
66	$2.641	$6.213	$1.504	$2.898
67	$2.904	$6.832	$1.654	$3.188
68	$3.193	$7.516	$1.818	$3.505
69	$3.513	$8.267	$2.000	$3.856
Children's monthly cost for a flat $5,000 (covers all dependent children) is $3.65				

To calculate your monthly premium, use the table above to find the unit rate that applies to you (based on age, gender and smoker status). Multiply the unit rate found by the number of $1,000 units of principal sum selected.

To calculate your spouse's monthly premium, use the table above to find the unit rate that applies (based on age, gender and smoker status). Multiply the unit rate found by the number of $1,000 units of principal sum selected for your spouse.

Example: Male-Non Smoker, aged 45 with a Principal Sum of $50,000 = $23.90 per month

Any misrepresentation of smoker status on your application will be deemed fraudulent and coverage will become void.

Area of Diagnosis

Should a critical illness occur or be diagnosed outside of Canada, payment of the principal sum may be considered upon the insured person's return to Canada for medical assessment and confirmation of the diagnosis of a critical illness.

Notice of Claim and Proof of Critical Illness

In the event of a diagnosis of critical illness, a notice of this critical illness must be given to the policyholder, who will then give notice of the claim to the insurer in a timely manner.

The notice must be received by the insurer within 30 days of the diagnosis.

The insurer, upon receipt of such notice will furnish to the claimant such forms as are usually furnished by it for filing proofs of a critical illness. If such forms are not furnished by the insurer within 15 days after the receipt of such notice, the claimant will be deemed to have complied with the requirements of the insurance program as to proof of such critical illness upon submitting, within the 90 days time fixed for filing proofs of critical illness, written proof covering the occurrence, character and extent of the critical illness for which claim a notice has been given.

Written proof of critical illness must be furnished to the insurer within 90 days after the date of diagnosis.

Failure to furnish such proof within such time will not invalidate any claim, if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but **in no event not later than one year** after the date of the diagnosis.

The insurer reserves the right to confirm the diagnosis by appointing a medical practitioner to examine the insured person.

The benefit provided under the insurance program's coverage will be paid immediately after receipt of due proof.

All moneys payable under the insurance program are payable in the lawful money of Canada.

Benefit payment

With respect to an insured employee or an insured spouse, the principal sum payable in the event of a critical illness will be payable to the insured employee or insured spouse respectively.

With respect to an insured employee or an insured spouse, the Complementary Benefit in Case of Certain Illnesses payable under the terms specified in the "Complementary Benefit in Case of Certain Illnesses" section will be payable to the insured employee or insured spouse respectively.

Accrued benefits, if any, unpaid at the time of the insured employee or insured spouse becoming unable to legally receive payment of benefits will be paid to the insured employee or insured spouse estates.

With respect to the insured dependent child, the principal sum payable in the event of a critical illness will be payable to the insured employee.

NOTE: The payment of the benefit is subject to the limitations of the survival period as defined in this document under the "*Definitions*" section.

Legal recourse

To take any legal action in order to recover a benefit amount under this program, the claimant must wait 60 days after having submitted proof of claim to the insurer. Thereafter, the claimant will be limited to a one-year period [3 years in the province of Quebec] during which legal action may be taken.

If any time limitation specified in this policy for giving notice of claim, or undertaking legal action is less than that permitted by law of the province in which the insured person is residing at the time of claim, then the time limitation will not be less than that provided for by provincial law.

Covered critical illnesses (for employee and insured spouse)

With respect to the insured employee and the insured spouse, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Alzheimer's disease
A definite diagnosis of a progressive degenerative disease of the brain. The insured person must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The diagnosis of Alzheimer's disease must be made by a specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic surgery
The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

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

- marrow stimulating agents;
- immunosuppressive agents;
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist.

Bacterial meningitis
A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign brain tumour
A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:

- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour.

This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for benign brain tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness
A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist.

Cancer (life-threatening)
A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:
- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the insured person has any of the following:
- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

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

Exclusion: No benefit will be payable under this condition for:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Coronary artery bypass surgery
The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a specialist.

Deafness
A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist.

Dilated cardiomyopathy
A condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of dilated cardiomyopathy must be made by a specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least 3 months.

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

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

Fulminant viral hepatitis
A definite diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

- a rapidly decreasing liver size as confirmed by abdominal ultrasound;
- necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
- rapidly deteriorating liver function tests;
- deepening jaundice.

The diagnosis of fulminant viral hepatitis must be made by a specialist.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

Heart attack
A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist.

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart valve replacement
The undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist.

Exclusion: No benefit will be payable under this condition for heart valve repair.

Kidney failure
A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist.

Loss of independent existence
A definite diagnosis of:

- A total inability to perform, by oneself, at least two of the following six Activities of Daily Living; or
- Cognitive Impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of loss of independent existence must be made by a specialist.

Activities of Daily Living are:

- Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting - the ability to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of limbs
A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist.

Loss of speech
A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist.

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

Major organ failure on waiting list
A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Major organ transplant
A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.

Motor neuron disease
A definitive diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy,

and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist.

Multiple sclerosis
A definite diagnosis of at least one of the following:

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

The diagnosis of multiple sclerosis must be made by a specialist.

Muscular dystrophy
A definite diagnosis of all of the following:

- clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- characteristic electromyography changes;
- muscle biopsy confirming diagnosis of muscular dystrophy.

The diagnosis of muscular dystrophy must be made by a specialist.

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

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

- The accidental injury must be reported to the insurer within fourteen days of the accidental injury;
- A serum HIV test must be taken within fourteen days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist.

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

- the insured person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis
A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist.

Parkinson's disease
A definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations:

- muscle rigidity;
- tremor; or
- bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The diagnosis of Parkinson's disease must be made by a specialist.

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

Primary pulmonary hypertension
(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)

A definite diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of primary pulmonary hypertension must be made by a specialist.

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

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

Severe burns
A definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.

Stroke (cerebrovascular accident)
A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist.

Exclusion: No benefit will be payable under this condition for:
- transient ischemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Illnesses Covered for Complementary Benefit in Case of Certain Illnesses – (for employee and insured spouse)

Under the Complementary Benefit in case of Certain Illnesses, only the four illnesses and surgical operations presented below are covered for an insured employee or an insured spouse:

Coronary angioplasty
The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist.

Ductal carcinoma in situ of the breast
The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

Stage A (T1a or T1b) prostate cancer
The diagnosis of this illness must be made by a specialist and must be confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma
A melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

Critical illnesses covered for dependent children

With respect to any insured child, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Blindness
A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:
- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist.

Cancer (life-threatening)
A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:
- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the insured person has any of the following:
- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Cerebral palsy
The definite diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems. The diagnosis of cerebral palsy must be made by a specialist.

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

Exclusion: No benefit will be payable under this condition for:
- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Congenital heart disease requiring surgery
The definite diagnosis of any serious cardiac malformation present at birth, for which corrective surgery has been performed. The diagnosis of congenital heart disease must be made by a specialist.

Cystic fibrosis
The definite diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems. The diagnosis of cystic fibrosis must be made by a specialist.

Deafness
A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist.

Down's syndrome
A congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present. The diagnosis of Down's syndrome must be made by a specialist.

Loss of speech
A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist.

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

Major organ transplant
A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.

Mental deficiency
The definite diagnosis of an intellectual deficiency as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70. The diagnosis of mental deficiency must be made by a specialist.

Muscular dystrophy
A definite diagnosis of all of the following:
- clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- characteristic electromyography changes;
- muscle biopsy confirming diagnosis of muscular dystrophy.

The diagnosis of muscular dystrophy must be made by a specialist.

Paralysis
A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist.

Severe burns
A definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.

Spina bifida cystica
Definite diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:
- hydrocephalus;
- paralysis;
- bowel problems; and
- bladder problems.

The diagnosis of spina bifida cystica must be made by a specialist.

Exclusion: Spina Bifida Occulta is specifically excluded.

Frequently Asked Questions

How do we enrol?
Each employee must complete an enrolment card in order to obtain coverage as well as for spouse and dependent children coverage.

How can we apply for additional coverage?
To apply for any amounts in excess of the guaranteed issue amount under the optional coverage plan, please complete an application form.

Who is to receive the applications?
While enrolment cards should be returned to the program administrator, in consideration of the applicant's privacy, applications requiring medical information review should be sent directly to GroupHEALTH Benefit Solutions for underwriting.

What happens to incomplete applications?
Incomplete applications are returned to the applicant immediately. Delays in processing the application may result.

When does coverage take effect?
For persons who have applied for an amount up to the guaranteed issue amount, coverage will take effect on the 1st of the month following the receipt of the enrolment card by the policyholder.

For persons who have applied for coverage in excess of the guaranteed issue amount, submitted the application form and the medical proof and this medical proof meets requirements for higher insurance amounts, coverage will take effect on the 1st of the month following confirmation of acceptance by the insurer.

How do I qualify for the reduced non-smoker rates?
To qualify for the non-smoker rates you must not have smoked any cigarettes, cigarillos, cigars, marijuana, used pipes, chewed tobacco or used any other nicotine products (patch, gum, etc.) within the past 12 months.

Will I remain entitled to long term disability (LTD) benefits if I receive a benefit for a critical illness?
Critical·Choice·Care benefits will not affect your long term disability benefit payments.

How can I make changes to my coverage?
Changes to coverage amounts must be requested during the yearly renewal period of the insurance program. Contact the program administrator to be informed on the renewal period dates.

To apply for an insurance amount increase, a new application form must be completed and submitted to the insurer. For a reduction of coverage to any amount down to the guaranteed issue amount, complete a new Enrolment card choose "Change in amount" and indicate the new coverage amount requested.

Will I remain insured for critical illness after having received a benefit under this program?
Yes, coverage remains in force after the payment of a benefit, subject to the limitations specified in the "Re-Entry Exclusions" section.

What is the Second Medical Opinion program?
The insurer, in cooperation with SSQ Assistance Canada agrees to provide the Second Medical Opinion program to insured persons. This Second Medical opinion program does not form part of policyholder's contract with the insurer.

In accordance with this agreement, the following services will be provided, free of charge unless stated otherwise, to any insured person diagnosed with one of the critical illnesses covered under this Critical•Choice•Care insurance program:

- Selection of the specialist best suited to provide medical services included in the Second Medical Opinion program pertaining to the insured person's diagnosed critical illness;
- Transmission, to the selected specialist, of necessary and pertinent medical documents received from the insured person or attending physician;
- Communication of the second medical opinion's schedule, as established after evaluation;
- Arrangements for a meeting with the selected specialist, if deemed necessary and if the insured person agrees to the meeting. The expenses incurred will be charged to the insured person;
- Analysis of the medical documents and rendering of a diagnosis by the selected specialist as well as recommendations on treatment options, all registered in a medical report;
- Transmission of the medical report to the insured person and the attending physician;
- At the insured person's request, referral to 3 specialists medically qualified to treat the insured person.

In accordance with this agreement, the services listed below will be provided for out-of-country medical care to any insured person diagnosed with a critical illness covered under this Critical•Choice•Care insurance program. Incurred expenses will be charged to the insured person:

- Arrangements to set up medical appointments with attending physicians or specialists outside Canada;
- Admission in medical clinics located outside Canada;
- Hotel reservations;
- Travel arrangements;
- Referrals for translation services or interpreter services when appropriate;
- Administrative assistance for settlement of medical fees and claims, relative to medical services or treatments received outside Canada, if such assistance is requested by the insured person.

Insured persons requiring Second Medical Opinion program services must contact SSQ and must be prepared to give the following information:

- the name of the person calling, telephone # and relationship to the insured employee;
- the insured employee's name, and the Policy #;
- the name, address and telephone number of the attending physician's workplace, and such information for specialists when applicable.

The telephone number to be used is 1.877.266.6550.

Contacts

In this section you will find contact information for your company's benefits advisor. Please contact your advisor for any information regarding your benefit plan, and for any personal insurance requirements for you and your family.

Any questions regarding administrative matters should be directed to the plan administrator at your company.

Benefits Advisor

Your benefits program was arranged by Benefit Innovations, your employer's benefits advisor. Please contact them for any questions pertaining to your new benefits, and how to coordinate them with your personal insurance.

Benefit Innovations Inc.

100 Park Royal, Suite 200
West Vancouver, BC V7T 1A2

Tel 1.866.925.3220
Fax 1.866.840.6936

info@benefitinnovations.ca

Benefits Administrator

As your benefits administrator we are responsible for all day-to-day matters pertaining to the administration of your benefits program, such as premium billing, establishing and maintaining all necessary records, and acting as your advocate with the insurance providers. The Plan Administrator at your organization who was appointed by your employer works with us to ensure that all information is reported quickly and accurately and that the plan is meeting all of your expectations. Please contact your Plan Administrator if you have any questions or concerns about your coverage.

GroupHEALTH Benefit Solutions

2626 Croydon Drive, Suite 200
Surrey, BC V3Z 0S8

www.grouphealth.ca

NOTICE OF NEW FILE

(For benefits insured by SSQ, Life Insurance Company Inc.)

File and Personal Information

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, in particular, for processing most prescription drug, dental care, and travel insurance claims. 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 (e.g. when you use a prescription drug insurance card), 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.

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