SSQ insurance

communities make us

Group insurance

Your plan



Group 31M51
ONGWANADA
OPSEU Members

May 1, 2022

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

SSQ, LIFE INSURANCE COMPANY INC.

YOUR GROUP INSURANCE PLAN

ONGWANADA

This document shows the contractual provisions in force on May 1, 2022, for the following participants:

Group 31M51 - OPSEU Members

(Policy No.: 31M50)

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

NOTICE OF NEW FILE

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., 110 Sheppard Avenue East, Suite 500, Toronto, ON M2N 6Y8. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

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

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

For more information, consult the SSQ Personal Information Protection Policy available at ssq.ca.

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SCHEDULE OF INSURANCE

This Schedule of Insurance gives you an overview of the benefits included in your group insurance plan.

Participating Employer	Ongwanada
Group Name and No.	31M51 - Ongwanada - OPSEU Members
Effective date of this document	May 1, 2022
Individuals eligible for insurance	All full-time employees working a minimum of 25 hours per week for Ongwanada
Date eligible for insurance	After the completion of 3 months of employment

This booklet comprises part of the "Schedule A" referenced in the Agreement to Participate signed and dated on March 21, 2006, by a representative of Ongwanada.

LIFE INSURANCE

Participant's Basic Life

Amount of Insurance	300% of annual salary
Non-evidence Maximum	$200,000
Maximum with Evidence	$200,000
Reduction in Amount of Coverage	50% of the amount insured at age 65, minimum $1,000
Rounded	Up to next $1,000
Termination of Coverage	Age 70 or retirement, whichever is earliest

LONG TERM DISABILITY INSURANCE

Amount of Insurance	Employees with less than 20 years of service: 65% of gross monthly salary Employees with 20 or more years of service but less than 30 years: 70% of monthly salary Employees with 30 or more years of service: 75% of monthly salary
Non-evidence Maximum	$6,000
Maximum with Evidence	$6,000
Elimination period	
In the event of accident:	210 days
In the event of hospitalization:	210 days
In the event of illness:	210 days
Frequency of Benefit Payment	Monthly
Benefit	Taxable
Termination of Coverage	Age 65 or retirement, whichever is earliest
Termination of Benefit	Age 65 or retirement, whichever is earliest

HEALTH INSURANCE

Coverage	Eligible Expenses	Maximum Amount Covered	Combined Maximum	% Reimbursed
Drugs				
* Drugs Regular drugs				80%
* Sclerosing injections	$20 eligible / treatment			80%
* Smoking Cessation Drugs		$300 / lifetime		80%
** Hepatitis A and Hepatitis B vaccines * Gardasil vaccine * Prevnar 13 vaccine * Zostavax vaccine * Zostavax II vaccine			$1,000 / calendar year	100%
Basic Health Care Hospital in Canada	Semi-private or private room	Private room: $20 / day over semi-private room charge		100%
Travel Assistance Insurance		$5,000,000 / trip		100%
Travel Cancellation Insurance		$5,000 / trip		100%
Medical Assistance				100%
Health Care Professionals Acupuncturist Chiropodist Chiropractor Christian Science Practitioner * Massage therapist Naturopath Osteopath Podiatrist *Psychologist *Speech therapist			$1,500 / calendar year	100%

Coverage	Eligible Expenses	Maximum Amount Covered	Combined Maximum	% Reimbursed
Physiotherapist		***unlimited		100%
Chiropractor – X-Ray		$35 / calendar year		100%
Vision Care * Contact lenses * Eyeglasses * Laser vision correction			$350 / 24 consecutive months for adults $350 / 12 consecutive months for children under age 21	100%
* Contact lenses Required for severe corneal astigmatism/ scarring, keratoconus (conical cornea) or aphakia, to improve acuity to the 20/40 level when not possible with eyeglasses		$350 / 24 consecutive months for adults $350 / 12 consecutive months for children under age 21		100%
Other Medical Expenses Ambulance				100%
* Blood glucose monitor		1 device / 24 consecutive months		100%
* Continuous glucose monitor * Infusion insulin pump			$7,500 / 60 consecutive months	100%
* Convalescent Home * Residential and long-term care centre (chronic care)	$20 / day		up to 120 days / calendar year	100%
Dental treatment following accidental injury to natural teeth	Within 12 months of accident			100%
Detoxification		$5,000 / lifetime		100%

Coverage	Eligible Expenses	Maximum Amount Covered	Combined Maximum	% Reimbursed
* External prosthesis and artificial limb		$5,000 / prosthesis or limb		100%
Eye examination		1 exam / calendar year		100%
* Foot Orthoses		$500 / 2 calendar years		100%
* Hearing aids		$1,100 eligible / 36 consecutive months		100%
* Hospital bed				100%
* Ileostomy, colostomy and incontinence supplies				100%
* Laboratory analyses				100%
* Nursing Care		$10,000 / calendar year		100%
* Orthopaedic apparatus				100%
* Orthopaedic shoes		1 pair / calendar year, maximum $200		80%
Out of Country Referral		$3,000 / 3 years		50%
* Respirator (breathing apparatus)				100%
* Support hose		2 pairs / calendar year		100%
Surgical brassiere		4 / calendar year		100%
* Therapeutic devices				100%
* Transcutaneous electrical nerve stimulator (TENS)		$700 / lifetime		100%
Visual Training		$200 / lifetime		100%
* Wheelchair		$3,000 / 60 consecutive months		100%

Coverage	Eligible Expenses	Maximum Amount Covered	Combined Maximum	% Reimbursed
* Wig following chemotherapy		$250 / lifetime		100%
* X-rays				100%
Termination of Benefit	For Medical Assistance: age 65 or retirement, whichever is earliest For all other coverage under the Health Insurance: age 70 or retirement, whichever is earliest			

*Physician's referral required

**Restricted to those listed in the benefit description section under Hepatitis A and Hepatitis B vaccines

*** Although the maximum amount covered may be referred to as "unlimited", eligible expenses are subject to reasonable and customary charges, and any terms, conditions, exclusions, limitations and restrictions specified in the benefit description.

Note(s):

Health Care Professional X-rays: X-rays by a chiropractor, chiropodist or a podiatrist are eligible, up to a maximum of $35 per calendar year per type of practitioner .

DENTAL CARE INSURANCE

Rates based on dental procedure fee guide: province of residence

Fee guide year: Year during which expenses are incurred

The first calendar year is established as follows: 2006

Coverage	Maximum Amount Covered	% Reimbursed
Basic Dental Care Diagnostic Services Preventive Dental Care	$2,000 / person covered / calendar year	100%
Routine Dental Care 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 Major Restorative Services and Fixed Prosthodontics Removable Dentures Fixed Bridges	$1,000 / person covered / calendar year	50%
Orthodontics (Applicable only to children under age 19)	$2,000 / person covered / lifetime	50%
Frequency of recall examinations	6 months	
Termination of Benefit	Age 70 or retirement, whichever is earliest	

Note(s):

Scaling for children under 13: Children under age 13 are eligible for only one unit of scaling every 6 months.

GENERAL PROVISIONS

Note: For greater clarity, many terms used in the text are explained in the Definitions section provided at the end of this document.

ELIGIBILITY CONDITIONS

1. Eligibility for insurance

You are eligible for insurance if you meet the conditions specified in the *Schedule of Insurance*.

Your insurance becomes effective on the date you become eligible, if you are actively at work on that date, with full pay and on your regular work schedule. Otherwise, your coverage will become effective on the date you return to work with full pay and on your regular work schedule.

If you are in the service of the employer on the date this policy comes into force, and your insurance under another group policy terminates on the same date, you are considered eligible for insurance on the date this policy comes into force.

2. Eligibility of your spouse and children

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

3. Participation in the group insurance plan

Your participation in the group insurance plan is mandatory.

Your spouse and children, if applicable, are also required to participate in this insurance plan, unless they are covered under another group insurance policy.

4. Evidence of insurability

SSQ may request certain evidence of insurability from you, your spouse and any dependent children, if applicable. This evidence of insurability allows SSQ to determine whether or not it can approve your application for insurance and, if so, under which terms and conditions.

APPLICATION FOR AND EFFECTIVE DATE OF INSURANCE

1. Effective date of your insurance

If you are eligible for insurance, you must complete, and return to SSQ, an application for insurance.

If SSQ receives your application for insurance 31 days following the date you become eligible for insurance, your coverage will become effective on:

- the date you become eligible for insurance.

Otherwise, you will be required to provide evidence of insurability and your insurance will become effective on the date SSQ accepts this evidence.

2. Effective date of insurance for your spouse and children

If your spouse and children are eligible for insurance, an application for insurance must be completed, and returned to SSQ.

If SSQ receives the application for insurance within 31 days following the date they become eligible for insurance, their coverage will become effective on:

- the date they become eligible for insurance.

Otherwise, they will be required to provide evidence of insurability and their insurance will become effective on the date SSQ accepts this evidence.

If you already have family coverage, protection for an additional child will become effective automatically on the date the child meets the definition of a dependent child. However, you must notify SSQ in writing of any additional dependent you wish to be covered.

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

3. Time insurance becomes effective

Any date specified in the context of this policy is deemed to commence at 00:01 in the time zone of the insured's place of residence.

4. Changes to your family or employment situation

Any change to your family or employment situation may have an impact on your insurance coverage. Therefore, your employer must notify SSQ in writing within 31 days following the date of any such change.

4.1 Increase in coverage

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

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

If you are not actively at work on the date your coverage is scheduled to change, the change in coverage will become effective on the date you return to work with full pay, on your regular work schedule.

4.2 Reduction in coverage

Any reduction in coverage becomes effective on the date requested by your plan administrator if notification is received within 31 days following the date of the event motivating the change. If notification is not received within the time specified, the reduction in coverage will become effective on the date such notification is received by SSQ.

TERMINATION OF INSURANCE

1. Termination of your insurance

Your insurance terminates:

a) On the date you cease to be eligible for insurance for any of the following reasons:

- You are no longer an employee of the participating employer;
- You no longer meet the eligibility conditions stipulated in the provision *Eligibility for insurance;*
- You reach the age limit specified in the *Schedule of Insurance;*
- You are no longer actively at work, except if you have maintained your coverage in force, in accordance with the provisions specified under Section 3 *Maintaining coverage in the event of a temporary interruption of work* below.

b) On the date when premiums are due, if such premiums are not paid to SSQ prior to the expiration of the grace period.

c) On the termination date of this insurance policy.

d) If you have been exempted from payment of premiums for one or more benefits, and on the termination date of the premium waiver you have not resumed premium payments as a regular employee with full pay and on your regular work schedule.

e) On the date you collect any benefits that you are not entitled to under this policy, as a result of false claims or misrepresentations you or a third party make, irrespective of the compulsory nature of any coverage or any other action SSQ may take.

2. Termination of insurance for your spouse and children

Unless specified otherwise in the policy, your spouse's and children's insurance coverage will terminate upon the earliest of the following:

a) The date your insurance ends;

b) The date your spouse and/or children cease to be considered as dependents in the context of this policy;

c) The date you, your spouse and/or any dependent children collect any benefits that you are not entitled to under this policy, as a result of false claims or misrepresentations you or a third party make, irrespective of the compulsory nature of any coverage or any other action SSQ may take.

3. Maintaining coverage in the event of a temporary interruption of work

In the event of a temporary interruption of work, your insurance coverage can be maintained, in accordance with the conditions specified in the following sections, unless otherwise specified in your collective agreement or relevant legislation, and provided your premiums continue to be paid to SSQ.

Within 31 days following the date that your temporary interruption of work begins, and the date it ends, your plan administrator must provide SSQ with the information needed to determine the dates your coverage is to be suspended or reinstated. Your plan administrator must also specify which benefits you wish to maintain during your temporary interruption of work leave.

3.1 Disability

If you are disabled, you may continue to be insured during your disability until the final date of your employment in an employee class eligible for insurance.

3.2 Maternity leave, parental leave and compassionate leave

If you are on parental leave, maternity leave or compassionate leave, you may continue to be insured for the duration of your leave.

You may maintain any Disability Insurance coverage provided for in the policy for the duration of your leave. For each premium period you are on leave, the total premium amount must be paid for the coverage maintained

If you choose not to maintain your coverage for the whole or part of the duration of your leave, then coverage may not be reinstated at a later time during your leave. If you return to work and meet the definition of an eligible employee, as specified in the Schedule of Insurance, immediately following the end of your leave, your coverage may be reinstated on the date you return to work.

3.3 Leave without pay

If you are on leave without pay, you may be eligible to maintain your coverage for the duration of your leave, with the exception of Disability Insurance. For each premium period you are on leave, the total premium amount must be paid for the coverage maintained. To find out if you are eligible, contact your group plan administrator.

If you choose not to maintain your coverage for the whole or part of the duration of your leave, then coverage may not be reinstated at a later time during your leave. If you return to work within 12 months following the start date of your leave, and meet the definition of an eligible employee, as specified in the Schedule of Insurance, your coverage may be reinstated on the date you return to work.

3.4 Suspension

If you are suspended from your duties, you may be eligible to maintain your coverage for the duration of your leave, with the exception of Disability Insurance. For each period you are on leave, the total premium amount must be paid for the coverage maintained. To find out if you are eligible, contact your group plan administrator.

If you choose not to maintain your coverage for the whole or part of the duration of your suspension, then coverage may not be reinstated at a later time. If you return to work within 12 months following the start date of your suspension, and meet the definition of an eligible employee, as specified in the Schedule of Insurance, your coverage may be reinstated on the date you return to work.

3.5 Temporary layoff

If you are laid off temporarily, you may be eligible to maintain your coverage if your collective agreement allows for it, with the exception of Disability Insurance. For each premium period you are laid off temporarily, the total premium amount must be paid for the coverage maintained. To find out if you are eligible, contact your group plan administrator.

If you do not maintain your coverage for the whole or part of the duration of your temporary layoff, then coverage may not be reinstated at a later time during your leave. If you return to work on your regular work schedule immediately following the end of the layoff, you may resume your coverage on the date you return to work.

Any coverage that cannot be maintained, in accordance with your collective agreement, terminates on the date you are laid off and will resume on the date you return to work with full pay and on your regular work schedule.

3.6 Strike, lock-out or temporary collective work stoppage

If you are no longer actively at work due to a strike, lock-out or any other temporary collective work stoppage, you may maintain all or part of the coverage in force if relevant agreements are made between your employer and SSQ. To find out if your group has such agreements, contact your group plan administrator.

BENEFIT PROVISIONS

1. Payment of benefits

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

2. Beneficiary

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

If you do not designate a beneficiary, your estate will be considered as your beneficiary.

If you designate more than one beneficiary, but there is no mention of respective interests, benefits will be shared equally among the beneficiaries.

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

3. Proof, medical records and examinations

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

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

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

No notice may be served or action taken to recover benefits until 30 days have elapsed following the date of receipt of the proof required by SSQ.

4. Premium amount

The amount of the premiums you pay to SSQ determines the amount of coverage for which you, your spouse and any dependent children, if applicable, are insured. In no case may an insured obtain benefits in excess of those payable in accordance with the premiums paid to SSQ.

5. Third-party liability (subrogation)

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

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

6. 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.

WAIVER OF PREMIUMS

1. Eligibility

If you become disabled, you may be exempted from paying premiums for the following benefits:

- Participant's Life Insurance
- Long Term Disability Insurance

To benefit from the premium waiver privilege, you must meet the following conditions:

a) Your disability began while you were covered under this policy, and prior to the termination of your permanent employment position;

b) You are under the continuous care of a physician, except if your condition is declared stable by your attending physician, to the satisfaction of SSQ;

c) Your condition meets the definition of a disability specified in this policy.

If you are eligible for a waiver of premiums, your coverage will be maintained without premium payment, in accordance with the terms and conditions of the policy in force at the onset of your disability. The start and end dates for the waiver of premiums are specified in Section 2 *Start and end of premium waiver*.

2. Start and end of premium waiver

Your premium waiver will automatically end upon the earliest of the following:

a) The date your disability no longer meets the definition of a disability specified in this policy;

b) The date you are no longer under the continuous care of a physician;

c) The date you do not submit proof of your continued disability as requested by SSQ (you will have 90 days to submit proof from the date it is requested by SSQ; if not submitted, your premium waiver will be terminated as of the date of SSQ's request);

d) The date you do not undergo any examination or participate in any treatment likely to be beneficial to your recovery.

In addition, the following start and end dates apply:

2.1 Participant's Life Insurance

Start date:

- As of the first day of the premium period following 210 days of disability

End date:

- The date you reach age 65

2.2 Long Term Disability Insurance

Start date:

- As of the first payment of Long Term Disability benefits

End date (the earliest of the following):

- The date that your premium waiver for Participant's Life Insurance terminates
- The date you reach age 65

3. Claims, proof and medical examinations

To benefit from the premium waiver privilege, you must notify SSQ within 12 months of your last day worked, and provide proof of your disability to SSQ within 18 months from your last date worked due to total disability.

If you do not provide proof of your disability within the time limit specified, you will not be exempted from premium payments for the period preceding the date SSQ receives such proof. Furthermore, if proof is submitted to SSQ later than 12 months following the beginning of your right to waiver, you will not be entitled to the waiver of premium.

HOW TO CLAIM

If you are filing a Disability claim with SSQ, the form that you submit for your disability claim will also serve as your application for Waiver of Premium. You can obtain the claim form from your plan administrator or SSQ Customer Service. You may be required to submit proof and supporting documents with your claim.

If you are not filing a Disability claim with SSQ, you may file a claim for Waiver of Premium by completing the appropriate form, which may be obtained from your plan administrator or SSQ Customer Service. You may be required to submit proof and supporting documents with your claim.

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

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

4. Additional provisions in the event of termination of coverage

If you are exempt from payment of premiums due to a disability that began while you were covered under this benefit, and this policy is terminated and coverage is transferred to another insurer offering a comparable benefit, your life insurance coverage will be extended to the earliest of the dates outlined in the *Waiver of premiums* section above and the earliest of the following dates:

- the date on which you become covered by the other insurer under the new group insurance policy;
- the date you return to work with full pay and on your regular work schedule, provided you complete 30 calendar days of full-time work following the termination of this policy's Life Insurance benefit.

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

PARTICIPANT'S LIFE INSURANCE

1. Scope

Under the Participant's Life Insurance benefit, in the event of your death, SSQ will pay the amount of your life insurance coverage to your beneficiary, in accordance with the provisions of this policy. You must be covered under this benefit at the time of your death.

2. Amount of life insurance

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

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

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

3. Evidence of insurability

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

a) When the amount of your life insurance exceeds the maximum amount that may be underwritten without evidence of insurability. This amount is specified in the *Schedule of Insurance;*

b) If you apply for insurance more than 31 days after the date you become eligible.

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

4. Prepayment entitlement (within your lifetime)

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

a) send a written request to SSQ;

b) be exempt from payment of your Life Insurance premiums under the waiver of premiums provision;

c) provide proof that your life expectancy is less than 12 months at the time of your request;

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

d) obtain the consent of the designated beneficiary of your Life Insurance benefit.

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

Upon your death, the amount payable to the designated beneficiary of your life insurance will be reduced by the amount of the prepayment entitlement plus interest calculated at the average return rate of a 1 year Treasury Bill plus 2%.

5. Claims and proof

The form required to make a Life Insurance claim is available from your plan administrator or from SSQ Customer Service. Claims must be submitted, along with written proof of the death which has occurred, within 6 months of death. SSQ reserves the right to request additional information when processing the claim. If the claim, proof and additional information, if applicable, are not submitted within the specified time, benefits will still be payable, provided the required documents are submitted to SSQ as soon as is reasonably possible. However, no benefits will be payable if claims, proof or additional information are submitted more than 3 years after the date of death.

6. Exclusions

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

a) As a result of a criminal act you commit or attempt to commit;

b) As a result of your active participation in a riot or insurrection;

c) Directly or indirectly due to war or civil war, whether declared or undeclared;

d) While an active member of the armed forces of a country.

7. Conversion privilege

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

7.1 General provisions

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

a) ***Amount***

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

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

b) ***Premium***

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

c) ***How to convert your group life insurance***

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

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

d) ***Effective date***

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

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

7.2 Limitations

- Individual life insurance does not provide for a premium waiver in case of disability.
- If you are no longer eligible for insurance because your group policy is terminated or modified and the policy is not replaced, you will not be eligible for the conversion privilege unless you have been covered under this benefit for at least 5 years.
- If the terminated policy is replaced by another group policy within a period of 180 days, the individual policy issued will terminate on the date you become eligible for coverage under the new group policy.
- If you are no longer eligible for coverage because you have enlisted in the armed forces of a country, your life insurance coverage may not be converted.
- If you have already exercised your conversion privilege, you may convert the difference between the amount eligible for conversion under this benefit and the amount of individual life insurance resulting from any previous exercise of conversion privileges.

LONG TERM DISABILITY INSURANCE

NOTE

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

1. Scope

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

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

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

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

2. Calculation of benefits

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

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

2.1 Benefits and income from other sources

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

a) Benefits payable under any applicable legislation respecting industrial accident or occupational illnesses;

b) Benefits payable under any applicable legislation respecting automobile accidents;

c) Disability benefits payable under the Canada or Quebec Pension Plan;

d) Maternity, parental or compassionate care benefits payable under the *Employment Insurance Act*.

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

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

a) Benefits payable under this LTD coverage;

b) Any compensation received from your employer;

c) Benefits payable under any applicable legislation respecting industrial accidents or occupational illnesses, applicable legislation respecting automobile accidents or similar coverage, applicable social legislation other than the *Employment Insurance Act*, the Canada or Quebec Pension Plan, any retirement plan offered by your employer, or any group insurance policy;

d) Maternity, parental or compassionate care benefits payable under the *Employment Insurance Act*;

e) Retirement income benefits from the Canada or Quebec Pension Plan;

f) Retirement income from your employer's pension plan.

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

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

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

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

3. Disability management

3.1 Gradual return to work

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

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

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

3.2 Refusal to undergo examination or treatment

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

Failure to do so will result in suspension or termination of benefit payments.

3.3 Rehabilitation

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

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

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

The rehabilitation program resources may include, among others:

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

Remuneration you receive during the rehabilitation period will not reduce your LTD benefit unless that remuneration, together with other income or benefits specified under Section 2.1 *Benefits and income from other sources*, exceeds 100% of your monthly pre-disability gross income.

3.4 Health Support Service (Participating Employer services)

The services package named "Health Support Service" is available only through designated representatives of the group insured. Some of these services are intended to help individuals who are covered under a Long Term Disability Insurance benefit and who suffer from personal problems that may affect their productivity, which may also include helping their dependents. The remaining services are intended directly for the participating employer.

The services which representatives of the group can make available to insured persons include maximums applicable per calendar year and per family unit (the participant, his or her spouse and the participant's dependent children).

The available services are the following:

a) Over-the-phone counselling, up to a maximum of 3 hours, it being understood that legal and financial counselling is limited to only one of these 3 hours;

b) Counselling with professionals, in their office or using secure internet connections, up to a maximum of 6 hours.

The following services are intended directly for the participating employer:

a) Over-the-phone consulting services and video briefs on health-oriented management practices;

b) Crisis intervention;

c) Health bulletins.

4. Claims, proof and medical examinations

The Disability Insurance claim form is available from your plan administrator or from SSQ Customer Service.

You must submit your claim and forward written proof of your disability to SSQ within 6 months following the end of the elimination period. The elimination period begins on the first day that you are incapable of carrying out the main functions of your usual employment.

If you do not submit a claim or provide such proof within the time specified, you will not be entitled to benefits for the period prior to the date such proof is received by SSQ. Furthermore, if proof is submitted to SSQ later than 12 months following the end of the elimination period, no benefits will be payable.

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

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

In the case your claim is declined or benefit payments are terminated, you will have 60 days following the date of written notice of the above by SSQ in which to provide supplementary proof justifying the continuation of your disability or to have your file reviewed. If you do not provide such proof within 60 days, you will not be entitled to benefits for the period prior to the date of receipt of such proof by SSQ. Furthermore, if proof is submitted to SSQ later than 12 months following the date of written notice by SSQ, no benefits will be payable.

In the case that your LTD coverage ends, you must forward to SSQ, no later than 6 months after the date of the onset of your disability, written proof of:

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

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

5. Interruption of work

5.1 Maternity leave, parental leave, compassionate leave

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

5.2 Strike or lock-out

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

6. Overlapping Disability Insurance coverage

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

7. Lump sum benefit payable upon death

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

8. Exclusions

You will not be covered if you become disabled:

a) As a result of a criminal act you commit or attempt to commit;

b) As a result of your active participation in a riot or insurrection;

c) Directly or indirectly as a result of war or civil war, whether declared or undeclared;

d) While you are an active member of the armed forces of a country;

e) As a result of intentional self-inflicted injuries, regardless of whether or not you were conscious of your acts;

f) As a result of aesthetic or cosmetic treatments, unless they have become necessary as a result of an illness or an injury;

g) And you refuse to undergo a medical examination upon request by SSQ;

h) And you are not under the continuous care of a physician, except when your condition is declared stable by a physician, to the satisfaction of SSQ;

i) And you hold a position or perform work, for which you earn any salary or profit (except as stipulated in the sections *Gradual return to work* and *Rehabilitation*);

j) And you refuse to participate in a rehabilitation program recommended by SSQ.

9. Limitation

No benefits are payable for any period during which you are serving a prison sentence or are detained in a similar institution.

HEALTH INSURANCE

In this section, the term *insured* refers to you, your spouse and any dependent children, if applicable.

1. Scope

Your Health Insurance benefit covers expenses incurred for care, services, products or other eligible items provided for under your plan and listed in the following sections, insofar as they are deemed reasonable and customary. They must be prescribed by a physician as necessary for the treatment of illness or injury.

To be eligible for Health Insurance benefits, insureds must be covered by the health and hospitalization plan of their province of residence.

Expenses must be incurred while your insurance is in force.

2. Calculation of benefits

The amount reimbursed takes into account the following:

2.1 Deductible

The deductible, if applicable, is the amount you must pay out of pocket before SSQ will reimburse any covered expenses. The amount of the deductible is specified in the *Schedule of Insurance*.

The deductible applies once per calendar year to the total amount of eligible expenses incurred for you, your spouse and any dependent children, if applicable.

Any expenses incurred during the last 3 months of a calendar year that have been used to meet the amount of the deductible, in whole or in part, will reduce the next year's deductible by the same amount.

2.2 Maximum

This is the maximum amount payable for a treatment or series of treatments. The maximums provided for under your contract are specified in the *Schedule of Insurance.*

3. Exemption entitlement

If you are eligible for health insurance under another group insurance policy, you may choose to waive such coverage with SSQ.

However, if coverage under the other policy ends, you will still be eligible for the SSQ coverage you waived, as of the termination date of coverage under the other policy.

To do so, you must submit an application in writing to SSQ within 31 days following the date the other insurance terminates.

4. Hospital and medical expenses related to a workplace or automobile accident

Most medical and hospital expenses incurred as the result of an accident in the workplace are reimbursed by the workplace safety board of your province of residence.

Similarly, most medical and hospital expenses incurred as the result of an automobile accident are covered under your provincial auto insurance plan, provided one exists.

Therefore, before filing a claim with SSQ, you should first submit your expenses to these government agencies.

5. 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 SSQ. You may also contact ClaimSecure for more information.

6. Multiple coverage and coordination of benefits

Benefits for you, your spouse or any dependent children, if applicable, will be reduced by any amount payable under a government plan. If you, your spouse or dependent children are entitled to benefits for the same expenses under this or another group plan, benefits from all plans will be coordinated so that the amounts paid do not exceed the actual expenses incurred.

You and your spouse should first submit your own claims to your own group insurance plan. Claims for your dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If you are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If you share joint custody, claims for dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

You may submit a claim to your spouse's plan for any amount which is not paid by SSQ, and vice-versa.

7. Deadline for filing claims

SSQ suggests you file your claims at regular intervals, once every three (3) months. Claims must be submitted no later than 18 months following the date expenses were incurred. However, upon termination of your insurance, all claims that were incurred while you were insured must be submitted no later than 6 months following the termination date.

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

8. Exclusions

The insured is not covered for expenses incurred:

a) As a result of a criminal act the insured commits or attempts to commit;

b) As a result of the insured's active participation in a riot or insurrection;

c) Resulting directly or indirectly from a war or civil war, whether declared or undeclared;

d) While an active member of the armed forces of a country;

e) That are covered under any social legislation or law governing industrial accidents and occupational illnesses, or for treatment or services available through a municipal, provincial or federal clinic;

f) For the treatment of mental illnesses usually covered by government agencies;

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

h) For services, supplies, examinations or treatments required by a third party or received as a group;

i) For intentionally self-inflicted injury.

9. Extension of coverage

9.1 In the event of your death

In the event of your death, health insurance in force for your spouse and dependent children will be maintained with premium payment until the earliest of the following:

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

HEALTH INSURANCE – HOSPITAL ROOM

1. Scope

Your Health Insurance benefit covers the difference between the cost of hospital ward accommodation and a hospital room. The conditions applicable are specified in the *Schedule of Insurance.*

2. Conditions

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

3. Exclusions specific to hospital room coverage

This clause does not cover:

a) Administrative or incidental fees charged to the patient by the hospital;

b) Fees charged by an establishment for long-term accommodation or care that the patient is responsible for paying.

4. How to claim

Present your SSQ card at the hospital and the hospital will send your claim to ClaimSecure.

HEALTH INSURANCE – DRUGS

1. Expenses covered

Drugs

Your Health Insurance benefit covers drugs that meet all of the following conditions:

a) bear a valid DIN (Drug Identification Number) issued by the federal government;

b) are available only on prescription from a health care professional legally authorized to do so;

c) are only available in a pharmacy;

d) are dispensed by a pharmacist or health care professional legally authorized to do so;

e) must be used in compliance with government-approved directives or, where no such directives exist, with the manufacturer's instructions.

Your insurance covers all medical supplies and pharmaceutical services eligible for reimbursement under your provincial prescription drug insurance plan, if your province has one.

Furthermore, your Health Insurance covers the following drugs and medical supplies. To know if these drugs or supplies are subject to reimbursement maximums, please consult the *Schedule of insurance.*

- Intrauterine devices (IUDs), if prescribed by a physician
- Insulin, syringes, lancets, needles and test strips for the treatment of diabetes
- Substances injected for the treatment of varicose veins are covered, provided that treatment is for curative and not aesthetic purposes and that the substances are provided and injected by a physician. Any professional fees charged by the physician are not covered
- Smoking cessation products
- The preventive vaccines Gardasil, Prevnar 13, Zostavax, Zostavax II and the following Hepatitis A and Hepatitis B vaccines listed along with their DIN numbers:

  2237792 AVAXIM VACCINE 1ML INJ

  2243741 AVAXIM (PEDIATRIC)

  2187078 HAVRIX 1440 VACCINE 1mL

  2231056 HAVRIX 720 JUNIOR INJ 0.5ML

  2229702 VAQTA 0.5mL vial/prefill syr

  1919431 ENGERIX B VACCINE 1ML

  2296454 ENGERIX-B (PEDIATRIC DOSE)

  2243676 RECOMBIVAX HB INJ 1ml

  2245977 RECOMBIVAX HB VACC 1ml (ADULT DYALISIS F

2230578 TWINRIX INJ (HEP A&B VACCINE) 1ML

2237548 TWINRIX JR (HEP A &B VACC) 0.5ML

"Exception" or "Prior approval" drugs

Some prescription drugs, commonly referred to as "exception" or "prior approval" drugs, are only covered under specific clinical criteria and directions for use determined by the appropriate government authorities. Reimbursement for these drugs is subject to prior approval by SSQ.

2. Limitation specific to drug insurance

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.

Payment of any covered expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 month's supply at any one time.

3. Exclusions specific to drug insurance

The following products are not covered, regardless of whether or not they are considered medical drugs:

a) Products used for aesthetic, cosmetic or personal hygiene purposes;

b) Substances or drugs used or administered for preventative purposes, except those preventive vaccines listed in the Expenses Covered section of this benefit description;

c) Experimental drugs or those obtained under the federal Emergency Drug Release Program;

d) Homeopathic or natural products;

e) Dietary supplements intended as a meal supplement or replacement

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

f) 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 presented to SSQ;

g) Drugs used for the treatment of infertility, artificial insemination, in vitro fertilization or any other related procedures;

h) 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 SSQ;

i) Drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital;

j) Drugs used to treat erectile dysfunction (Viagra and other similar drugs);

k) The patient's contribution required for an insured who is eligible for a public prescription drug insurance plan.

4. How to claim

You must complete a Health Claim Form and send it to ClaimSecure for processing. Send the originals of all receipts or paid invoices along with the completed claim form.

If expenses were incurred for a dependent child who has reached the legal age of majority and is a full-time student, you must include the following information with your claim:

- The name of the educational establishment where your child is enrolled;
- The school year in which your child is enrolled.

HEALTH INSURANCE – HEALTH CARE PROFESSIONALS

1. Expenses covered

Your Health Insurance benefit covers expenses incurred for treatment or services obtained from the following types of health care professionals:

Acupuncturist

Audiologist

Chiropodist

Chiropractor

Christian Science Practitioner

Massage therapist

Naturopath

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 not recognized by SSQ are not covered.

Osteopath

Physiotherapist and physical rehabilitation therapist

A physical rehabilitation therapist must practise under the supervision of a physiotherapist or physiatrist.

Podiatrist

Psychologist

Speech therapist

X-rays taken by a chiropractor

X-rays taken by a chiropractor to determine the necessity for corrections to the spinal column, pelvic bones or other articulations of the body.

2. Limitations

Only one treatment by the same professional is covered per day, per insured, regardless of the number of fields of specialization the professional is licensed to practise in. Similarly, only one treatment per insured, per day is covered for the same field of specialization.

Expenses are eligible for reimbursement subject to the following conditions:

- They must be incurred for consultations or treatment provided by a health care professional or for products or supplies prescribed by a physician;
- The health care professional must be a member of a professional order governing the practice of the professional's activities and/or use of the professional title. In the absence of such an order, the health care professional must be a member of a professional association recognized by SSQ;

- The health care professional must not reside with you, your spouse or any dependent children, nor be a relative.

Preapproval recommendation:

You are advised to contact your group administrator or ClaimSecure before incurring expenses for costly treatment or medical products. Your group administrator or ClaimSecure will confirm if these expenses are covered and provide any other information you may require.

3. How to claim

To obtain reimbursement for services or supplies received from one of the health care professionals listed under Section 1 *Expenses covered* above, you must provide a 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 was received or supplies were purchased;

c) The cost of treatment or supplies;

d) The name of the insured who received the treatment or supplies.

To file a claim for expenses related to the treatment or supplies, you must complete a Health Claim Form and send it 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.

If expenses were incurred for a dependent child who has reached the legal age of majority and who is a full-time student, you must include the following information with your claim:

- The name of the educational establishment your child is enrolled in;
- The school year in which your child is enrolled.

3.1 Treatment or supplies requiring a prescription

Certain treatments and supplies are only covered when prescribed by a physician. These are listed in the *Schedule of Insurance*. When filing a claim for these treatments or supplies, you must provide the physician's prescription and the original receipt or paid invoice with your claim.

HEALTH INSURANCE – VISION CARE

1. Expenses covered

Your Health Insurance benefit covers expenses incurred for the following eye care services:

Eyeglasses

Purchase of glasses for correction of vision prescribed by an optometrist or ophthalmologist.

Contact lenses

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

Laser vision correction

Correction of myopia (shortsightedness), hypermetropia (longsightedness) or astigmatism by laser surgery when prescribed by an ophthalmologist.

2. How to claim

To be eligible for reimbursement, you must provide a receipt or paid invoice for the treatment or supplies obtained from an optometrist or ophthalmologist.

The receipt or paid invoice must include the following information:

- The name of the optometrist or ophthalmologist;
- The date when treatment was received or supplies were purchased;
- The cost of treatment or supplies;
- The name of the insured who received the treatment or supplies.

You must complete a Health Claim Form and send it to ClaimSecure for processing.

Send the prescription and receipt or paid invoice issued by the optometrist or ophthalmologist who provided the treatment or supplies along with the completed claim stub.

If expenses were incurred for a dependent child who has reached the legal age of majority and who is a full-time student, you must include the following information with your claim:

- The name of the educational establishment your child is enrolled in;
- The school year in which your child is enrolled.

HEALTH INSURANCE – OTHER MEDICAL EXPENSES

1. Expenses covered

Ambulance and transport by airplane or train

Transport to or from a hospital by a licensed ambulance service, including oxygen therapy treatments administered during or immediately before transportation.

Return transportation by airplane or train of a bedridden patient occupying the equivalent of 2 single seats, when part of the journey requires the use of one of these means of transportation.

Note: Certain government programs reimburse the cost of an ambulance for individuals aged 65 years and over. Insureds age 65 and over should verify if such programs exist in their province of residence before submitting a claim for ambulance expenses.

Blood glucose monitor

Device used to measure blood sugar levels.

Continuous glucose monitor

Purchase of continuous glucose monitor.

Convalescent home immediately following hospitalization

The daily cost of accommodation and meals in a convalescent home is covered, including all related care and services, provided that the establishment is:

- recognized by SSQ or your provincial ministry governing health and social services; and
- capable of providing the medical care of a registered nurse or a licensed physician 24 hours per day.

Your Health Insurance benefit covers the difference between the cost of hospital ward accommodation and a semi-private hospital room, up to the amount indicated in the *Schedule of Insurance*.

Preapproval recommendation:

Before incurring any expenses for this type of care, contact ClaimSecure to verify if the convalescent home where you, your spouse or dependent child, if applicable, wish to undergo treatment is recognized by SSQ.

To be eligible for reimbursement, such care is 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 your employer or through ClaimSecure.

If eligible for reimbursement, you must provide SSQ with the originals of all receipts or paid invoices for treatment received.

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.

These expenses are only covered if:

- you, your spouse, or any dependent children, if applicable, were insured at the time the accident occurred;
- treatment is administered by a licensed dentist or denturist; and
- treatment is received while you are covered under this benefit.

Expenses will be covered up to the amount specified in the official dental procedure fee guide approved by your provincial Dental Association.

Detoxification

The daily cost of acommodation and meals in a facility specialized in the rehabilitation of alcohol and other substance abuse addictions is covered, including all care and services related to treatment, provided the following conditions are met:

- the facility is recognized by SSQ;
- the insured is receiving curative treatment;
- the facility is run by a licensed physician and is under the constant supervision of a registered nurse.

External prosthesis and artificial limb

The cost of purchasing an external prosthesis or artificial limb is covered, provided you, your spouse or dependent child, if applicable, were covered under this clause at the onset of the disability causing the loss of the natural limb.

Dental prostheses, hearing aids, eyeglasses and contact lenses are excluded, unless specifically covered under another provision of the Health Insurance benefit.

Eye examination

Eye examination by an optometrist or ophthalmologist.

Foot orthoses

Foot orthoses must be obtained from an officially licensed laboratory specialized in foot orthotics. Expenses covered are limited to those specified in the price list issued by the appropriate authorities.

Hearing aids

Purchase, adjustment, replacement or repair of a hearing aid. Ear molds are also covered.

Hospital bed

Rental or purchase, whichever is most economical, of a hospital bed of the type normally used in a hospital centre. Expenses eligible for reimbursement under the health insurance plan of the insured's province of residence are not covered.

Infusion insulin pump

Purchase or repair of an infusion insulin pump.

Laboratory analyses

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.

Nurse

Continuous and exclusive care provided to the insured, at home, by a registered nurse or a registered nursing assistant, who is not a member of the insured's family. SSQ will reimburse only those expenses for care that requires the specific skills of one of the aforementioned nurses.

Orthopaedic apparatus

Purchase, adjustment, replacement or repair of corsets, splints, crutches, casts or items for severe burn victims.

For any other orthopaedic apparatus, benefits are payable up to the cost of the apparatus necessary to perform basic daily activities. This clause does not cover orthopaedic shoes or foot orthoses.

Orthopaedic shoes

Custom-made or modified stock-item orthopaedic shoes which are required due to a medical abnormality which, based on medical evidence, cannot be accommodated in the stock-item orthopaedic shoe, up to a maximum of 1 (one) pair every calendar year subject to a maximum of $200 every calendar year with an 80% co-payment. Shoes must be prescribed by a physician and constructed by one of the following certified orthopaedic footwear specialists:

- Orthotist CO (c) or CPO (c)
- Pedorthist CPed (c) or CPed (MC)
- Podiatrist (DPM)
- Chiropodist (D CH or D Ped M)

Claim must include all of the following:

- Diagnosis of the condition;
- A list of symptoms and the chief complaint;
- A description of the physical finding from the clinical examination;
- A brief narrative description of the gait abnormality associated with the diagnosis;
- Confirmation that the product has been custom-made/modified.

Out of Country Referral

Referral outside Canada for treatment which is available in Canada, to a maximum of $3,000 every 3 calendar years.

If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar years.

Residential and long-term care centre (chronic care)

Daily cost of accommodation and meals when admitted to a residential and long-term care centre recognized by the ministry of health and social services in the province of residence. Admittance must immediately follow a period of hospitalization, and the patient must not have been admitted to a residential and long-term care centre prior to such hospitalization.

Respirator (breathing apparatus)

Rental or purchase, whichever is more economical. Oxygen is also covered.

Support hose

Purchase of graduated compression stockings, more than 20mmHg, 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 and worn by mastectomy patients.

Therapeutic devices

Rental, repair or purchase, whichever is more economical, of therapeutic devices.

This clause does not cover insulin pumps, monitoring devices such as blood glucose monitors, dextrometers, stethoscopes, sphygmomanometers or other similar devices, as well as home accessories such as whirlpool baths, air purifiers, humidifiers, air conditioning units, or other devices of a similar nature.

Transcutaneous electrical nerve stimulator

Purchase, rental, adjustment, replacement or repair of a transcutaneous electrical nerve stimulator.

Wheelchair

Rental, purchase or repair, whichever is most economical, of a non-motorized wheelchair of the same type normally used in a hospital centre, or where medically necessary, an electric wheelchair and initial batteries. Additional batteries are not covered. Expenses eligible for reimbursement under the health insurance plan of the insured's province of residence are not covered.

Wig following chemotherapy

Purchase of a wig (capillary prosthesis) necessary as a result of chemotherapy.

X-rays

X-rays taken outside a hospital centre in a private clinic for the purpose of prevention or diagnosis.

2. How to claim

To obtain reimbursement for expenses incurred, you must submit the original copy of the paid invoices for any services or supplies listed above.

2.1 Medical treatment

Invoices must include the following information:

- The health care professional's name, association or professional order, and the professional's membership number;
- The date when treatment was received;

- The cost of treatment;
- The name of the insured who received the treatment.

2.2 Medical supplies

Invoices must include the following information:

- The date of purchase;
- The cost of the supplies;
- The name of the insured for whom supplies were purchased;
- The supplier's full contact details.

You must complete a Health Claim Form and send it to ClaimSecure for processing. Send the receipt or paid invoice issued by the health care professional who provided the treatment or supplies along with the completed claim stub.

If expenses were incurred for a dependent child who has reached the legal age of majority and who is a full-time student, you must include the following information with your claim:

- The name of the educational establishment your child is enrolled in;
- The school year in which your child is enrolled.

2.3 Treatment or supplies requiring a prescription

Certain treatments and supplies are only covered when prescribed by a physician. These are listed in the *Schedule of Insurance*. When filing a claim for these treatments or services, you must include the physician's prescription and the original receipt or paid invoice with your claim.

HEALTH INSURANCE – TRAVEL ASSISTANCE INSURANCE

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

In Canada or the United States: 1-800-465-2928

Elsewhere in the world: +1-514-286-8412 (collect call)

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

1. Eligibility

To be eligible for Travel Assistance Insurance, you, your spouse and any dependent children, if applicable, must be entitled to benefits under your provincial health insurance and hospitalization plan for the duration of your trip outside your province of residence.

2. Scope

SSQ will cover eligible expenses if the insured has an accident, sudden and unexpected illness, or dies while temporarily outside their province of residence.

Coverage under this benefit is limited to the period while individuals are outside their province of residence and are also covered under their public health and hospitalization plans. For any trip scheduled for a period of time exceeding the period covered by these public plans, all excess days are not covered by this coverage. Furthermore, coverage under this benefit only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the insured's province of residence.

3. Stability of health condition

If the insured already has a known disease or illness before the trip, you must ensure before departure that the insured:

- Is in a good, stable state of health;
- Is able to carry out usual daily activities; and
- Is 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.

In other words, for the insured to be covered, the known disease or illness must be under control before departure.

SSQ strongly recommends contacting CanAssistance, its travel assistance provider, several weeks prior to departure, if for the disease or illness:

- Symptoms worsen;
- A relapse is suffered;
- The condition is unstable;

- It is in its terminal phase;
- It is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip.

CanAssistance can provide you with details of exactly what is meant by sudden and unexpected illness. They will also clarify if this benefit applies to your situation or that of your spouse or any dependent children, if applicable.

4. Conditions

Expenses incurred will only be eligible for reimbursement if:

- The situation requires emergency care;
- Deemed customary, reasonable and necessary;
- Incurred for supplies or services prescribed by a physician as treatment for an illness or injury.

For the following eligible expenses, approval must be requested **as soon as possible** from SSQ's travel assistance services, either by the insured or by any other adult able to do so:

- Hospitalization
- Medical care
- Transportation by ambulance

For the following eligible expenses, insureds must obtain **prior approval** from SSQ's travel assistance service:

- Treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist;
- Repatriation of the insured;
- Air transport for a medical escort;
- Living expenses and transportation of a close relative;
- Preparation and transportation of the insured's remains if deceased, or burial or cremation on the spot;
- Return of a vehicle;
- Expenses described under the Services, Products and Articles section below.

5. Expenses covered

Expenses are limited to $5,000,000 per insured for the duration of the trip outside the province of residence. The following expenses are covered:

5.1 Hospitalization

Hospitalization in a hospital where the insured receives curative treatment.

5.2 Professional fees

Fees charged by the following health care professionals:

Physician

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

Nurse

Registered nurse fees for private nursing care provided exclusively in a hospital when such care is medically necessary and prescribed by a physician.

The maximum amount payable is $5,000 per insured per trip. The nurse must not be related to the insured nor a travel companion.

Chiropractor, podiatrist or physiotherapist

The fees of a chiropractor, podiatrist or physiotherapist.

Dentist

Professional fees of a dentist for accidental injury to natural teeth. The accident must have occurred outside the insured's province of residence. Expenses covered are limited to those incurred while this benefit is in force.

Expenses must be incurred within the 12 months following the accident and treatment may be obtained after the insured's return to the province of residence.

The maximum amount payable is $1,000 per insured per trip.

5.3 Prescription drugs

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

5.4 Transportation

The following transportation costs are covered:

Ambulance

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.

Air transport for medical escort

The cost of economy class round-trip transportation by air for a medical escort when required by the air carrier or the attending physician of the insured.

The medical escort must not be a family member of the insured nor a travel companion.

Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class round-trip transportation for one close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days or, in case of death, between the place of residence and the place where the deceased insured's body must be identified.

The following members of the insured's family are considered to be close relatives: spouse, son, daughter, father, mother, brother, sister.

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.

Eligible expenses 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 for the whole duration of the stay.

In case of death of the insured, preparation and transportation of the body or burial or cremation on the spot

The expenses of preparing and returning the remains of the insured by the most direct route home, or burial or cremation on the spot, excluding expenses incurred for a coffin or funeral urn. The maximum amount payable is $10,000 for preparation of the body and transportation.

Return of a vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency.

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. The maximum amount payable is $2,000 per trip.

5.5 Services, products and articles

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

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

5.6 Living expenses

The cost of accommodation and meals in a commercial establishment incurred by the insured, when obliged to modify the planned trip due to hospitalization of the insured, a family member or a travel companion.

The duration of hospitalization must be at least 24 hours. The maximum amount payable is $300 per day, up to a limit of $2,400 per trip outside the province of residence for all persons covered.

5.7 Travel assistance services

Your insurance covers certain travel assistance services. These services may not be available in all countries and are subject to change by SSQ without notice.

These services include:

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 services 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) If necessary, 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) If necessary, arranging for the return of insured persons to their home (return expenses not included);

h) If necessary, arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident;

i) If necessary, communicating with the insured's family or employer;

j) Acting as an interpreter for emergency calls;

k) Recommending a lawyer in the case of a serious accident. Legal fees are not covered.

6. Coordination and reduction of benefits

The benefits payable under your Travel Assistance Insurance will be reduced by the amount of any similar benefits payable under another insurance policy. However, if the insured is entitled to similar benefits under other clauses of your SSQ Health Insurance coverage, benefits shall be payable under the Travel Assistance Insurance clause.

7. Exclusions, limitations and restrictions

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

The following expenses are not eligible for reimbursement under the Travel Assistance 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 an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the insured is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline;

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.

8. How to claim

To file a claim, obtain approval before incurring or paying any eligible expenses, or to request assistance, contact the insurer's travel assistance service at one of the numbers below:

In Canada or the United States: 1-800-465-2928

Elsewhere in the world: +1-514-286-8412 (collect call)

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

All the travel assistance services, and reimbursement for most expenses eligible under Travel Assistance Insurance, will be coordinated by the insurer's travel assistance service, provided the insured contacts one of its representatives.

When the insured returns home, the insurer's travel assistance service will send you:

- The documents you need to file your claim. All receipts and paid invoices for eligible expenses paid must be enclosed with your claim;
- A form for you to sign, authorizing the insurer's travel assistance service to obtain reimbursement in your name for expenses incurred from your provincial health and hospitalization plan.

HEALTH INSURANCE – TRAVEL CANCELLATION INSURANCE

In the event of trip cancellation prior to departure due to a travel advisory issued by the Government of Canada, you must contact SSQ's travel assistance service for the procedure to follow either 72 hours before a deposit becomes due or 72 hours before the scheduled date of departure, whichever comes first.

In the event of trip cancellation prior to departure for any reason other than a travel advisory, you must contact SSQ's travel assistance service for the procedure to follow at the latest 48 hours following the event causing cancellation.

The telephone numbers to contact SSQ's travel assistance service are the following:

In Canada or the United States: 1-800-465-2928

Elsewhere in the world: +1-514-286-8412 (collect call)

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

1. Scope

If an insured has to cancel, extend or interrupt a trip, the insurer will reimburse eligible expenses incurred.

SSQ will reimburse eligible expenses up to a maximum of $5,000 per insured, per trip.

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

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

c) Death of a family member of any of the following individuals: the insured; the insured's spouse; the insured's child; the insured's travel companion. The funeral must be scheduled to take place during the period extending from 31 days before and 31 days after the planned trip;

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

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

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

g) Death or emergency hospitalization of the host at destination;

h) The insured's or travel companion's summons for jury duty or subpoena to act as a

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

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

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

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

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

m) For trip cancellation

The issuance by the Government of Canada of an advisory:

- To avoid all travel, or to avoid non-essential travel, to a location where the insured plans to travel; or
- To avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

The advisory must be issued after the insured has made the travel arrangements. The advisory must be in force on the scheduled date of departure;

For trip interruption

The issuance by the Government of Canada of an advisory:

- To avoid all travel, or to avoid non-essential travel, to a location where the insured is on a trip; or
- To avoid all cruise ship travel when the insured is already on a cruise ship;

The advisory must be in force during the trip. The insured must comply with the advisory within 14 days following its issuance;

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 cancelled or 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 public carrier, provided the scheduled connection after departure is cancelled or 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.

3. 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 made, 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.

Eligible expenses are described hereafter and are reimbursed according to the indications in the *Schedule of Insurance*:

3.1 Cancellation prior to departure

In the case of cancellation prior to departure, your insurance covers:

a) The non-refundable, unusable, non-transferrable and irrecoverable portion of prepaid travel expenses. Any form of credit, compensation or indemnification (with or without restriction on use) offered by a travel provider, a travel agency, a public carrier, an accommodation facility or an agency is considered as a reimbursement 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.

3.2 Missed departure, flight cancellation or if the trip must be interrupted temporarily

Your insurance covers:

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 cancelled flight or 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.

3.3 If the return is earlier or later than planned

Your insurance covers:

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.

3.4 Round-trip transportation

Your insurance will cover 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 to the province of residence 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.

4. Coordination and reduction of benefits

Benefits payable under your Travel Cancellation Insurance will be reduced by the amount of any similar benefits payable under another insurance policy. However, if the insured is entitled to similar benefits under other clauses of your SSQ Health Insurance coverage, benefits shall be payable under the Travel Cancellation Insurance clause.

5. Exclusions, limitations and restrictions

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

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

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

   a) 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;

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

   c) Intentional self-inflicted injury by the insured or travel companion, or suicide or attempted suicide by the insured, regardless of the state of mind of the person;

   d) 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;

   e) 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;

   f) 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;

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

2) No expenses are payable if the insured made travel arrangements while a Government of Canada advisory was in effect recommending:

   - To avoid all travel to a location where the insured plans to travel; or
   - To avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship.

   However, this exclusion does not apply:

   - To any trip cancellation for an eligible reason for cancellation other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure; and
   - To any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure or during the insured's trip.

3) No trip interruption expenses are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending:

   - To avoid all travel to a location where the insured plans to travel; or
   - To avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship.

   However, this exclusion does not apply to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level during the insured's trip.

4) No trip interruption expenses caused by the following advisory are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending to avoid non-essential travel to a location where the insured plans to travel.

   However, this exclusion does not apply to any trip interruption caused by the advisory, if there is a change to the risk level of the advisory to a higher risk level during the insured's trip.

5) No trip interruption expenses caused by one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

   - To avoid all travel or to avoid non-essential travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
   - To avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

   If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

6) No trip interruption expenses for an eligible reason for interruption other than one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

   - To avoid all travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
   - To avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

   If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

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.

6. How to claim

To file a claim, contact CanAssistance at one of the numbers below:

In Canada or the United States: 1-800-465-2928

Elsewhere in the world: +1-514-286-8412 (collect call)

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

You must include the following supporting documents with your 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 agency or a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services, specifying the non-refundable amounts in the event of cancellation;

d) Written proof that you have requested a reimbursement of travel expenses along with the reply you receive from the travel agency, public carrier or business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services;

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.

MEDICAL ASSISTANCE – HEALTH INSURANCE

1. Medical second opinion

This Medical Assistance applies to any person under age 65 who is insured under the Health Insurance benefit at the time of request for a medical second opinion.

When SSQ's service provider of Medical Assistance receives a request for a medical second opinion from an insured person who has been diagnosed with an illness or necessity of a surgery, and that diagnosis is eligible under this Medical Assistance program, a team of medical specialists will review 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.

Eligible medical conditions may be degenerative neurological diseases, severe afflictions, or other conditions seriously endangering life, including those listed in the "Eligible Diagnoses" section below.

2. Eligible diagnoses

1. Aortic surgery
2. Aplastic anemia
3. Bacterial meningitis
4. Benign brain tumour
5. Blindness
6. Cancer (life-threatening)
7. Coma
8. Coronary angioplasty
9. Coronary artery bypass surgery
10. Crohn's disease requiring surgery
11. Deafness
12. Dementia, including Alzheimer's disease
13. Dilated cardiomyopathy
14. Ductal carcinoma in situ of the breast
15. Fulminant viral hepatitis
16. Heart attack
17. Heart valve replacement
18. Kidney failure

19. Liver failure of advanced stage
20. Loss of independent existence
21. Loss of limbs
22. Loss of speech
23. Major organ failure on waiting list
24. Major organ transplant
25. Motor neuron disease
26. Multiple sclerosis
27. Muscular dystrophy
28. Occupational HIV infection
29. Paralysis
30. Parkinson's disease
31. Primary pulmonary hypertension
32. Progressive systemic sclerosis
33. Severe burns
34. Severe rheumatoid arthritis
35. Stage 1A malignant melanoma
36. Stage A (T1a or T1b) prostate cancer
37. Stroke (cerebrovascular accident)
38. Systemic lupus erythematosus

This Medical Assistance program also provides for the following diagnosed illnesses for dependent children who are insured under the Health Insurance benefit:

1. Cerebral palsy
2. Congenital heart disease requiring surgery
3. Cystic fibrosis
4. Down's syndrome
5. Mental deficiency
6. Spina bifida cystica

3. Request for a medical second opinion

To request a medical second opinion, the insured must first contact the Medical Assistance provider at the telephone number indicated in their insurance documents.

4. Availability of services

Availability of Medical Assistance 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 INSURANCE

For the purposes of this benefit, the term *insured* refers to you, your spouse and any dependent children, if applicable.

1. Scope

When an insured covered by the Dental Care Insurance benefit incurs dental expenses, SSQ reimburses these in accordance with the provisions specified in the *Schedule of Insurance.*

Expenses incurred are eligible for reimbursement if they meet the following conditions:

- Dental services and treatment are provided by an accredited dentist, dental specialist, dental hygienist or denturist who neither resides with the insured, nor is a relative;
- Dental services and treatment expenses have been paid;
- Dental services and treatment are received while this contract is in force.

Any medications, products, devices or materials not used in conformity with the directions approved by the competent authorities or, in the absence of such authorities, with the instructions provided by the manufacturer, are not covered.

2. Calculation of benefits

The amount reimbursed takes into account the following:

2.1 Deductible

The deductible, if applicable, is the amount you must pay out of pocket before SSQ will reimburse any eligible expenses under the Dental Care Insurance benefit. This amount is specified in the *Schedule of Insurance*.

The deductible applies, once per calendar year, to the total amount of eligible expenses incurred for you, your spouse and any dependent children, if applicable.

Any expenses incurred during the last 3 months of a calendar year that have been used to meet the amount of the deductible, in whole or in part, will reduce the next year's deductible by the same amount.

2.2 Maximum

This is the maximum amount payable for a treatment or series of treatments. The maximums provided for under your contract are specified in the *Schedule of Insurance.*

2.3 Dental fee guide

The amounts eligible for reimbursement are specified in the general practitioners' fee guide approved by your provincial dental association for the year indicated in the *Schedule of Insurance.*

Eligible laboratory expenses are limited to 50% of the fees specified for the dental treatment or service in question.

3. Exemption entitlement

If you are eligible for dental care insurance under another group insurance policy, you may choose to waive such coverage with SSQ.

However, if coverage under the other policy ends, you will still be eligible for the SSQ coverage you waived, as of the termination date of coverage under the other policy.

To do so, you must submit an application in writing to SSQ within 31 days following the date the other insurance terminates.

4. Expenses covered

4.1 Basic dental care

a) Diagnostic services

1. Clinical oral examination
   - Recall or periodic oral examination: one examination per period of 6 months
   - Complete oral examination: one examination per period of 2 calendar years
   - Complete periodontal examination: one examination per period of 2 calendar years
   - Emergency examination: 2 examinations per calendar year
   - Specific oral examination: 2 examinations per calendar year
2. Radiographs (X-rays)
   a) Intraoral films
      - Periapical film
      - Occlusal film
      - Bitewing film

   b) Extraoral films
      - Extraoral film
      - Sinus examination
      - Sialography
      - Use of radiopaque dyes to demonstrate lesions
      - Temporomandibular joint
      - Panoramic film: one film per period of 2 calendar years
      - Cephalometric film

   c) Other
      - Interpretation of radiographs from another source: one film per calendar year
      - Duplicate radiograph: 2 times per calendar year

3. Laboratory tests and examinations
    - Histological tests: Biopsy of soft tissue, biopsy of hard tissue
    - Cytological tests
    - Diagnostic casts (excluded if associated to restorative treatment or prosthodontics)
    - Case presentation / treatment plan
    - Consultation with patient
    - Vitality test

b) *Preventive services*

1. Preventive services
    - Polishing of coronal portion of teeth: one visit per period of 6 months
    - Scaling/root planing: 16 units of time per calendar year; one unit every 6 months for children under age 13
    - Topical application of fluoride: once per period of 6 months
    - Oral hygiene instruction: initial plus one recall
    - Finishing restorations
    - Pit and fissure sealants, including prophylactic odontotomy and acid etch preparation (only on occlusal surfaces of premolar and permanent molar teeth)
    - Removal of subgingival filling material requiring anesthesia, without flap
    - Interproximal discing
    - Enameloplasty (recontouring of natural tooth for non-aesthetic reasons)
2. Space maintainers
3. Control of oral habits*
    - Fixed or removable appliance
    - Myofunctional evaluation: one visit per period of 24 months
    - Motivation of patient: one visit per lifetime
    - Myofunctional therapy: 5 visits per lifetime

* Only children under age 16 are eligible for these services.

4.2 Routine dental care

a) *Minor restorative services*

- Sedative filling
- Smoothing of traumatized tooth
- Amalgam and composite restorations*

- Retentive pins

* 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.

b) *Endodontics**

- Endodontic emergency: pulpotomy, pulpectomy, open and drain
- Endodontic trauma, treatment and surgery
- Apexification

* Root canals and therapy are limited to one intital treatment plus one re-treatment per lifetime. Re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

c) *Periodontics*

- Non-surgical treatment
- Periodontal surgery
- Gingival curettage (6 units of time per calendar year or one visit per tooth per period of 24 months)
- Splinting
- Periodontal irrigation
- Appliance for bruxism (one appliance per period of 36 months): repair (one visit per calendar year) and adjustment (one visit per calendar year)
- Occlusal equilibration (8 units of time per calendar year or one major and 3 minor occlusal equilibrations per calendar year)

d) *Rebase (jump), reline, adjustment and repair of removable dentures*

- Rebase, reline
- Repairs with or without impression
- Palatal lift
- Remount and equilibration of complete or partial dentures: one visit per period of 60 months

e) *Repair of fixed bridges and crowns*

- Repair of fixed bridges
- Repair of crowns
- Recementation, immobilization, sectioning

f) *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 tumors
- 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

g) *Additional services*

- Local anesthesia
- General anesthesia (anaesthetic cost only)
- Conscious sedation
- Home, hospital or dental office visit outside normal office hours

4.3 Dental restorative services

a) *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
- Preformed crowns - stainless steel, plastic or other similar material; also transitional crowns: once per period of 12 months for any one tooth
- Individual crown
- Coping crown (cap), precious metal or not
- Cast metal posts
- Laboratory processed veneer for anteriors and premolars
- Other restorative services
- Recementation/rebonding of inlay, onlay, crown, veneer, post or broken tooth chip: 2 visits per calendar year for any one tooth
- Post removal
- Prefabricated post
- Tooth reconstruction (core build up) in preparation for crown
- Supplement for restoration
- Implants and any implant-related treatment or prosthesis

b) *Removable dentures (see limitation on replacement dentures)*

- Complete dentures*
- Partial dentures*

* Equilibrated dentures are reimbursed on the basis of the equivalent standard dentures.

c) *Fixed bridges (see limitation on replacement dentures)*

- Pontics
- Butterfly bridge (Maryland, Rochette or other)
- Metal cast retainer (inlay) for Monarch bridge
- Abutment
- 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

4.4 Orthodontics

This clause only covers expenses incurred for your insured dependent children, provided they are under age 19.

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. SSQ will determine the amount of subsequent reimbursements and spread these out over the duration of treatment. 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
- Orthopaedic treatment
- Radiograph: hand and wrist (as diagnostic aid for dental treatment)
- Complete treatment of dental malocclusion

5. Limitations

a) All insureds are considered as being eligible for the public health insurance plan of their province of residence. If this is not the case, SSQ 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.

b) Where the dental procedure fee guide approved by the dental association of the province mentioned in the *Schedule of Insurance* 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.

c) Where the dental procedure fee guide approved by the dental association of the province mentioned in the *Schedule of Insurance* 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 this contract. Any costs related to additional units are not covered under the contract.

d) No benefits will be paid for gold foil, inlays or replacement dentures (individual crown, veneer, cast post, prefabricated post, removable dentures, fixed bridge, implants) 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).

e) If you or your dependents become insured for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $125 for each insured person.

6. Exclusions

The insured is not covered for any losses or expenses incurred:

a) As a result of a criminal act the insured commits or attempts to commit;

b) As a result of the insured's active participation in a riot or insurrection;

c) Resulting directly or indirectly from a war or civil war, whether declared or not;

d) While an active member of the armed forces of a country;

e) For services, supplies, examinations or treatments that do not comply with reasonable and customary standards of current practice in the healthcare profession in question;

f) For services, supplies, examinations or treatments required by a third party or received collectively;

g) For aesthetic care, including transformation, extraction or replacement of healthy teeth to modify their appearance;

h) In relation to self-inflicted injuries;

i) For any drugs, products, devices, services or supplies used for experimental purposes or at the medical research stage;

j) For an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction and vertical dimension correction;

k) For the replacement of removable appliances or dentures that are lost or stolen;

l) 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;

m) For sports appliances, e.g. mouth guards;

n) For expenses that the insured would not have had to assume if uninsured, that the insured is not obliged to pay or that the insured would not be obliged to pay if covered under the provisions of a public insurance or social security plan, government program, applicable legislation, or any regulation or decree adopted with regard to such plans, programs or legislation;

o) For the services of a professional who normally lives in the insured's home, or who is a relative of the insured;

p) For a dental appliance for treatment of snoring and sleep apnea;

q) For transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort;

r) For transitional pontics or abutments made during healing;

s) For treatment or services in relation to microbiological tests or analyses;

t) For diagnostic photographs.

7. Preapproval of treatment costs

When expenses exceed eight hundred dollars ($800), particularly in the case of major restorative services, a detailed written treatment plan and radiographs must be submitted to SSQ prior to the start of treatment. This allows SSQ to determine the eligibility of treatment and the amount of benefits payable.

Certain expenses are only eligible for reimbursement if pre-approved by SSQ, following analysis of appropriate supporting documents, such as a copy of the patient's chart, radiograph(s), periodontal chart, diagnostic cast, etc.

8. Deadline for filing claims

SSQ suggests you file your claims at regular intervals, once every three (3) months. Claims must be submitted no later than 18 months following the date expenses were incurred. However, upon termination of your insurance, all claims that were incurred while you were insured must be submitted no later than 6 months following the termination date.

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

9. How to claim

If your dentist uses electronic claim submission

When you, your spouse, and any dependent children, if applicable, incur dental expenses, present your SSQ Card 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.

For more information about electronic dental claim processing, you may wish to consult the information you received with your SSQ Card.

If your dentist does not use electronic claim submission

If your dentist does not use electronic claim submission, you may file your claim by completing and returning to ClaimSecure the standard dental claim form provided by your dentist.

10. Multiple coverage and coordination of benefits

Benefits for you, your spouse and any dependent children, if applicable, will be reduced by any amount payable under a government plan. If you, your spouse or dependent children are entitled to benefits for the same expenses under this or another group plan, benefits from all plans will be coordinated so that the amounts paid do not exceed the actual expenses incurred.

You and your spouse should first submit your own claims to your own group insurance plan. Claims for your dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If you are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If you share joint custody, claims for dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

You may submit a claim to your spouse's insurance plan for any amount which is not paid by SSQ, and vice-versa.

11. Extension of coverage

11.1 In the event of your death

In the event of your death, dental care insurance in force for your spouse and dependent children will be maintained with premium payment until the earliest of the following:

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

DEFINITIONS

Accident

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

Actively at work

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

Basic daily activities

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

Business partner

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

Commercial activity

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

Day

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

Dentist

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

Dependent child

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

- under age 21, or
- 21 or over but under age 25 and a full-time student in an accredited educational institution, subject to proof deemed satisfactory by SSQ; or
- any age, if suffering from a severe, incurable and chronic physical or mental disability. The disability must occur while the child still meets the requirements of a dependent child indicated above. This disability renders the child incapable of pursuing gainful employment. Satisfactory medical evidence must be provided to SSQ.

Disability

During the Long Term Disability Insurance elimination period and the following 24 months:

A total and continuous incapacity caused by an accident or illness that prevents you from carrying out the main duties of your usual employment.

After the above-mentioned period:

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

Disability period

A continuous absence from work due to disability.

Elimination period

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

Employee

Any salaried individual who works on a regular basis for the employer.

Employer

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

Family member

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

Hospital

A hospital as defined under applicable federal or provincial laws.

Hospitalization

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

Host at destination

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

Illness

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

Insured

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

Medical specialist

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

Net salary

Your salary at the onset of disability, after deduction of federal and provincial income taxes.

Participant

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

Physician

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

Premium period

Interval for the payment of premiums as agreed to by the participating employer and SSQ.

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 or accommodation from a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services;
- 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.

Proof

Evidence or proof deemed satisfactory by SSQ.

Public carrier

Refers to any carrier approved by the appropriate authorities and operating with a transport licence for the transportation (air, sea, land) of passengers for remuneration.

Reasonable and customary expenses

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

Recurring disability

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

- they are due to the same causes and are separated by less than 31 consecutive days during which you are actively back at work in your usual duties on full pay and on your regular schedule.
- they are due to entirely different causes and are separated by less than one full day during which you are actively back at work in your usual duties on full pay and on your regular work schedule.

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

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

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

Relative

See **Family member**.

Salary

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

Spouse

For the purposes of this policy, your spouse is the person who:

- is married to you through a civil union or other legally recognized marriage; or
- is living common-law with you, and has a child with you, and whom you have designated in writing to SSQ as your spouse; or
- has been living common-law with you for at least 12 months, and whom you have designated in writing to SSQ as your spouse.

The status of spouse ends when:

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

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

Travel companion

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

Trip

For Travel Assistance Insurance purposes: A trip taken outside the insured's usual province of residence. In this case, the term trip also applies to the insured's transportation between the departure and the return.

For Travel Cancellation Insurance purposes: An occasional trip made by an insured from the usual place of residence to temporarily visit a place at least 200 kilometres away. To be recognized as a

trip under Travel Cancellation Insurance, the trip must also require a period of absence of at least 2 consecutive nights and must be for tourism, pleasure or attendance at a commercial activity. In addition, in the case of a cruise, it must be operated under the responsibility of a business which is accredited or authorized by the appropriate authorities to operate such a business or provide such services.

You

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

DISPUTE RESOLUTION PROCEDURE

In the event of a dispute between you and SSQ with respect to benefits under this plan, there is an Insurance Dispute Resolution Procedure to be followed. You may begin the appeal process of SSQ's decision by submitting new documentation for review by SSQ within 60 days of receipt of the claim denial or termination letter.

If you still dispute SSQ's decision after the appeal process, you may begin the arbitration process. The written Arbitration Notice must be submitted to SSQ within 60 days of receipt of the denial of the claim after the appeal process.

Details of the Dispute Resolution Procedure are available from the OJTBF, 505 Consumers Road, Suite 511, Toronto, Ontario M2J 4V8 Tel. 416-443-9223 or toll free at 1-877-766-7823 ojtbf.ca

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