SSQ insurance

communities make us

Group insurance

Your plan



Policies 13K00 and 1HB60

Fédération des médecins omnipraticiens du Québec

PHYSICIANS, MEMBERS OF FMOQ,

Updated in January 2024

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

SSQ, LIFE INSURANCE COMPANY INC.

and

SSQ INSURANCE COMPANY INC.

YOUR GROUP INSURANCE PLAN

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

Policy Numbers:

13K00

1HB60 (Critical Illness Insurance)

UPDATED IN JANUARY 2024

NOTICE REGARDING THE PROTECTION OF YOUR PERSONAL INFORMATION

Protecting your personal information is a priority for SSQ Insurance. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g.: pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g.: preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does SSQ Insurance collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does SSQ Insurance share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers

- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Chief Privacy Officer

625 rue Jacques-Parizeau

Quebec QC G1R 2G5

cpo@beneva.ca

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at:

https://www.beneva.ca/en/legal-notes-confidentiality/personal-information-protection

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but SSQ Insurance will not be able to continue providing you with its products or services.

AVAILABLE INFORMATION ON YOUR GROUP INSURANCE PLAN

If your contract has been modified since the production date of this booklet, there may be wording differences between the booklet and the policy. If so, the policy wording will prevail; hence, you are entitled to consult the policy at the policyholder's address and obtain a copy thereof.

The masculine gender is used throughout this document solely for readability purposes and applies to both men and women.

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SSQ, LIFE INSURANCE COMPANY INC.

YOUR GROUP INSURANCE PLAN

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

This document shows the contractual provisions
for physicians who are members of the FMOQ.

Provisions in force on January 1, 2024

Policy Number:

13K00

SCHEDULE OF INSURANCE

General Provisions

This document shows the contractual provisions in force on January 1, 2024 (unless indicated otherwise) for the group insurance plan of physicians who are members of the Fédération des médecins omnipraticiens du Québec (FMOQ). It contains a description of all available plans, your own insurance being limited to the plans you have selected.

Group name and no.	13K00 – Fédération des médecins omnipraticiens du Québec
Category of individuals eligible as participants	• All physicians who are members of the FMOQ, who are under age 65 and who conduct their professional activities on the basis of a regular schedule of 20 hours or more per week • All physicians who are members of the FMOQ, who are 65 or over and who conduct their professional activities regardless of the number of hours worked per week • All retired physicians who are under age 65 and members of the FMOQ, who were insured under this plan immediately prior to their retirement, without interruption • All retired physicians who are 65 or over, members or non members of the FMOQ, who were insured under this plan immediately prior to their retirement, without interruption
Eligibility date for new participants	Date of admission to the Collège des médecins du Québec
Waiting period for some benefits not requiring Evidence of insurability	120 days from the eligibility date
Restriction due to medical history	During the first 12 consecutive months of insurance for treatments and medical care received in the 6 months prior to the effective date of the insurance.

SCHEDULE OF INSURANCE

PLAN A – Health Care Insurance (Options R, A, B and C)

Deductible per calendar year, per person insured as a member or spouse:

Option R: $267 Option A: $300 Option B: $600 (participants under 65 years old)
Option B: $267 (participants age 65 and over)

Option C: $150 (individual and single-parent)
$300 (couple and family)

The deductible applies to all eligible expenses, except those incurred for hospital stays in Canada or Travel Cancellation Insurance. Eligible expenses incurred during the last 3 months of a calendar year and which have been used to satisfy the deductible of this benefit for that year will be used to satisfy the deductible of this benefit for the following calendar year.

Unless indicated otherwise, the maximum amounts specified in this Schedule are maximum reimbursements applicable to each insured person. To be eligible for a reimbursement, fees must comply with the necessary, customary and reasonable standards generally accepted by the health sector, and with their cost. Therefore, the fees indicated below may be subject to some limitations.

Coverage	Options R and C	Option A	Option B
Prescription Drugs [1]			
Percentage of reimbursement, up to the maximum limit set under Quebec's Basic Prescription Drug Insurance Plan (BPDIP)	Acording to the Basic Prescription Drug Insurance Plan	80%	Under 65 years old: 75% Age 65 and over: 80%
Drugs*	On the list of the Basic Prescription Drug Insurance Plan	Dispensed on prescription only	
Diabetic products* Exception or prior approval drugs* Anti-obesity drugs* Drugs administered in private clinics* Viscosupplementation therapy*	Not covered (except for drugs and products on the list of the Basic Prescription Drug Insurance Plan)	Reimbursement combined with drug coverage for calculation of maximum coinsurance under BPDIP	

[1] If you are insured and you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons by submitting the appropriate form duly completed by the attending physician and provided the request is approved by SSQ.

*** Medical prescription required**

SCHEDULE OF INSURANCE

Coverage	Options R and C	Option A	Option B
Travel Insurance			
Percentage of reimbursement	Not applicable	100%	100%
Travel insurance and assistance	Not covered	$5,000,000 reimbursement per event	
Travel cancellation insurance	Not covered	$10,000 reimbursement per event	

*** Medical prescription required**

SCHEDULE OF INSURANCE

PLAN A – Health Care Insurance (Option B only)

Coverage	Option B
Hospitalization	
Percentage of reimbursement	100%
Hospital room in Canada	Private room
Specialized Health Care Establishments	
Percentage of reimbursement	80%
Rehabilitation centre*	Semi-private room Maximum of 180 days per calendar year
Convalescent home*	Semi-private room
Health Care Professionals	
Percentage of reimbursement	80%
Audiologist	
Occupational therapist	
Speech therapist	
Osteopath Podiatrist	One treatment per day Maximum of $35 of eligible expenses per visit and of $700 per calendar year, for each of these professionals
Physiotherapist and physical rehabilitation therapist	
Psychoanalyst Psychiatrist Psychologist Psychotherapist Social worker	Maximum of $1,200 per calendar year for each of these professionals

*** Medical prescription required**

SCHEDULE OF INSURANCE

Coverage	Option B
Other Medical Expenses	
Percentage of reimbursement	80%
Ambulance transportation by air or train	
Breast prostheses*	See "Therapeutic devices"
CAT scan*	Maximum of one per calendar year
Cosmetic surgery following an accident*	Maximum of $5,000 per accident
Deep shoes*	
Dental treatment following accidental damage to natural teeth*	
Detoxification therapies*	Maximum of $80 of eligible expenses per day and $2,500 maximum for life
Electrocardiogram (ECG)*	
External prosthesis and artificial limbs*	Maximum of $5,000 per lost limb
Eyeglasses and contact lenses following cataract surgery*	Maximum of $820 for life
Foot orthoses*	
Glucometer*	Maximum of $300 of eligible expenses per period of 60 consecutive months
Hearing aid*	Maximum of $600 of eligible expenses per period of 48 consecutive months
Hospital bed*	
Insulin pump accessories*	

*** Medical prescription required**

Coverage	Option B
Insulin pump*	Maximum of $10,000 per period of 60 consecutive months
Intraocular lens*	
Intrauterine device (IUD)*	
Laboratory analyses*	
Magnetic resonance imaging*	Maximum of one per calendar year
Nurse*	Maximum of $10,000 per calendar year
Orthopaedic shoes*	
Ostomy appliances*	
Orthopaedic devices*	
Respirator*	
Sclerosing injections*, for insureds under age 65	Maximum of $20 of eligible expenses per visit
Support stockings*	Maximum of 3 pairs per calendar year
Surgical brassiere*	Maximum of 2 per calendar year
Therapeutic devices* Breast prostheses*	Combined maximum of $50,000 per calendar year
Transcutaneous electrical nerve stimulator*	Maximum of $1,000 of eligible fees per period of 60 consecutive months
Ultrasonograms* (outside hospital)	Maximum of $300 per calendar year
Wheelchair and walker*	
Wig*	Maximum of $300 for life
X-rays*	
Surgical brassiere*	Maximum of 2 per calendar year
Termination of insurance	See “Applicable Insurance Periods“

SCHEDULE OF INSURANCE

PLAN B – Your Life Insurance

Amount of insurance	Units of $10,000, based on payable premium
Minimum	$50,000
Maximum	$1,500,000 prior to age 65
	$500,000 from age 65 to age 69
	$250,000 from age 70
Evidence of insurability	Required. If you apply for insurance within 120 days after your admission to the Collège des médecins, you will not have to give Evidence of insurability for the following amounts of insurance: • $300,000 if you are less than 30 when applying; • $200,000 if you are 30 or more but less than 35 when applying; • $150,000 if you are 35 or more but less than 40 when applying.
Termination of insurance	See "Applicable Insurance Periods"

PLAN C – Your Spouse's Life Insurance

Amount of insurance	Units of 10,000, based on payable premium
Minimum	$50,000
Maximums	$250,000 prior to the date of your 70th birthday
	$100,000 from the date of your 70th birthday
	Evidence of insurability is required
Termination of insurance	See "Applicable Insurance Periods"

SCHEDULE OF INSURANCE

PLAN D – Your Dependent Children's Insurance

Life Insurance

Amount of insurance	Children aged 24 hours or more: $10,000
	Evidence of insurability is required
Termination of insurance	See "Applicable Insurance Periods"

Accidental Death and Dismemberment Insurance

Amount of insurance	Children aged 24 hours or more: $10,000
Termination of insurance	See "Applicable Insurance Periods"

SCHEDULE OF INSURANCE

PLAN E – Your Accidental Death and Dismemberment Insurance

Amount of insurance	Units of $10,000, based on payable premium
Minimum	$50,000
Maximum	Equal to the lesser of $250,000 or the amount of your life insurance
Termination of insurance	See “Applicable Insurance Periods“

PLAN F – Your Spouse’s Accidental Death and Dismemberment Insurance

Amount of insurance	Units of $10,000, based on payable premium
Minimum	$50,000
Maximum	Equal to the lesser of $250,000 or the amount of your spouse’s life insurance
Termination of insurance	See “Applicable Insurance Periods“

SCHEDULE OF INSURANCE

PLAN G – Your Long Term Disability Income Replacement Insurance

Monthly sum insured	Units of $100, based on paid premium
Minimum	$500
Maximum	The least of the following amounts: a) 100% of your gross monthly income immediately prior to the beginning of disability; b) $20,000.
Evidence of insurability	Required. Provided you apply for insurance within 90 days after your admission to the Collège des médecins, you will not have to give Evidence of insurability for the following sum insured: • $3,000 if you are less than 35 on the date the application is received by the administrator; • $2,000 if you are 35 or more, but less than 40 on the date the application is received by the administrator. You are not eligible for this exemption if you already have disability insurance coverage.
Amount of benefits	
Total disability and presumptive total disability	100% of the sum insured
Partial disability	The sum insured multiplied by the percentage of net loss of income
Elimination period	Choice of 30, 90 ou 180 days of total disability
Frequency of benefit payments	Monthly
Taxability of benefits	Non-taxable, provided you have paid all the premiums personally

SCHEDULE OF INSURANCE

Termination of benefit payments	
Total disability:	i) **70 years old option :** the date of your 70th birthday. However, when the period of total disability begins between age 68 and 70, benefit payments may not last more than 24 months. ii) **65 years old option :** the date of your 65th birthday. However, when the period of total disability begins between age 63 and 70, benefit payments may not last more than 24 months.
Partial disability:	The date of your 65th birthday
Termination of insurance	The date of your 70th birthday or the date you notify the administrator of your retirement if earlier (see also "Applicable Insurance Periods")

SCHEDULE OF INSURANCE

PLAN H – Your Business Overhead Expenses Insurance

Amount of insurance	Units of $100, based on payable premium
Minimum:	$500
Maximum:	$10,000
	Evidence of insurability is required*
Waiting period	30 days
Maximum normal duration of benefits	18 months from the start of benefits
Extension of benefits	If the expenses incurred during a month for which monthly benefits are payable in accordance with this plan do not add up to the maximum amount of insurance you have subscribed, the maximum duration of benefits will be extended to 36 months from the start of the benefit payment, up to the maximum amount.
Frequency of benefit payments	Monthly
Termination of insurance	The date of your 70th birthday or your retirement date if earlier (see also "Applicable Insurance Periods")

* Starting July 1st, 2013, new participants will be allowed to subscribe a $2,000 initial amount of insurance without Evidence of insurability, provided they do so in the first 120 days following their eligibility date.

SCHEDULE OF INSURANCE

PLAN L – Dental Care Insurance
(available only with Health Care Insurance Option B)

Reference year for maximum recommended fees: The year during which services are provided.

Coverage	Maximum	Percentage of reimbursement
Diagnostic and Preventive Services		
Diagnostic services Preventive services and space maintainers	$2,000 per calendar year per insured person	80%
Basic 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		75%
Prosthodontics		
Major Restorative Services and Fixed Prosthodontics Removable Dentures Fixed Bridges		50%
Frequency of recall examinations	6 months	
Termination of insurance	See "Applicable Insurance Periods" hereunder	

SCHEDULE OF INSURANCE

VOLUNTARY INSURANCE PROGRAM FOR CRITICAL ILLNESS

Volontary Insurance Program for Critical Illness	Insurer: SSQ Insurance Company Inc. Policy 1HB60

GENERAL PROVISIONS

Definitions

Some of the terms used to describe your plan are defined below. These terms should be interpreted as defined wherever the context allows. These definitions apply to terms that are used in more than one part of the text. Where required, other terms are defined in the description of the benefit in which they are used.

Accident

An unintentional, sudden, unforeseen and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injury.

Contract

Agreement between SSQ and the Policyholder regarding the policy whose number identifies the present document.

Dependent

A member's spouse and/or dependent children.

Dependent child

A child for whom you or your spouse exercise parental authority, or would exercise if a minor, and whom you or your spouse support. To be eligible, the child must also be unmarried and:

- under age 21;

  or

- age 21 or more but under age 26 and a full-time student in an accredited educational institution; proof of the child being enrolled in an educational program must be submitted to SSQ;

  or

- regardless of age, be domiciled at your home or that of your spouse and be suffering from a severe, incurable and chronic physical or mental disability that began while the child met any of the conditions indicated above in this definition, and have remained continuously disabled since that date; the disability must render the child incapable of pursuing any gainful activity. SSQ may require medical evidence of such as it deems necessary.

Disability (for Plan G)

1) Own occupation option

Total disability: Your inability as a result of an illness or accident to perform the main duties of your usual professional occupation, which requires continuing medical care from a physician other than the participant themselves and which, if it persists beyond your 65th birthday, without necessarily requiring continuing medical care, totally prevents them from working in any gainful occupation.

It is understood that when medical care is necessary and that it comes within the competence of a specialist, such care must be provided by a specialist in the appropriate field in order for the total disability to be recognized as such.

For the purpose of this definition, a gainful occupation means an occupation which provides a gross annual income of at least $60,784 on June 1, 2022, and for which the participant is qualified by training, education or experience. Such minimum amount of $60,784 is indexed as provided for under the Long Term Disability Income Replacement Insurance.

A participant infected with blood-borne diseases agents and for whom performing the usual tasks of their occupation is professionally and medically contraindicated, as recommended by an expert panel of the COLLÈGE DES MÉDECINS, is considered totally disabled, provided their income from medical procedures conducive to a blood-borne infection represents 80% of their net income from their practice. Such participant whose income from these medical procedures conducive to a blood-borne infection represents less than 80% of their total income may be considered partially disabled.

Presumptive total disability: The participant who suffers one of the following total and irrecoverable losses due to an accident or illness is considered totally disabled:

- loss of speech;
- loss of sight in both eyes;
- loss of hearing in both ears;
- loss of use of both hands or both feet;
- loss of use of one hand and one foot;
- the complete severance of one hand or foot through or above the wrists or ankle joints.

A member who is practising a surgical specialty is deemed totally disabled if they suffer the irrevocable loss of use of one hand, including the complete severance through or above the wrist, provided such loss is due to an accident or illness.

Partial disability: Inability as a result of an illness or accident:

- that prevents you from performing one or several of the main duties of your usual professional occupation, or extends the usual duration of fulfilment of the main tasks of such occupation;
- that leads to a loss of income of at least 20% of the gross income earned by you immediately before becoming disabled;
- which requires continuing medical care with a physician other than the participant themselves.

It is understood that when medical care is necessary and that it comes within the competence of a specialist, such care must be provided by a specialist in the appropriate field in order for the partial disability to be recognized as such.

2) Integrated income option

Total disability: Your inability as a result of an illness or accident to perform the main duties of your usual professional occupation, which requires continuing medical care from a physician other than the participant themselves. You must not be working in any gainful occupation.

It is understood that when medical care is necessary and that it comes within the competence of a specialist, such care must be provided by a specialist in the appropriate field in order for the total disability to be recognized as such.

A participant infected with blood-borne infectious diseases and for whom performing the usual tasks of their occupation is professionally and medically contraindicated, as recommended by an expert panel of the COLLÈGE DES MÉDECINS, is considered totally disabled, provided their income from medical procedures conducive to a blood-borne infection represents 80% of their net income from their practice. Such participant whose income from these medical procedures conducive to a blood-borne infection represents less than 80% of their total income may be considered partially disabled.

Presumptive total disability: The participant who suffers one of the following total and irrecoverable losses due to an accident or illness is considered totally disabled:

- loss of speech;
- loss of sight in both eyes;
- loss of hearing in both ears;
- loss of use of both hands or both feet;
- loss of use of one hand and one foot;
- the complete severance of one hand or foot through or above the wrists or ankle joints.

A member who is practising a surgical specialty is deemed totally disabled if they suffer the irrevocable loss of use of one hand, including the complete severance through or above the wrist, provided such loss is due to an accident or illness.

Partial disability: Inability as a result of an illness or accident:

- that allows you to work in a gainful occupation, but results in a loss of income of more than 20% of the gross income earned by you immediately before becoming disabled; and
- which requires continuing medical care with a physician other than the participant themselves.

It is understood that when medical care is necessary and that it comes within the competence of a specialist, such care must be provided by a specialist in the appropriate field in order for the partial disability to be recognized as such.

Illness

A disease, deterioration of health or bodily disorder, as diagnosed by a physician. For the purposes of the contract, this term is also used to refer to pregnancy-related complications and organ donations and any related complications.

Insured

An individual covered under the benefit referred to in the context in which the term is used.

Member

Any physician who is a general practitioner and a member of the FMOQ, any retired physician recognized as a member by the FMOQ and who has not resigned his membership in the FMOQ.

Partial disability (for Plan H)

A medical condition caused by an accident or illness that brings about the loss of at least 20% of the net adjusted monthly income at the onset of disability. Only participation in Long Term Disability Insurance allows for the payment of Partial Disability benefits.

Participant

An individual enrolled in the insurance plan as a member of a class of eligible individuals.

Physician

An individual who is legally authorized to practise medicine where he or she practises.

Period of disability (for Plan G)

Any continuous period of partial or total disability or successive periods of partial or total disability resulting from the same illness or accident.

During the elimination period, successive periods of disability are cumulated. The time allotted to satisfy the elimination period by cumulating periods of disability is 12 months.

Once the elimination period has elapsed, the continuous periods of disability must be separated by less than 12 consecutive months during which you are actively at work on a full-time basis. In such a case, the elimination period does not have to be satisfied again.

If a disability results from an illness or accident entirely unrelated to the illness or accident that caused the disability of the previous period of disability and the successive periods of disability are separated by at least one day of full-time active work, the periods of disability are considered distinct from each other. In such a case, the elimination period must be satisfied again.

Plan administrator

Any corporation designated by the policyholder of this contract. (For the purposes of this contract, the policyholder designated SOGEMEC ASSURANCES INC. as the administrator.)

Recurring total disability (for Plan H)

Successive periods of total disability

- due to the same causes and separated by less than 6 consecutive months during which you return to your pre-disability work schedule or were able to do so;

  or

- due to entirely different causes and separated by less than one full day during which you return to your habitual professional duties.

Upon termination of the contract, the durations used to determine the ending of total disability periods are those provided by law.

Retiree

Any participant considered as a retiree by the FMOQ.

Spouse

An individual who:

- is married to you through a civil union or other legally recognized marriage;

  or

- you are able to prove lives with you on a regular basis and whom you have designated in writing to SSQ as your spouse, provided that a child has been born of your union;

  or

- you are able to prove has been living with you on a regular basis for at least one year and whom you have designated in writing to SSQ as your spouse.

The status of spouse ends when:

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

In the case of more than one spouse, only the last person you have designated as such in writing to SSQ will be recognized as your spouse. If no spouse is designated, only a person linked to you by civil union or marriage will be recognized as your spouse.

Subrogation

The substitution of one person or thing in the place of another with respect to a lawful claim. SSQ's right of subrogation is described later in this "General Provisions" section.

Total disability (for Plan H)

A disability caused by an accident or illness that renders you totally incapable of carrying out the main duties of your usual employment.

Total disability period (for Plan H)

A period during which you are totally disabled, be it for a continuous period or for successive periods as described in the definition of "Recurring total disability" below.

Totally disabled

Describes an individual who meets the definition of "total disability" specified in the contract.

You

Personal pronoun used to refer to the participant. "You", "your" and "yours" refer to the participant directly.

Participation requirements

1. Plan type and rules of participation

1.1. Participation in your group insurance plan is optional.

1.2. For members who are less than 65 years of age, the minimal duration of participation in one same option of Plan A is 24 consecutive months.

1.3. Participation rules in the other plans are as follows:

Column 1: plan in which a participant wishes to participate	Column 2: plan(s) in which a participant must participate in order to participate in a plan shown in Column 1
Plan A	N/A
Plan B	N/A
Plan C	Plan B or Plan G or Plan H
Plan D	Plan B or Plan G or Plan H
Plan E	Plan B or Plan G or Plan H
Plan F	Plan B or Plan G or Plan H
Plan G	N/A
Plan H	N/A
Plan L	Plan A (option B) and any one of Plans B, G, H or Voluntary Insurance Program for Critical Illness
Voluntary Insurance Program for Critical Illness Participant Spouse	 Plan A Plan A and Voluntary Insurance Program for Critical Illness

1.4. Individuals who are eligible for insurance, either as participants, spouses or dependent children, including new spouses or dependent children, must provide Evidence of insurability deemed satisfactory by SSQ in order to participate in any of plans listed above. Notwithstanding, certain amounts of insurance can be subscribed without Evidence of insurability provided the request is made no later than 120 days after the date the participant has been admitted as a member of the Collège des médecins du Québec.

1.5. The minimum duration of participation in Dental Care Insurance Plan L is 36 consecutive months and the member who ends participation in it cannot enlist again. In addition, the type of protection (individual, family, single parent or couple) must be the same as for Health Care Insurance Plan A. Participation in Plan L is possible only when:

a) the initial enrollment takes place; or

b) the participant opts for a more generous type of protection (see "Increase in coverage" and "Change in coverage");

c) the right to exemption from participating in Plan A terminates;

d) a more generous Plan is chosen.

2. Conditions of eligibility

2.1. Unless specified otherwise, any active member who is aged less than 65 years at the time the enrollment application is submitted and who meets the eligibility requirements set forth in the "**Schedule of Insurance**", is eligible for insurance as a participant, as is any retired participant who was insured under the FMOQ insurance plan immediately prior to the date of retirement and whose insurance has remained uninterrupted since.

2.2. For Plan G, insurance becomes effective if the participant is at work or was at work on the last scheduled work day, on a full-time basis, and performs the main duties of their usual professional occupation. If a member is not actively working on a full-time basis the day coverage is to be effective, insurance becomes effective on the day they return to work on a full-time basis and performs all their usual professional duties, subject to all other policy provisions.

2.3. Without exception, members staying outside Canada must be covered by the health insurance plan of their province of residence in order to be covered by the FMOQ insurance program, subject to the provisions relative to maintaining participation in insurance. For Plan G, a participant who no longer qualifies as a member, as defined in this policy, remains eligible for insurance provided they continue to practice their usual profession in the United States or in Canada, and they are a member of an association of general practitioners.

2.4. For Plan G, any general practitioner with a limited licence (physician with limited practice) for a reason other than criminal, remains eligible for insurance.

2.5. Deaths and disabilities resulting from disabilities that arose while an individual was insured as a participant under a previous group insurance contract are not covered under subsequent contracts, except as provided for under any applicable legislation or in accordance with the Canadian life and health insurance standards.

2.6. Despite what precedes, any individual insured under the previous contract may not be excluded from the new contract or be denied benefits solely because of a pre-existing condition that was no longer applicable or that was not provided for in the previous contract, or because the individual is not at work on the effective date of the new contract.

2.7. All individuals insured under the previous contract are covered with full rights under the new contract upon termination of the previous contract if the termination of their insurance is exclusively attributable to the termination of the contract and if they belong to a class of participants covered by the new contract.

2.8. Spouses and dependent children of individuals insured as participants are themselves eligible for insurance as spouses and dependent children.

2.9. When both spouses are eligible as members, each one can choose to be insured both as a member and as the spouse of a member.

3. Applications for insurance

3.1. An application for insurance must be submitted to SSQ for insurance to become effective, even in cases where participation in insurance is compulsory. If an application for insurance is not submitted within the time provided for under this plan, SSQ may require evidence of insurability and decline the application.

3.2. Certain events, such as marriage or the birth of a child, may enable you to make changes to the insurance that became effective at the time of enrollment. Please refer to the provisions regarding periods of insurance for more information about making such changes.

3.3. In all cases, you must notify SSQ in writing of any new person to be covered as a spouse or dependent child.

3.4. Any member who wishes to apply to Plan G may choose one or many sum insured along with any one of the choices of each of the following:

a) disability definition : own occupation or integrated income options;

b) elimination period : 30, 90 or 180 days;

c) duration of the monthly benefit payments : 70 or 65 years old options.

4. Evidence of insurability

You must provide evidence of insurability deemed satisfactory by SSQ to be entitled to the following:

a) any amount of insurance that exceeds the maximum amount that may be obtained without evidence of insurability;

b) any amount of insurance for which an application is not submitted within the specified time frame.

The following rules apply to Plan A:

a) no evidence of insurability is required to subscribe to Options R and C;

b) you and your dependents must provide evidence of insurability to subscribe to options A and B, unless you submit an application for insurance within 120 days after you have been admitted as a member of the Collège des médecins;

c) if you have already subscribed to Option A or Option B, you may move from one to another without having to provide any additional evidence of insurability, subject to the rules that apply to the change of option.

From the date you reach age 65, you have 31 days to subscribe to Option B without having to provide any evidence of insurability. This choice is irrevocable.

5. Insured persons age 65 or over residents of Quebec

5.5. SSQ assumes that any member who reaches age 65 elects to be insured under the Basic Prescription Drug Insurance Plan provided by the Régie de l'assurance maladie du Québec (RAMQ). A member can still choose to continue to be insured under the FMOQ's plan but then has to pay an additional premium. At any time thereafter, the member can choose to be insured under RAMQ's plan for drugs but cannot revert to being insured under the FMOQ plan afterwards.

Applicable Insurance Periods

1. Time insurance becomes effective

Any date on which insurance becomes effective begins at 12:01 a.m. at the insured's place of residence.

2. Effective date of insurance

2.1. Provided advance payment of the required premium, insurance you obtain without evidence of insurability becomes effective on the date you become eligible for coverage if the premium is received within 31 days following this date, or if not, on the date SSQ or your plan administrator receives your application. However, coverage for which you are required to provide evidence of insurability will become effective on the date such evidence is approved.

2.2. Changes to coverage or to the amount of insurance become effective on the later of the following:

a) the day ensuing the date the request for change is received by SSQ, if evidence of insurability is not required;

b) the date evidence of insurability is deemed satisfactory by SSQ, when such evidence is required.

2.3. Provided advance payment of the required premium, your spouse's insurance and your dependent children's insurance will become effective on the later of the following dates:

a) the date your insurance under Plan A becomes effective;

b) the date these individuals become eligible for insurance as spouse or dependent children;

c) the date on which you notify the plan administrator about the addition of these individuals as dependents;

d) the date SSQ deems the evidence of insurability acceptable, when such evidence is required.

2.4. Any benefit under which your dependent children are covered applies to any new dependent child (24 hours after birth in the case of Life Insurance benefits).

2.5. Insurance for any individual who is eligible as a spouse or dependent child cannot become effective before your own insurance.

3. Effective date of modifications to insurance

3.1 Insurance not modifiable after age 65 or in case of total disability or retirement

Upon reaching age 65 (subject to the temporarily applicable rules set at the time Options R, A and B became effective) or if retired or totally disabled, amounts of insurance cannot be increased and the provisions used to establish these amounts cannot be modified. Such modifications shall only become effective once the participant has actively returned to work and provided he is not totally disabled at this time or aged 65 or more.

3.2 Increase in insurance coverage

i) For Plan G, subject to all other policy provisions, a participant who wishes to modify their coverage must complete a request for modification. They must also provide evidence of insurability satisfactory to the insurer if such modification results in a coverage higher than what they previously held. In such a case, the possible modifications are:

   a) increase of the sum insured other than those provided for by the indexation provisions under this coverage;

   b) change from the integrated income option to the own occupation option for the disability definition;

   c) modification from the 65 years old option to the 70 years old option for the duration of the monthly benefit payment;

   d) reduction of the duration of the elimination period.

   Guaranteed insurability applies to physicians who become FMOQ members and who subscribe to this plan during the eligibility period without evidence of insurability. The particulars of guaranteed insurability can be found in Appendix A.

ii) For the other plans, increase in insurance coverage can only take place for participants who are less than 65 years of age, who are not disabled and who have submitted evidence of insurability. Under no circumstances can the increase be less than the following:

   - for Plan B, $50,000;
   - for Plan C, $50,000;
   - for Plan H, $500;
   - for Voluntary Insurance Program for Critical Illness, $50,000.

3.3 Increase in insurance coverage following a change in family status

Any increase in your insurance coverage following a change in family status becomes effective on the date of the change, provided SSQ receives a written application to such effect within 90 days following the change and subject to the provisions on total disability. Otherwise, the change in coverage will become effective on the date you actively return to work, provided you are not totally disabled and are not 65 years or more of age, subject to any other eligibility provisions in force.

If SSQ receives the application more than 90 days after the date of the event justifying an increase in insurance, you will be required to provide evidence of insurability and the increase in insurance will become effective on the date SSQ approves such evidence.

Any option subscribed to with respect to Plan A requires maintaining participation for a duration of at least 2 years. After that period, any change of option will become effective on January 1 following the date the request for change is made.

3.4 Decrease in insurance coverage following a change in family status

Any decrease in insurance coverage following a change in employment or family status becomes effective on the date of the change, provided SSQ receives a written application to such effect within 90 days following the change. If SSQ receives the application more than 90 days after the date of the event justifying a decrease in insurance, the decrease becomes effective on the date SSQ receives the application.

4. Stay outside Canada, sabbatical leave, leave for study, maternity leave, parental leave, adoption leave or other leaves recognized by SSQ

Participation in insurance may be maintained in the case of stays outside Canada, sabbatical leaves, leaves for study, maternity leaves, parental leaves, adoption leaves or other leaves recognized by SSQ, except as provided in this clause. In order to maintain participation in insurance, you must notify the plan administrator in writing no later than 31 days after the start of your leave and specify your expected date of return to work if you know it.

4.1. Maximum durations for maintaining participation

Subject to any limits provided for by law and subject to payment of the required premiums, the maximum time during which participation in insurance may be maintained during periods of temporary interruption of work is 24 months.

4.2. Minimum durations for maintaining participation

Any individual affected by a temporary interruption of work must contact the plan administrator for more information about whether participation in insurance may or must be maintained, and for how long it may or must be maintained.

4.3. Information to provide to the plan administrator

You must provide the plan administrator with the following information within 31 days following the date of your temporary interruption of work in order for SSQ to have knowledge of:

a) the date you stopped working;

b) the planned date of your active return to work;

c) the choice made as to whether or not to apply to maintain participation in insurance during the period of interruption of work and whether or not you chose to maintain Disability Insurance coverage if both options are available.

Regardless of whether or not you maintain participation in insurance, the plan administrator must be notified as soon as possible of the date you actively return to work.

4.4. Total disability beginning during a period of interruption of work

In the event of a total disability that begins during a period of unpaid leave during which you have maintained participation in insurance by paying all premiums, the elimination period begins on the planned date of your return to work.

4.5. Suspension of insurance

If you fail to notify the plan administrator prior to expiration of the 31-day deadline provided, your participation in insurance is suspended for the whole duration of your interruption of work. Subject to applicable legislation, if your interruption of work has led to a suspension of your coverage, you may only resume participation in insurance once you return to work as an eligible member and new evidence of insurability is accepted.

5. Maintaining participation for the spouse and dependent children of a deceased participant

In the event of your death, your insured spouse and dependent children may maintain participation in insurance with premium payment for the option B (without Prescription Drugs) of the Health Insurance benefit under Plan A and Dental Care Insurance under Plan L, until the earliest of the following:

a) the date when their participation in insurance would have ended, had your death not occurred.

b) the date when they become eligible for similar coverage under another insurance benefit;

c) the date the contract terminates.

For any benefit that provides for a conversion privilege, this entitlement applies to the end of the extended coverage, in accordance with the conditions applicable.

6. Termination of insurance

Your insurance

6.1. Your insurance terminates no later than 11:59 p.m. on the earliest of the following dates:

a) the date you no longer qualify as an individual eligible as a participant, as specified in the "**Schedule of Insurance**";

b) the last day of the month during which the plan administrator receives your request for termination for each benefit;

c) the date you reach the age limit for coverage under a benefit specified in the "**Schedule of Insurance**";

d) the date your participation is suspended following a temporary interruption of work;

e) the date when premiums are due, if such premiums are not paid to SSQ before the end of the grace period;

f) for a benefit subject to waiver of premium, the date on which such a waiver terminates, unless you resume payment of your premium;

g) your retirement date, if specified in the "**Schedule of Insurance**";

h) the termination date of the contract;

i) the date you submit, as a result of misrepresentations, a claim or collect any benefits that you are not entitled to under this policy, irrespective of the compulsory nature of any coverage or any other action SSQ may take.

Insurance for your spouse and dependent children

6.2. Insurance for your spouse and dependent children terminates no later than 11:59 p.m. on the earliest of the following dates:

a) the date your insurance terminates;

b) the date when premiums for their insurance are due, if such premiums are not paid to SSQ before the end of the grace period;

c) the last day of the month during which the plan administrator receives your request for termination.

Payment of benefits

1. Amounts of coverage

In no case may you benefit from an amount of coverage greater than that for which SSQ has received the required premiums.

2. Deadlines for filing claims

Deadlines for filing claims vary from one benefit to another, and are specified in the description of each benefit.

3. Evidence that SSQ may require

You must provide SSQ with any information and supporting documents necessary to establish your eligibility for benefits and any amount payable, at your own expense. In the event that benefits may be payable, SSQ may require the insured to undergo examination, at any time, by one or more health care professionals selected and compensated by SSQ. If the insured fails to undergo an examination required by SSQ within 30 days of SSQ's request, SSQ may decline the claim or suspend or terminate benefits. SSQ may also request that an autopsy be performed in accordance with applicable legislation.

4. Currency

All amounts referred to in the contract are in the legal tender of Canada. For foreign currency expenses related to Travel Insurance, SSQ uses the exchange rate of the last day of the month during which expenses were incurred. However, if expenses are incurred and subsequently reimbursed within the same month, the exchange rate from the end of the previous month is used.

5. Third-party liability and subrogation

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

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

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

6. Designating and revoking beneficiaries

In compliance with applicable legislation, you have the right to designate or revoke one or more beneficiaries of any benefits payable in the event of your death by providing written notice of such to your plan administrator.

For Plans C, D and F, you are the beneficiary, unless you stipulate otherwise.

Waiver of premiums in the event of total disability

1. Entitlement to waiver of premiums

1.1. If you become totally disabled while your insurance is in force under the contract, while you are insured under Plan G and before you reach age 60 (age 65 for Plan G), your participation in insurance will be maintained, without payment of premiums, effective as of the waiver of premiums start date provided for under this plan.

1.2. To qualify for the waiver of premiums privilege, you must meet the following conditions:

a) you must be under the continuous care of a physician other than yourself, except if your total disability is declared stable by your attending physician, to the satisfaction of SSQ;

b) your condition must meet the definition of a total disability that was in force at the time you became totally disabled;

c) if your total disability begins during the 12 months following the effective date of your insurance, it must not be the result of an illness or accident for which you received treatment or consulted a health care professional during the 3 months preceding such date.

2. Start and end of waiver of premiums for Plan G

The waiver of premiums starts as of the first day of the month following the date the total disability commenced and for as long as it persists, and remains so disabled for at least three consecutive months. It ends on the earliest of the following dates:

a) the date on which you cease to be totally disabled;

b) if you elected the 65 years old option, the date the Long Term Disability Income Replacement Insurance benefits cease;

c) the date you reach age 70;

d) the date you are no longer under the continuous care of a physician other than yourself, except if your total disability, as defined in the contract, is a condition that is declared stable by a physician, to the satisfaction of SSQ;

e) the date you are unable, unwilling or neglect to provide satisfactory proof of total disability to the insurer.

3. Start and end of waiver of premiums for the other plans

The waiver of premiums starts when you have been totally disabled without interruption for 3 months. It ends on the earliest of the following dates:

a) the date on which you cease to be totally disabled;

b) the date you reach age 65;

c) the date you are no longer under the continuous care of a physician other than yourself, except if your total disability, as defined in the contract, is a condition that is declared stable by a physician, to the satisfaction of SSQ;

d) the date SSQ requests proof of your total disability, if you are unable to submit or fail to submit such proof within 90 days of SSQ's request;

e) the date you refuse to participate in a rehabilitation program recommended by SSQ;

f) the date SSQ requests that you undergo an examination by a health care professional or a treatment likely to be beneficial to your recovery, if you fail to do so within 90 days of SSQ's request;

g) for the Business Overhead Expenses Insurance benefit, Health Care Insurance benefit and Dental Care Insurance benefit, the termination date of the contract.

4. Application for waiver of premiums

4.1. If no claim for Disability Insurance benefits is filed, applications for a waiver of premiums must be submitted in writing to SSQ. Otherwise, the Disability Insurance claim form may also be used to apply for a waiver of premiums. In either case, SSQ may require additional proof and supporting documents. In all cases, your application for a waiver of premiums and supporting document must be submitted to SSQ within 9 months of the date you became totally disabled. If you fail to meet this deadline, you must prove that you were unable to submit your application and supporting documents earlier, otherwise SSQ may decline your application or interrupt the waiver period.

4.2. From the time SSQ notifies you that your application has been declined or your waiver of premiums has been interrupted, you have 90 days in which to provide additional proof justifying your continued entitlement to a waiver or request that your file be reviewed.

4.3. Unless you submit your application for waiver or request for review within the time specified, your right to waiver will not apply to any period prior to the date SSQ receives your application or request.

4.4. For an application for waiver of premiums to be approved, all required documents must be submitted to SSQ no later than 12 months following the start date of your total disability. In addition, in the event that an application for waiver is declined or a waiver of premiums is interrupted, no waiver period will apply to your disability if all of the required documents are not submitted to SSQ at the latest 12 months after the date on which notice of refusal or interruption is issued.

Limitation based upon medical history

Insurance obtained without evidence of insurability does not cover events or health conditions resulting from accidents or illnesses that required treatments or medical care during the period specified in the "**Schedule of Insurance**". This limitation ceases to apply from the date said insurance has been in force without interruption for the duration specified in the "**Schedule of Insurance**", provided these accidents and illnesses have not brought about any event covered by the insurance.

Limitation of contractual liability

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

Changes of insurer

The expiry or cancellation of a group life insurance benefit may not be set up against a claim based on an insured event, including a death that results from a total disability, if this insured event occurred while the benefit was in force.

The expiry or cancellation of a group sickness or accident insurance that is not part of the Health Care Insurance Plan may not be set up against a claim based on death or insured mutilation resulting from an accident that occurred while the benefit was in force. It may neither be set up against a claim based on a total disability that arose or a sickness that was contracted while the benefit was in force.

The insurer of a group disability insurance benefit that expires is bound to compensate the participant for salary loss if the participant is still totally disabled after the benefit expires.

In the event of a change in insurer, be it at the beginning or end of the contract, SSQ's responsibilities are limited to what the law and standards that govern the industry of insurance of persons impose in order to protect the rights of insured individuals. As a result, SSQ is not responsible in the event of recurrence of the disabling affliction after the expiry of the period that has been determined in this regard by the law or standards of the industry and the provisions of the former and subsequent contracts are not binding on SSQ.

PLAN A – HEALTH CARE INSURANCE

Provisions pertaining to all options

1. Definitions

Some of the terms used to describe your plan are defined in the "General Provisions" section herein. Whenever the context allows, the following definitions shall apply specifically to the interpretation of Health Care Insurance Plan A.

Basic activities of daily living

Refers to each and every one of the following 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 shareholders or fewer, or a commercial or non-commercial corporation comprised of 4 partners or fewer.

Close relative

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

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 is to be held. The commercial activity must be the main reason for the trip.

Deductible

The amount of eligible health care expenses that you must pay each year before being entitled to any reimbursement.

Eligible expenses

For Health Insurance, health care expenses eligible for inclusion in the calculation of reimbursements, taking into account any deductible, percentage of reimbursement and other maximum provided for under the contract.

Family member

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, grandchild, uncle, aunt, nephew or niece.

Hospital

Any establishment considered a hospital under applicable federal or provincial laws.

Host at destination

An individual at whose principal residence the insured is planning to stay for at least part of the trip.

Prepaid travel expenses

Refers to the following:

- Expenses incurred by the insured to purchase a 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.

Province

Used to refer to the provinces of Canada, as well as the Yukon, Northwest Territories and Nunavut.

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.

Travel companion

Refers to the person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the insured.

Trip

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.

2. Coverage

2.1. If an insured incurs expenses that are eligible under this benefit, SSQ agrees to reimburse such expenses as indicated in the "**Schedule of Insurance**", subject to the provisions of the contract.

2.2. Eligible expenses for Health Insurance are grouped together by type of service. All types are described in this booklet, whether or not they are included in the person's actual coverage, which depends on the chosen option.

For Options R and C

- Prescription Drugs

For Option A

- Prescription Drugs
- Travel Assistance Insurance
- Travel Cancellation Insurance

For Option B

- Prescription Drugs
- Travel Assistance Insurance
- Travel Cancellation Insurance
- Hospitalization
- Specialized Health Care Establishments
- Health Care Professionals
- Other Medical Expenses

3. General conditions for eligibility of expenses

In all cases, expenses must meet the following conditions to be considered eligible:

- be incurred for an individual who is insured under this benefit;
- comply with the necessary, customary and reasonable standards of practice generally accepted in the health care sector, including with regard to cost;
- be used in compliance with the manufacturer's instructions, or, where no such instructions exist, in accordance with government-approved directives;
- be necessary for the medical treatment of the insured and, unless specified otherwise, not be administered for preventive purposes;
- services must be provided by an individual who does not reside with the insured and who is not a close relative of the insured.

4. General exclusions, limitations and restrictions

4.1. All insureds are presumed to be covered under the public health and hospitalization plans of their province of residence; in the event that an insured is not covered, amounts paid by SSQ are limited to the amounts that would have been payable had the insured been covered under the relevant plan.

4.2. Health Insurance provides for no reimbursement in the following cases:

a) expenses incurred due to

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

ii) the insured's active participation in a riot or insurrection;

iii) war, whether declared or undeclared;

iv) the insured's active service in the armed forces;

v) attempted suicide or self-inflicted injuries, regardless of the state of mind of the insured;

b) expenses payable by the Government or by another insurer;

c) expenses for which a third party is liable, except in the case of subrogation;

d) expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract or for expenses incurred collectively;

e) expenses for products or services related to the treatment of cellulite that are not covered under the government prescription drug insurance plan;

f) expenses for dietary supplements or infant formula that are not covered under the government prescription drug insurance plan;

g) expenses for products or services designed as smoking cessation products that do not qualify as eligible expenses under the government prescription drug insurance plan;

h) expenses for products or services designed to treat sexual dysfunction that are not covered under the Prescription drugs benefit of this plan;

i) expenses for products or services designed to stimulate hair growth or prevent hair loss that are not covered under the government prescription drug insurance plan;

j) expenses for products or services designed for the treatment of infertility that are not covered under the government prescription drug insurance plan;

k) expenses that you are unable to prove were incurred by the insured;

l) expenses incurred for products or treatments of an experimental nature or obtained under a federal program providing special access to health products;

m) expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes or incurred further to a request by a third party;

n) expenses incurred in relation to eye tests or eye refraction examinations, or for the purchase of eyeglasses or contact lenses not explicitly insured under the contract;

o) expenses incurred in relation to services that are not provided while the individual is insured;

p) expenses incurred for service contracts or maintenance fees;

q) expenses for surgically-implanted prostheses;

r) expenses for delivery or mailing costs.

4.3. Some other exclusions apply specifically to certain benefits provided under Health Insurance. These exclusions are shown following the description of expenses covered under the benefits in question.

5. Multiple coverage and coordination of benefits

5.1. Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not you have submitted a claim for such benefits.

5.2. If you are entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

5.3. If you and your spouse each have group health insurance coverage, each of you should first submit your own claims to your own group insurance plan.

5.4. If you and your spouse each have family coverage status for your group health insurance, 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 children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

5.5. Expenses eligible for reimbursement under the Travel Assistance Insurance or Travel Cancellation Insurance benefits will be reduced by the amount of any corresponding benefits payable under another insurance contract. If you are entitled to receive benefits under Travel Assistance Insurance or Travel Cancellation Insurance as well as under another benefit of this plan, benefits shall only be payable under Travel Assistance Insurance or Travel Cancellation Insurance.

6. Claims

6.1. Except when a payment card is used, all claims must be submitted using the claim form available on SSQ's web site or from SSQ's Customer Service. You must complete the form and send it to SSQ along with the originals of all receipts or paid invoices. As SSQ does not return receipts, you are advised to always keep copies for your records.

Upon request, reimbursements may be issued by direct deposit.

6.2. Prescription drug expenses

Present your direct payment card to your pharmacist, who will obtain payment directly from SSQ for the portion of prescription drug expenses payable under the contract. You are then responsible for paying the portion of expenses that is not covered by SSQ.

6.3. Expenses for care provided in hospital

Present your SSQ Card at the hospital and the hospital will submit a claim for the expenses incurred directly to SSQ.

6.4. Expenses incurred for prescription drugs where no payment card is used, expenses incurred in specialized health care establishments, expenses for consultations with health care professionals, other medical expenses

In cases where a medical prescription is required, you must attach the prescription to your claim.

Receipts and paid invoices submitted with claims must clearly show the following information:

a) the name of the individual who provided the services, the individual's association or professional order and the individual's membership number, or the name and address of the supplier from whom (or establishment from which) services were obtained le nom;

b) the dates when services were provided;

c) the cost of services provided;

d) the name of the insured for whom services were provided.

6.5. Expenses covered under Travel Assistance Insurance

In the event of an emergency that occurs during an insured's stay outside the province of residence, all travel assistance services, and reimbursement for most expenses eligible under Travel Assistance Insurance, will be coordinated by SSQ's travel assistance service, provided the insured contacts one of its representatives.

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

- The documents you need to file your claim. Originals of all receipts and paid invoices for eligible expenses paid should be enclosed with your claim
- A form for you to sign, authorizing SSQ's travel assistance service to obtain reimbursement on your behalf for expenses eligible under your provincial health and hospitalization plan

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

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

From elsewhere in the world: 514 286-8412 (collect call)

You must provide the contract number specified on your SSQ card when calling.

6.6. Expenses covered under Travel Cancellation Insurance

To file a claim, contact SSQ's travel assistance service at one of the numbers below.

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

From elsewhere in the world: 514-286-8412 (collect call)

You must provide the contract number specified on your SSQ card when calling.

Insureds must include the following supporting documents with their claim:

a) unused travel tickets;

b) official receipts for additional transportation expenses;

c) receipts for travel arrangements. Receipts must include the contracts officially issued by a travel 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.

7. Deadlines for filing claims

Claims should be submitted to SSQ no later than 3 months following the date expenses are incurred. In all cases, SSQ declines all claims submitted more than 12 months after the date expenses are incurred and all claims submitted more than 12 months after termination of coverage under the benefit in question.

Prescription Drugs (Health Care Insurance)

1. Expenses covered

To be eligible, expenses for prescription drugs must be incurred for the purchase of the products described below for an individual who is insured at the time of purchase. The coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**", along with information about applicable deductibles and reimbursement percentages. However, the out-of-pocket maximum provided for under the Quebec Basic Prescription Drug Insurance Plan (BPDIP) applies to expenses incurred by insured persons who are residents of Quebec, following application of the deductible, deterrent fee, if applicable, and percentage of reimbursement provided for under this coverage. For this purpose, prescription drug expenses incurred for dependent children are included only in the participant's own out-of-pocket maximum; it cannot be included in the spouse's maximum. The percentage of reimbursement applicable thereafter to eligible expenses incurred during the same calendar year is 100%.

1.1. For Options R and C - Prescription drugs and pharmaceutical products on the list of the Basic Prescription Drug Insurance Plan

To be eligible, expenses must be incurred to purchase prescription drugs or pharmaceutical products that are covered under the Basic Prescription Drug Insurance Plan (BPDIP) of the "Régie de l'assurance maladie du Québec", subject to the same conditions as those applicable under the BPDIP Plan.

1.2. For other Options

Medications obtainable with a medical prescription only

To be eligible, expenses must be incurred to purchase prescription drugs that meet all of the following conditions:

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

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

c) available exclusively in pharmacies and dispensed by a pharmacist or health care professional legally authorized to do so.

Diabetic products

Insulin, syringes, lancets, needles, test strips and glucose sensors, for the treatment of diabetes. For test strips and glucose sensors to be considered eligible expenses, the following conditions must be met:

- the number of test strips that can be reimbursed is limited to an annual maximum; this maximum may be increased based on the insured's medical condition, provided prior approval by SSQ is obtained
- the number of glucose sensors that can be reimbursed is limited to an annual maximum, and prior approval by SSQ is required

Exception / 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. Prior approval by SSQ is required for these drugs to be eligible.

Anti-obesity drugs

Drugs for the treatment of obesity are eligible on condition that the following supporting documents be included with the claim: recommendation from the attending physician; information pertaining to the height, weight and body mass index of the insured; and diagnosis as to the fact that the insured's medical condition is specifically related to obesity.

Drugs injected in a private clinic

As regards medication injected by a health professional in a private practice, only the injected substance is covered, not the medical procedure.

Viscosupplementation therapy

Viscosupplementation therapy.

2. Exclusions, limitations and restrictions

2.1. In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to the Prescription Drugs benefit.

2.2. Expenses incurred for the following are not eligible under this benefit, regardless of whether or not they are considered prescription drug expenses:

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

b) substances or drugs used or administered for preventive purposes, except in cases where eligible expenses are explicitly provided for such substances or drugs;

c) experimental drugs or products or those obtained under a federal program providing special access to health products;

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 official conditions and directions for use. A complete medical report detailing all conditions justifying the prescription of such products must be presented to SSQ;

f) sunscreens; however -- sunscreens that are necessary for individuals afflicted with an illness requiring treatment with such products may be eligible. A complete medical report detailing all conditions justifying the prescription of such products must be presented to SSQ;

g) drugs used for artificial insemination or in vitro fertilization;

h) growth hormones -- however, growth hormones can be eligible, upon submission of a detailed medical report to SSQ, if they are prescribed in compliance with the conditions and directions for use determined by the provincial prescription drug insurance programs;

i) sclerosing injections for individuals aged 65 or more;

j) the cost of services payable by an insured as a contribution to a public prescription drug insurance plan, which may consist of a premium, a deductible amount or a coinsurance payment;

k) drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital;

l) the medical procedure related to drugs injected by a health care professional in a private clinic;

m) the patient's contribution to Quebec's Public Prescription Drug Insurance Plan.

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

Hospitalization (Health Care Insurance)

1. Expenses covered

To be eligible, expenses for hospital care must be incurred for the services described below, and insureds must be covered under an Option that provides such coverage at the time such services are obtained. Any coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**", along with information about applicable deductibles and reimbursement percentages.

Hospital room

The difference between the cost of hospital ward accommodation and the cost of accommodation in the type of room specified in the "**Schedule of Insurance**" during a period of short-term care provided in Canada in an establishment that meets the definition of a hospital specified for this group insurance plan. Care provided for chronic illness or loss of independence, including that provided in residential long-term care facilities, is not considered to be hospital care for the purposes of this contract.

2. Exclusions, limitations and restrictions

2.1. In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to expenses for hospital care.

2.2. Administrative or incidental fees (TV, telephone, etc.) charged to the patient by the hospital are not eligible for reimbursement under this insurance contract.

Travel Assistance Insurance (Health 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:

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

From elsewhere in the world: 514 286-8412 (collect call)

You must provide the contract number specified on your SSQ card when calling.

1. Expenses covered

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

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.

In the event that the insured dies during the coverage period, or suffers accidental injury or a sudden and unexpected illness during such period, emergency expenses incurred by or for the insured as described below are eligible, up to the maximum reimbursement specified in the "Schedule of Insurance".

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

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

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

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

Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

Physician fees

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

Nursing fees

When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $10,000 per insured per trip.

Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees

Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $2,000 per insured per trip.

Prescription drugs

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

Transportation by ambulance

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

Repatriation of the insured

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

Transportation by plane of a medical escort

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

Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class 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. 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

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.

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. Eligible expenses are limited to a total maximum of $15,000 for preparation of the body and transportation.

Return of vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per trip.

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

Services, products and articles

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

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

Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to 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. Eligible expenses are subject to a maximum of $300 per day, or $2,400 per trip outside the province of residence of the insured, for all individuals covered.

Accommodation and meals

Accommodation and meal expenses incurred in a commercial establishment when an insured, a close relative accompanying the insured, or the insured's travel companion must postpone the return trip due to an accident or an illness. Reimbursement is limited to $200 per day, up to a maximum of eight days, per trip.

Travel assistance services

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

The following services are available:

a) Directing the insured to an appropriate clinic or hospital;

b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front;

c) Ensuring the proper follow-up of the insured's medical file;

d) Coordinating the return and transport of the insured as soon as medically possible;

e) Providing emergency support and coordinating settlement applications;

f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured;

g) Arranging for the return of insured persons to their home (return expenses not included);

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

i) Communicating with the insured's family or employer;

j) Acting as an interpreter for emergency calls;

k) Recommending a lawyer in the event of legal difficulties.

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel 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: acrobatic or stunt flying, mountaineering, hang gliding, scuba diving without the appropriate qualification or participating in any racing or speed contests;

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.

Travel Cancellation Insurance (Health 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:

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

From elsewhere in the world: (514) 286-8412 (collect call)

You must provide the contract number specified on your SSQ card when calling.

1. Expenses covered

To be considered eligible, trip cancellation expenses must be incurred for an individual who is insured under an Option that provides such coverage at the time of cancellation. The coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**".

2. Reasons for cancellation

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

a) an illness or accident suffered by the insured, a travel companion, a business partner of the insured, or a member of the insured's family -- the illness or accident must prevent the individual from performing his 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 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 and 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 by SSQ 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, except the insured's state of health, that could reasonably lead to the cancellation, extension or interruption of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation. Expenses are reimbursed in accordance with the provisions hereafter and with the provisions specified in the "**Schedule of Insurance**".

Eligible cancellation expenses may not exceed $10,000 per insured per trip.

3.1. In the event of cancellation prior to departure

In the event of cancellation prior to departure, the trip cancellation must be notified to the travel agent or carrier, as well as to SSQ, at the latest 48 hours following the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable, 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. In the event of missed departure, flight cancellation or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination. Departure must be missed due to a 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 the insured's travel companion, subject to the conditions specified under the eligible reasons for cancellation.

3.3. If the return is earlier or later than planned

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

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

Restriction

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

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

3.4. Round-trip transportation

The cost of transportation by the most economical means, following approval by SSQ's travel assistance service, for the insured to return to the province of residence and then back to the trip destination, provided the return 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. Exclusions, limitations et restrictions

4.1. 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.

4.2. 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.

4.3. 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.

4.4. 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.

4.5. 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.

4.6. 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 witin 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.

4.7 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.

4.8 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.

Specialized Health Care Establishments (Health Care Insurance)

1. Expenses covered

To be eligible, expenses in specialized health care establishments must be incurred for the services described below, and insureds must be covered under an Option that provides such coverage at the time such services are obtained. The coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**", along with information about applicable deductibles and reimbursement percentages.

1.1. Rehabilitation centre

Accommodation expenses incurred for rehabilitative care, during a period of care required in an appropriate establishment located in Canada. For the purposes of this contract, an establishment is deemed appropriate if it specializes in providing rehabilitative care to an extent deemed adequate by the relevant health care professionals. The required period of care and the recommended duration of such period must both be confirmed by the attending physician.

1.2. Convalescent home

Unless a different maximum is indicated in the "**Schedule of Insurance**", the difference between the cost of hospital ward accommodation and a semi-private (two beds) hospital room, during a necessary period of convalescence in an appropriate establishment located in Canada. For the purposes of this contract, an establishment is deemed appropriate to provide convalescent care if it offers on-site care by a registered nurse, nursing assistant or physician 24 hours a day and is recognized by SSQ or the ministry responsible for health in the province in which it is located. To be eligible, convalescent care must begin within the first few days following hospitalization. As medical evaluation is required in order to determine the necessity of the period of care, a "Convalescent Care" form must be completed by the attending physician and submitted to SSQ. A copy of this form may be obtained from your plan administrator or from SSQ Customer Service.

2. Exclusions, limitations and restrictions

2.1. In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to expenses incurred in specialized health care establishments.

2.2. Administrative or incidental fees (TV, telephone, etc.) charged to the patient by the establishment are not eligible for reimbursement under this insurance contract.

Health Care Professionals (Health Care Insurance)

1. Expenses covered

1.1. To be eligible, expenses must be incurred for services provided by the health care professionals described below, for an individual who is insured under an Option that provides such coverage at the time the services are obtained. The coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**", along with information about applicable deductibles and reimbursement percentages and the cases in which a prescription is required.

1.2. Only one treatment by the same professional or specialist is covered per day, per insured, or one treatment per day per profession or speciality, regardless of the number of fields of specialization the professional or specialist is licensed to practise in.

1.3. For expenses to be considered eligible, 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 addition, the services provided must be within the professional's area of expertise. In the absence of a relevant professional order, the individual must be a member of a professional association recognized by SSQ.

Audiologist

Professional fees.

Occupational therapist

Cost of treatment.

Speech therapist

Professional fees.

Osteopath

Cost of treatment. No amount shall be payable under this plan for expenses for which any portion is payable under the government health insurance plan of the insured's province of residence.

Physiotherapist, physical rehabilitation therapist and certified athletic therapist

Professional fees or cost of treatment.

Podiatrist

Professional fees. No amount shall be payable under this plan for expenses for which any portion is payable under the government health insurance plan of the insured's province of residence.

Psychoanalyst

Professional fees.

Psychiatrist

Professional fees.

Psychologist

Professional fees.

Psychotherapist

Cost of consultation.

Social worker

Cost of consultation.

2. Exclusions, limitations and restrictions

The general exclusions, limitations and restrictions applicable to the Health Insurance plan apply.

Other Medical Expenses (Health Insurance)

1. Expenses covered

To be considered eligible, expenses must be incurred for the services or articles described below, for an individual who is insured under an Option that provides such coverage at the time such services or articles are obtained. The coverage maximums applicable to these expenses are specified in the "**Schedule of Insurance**", along with information about applicable deductibles and reimbursement percentages.

Ambulance and transport by airplane or train

Ground transportation to or from a hospital by a licensed ambulance service. Oxygen treatments during or immediately prior to transportation are covered. 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.

Breast prostheses

Purchase of breast prostheses following a mastectomy.

Cosmetic surgery following an accident

Cosmetic surgery required following an accident. For expenses incurred for this type of treatment to be considered eligible, the following conditions apply:

- the accident must occur while the individual is insured;
- treatment must begin within 12 months following the date of the accident;

  and
- treatment must end within 36 months following the date of the accident and while the insured is still insured under this benefit

CAT scans

CAT scans.

Dental treatment required following accidental damage to natural teeth

Professional fees of a dentist to repair accidental damage to healthy and natural teeth.

For the purposes of this insurance contract, a "natural" tooth is one that has not been replaced. A tooth is considered "healthy" when it has not been affected by any pathology, either in the substance itself or in the adjacent structures. A treated or repaired natural tooth that has returned to its normal functioning and has not been affected by any pathology is also considered healthy. However, damage to teeth occurring while eating is not covered under the "Dental treatment required following accidental damage to natural teeth" provision.

For expenses to be considered eligible expenses for dental treatment following accidental damage to natural teeth, the following conditions must be met:

- the accident must occur while the individual is insured under this benefit;
- treatment must be administered by an accredited dentist or denturist;
- treatment must be provided within 12 months following the accident and while the individual is insured under this benefit.

The expenses eligible for dental treatment following accidental damage to natural teeth are limited to the amounts specified in the fee guide for general dental practitioners of the dentist's province of practice for the year during which expenses are incurred.

For the purposes of this insurance contract, CERTAIN CONDITIONS APPLY. Expenses related to new or existing dental implants or implant-related prostheses are not covered under the "Dental treatment required following accidental damage to natural teeth" provision.

Deep shoes

Ready-made deep shoes. Shoes must be needed in order to use an orthosis designed to correct or compensate for a foot defect. Shoes must be obtained from a fully licensed specialized orthopaedic laboratory.

For the purposes of this insurance contract, sandals are not considered deep shoes.

Detoxification

Detoxification therapies provided by a clinic specialized in rehabilitation treatment for alcoholism or drug or gambling addiction, including all treatment-related expenses. For expenses incurred for this type of treatment to be considered eligible, the following conditions must apply:

- the clinic must be recognized by SSQ;
- the insured must be receiving curative treatment;
- the clinic must be run by a licensed physician and be under the continuous supervision of a registered nurse.

Electrocardiograms

Electrocardiograms.

Eyeglasses and contact lenses following cataract surgery,

Expenses incurred for the purchase of eyeglasses or contact lenses following cataract surgery, on condition that the insured be less than 65 years of age.

External prosthesis and artificial limb

External prostheses and artificial limbs required due to the loss of a natural limb occurring while the insured is covered under this benefit. Eligible expenses are subject to a maximum reimbursement of $5,000 per limb lost.

For the purposes of this insurance contract, the following articles are not considered to be external prostheses or artificial limbs: dentures, breast prostheses, wigs, hearing aids, eyeglasses, contact lenses and intraocular lens implants.

Foot orthoses

Foot orthoses obtained from an officially licensed laboratory or centre specialized in foot orthotics recognized by SSQ.

Glucometer

Purchase of a monitor equipped with a lancing device and used to measure blood glucose levels. Purchase of an intermittent blood glucose monitor requiring glucose sensors may also be eligible, provided prior approval by SSQ is obtained.

Hearing aid

Purchase and repair of hearing aids.

Hospital bed

Rental or purchase of a hospital bed, whichever is more economical. The hospital bed must be similar to the type normally used in a hospital.

Insulin pump

Purchase and repair of an insulin pump prescribed by a physician.

Insulin pump accessories

Purchase of accessories used exclusively with an insulin pump, when prescribed by a physician.

Intraocular lens implants

Purchase of intraocular lens implants required to correct the symptoms of an eye disease in cases where contact lenses or eyeglasses cannot be used to correct such symptoms.

Intrauterine devices (IUDs)

Purchase of IUDs not covered under the prescription drug insurance benefit of this plan.

Laboratory analyses

Analyses of tissue or body fluids (blood, urine, etc.), if carried out in a private laboratory for preventive or diagnostic purposes and of the same type as those carried out in a hospital.

Magnetic resonance imaging

Magnetic resonance imaging (MRIs).

Nurse

Treatment provided to the insured at home by a registered nurse or nursing assistant who does not reside in the same home as the insured and who is not a member of the insured's family. To be eligible, expenses must be incurred for continuous care that requires the specific skills of one of the aforementioned nurses.

Orthopaedic devices

Corsets, splints, crutches, casts and items for severe burn victims. For all orthopaedic devices, expenses may be considered eligible up to an amount deemed reasonable by SSQ for the device necessary for the insured to carry out basic activities of daily living. For the purposes of this insurance contract, orthopaedic shoes and foot orthoses are not considered to be orthopaedic devices.

Orthopaedic shoes

Purchase or repair of orthopaedic shoes, also known as "orthotic shoes". The "**Schedule of Insurance**" specifies any differences between coverage for adults and coverage for dependent children. The term "orthopaedic shoes" is used to mean shoes that are designed for the insured and custom-made from a mould. Open, flared or straight last shoes, or those required for use with Denis Browne splints are also eligible. However, to be covered, shoes must be required to correct or compensate for a foot defect. Shoes must be obtained from a fully licensed specialized orthopaedic laboratory. Also eligible are expenses incurred for corrections made by such a laboratory to prefabricated shoes.

For the purposes of this insurance policy, deep shoes and sandals are not considered orthopaedic shoes.

Ostomy appliances

Purchase of ostomy appliances prescribed by a physician, in excess of the amount reimbursed by the government.

Respirator (breathing apparatus)

Rental or purchase of breathing assistance apparatus, whichever is more economical. Oxygen is also included in the eligible expenses for this benefit.

Sclerosing injections

Only expenses for sclerosing injections that are not eligible under other provisions of the contract and that are provided and administered by a physician for curative and not aesthetic purposes. For the purposes of this insurance contract, the professional fees charged by the physician are not considered to be expenses for sclerosing injections.

Support stockings

Graduated compression stockings of 20 mm HG or over. Stockings must be obtained from a pharmacy or medical establishment, for cases of venous or lymphatic system deficiency.

Surgical brassieres

Purchase of surgical brassieres following a mastectomy or breast reduction.

Therapeutic devices

Rental or purchase of therapeutic devices, whichever is more economical, and repair of such devices. For the purposes of this insurance contract, the following articles are not considered to be therapeutic devices: insulin pumps, monitoring devices such as blood glucose monitors, dextrometers, stethoscopes, sphygmomanometers or other similar devices, home accessories such as whirlpool baths, air purifiers, humidifiers, air conditioning units, or other devices of a similar nature.

Transcutaneous electrical nerve stimulator

One transcutaneous electrical nerve stimulator.

Ultrasound examinations

Ultrasound examinations.

Wheelchair and walker

Rental or purchase, whichever is most economical, of a non-motorized wheelchair or walker. In the case of purchase, expenses incurred for the repair of a wheelchair or walker are also considered eligible. The wheelchair or walker must be similar to the type normally used in a hospital.

Wig

Purchase of an initial wig (capillary prosthesis) following chemotherapy.

X-rays

X-rays other than those covered under other provisions of the contract.

For the purposes of this insurance contract, MRI and CAT scans are not considered X-rays.

2. Exclusions, limitations and restrictions

The general exclusions, limitations and restrictions applicable to the Health Insurance plan apply.

PLAN B – YOUR LIFE INSURANCE

1. Definitions

The definitions that apply specifically to the interpretation of this benefit can be found in the "General Provisions" section.

2. Coverage

Subject to the provisions of the contract, SSQ agrees to pay the amount of insurance provided for under this benefit if you should die while covered under this insurance benefit. This amount is payable to your designated beneficiary. If no beneficiary is designated, the amount of insurance is payable to your estate.

3. Amount of insurance

The amount of insurance provided for under this benefit is established in accordance with the "**Schedule of Insurance**".

4. Accelerated benefit payment

4.1. If you are totally disabled and your life expectancy is less than 12 months, you may request advance payment of up to 50% of your amount of insurance, up to a maximum of $50,000. If you submit your request during the 24 months prior to the date when a reduction in the amount of insurance specified in the "**Schedule of Insurance**" is due to be effective, the amount paid may not exceed 50% of the amount that would be payable after the reduction. If you submit your request within 24 months preceding the date your insurance is scheduled to end, no accelerated benefit shall be payable. In all cases, your request must be approved by SSQ and the following conditions must be met:

a) you must send a written request to SSQ;

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

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

d) you must obtain the written consent of the beneficiary of your insurance, if irrevocable.

4.2. The amount payable upon your death will be reduced by the amount of the accelerated benefit payment plus interest calculated at the average return rate of a one (1) year Treasury Bill plus 2%. Interest is calculated from the date the accelerated benefit is paid, and will continue to accrue until the date of final payment of the remaining amount of insurance payable upon your death.

5. Exclusions, limitations and restrictions

Pre-existing conditions

The amount of insurance provided for under this benefit is not payable if you die during the 12 months following the effective date of your insurance and your death is the result of an illness or accident for which you consulted a physician or received medical treatment during the 6 months preceding the effective date of insurance. This condition does not apply to you, however, if you were insured under a similar benefit of a previous group contract that expired within 31 days preceding the effective date of this benefit, and the effective date of this benefit was the only reason for the termination of your coverage.

Suicide

SSQ will reimburse the premiums paid for this benefit in lieu of the amount of insurance if an insured commits suicide, regardless of the state of mind of the person, while having been covered for less than 12 months under this benefit.

This exclusion also applies to any amount of life insurance for which the individual is not required to apply, effective as of the date insurance for the amount in question comes into force.

6. Conversion privilege

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

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

a) a life insurance that is comparable to your group insurance as to the amount and duration, but that does not exceed $400,000 for all of your group life insurance benefits combined, including the ones you were insured for as a spouse or child, where applicable;

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

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

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

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

6.6. If your insurance under this benefit has been in force without interruption for a minimum of 5 years and then ends, or if the amount of your insurance is replaced by a lesser amount because the contract terminates without being replaced or is replaced by a contract with a lesser amount of insurance, you are entitled to convert your group life insurance coverage to individual life insurance, in accordance with applicable laws. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the termination of your group life insurance.

7. Claims

7.1. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier.

7.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN C – YOUR SPOUSE'S LIFE INSURANCE

1. Definitions

The definitions that apply specifically to the interpretation of this benefit can be found in the "General Provisions" section.

2. Coverage

Subject to the provisions of the contract, SSQ agrees to pay you the amount of insurance provided for under this benefit if your spouse should die while covered under this insurance benefit.

3. Amount of insurance

The amount of your spouse's life insurance is established in accordance with the "**Schedule of Insurance**".

4. Exclusions, limitations and restrictions

4.1. SSQ will reimburse the premiums paid for this benefit in lieu of the amount of insurance if your spouse commits suicide, regardless of the state of mind of the person, while having been covered for less than 12 months under this benefit.

4.2. This exclusion also applies to any increase in the amount of insurance held, as of the date the increase becomes effective.

5. Conversion privilege

5.1. If life insurance coverage for your spouse ends because you cease to belong to the group insured, you are entitled to convert all or part of this group life insurance coverage to individual life insurance without having to provide any evidence of insurability.

5.2. The conversion privilege applies only to those whose insurance terminates on or before their 65th birthday due to the fact that you cease to belong to the group on the day you reach age 65 or earlier. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the day you cease to belong to the group insured. The following types of individual life insurance are available as a result of conversion:

a) a life insurance that is comparable to the group insurance of the insured person as to the amount and duration, but that does not exceed $400,000 for all of the group life insurance benefits combined you had for this person, whether the person is insured as a participant or spouse;

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

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

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

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

6. Claims

6.1. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier.

6.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN D – YOUR DEPENDENT CHILDREN'S INSURANCE

Life Insurance

1. Definitions

The definitions that apply specifically to the interpretation of this benefit can be found in the "General Provisions" section.

2. Coverage

Subject to the provisions of the contract, SSQ agrees to pay you the amount of insurance provided for under this benefit if one of your dependent children should die while covered under this insurance benefit.

3. Amount of insurance

The amount of your dependent children's life insurance is established in accordance with the "**Schedule of Insurance**".

4. Exclusions, limitations and restrictions

4.1. SSQ will reimburse the premiums paid for this benefit in lieu of the amount of insurance if one of your dependent children commits suicide, regardless of the state of mind of the person, while having been covered for less than 12 months under this benefit.

4.2. This exclusion also applies to any increase in the amount of insurance held, as of the date the increase becomes effective.

5. Conversion privilege

5.1. If life insurance coverage for one of your dependent children ends because you cease to belong to the group insured, you are entitled to convert all or part of this group life insurance coverage to individual life insurance without having to provide any evidence of insurability.

5.2. The conversion privilege applies only if you cease to belong to the group on the day you reach age 65 or earlier. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the day you cease to belong to the group insured. The following types of individual life insurance are available as a result of conversion:

a) a life insurance that is comparable to the group insurance of the insured person as to the amount and duration, but that does not exceed $400,000 for all of the group life insurance benefits combined you had for this person, whether the person is insured as a participant or dependent children;

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

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

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

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

6. Claims

6.1. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier.

6.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN D – YOUR DEPENDENT CHILDREN'S INSURANCE (CONT'D)

Accidental Death and Dismemberment Insurance

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of your Accidental Death and Dismemberment Insurance benefits.

Hemiplegia

Complete paralysis of upper and lower limbs of one side of body.

Loss of an arm

Total and irrecoverable loss of use of the arm, or amputation at or above the elbow.

Loss of a foot

On the condition that no loss of a leg is suffered, total and irrecoverable loss of use of the foot, or amputation at or above the ankle joint.

Loss of a hand

On the condition that no loss of an arm is suffered, total and irrecoverable loss of use of the hand, or amputation at or above the wrist joint.

Loss of hearing

Total and irreversible loss of hearing.

Loss of a leg

Total irrecoverable loss of use of the leg, or amputation at or above the knee.

Loss of sight

Total and irrecoverable loss of sight.

Loss of speech

Total and irrecoverable loss of speech.

Loss of thumb and index finger

On the condition that no loss of an arm or a hand is suffered, total and irrecoverable loss of use of the thumb and finger, or amputation at the joint between the first phalanx and the hand.

Loss of a toe

On the condition that no loss of a foot or no loss of a leg is suffered, total and irrecoverable loss of use of a toe, or amputation at or above the sophalangeal joint

Paraplegia

Total paralysis of both legs.

Quadriplegia

Complete paralysis of upper and lower limbs.

2. Coverage

2.1. Subject to the provisions of the contract, SSQ agrees to pay the amount applicable if you suffer any of the losses provided for in the following "**Table of losses**" as a result of an accident occurring while covered under this benefit.

2.2. The loss must be incurred within 365 days following the date of the accident.

3. Amount of insurance

3.1. The amount of insurance provided for under this benefit in the event of an accident is established in accordance with the "**Schedule of Insurance**".

3.2. The amount payable for a given loss will correspond to a percentage of the amount of insurance in force at the time of the accident that caused the loss. This percentage is specified in the "**Table of losses**" below. The maximum amount payable under this benefit may not exceed 100% of the amount of insurance for this benefit for all losses related to the same accident (200% in the case of hemiplegia, paraplegia and quadriplegia). This maximum does not include any additional benefits provided for under this benefit.

3.3. In the event of accidental death, the amount of insurance payable under this benefit is in addition to (but does not replace) the amount of the Life Insurance coverage payable for your dependent children.

4. Table of losses

Loss	Percentage of amount of insurance payable
of life	**100%**
of both hands, both feet or sight in both eyes	**100%**
of one hand and one foot	**100%**
of one hand, and loss of sight in one eye	**100%**
of one foot, and loss of sight in one eye	**100%**
of hearing in both ears and loss of speech	**100%**
of one leg or one arm	**75%**
of one hand or one foot or sight in one eye or hearing in both ears or speech	**66,67%**
of thumb and index finger of one hand or of four fingers of one hand or of all toes of one foot	**33,33%**
of hearing in one ear	**25%**
hemiplegia, paraplegia or quadriplegia	**200%**

5. Additional benefits

5.1 Exposure and Disappearance

If, as the result of an accident, one of your dependent children is unavoidably exposed to the elements and if, as a result of such exposure, suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of Injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which a dependent child was riding, the dependent child disappears, and if the body of the dependent child is not found within one year after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the dependent child suffered loss of life as a result of Injury.

5.2 Transportation and accommodation of family members during hospitalization

If one of your dependent children is hospitalized following a loss for which an amount is payable under this benefit, you may be entitled to receive additional benefits to cover transportation and accommodation for members of your family. Additional benefits for transportation and accommodation expenses are limited to an overall maximum of $2,000 for all family members. Claims for such benefits must be submitted in writing to SSQ to cover transportation and accommodation expenses incurred by members of your family visiting your dependent child while in hospital. For benefits to be payable, the following conditions must be met:

a) transportation must be provided via the most direct route to the hospital;

b) the hospital must be located at a distance of at least 150 kilometres from the child's place of residence;

c) the child must be under the care of a physician other than the child and said physician must confirm that the visit by a family member is beneficial to the child;

d) expenses must be deemed necessary and reasonable by SSQ.

If a private vehicle is used for transportation, reimbursement is limited to $0,20 per kilometre.

5.3 Repatriation of the deceased

In the event of the death of one of your dependent children due to an accident for which an amount is payable under this benefit and if the death occurs more than 50 kilometres from the child's place of residence, individuals incurring the following expenses may be entitled to a reimbursement. The maximum amount of these benefits is $10,000. Claims for reimbursement must be submitted in writing to SSQ to cover expenses incurred for the following:

a) preparation of the child's body for transportation;

b) transportation of the body to the place of burial or cremation, including a funeral home, in proximity to the child's usual place of residence;

c) expenses must be deemed necessary and reasonable by SSQ.

If repatriation is provided for in this clause as well as in other provisions of the contract, benefits shall only be payable under one of these.

5.4 Home and vehicle alterations

In the event that one of your dependent children is permanently required to use a wheelchair due to an accident for which an amount is payable under this benefit, you may be entitled to additional benefits for alterations to the child's main residence and vehicle. The maximum amount of these benefits is $10,000. Claims for such benefits must be submitted in writing to SSQ to cover:

a) the cost of alterations to the child's main residence to make it adapted and accessible to wheelchair use;

b) the cost of alterations to the child's motor vehicle to make it wheelchair accessible and enable the child to drive it himself .

Expenses must be incurred within 365 days following the date of the accident and deemed by SSQ to be necessary and reasonable.

Any alterations to your home or vehicle must be carried out by experts in such matters, whose services have been recommended in writing by a recognized organization providing support to wheelchair users. Any vehicle alterations must be approved by the appropriate provincial authorities.

5.5 Accidents involving a motor vehicle

In the event that one of your dependent children suffers a loss due to an accident for which an amount is payable under this benefit and which occurred while the child was driving or was a passenger in a motor vehicle, the child may be entitled to receive an additional amount equal to 10% of the amount of insurance provided for in the "**Table of losses**" of this benefit. For benefits to be payable, the following conditions must be met:

a) the driver was driving with due care and attention at the time the accident occurred;

b) the child's seat belt must have been buckled at the time the accident;

c) the driver of the vehicle must have held a valid driver's licence at the time the accident occurred.

6. Exclusions, limitations and restrictions

This benefit does not cover any loss that is attributable, directly or indirectly, in whole or in part, to any of the following causes:

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

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

c) war, whether declared or undeclared;

d) the insured's active service in the armed forces;

e) poisoning, intoxication or drug use by the insured;

f) suicide or attempted suicide, regardless of the state of mind of the person;

g) self-inflicted injuries, regardless of the state of mind of the person;

h) a flight in any aircraft or flying machine while the insured is a member of the crew or is carrying out any duty in regard to such flight;

i) injuries exhibiting no visible external wound or contusion on the body, except in the case of drowning or internal injuries revealed by surgery or autopsy.

7. Claims

7.1. All claims, proof and supporting documents must be submitted to SSQ within 90 days following the loss. Claims and proof for additional benefits must be submitted within 90 days following accidental death or the accidental event due to which such additional benefits are payable. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier. However, all required documents must be submitted to SSQ no later than 12 months following the date of the loss (or accidental event due to which additional benefits are payable), and no later than 12 months after termination of this insurance benefit.

7.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN E – YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the definitions provided in the description of your accidental death and dismemberment insurance benefit shall apply specifically to the interpretation of this benefit.

Hemiplegia

Complete paralysis of upper and lower limbs of one side of body.

Loss of an arm

Total and irrecoverable loss of use of the arm, or amputation at or above the elbow.

Loss of a foot

On the condition that no loss of a leg is suffered, total and irrecoverable loss of use of the foot, or amputation at or above the ankle joint.

Loss of a hand

On the condition that no loss of an arm is suffered, total and irrecoverable loss of use of the hand, or amputation at or above the wrist joint.

Loss of hearing

Total and irreversible loss of hearing.

Loss of a leg

Total irrecoverable loss of use of the leg, or amputation at or above the knee.

Loss of sight

Total and irrecoverable loss of sight.

Loss of speech

Total and irrecoverable loss of speech.

Loss of a toe

On the condition that no loss of a foot or no loss of a leg is suffered, total and irrecoverable loss of use of a toe, or amputation at or above the sophalangeal joint

Loss of thumb and index finger

On the condition that no loss of an arm or a hand is suffered, total and irrecoverable loss of use of the thumb and finger, or amputation at the joint between the first phalanx and the hand.

Paraplegia

Total paralysis of both legs.

Quadriplegia

Complete paralysis of upper and lower limbs.

2. Coverage

2.1. Subject to the provisions of the contract, SSQ agrees to pay the amount applicable if you suffer any of the losses provided for in the following "**Table of losses**" as a result of an accident occurring while covered under this benefit.

2.2. The loss must be incurred within 365 days following the date of the accident.

3. Amount of insurance

3.1. The amount of insurance provided for under this benefit in the event of an accident is established in accordance with the "**Schedule of Insurance**".

3.2. The amount payable for a given loss will correspond to a percentage of the amount of insurance in force at the time of the accident that caused the loss. This percentage is specified in the "**Table of losses**" below. The maximum amount payable under this benefit may not exceed 100% of the amount of insurance for this benefit for all losses related to the same accident (200% in the case of hemiplegia, paraplegia and quadriplegia). This maximum does not include any additional benefits provided for under this benefit.

3.3. In the event of accidental death, the amount of insurance payable under this benefit is in addition to the amount of any Life Insurance coverage payable and does not replace it.

4. Table of losses

Loss	Percentage of amount of insurance payable
of life	**100%**
of both hands, both feet or sight in both eyes	**100%**
of one hand and one foot	**100%**
of one hand, and loss of sight in one eye	**100%**
of one foot, and loss of sight in one eye	**100%**
of hearing in both ears and loss of speech	**100%**
of one leg or one arm	**75%**
of one hand or one foot or sight in one eye or hearing in both ears or speech	**66,67%**
of thumb and index finger of one hand or of four fingers of one hand or of all toes of one foot	**33,33%**
of hearing in one ear	**25%**
hemiplegia, paraplegia or quadriplegia	**200%**

5. Additional benefits

5.1 Exposure and Disappearance

If, as the result of an accident, you are unavoidably exposed to the elements and if, as a result of such exposure, suffer a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of Injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within one year after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

5.2 Rehabilitation

If you suffer a loss for which an amount is payable under this benefit, you may be entitled to receive additional rehabilitation benefits. The maximum amount of these benefits is $10,000 per accident. Claims for such benefits must be submitted in writing to SSQ to cover expenses incurred related to a rehabilitation program approved by SSQ. For benefits to be payable, the following conditions must be met:

a) the loss must render you unable to perform the main functions related to your occupation;

b) the loss must require you to undertake special training in order to be able to pursue a different occupation;

c) expenses must be incurred within 3 years following the date of the accident and deemed by SSQ to be necessary and reasonable;

d) this benefit does not cover usual living expenses (e.g. room and board), transportation and clothing.

5.3 Occupational training for spouse

In the event of your death due to an accident for which an amount is payable under this benefit, your spouse may be entitled to receive additional benefits for occupational training. The maximum amount of these benefits is $10,000. Claims for such benefits must be submitted in writing to SSQ to cover expenses incurred for an occupational training program recognized by competent government authorities and approved by SSQ. The program must allow your spouse to pursue employment otherwise inaccessible.

Expenses must be incurred within 3 years following the date of the accident and deemed by SSQ to be necessary and reasonable. This benefit does not cover usual living expenses, transportation and clothing.

5.4 Education for spouse and children

In the event of your death due to an accident for which an amount is payable under this benefit, your spouse and children may be entitled to receive additional benefits for education. These additional benefits are limited to an overall maximum of $5,000 per academic year for your spouse and children, for a maximum of 4 consecutive years. Claims for such benefits must be submitted in writing to SSQ. Annual tuition fees and textbooks are covered, in order to allow your spouse and children to pursue full-time studies in a post-secondary educational institution. For benefits to be payable, the following conditions must be met:

a) at the time of your death, the individual must be enrolled as a full-time student in a post-secondary institution; if enrolled in a secondary school at the time of your death, the individual must enrol as a full-time student in a post-secondary educational institution within 365 days following your death;

b) proof of full-time student status must be provided to SSQ at the start of each academic year.

5.5 Transportation and accommodation of family members during hospitalization

In the event that you are hospitalized following a loss for which an amount is payable under this benefit, you may be entitled to receive additional benefits to cover transportation and accommodation for members of your family. Additional benefits for transportation and accommodation expenses are limited to an overall maximum of $2,000 for all family members. Claims for such benefits must be submitted in writing to SSQ to cover transportation and accommodation expenses incurred by members of your family visiting you while you are in hospital. For benefits to be payable, the following conditions must be met:

a) transportation must be provided via the most direct route to the hospital;

b) the hospital must be located at a distance of at least 150 kilometres from your place of residence;

c) you must be under the care of a physician other than yourself;

d) expenses must be deemed necessary and reasonable by SSQ.

If a private vehicle is used for transportation, the maximum amount of reimbursement for transportation is $0,20 per kilometre.

5.6 Repatriation of the deceased

In the event of your death due to an accident for which an amount is payable under this benefit and if your death occurs more than 50 kilometres from your place of residence, individuals incurring the following expenses may be entitled to a reimbursement. The maximum amount of these benefits is $10,000. Claims for reimbursement must be submitted in writing to SSQ to cover expenses incurred for the following:

a) preparation of your body for transportation;

b) transportation of your body to the place of burial or cremation, including a funeral home, in proximity to your place of residence;

c) expenses must be deemed necessary and reasonable by SSQ.

If other clauses of the contract provide for repatriation, benefits will be paid either under those clauses or this one.

5.7 Home and vehicle alterations

In the event that you are permanently required to use a wheelchair due to an accident for which an amount is payable under this benefit, you may be entitled to additional benefits for alterations to your home and vehicle. The maximum amount of these benefits is $10,000. Claims for such benefits must be submitted in writing to SSQ to cover:

a) the cost of alterations to your main residence to make it adapted and accessible to wheelchair use;

b) the cost of alterations to your motor vehicle to make it wheelchair accessible and enable you to drive it yourself.

Expenses must be incurred within 365 days following the date of the accident and deemed by SSQ to be necessary and reasonable.

Any alterations to your home or vehicle must be carried out by experts in such matters, whose services have been recommended in writing by a recognized organization providing support to wheelchair users. Any vehicle alterations must be approved by the appropriate provincial authorities.

5.8 Accidents involving a motor vehicle

In the event that you suffer a loss due to an accident for which an amount is payable under this benefit and which occurred while you were driving or were a passenger in a motor vehicle, you may be entitled to receive an additional amount equal to 10% of the amount of insurance provided for in the "**Table of losses**" of this benefit. For benefits to be payable, the following conditions must be met:

a) the driver was driving with due care and attention at the time the accident occurred;

b) your seat belt must have been buckled at the time the accident occurred;

c) the driver of the vehicle must have held a valid driver's licence at the time the accident occurred.

5.9 Daycare centre

In the event of your death due to an accident for which an amount is payable under this benefit and your children are enrolled in a daycare centre or childcare service provided in an educational establishment, or enrol within 365 days following your death, the individuals incurring the enrolment fees may be entitled to receive additional benefits. Enrolment fees must be supported by childcare tax receipts and deemed by SSQ to be reasonable and necessary.

These additional benefits are limited to $5,000 per child per calendar year. These benefits are payable for a maximum of 4 consecutive years for children under age 13 only. SSQ reimburses expenses based on the amounts specified on the childcare tax receipts submitted.

6. Exclusions, limitations and restrictions

This benefit does not cover any loss that is attributable, directly or indirectly, in whole or in part, to any of the following causes:

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

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

c) war, whether declared or undeclared;

d) the insured's active service in the armed forces;

e) poisoning, intoxication or drug use by the insured;

f) suicide or attempted suicide, regardless of the state of mind of the person;

g) self-inflicted injuries, regardless of the state of mind of the person;

h) a flight in any aircraft or flying machine while the insured is a member of the crew or is carrying out any duty in regard to such flight;

i) injuries exhibiting no visible external wound or contusion on the body, except in the case of drowning or internal injuries revealed by surgery or autopsy.

7. Claims

7.1. All claims, proof and supporting documents must be submitted to SSQ within 90 days following the loss. Claims and proof for additional benefits must be submitted within 90 days following accidental death or the accidental event due to which such additional benefits are payable. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier. However, all required documents must be submitted to SSQ no later than 12 months following the date of the loss (or accidental event due to which additional benefits are payable), and no later than 12 months after termination of this insurance benefit.

7.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN F – YOUR SPOUSE'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Hemiplegia

Complete paralysis of upper and lower limbs of one side of body.

Loss of an arm

Total and irrecoverable loss of use of the arm, or amputation at or above the elbow.

Loss of a foot

On the condition that no loss of a leg is suffered, total and irrecoverable loss of use of the foot, or amputation at or above the ankle joint.

Loss of a hand

On the condition that no loss of an arm is suffered, total and irrecoverable loss of use of the hand, or amputation at or above the wrist joint.

Loss of hearing

Total and irreversible loss of hearing.

Loss of a leg

Total irrecoverable loss of use of the leg, or amputation at or above the knee.

Loss of sight

Total and irrecoverable loss of sight.

Loss of speech

Total and irrecoverable loss of speech.

Loss of a toe

On the condition that no loss of a foot or no loss of a leg is suffered, total and irrecoverable loss of use of a toe, or amputation at or above the sophalangeal joint

Loss of thumb and index finger

On the condition that no loss of an arm or a hand is suffered, total and irrecoverable loss of use of the thumb and finger, or amputation at the joint between the first phalanx and the hand.

Paraplegia

Total paralysis of both legs.

Quadriplegia

Complete paralysis of upper and lower limbs.

2. Coverage

2.1. Subject to the provisions of the contract, SSQ agrees to pay the amount applicable if your spouse suffers any of the losses provided for in the following "**Table of losses**" as a result of an accident occurring while covered under this benefit.

2.2. The loss must be incurred within 365 days following the date of the accident.

3. Amount of insurance

3.1. The amount of insurance provided for under this benefit in the event of an accident is established in accordance with the "**Schedule of Insurance**".

3.2. The amount payable for a given loss will correspond to a percentage of the amount of insurance in force at the time of the accident that caused the loss. This percentage is specified in the "**Table of losses**" below. The maximum amount payable under this benefit may not exceed 100% of the amount of insurance for this benefit for all losses related to the same accident (200% in the case of hemiplegia, paraplegia and quadriplegia). This maximum does not include any additional benefits provided for under this benefit.

3.3. In the event of accidental death, the amount of insurance payable under this benefit is in addition to (but does not replace) the amount of the Life Insurance coverage payable for your spouse.

4. Table of losses

Loss	Percentage of amount of insurance payable
of life	**100%**
of both hands, both feet or sight in both eyes	**100%**
of one hand and one foot	**100%**
of one hand, and loss of sight in one eye	**100%**
of one foot, and loss of sight in one eye	**100%**
of hearing in both ears and loss of speech	**100%**
of one leg or one arm	**75%**
of one hand or one foot or sight in one eye or hearing in both ears or speech	**66,67%**
of thumb and index finger of one hand or of four fingers of one hand or of all toes of one foot	**33,33%**
of hearing in one ear	**25%**
hemiplegia, paraplegia or quadriplegia	**200%**

5. Additional benefits

5.1 Exposure and Disappearance

If, as the result of an accident, your spouse is unavoidably exposed to the elements and if, as a result of such exposure, suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of Injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which your spouse was riding, the spouse disappears, and if the body of the spouse is not found within one year after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that your spouse suffered loss of life as a result of Injury.

5.2 Transportation and accommodation of family members during hospitalization

In your spouse is hospitalized following a loss for which an amount is payable under this benefit, you may be entitled to receive additional benefits to cover transportation and accommodation for members of your family. Additional benefits for transportation and accommodation expenses are limited to an overall maximum of $2,000 for all family members. Claims for such benefits must be submitted in writing to SSQ to cover transportation and accommodation expenses incurred by members of your family visiting your spouse while in hospital. For benefits to be payable, the following conditions must be met:

a) transportation must be provided via the most direct route to the hospital;

b) the hospital must be located at a distance of at least 150 kilometres from your spouse's place of residence;

c) your spouse must be under the care of a physician other than himself or herself and said physician must confirm that the visit by a family member is beneficial to your spouse;

d) expenses must be deemed necessary and reasonable by SSQ.

If a private vehicle is used for transportation, the maximum amount of reimbursement for transportation is $0,20 per kilometre.

5.3 Repatriation of the deceased

In the event of the death of your spouse due to an accident for which an amount is payable under this benefit and if the death occurs more than 50 kilometres from your spouse's place of residence, individuals incurring the following expenses may be entitled to a reimbursement. The maximum amount of these benefits is $10,000. Claims for reimbursement must be submitted in writing to SSQ to cover expenses incurred for the following:

a) preparation of your spouse's body for transportation;

b) transportation of the body to the place of burial or cremation, including a funeral home, in proximity to the spouse's usual place of residence;

c) expenses must be deemed necessary and reasonable by SSQ.

If repatriation is provided for in this clause as well as in other provisions of the contract, benefits shall only be payable under one of these.

5.4 Home and vehicle alterations

In the event that your spouse is permanently required to use a wheelchair due to an accident for which an amount is payable under this benefit, you may be entitled to additional benefits for alterations to your spouse's main residence and vehicle. The maximum amount of these benefits is $10,000. Claims for such benefits must be submitted in writing to SSQ to cover:

a) the cost of alterations to your spouse's main residence to make it adapted and accessible to wheelchair use;

b) the cost of alterations to your spouse's motor vehicle to make it wheelchair accessible and enable your spouse to drive it by himself or herself.

Expenses must be incurred within 365 days following the date of the accident and deemed by SSQ to be necessary and reasonable.

Any alterations to your home or vehicle must be carried out by experts in such matters, whose services have been recommended in writing by a recognized organization providing support to wheelchair users. Any vehicle alterations must be approved by the appropriate provincial authorities.

5.5 Accidents involving a motor vehicle

In the event that your spouse suffers a loss due to an accident for which an amount is payable under this benefit and which occurred while he or she was driving or was a passenger in a motor vehicle, he or she may be entitled to receive an additional amount equal to 10% of the amount of insurance provided for in the "**Table of losses**" of this benefit. For benefits to be payable, the following conditions must be met:

a) the driver was driving with due care and attention at the time the accident occurred;

b) your spouse's seat belt must have been buckled at the time the accident;

c) the driver of the vehicle must have held a valid driver's licence at the time the accident occurred.

6. Exclusions, limitations and restrictions

This benefit does not cover any loss that is attributable, directly or indirectly, in whole or in part, to any of the following causes:

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

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

c) war, whether declared or undeclared;

d) the insured's active service in the armed forces;

e) poisoning, intoxication or drug use by the insured;

f) suicide or attempted suicide, regardless of the state of mind of the person;

g) self-inflicted injuries, regardless of the state of mind of the person;

h) a flight in any aircraft or flying machine while the insured is a member of the crew or is carrying out any duty in regard to such flight;

i) injuries exhibiting no visible external wound or contusion on the body, except in the case of drowning or internal injuries revealed by surgery or autopsy.

7. Claims

7.1. All claims, proof and supporting documents must be submitted to SSQ within 90 days following the loss. Claims and proof for additional benefits must be submitted within 90 days following accidental death or the accidental event due to which such additional benefits are payable. Otherwise, the individual filing the claim must prove that he or she was unable to submit the documents earlier. However, all required documents must be submitted to SSQ no later than 12 months following the date of the loss (or accidental event due to which additional benefits are payable), and no later than 12 months after termination of this insurance benefit.

7.2. All claims must be submitted using the claim form provided. SSQ may require additional proof and supporting documents.

PLAN G – YOUR LONG TERM DISABILITY INCOME REPLACEMENT INSURANCE

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

After-tax net income

Net income less the following amounts:

1) contributions to the Quebec Pension Plan, Employment Insurance and Quebec Parental Insurance Plan (QPIP);
2) tax payable to provincial and federal governments.

For the purpose of this definition, tax payable to provincial and federal governments is determined by applying the appropriate tax tables to the taxable income and by taking into account amounts, exemptions, tax credits and the following deductions:

1) business overhead expenses;
2) contributions to the Quebec Pension Plan, the Employment Insurance and the Quebec Parental Insurance Plan (QPIP);
3) the general deduction for professional fees;
4) the basic personal amount eligible for tax credit;
5) upon request from the participant and provided supporting documents are submitted, the spouse's amount eligible for tax credit, if applicable. In such a case, the Spouse definition under this policy applies;
6) upon request from the participant and provided supporting documents are submitted, amounts paid for support allowance;
7) upon request from the participant and provided supporting documents are submitted, amounts for dependent children (and any other dependents) eligible for tax credit, as well as child-care expenses.

Elimination period

Period of disability beginning on the date the participant stops working due to a disability and that must elapse before they may be entitled to disability benefits under this coverage. The duration of the elimination period must be determined based on the choices available in the "**Schedule of Insurance**" when applying for this benefit.

Experts committee

Committee formed of medical specialists the policyholder can mandate to revise a dispute about a participant's disability, whether permanent or not.

Gross income

Fees paid by the Régie de l'assurance maladie du Québec, the Minister of Health and Social Services and the Commission des normes, de l'équité, de la santé et de la sécurité au travail, plus income for working as a teacher, researcher or administrator and any other amount received for professional services. For the purpose of this policy, such gross income is equal to the highest of the following amounts:

1) the highest averaged monthly income for 6 consecutive months within the 18-month period immediately preceding the period of disability;
2) the highest averaged monthly income for any period of 2 consecutive years within the 5-year period immediately preceding the period of disability.

Gross income (for participant earning business income)

The salary, the fees received for professional services and the medical business income after operating expenses but before tax, all being prorated to the number of shares owned by the participant. Investment income, dividends, rental income and any other income not related with their professional medical activities are excluded. For the purpose of this policy, such gross income is calculated based on the participant's number of years of practice:

1) 3 years of practice or more: the highest averaged monthly income for any period of 2 consecutive years within the 5-year period immediately preceding the period of disability;
2) 18 months of practice but less than 3 years: the highest averaged monthly income for the year immediately preceding the period of disability or for the 2 consecutive years immediately preceding the period of disability, where applicable;
3) less than 18 months of practice: an estimate of monthly income, subject to a minimum monthly income of $800.

For the gross income to be determined, the participant must submit to the insurer, at the time of a claim, their personal and business income tax reports, and their share in the business.

Net income

Income less business overhead expenses.

2. Coverage

Subject to the provisions of the contract, SSQ agrees to pay you an amount of monthly benefits during your disability, if you become disabled while insured under this benefit and your disability continues after the elimination period.

3. Benefits

3.1 Monthly sum insured

The monthly sum insured is established in accordance with the "**Schedule of Insurance**" and for which the premium is paid to the insurer.

3.2 Indexation of the monthly sum insured

The monthly sum insured is indexed on June 1 of each year solely for participants aged 54 or under who are performing or able to perform all the main duties of their usual professional occupation on a full-time basis. This annual indexation is equal to the lesser of 5% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding December 31; this indexation cannot be negative. The indexed monthly sum insured is rounded to the next multiple of $100.

The minimum income described in the total disability definitions Own occupation option is also indexed on June 1 of each year. This annual indexation is equal to the lesser of 5% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding December 31; this indexation cannot be negative. The indexed minimum income is rounded to the nearest multiple of $1,000.

3.3 Increase of the monthly sum insured

Participants under age 40, who applied to this coverage on or after June 1, 2015 and who are performing all the main duties of their usual professional occupation on a full-time basis are allowed to increase their monthly sum insured by 10% on January 1 of each year. The increase must be a multiple of $50 and cannot exceed $250 for all the sum insured the participant owns. In addition, the lifetime overall maximum increase is $2,000.

Evidence of insurability is not required to increase the monthly sum insured, provided the participant requests the increase within the 60-day period preceding January 1. They must specify the selected amount of increase for each sum insured they own and pay the required premium based on their age on the most recent renewal of this policy. If the participant wants the maximum increase to be applied to only one of the sum insured they own, the sum insured with the longer elimination period will be increased.

A participant may refuse to have their monthly sum insured increased on January 1 of a given year. In such a case, the 10% increase for this year is forfeited. However, the participant's right to have future monthly sum insured under this provision increased is not denied because of such refusal.

3.4 Maximum duration of monthly benefits

Benefits under this insurance coverage are payable at the end of the period to which they apply.

In case of a presumptive total disability due to one of the losses specified in the presumptive total disability definition, the monthly benefit begins on the day the participant suffers such loss, even if it occurs during the elimination period.

The duration of benefits payable under this insurance coverage are established in accordance with the "**Schedule of Insurance**". In any cases, benefit payments cease on the date the participant is unable, unwilling or neglects to provide satisfactory proof of disability.

3.5 Amount of monthly benefits

The amount of monthly benefits under this insurance coverage is established in accordance with the "**Schedule of Insurance**", the contract's provisions at the onset of disability and the category of eligible individuals to which you belong.

However, for participants earning business income, the payable monthly benefit is based on the gross montly income earned during disability. The monthly benefit is determined using the formula A - ((A + B) - C), where:

A = sum insured

B = gross montly income earned during disability

C = 67% of the first $4,500 of gross monthly income, plus 57.5% of the next portion from $4,501 to $9,000 inclusive, and 51.5% of the balance.

In case of a partial disability, the monthly benefit is equal to the sum insured multiplied by the percentage of loss of net income sustained by the participant while disabled.

For participants who chose the own occupation option of the disability defintion, the monthly benefit is equal to the benefit payable in case of a total disability if the loss of net income is higher than 80%. In addition, the monthly benefit payable during the first six months of a partial disability cannot be less than 50% of the monthly benefit payable in case of a total disability. For this purpose, the gross income used to determine the monthly benefit is the one used for total disability, in accordance with the gross income definition.

When necessary, the monthly benefit is prorated at the rate of 1/30 per day of disability for the month during which the total disability begins or ends.

3.6 Indexation of monthly benefits

Disability benefits payable are indexed as of January 1 following the date the elimination period is satisfied. The annual indexation is applied on January 1 of each year as long as benefits are payable and, at the participant's choice, is equal to:

- the lesser of 3% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding June 30; or
- the lesser of 5% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding June 30.

This indexation cannot be negative. The indexed benefit is rounded to the nearest multiple of $1.

3.7 Indexation of income

In case of a partial disability, the gross income earned immediately prior to disability is indexed on January 1 of each year following a period of disability of 12 months. The annual indexation is equal to the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding June 30. This indexation cannot be negative. The indexed benefit is rounded to the nearest multiple of $1.

3.8 Coordination of benefits

At no time may the total of all amounts payable to you for a given month from the sources specified below exceed 100% of your after-tax net income (for participants earning business income, 100% of the maximum monthly benefit as determined under paragraph 3.5 of this provision) at the onset of disability. The after-tax net income (for participants earning business income, the monthly gross income earned prior to disability) is indexed on June 1 of each year and is equal to the lesser of 5% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending on the preceding December 31. This indexation cannot be negative.

Benefits are therefore reduced by any excess amount. The following income is taken into account for calculation purposes:

a) amounts under this benefit;

b) income from all other sources are any initial means any initial disability benefit payment made by any government income protection plan, and other group or associations plans. However, the monthly benefit cannot be less than 50% of the sum insured for which the required premium has been paid to the insurer.

4. Lump-sum benefit payable in the event of death during a benefit period

If, on the date of their death, the participant was under age 65 and entitled to monthly benefit under this coverage, the insurer pays the estate a lump sum equal to three times the monthly benefit the participant was entitled to immediately prior to death. The lump sum is calculated based on the amount of the last payment made.

5. Exclusions, limitations and restrictions

5.1. No Long Term Disability Insurance benefits shall be payable for a period during which:

a) you are not under the care of a physician other than yourself, except if your total disability, as defined in the contract, is a condition that is declared stable by a physician, to the satisfaction of SSQ;

5.2. This benefit does not cover:

a) disabilities resulting from a normal uncomplicated pregnancy;

b) disabilities resulting from pregnancy, delivery, miscarriage or any complication directly or indirectly related to these causes, during the earliest of the following periods:

i) a maternity leave, which is deemed to commence on the delivery date;

ii) a maternity leave taken in accordance with a provincial or federal legislation;

iii) while maternity or parental benefits are payable under the Employment Insurance Act or the Quebec Parental Insurance Plan (QPIP);

d) disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:

i) your active participation in a riot or insurrection;

ii) war, whether declared or undeclared;

iii) intentional self-inflicted injuries, unless such injuries are sustained while suffering from a mental illness diagnosed beforehand by a physician other than themselves;

iv) from alcohol or drug abuse unless, for such abuse, the participant is actively taking part in a therapeutic program supervised by a physician on an on-going basis. They must be receiving continuing medical care or treatment for rehabilitation while staying in a recognized specialized centre.

5.3. No payment will be made for any amount obtained without evidence of insurability at the time of enrolment in case of a disability occurring within the first 24 months following the participant's effective date of insurance under this coverage and resulting from a an injury, illness or physical state, whether diagnosed or not, for which symptoms showed for the first time or for which treatment was recommended, requested or obtained, or for which medication was prescribed and/or taken during the 36-month period preceding the effective date of insurance.

6. Dispute

A dispute may arise between the participant and the insurer about the existence of a total disability or the existence and degree of a partial disability. This dispute may not have been resolved satisfactory to both the participant and the policyholder, after customary and usual representations and negotiations in such circumstances have been used between the participant, the administrator and the insurer. In such a case, the policyholder may, through the administrator, require that an experts committee be appointed to revise the dispute and provide opinions and appropriate recommendations.

Such committee will be formed of at least two but not more than three medical specialists who will be designated by both the insurer and administrator. The insurer will propose one of the experts and the administrator will propose the other one or two, as applicable. The appointment of the final committee is subject to the approval of both the administrator and the insurer.

Upon written request from the person in charge of apointing a committee, the insurer and the administrator will be required to propose their experts in a reasonable delay and arrange for the appointment of the committee. Except in the case of a fortuitous event or particular circumstances, the appointment of the committee should be completed within 30 days of the request from the person in charge and the committee should produce a report within 60 days of such request.

The experts' committee report is forwarded to both the administrator and the insurer. It is understood that the insurer reserves the privilege of the final decision about the dispute. Should such decision be against the committee's opinions and recommendations, the insurer will provide explainations in writing to the administrator.

7. Disability Management

7.1 Return to work

Further to a total disability that lasted more than 12 months and for which monthly benefits were paid, should a participant return to full-time work but earn less gross income than prior to disability, they may be entitled to a monthly benefit. This benefit will be prorated to the gross income lost in comparison with the income earned prior to disability, provided the participant is no longer disabled and is performing their usual professional duties. In addition, the loss of gross income must represent at least 20% of the gross income earned prior to disability. During the period of return to full-time work that immediately follows the disability, the monthly benefit is payable for 4 months if the participant has been totally disabled for 12 to 23 months inclusive, and for 6 months if the participant has been totally disabled for 24 months or more. Under no circumstances can the monthly benefit be continued beyond the participant's 65th birthday.

7.2 Rehabilitation

In the event you become disabled, you can participate in any rehabilitation program approved and supervised by SSQ. Your benefits will be reduced by 50% of the net monthly income provided by your rehabilitation work.

8. Conversion privilege

If this coverage terminates without any possiblity to replace it by another insurer's group insurance plan including a similar coverage, any participant may obtain a one-year term non-cancellable individual loss of income insurance with guaranteed renewal, in accordance with applicable laws and subject to the following conditions:

a) the participant must apply in writing to the insurer within 31 days following the termination of this coverage and pay the initial premium for the coverage they have applied for;

b) premiums for the individual contract are based on the usual premium rates with the insurer at the time the conversion privilege is exercised;

c) the individual insurance so obtained is similar to the loss of income insurance under this policy as to the sum insured and termination age of insurance;

d) the individual insurance does not include any indexation of the sum insured. Indexation of the benefits is however provided and equal to the lesser of 5% and the annual percentage change in the Consumer Price Index for the province of Quebec, as published by Statistics Canada for the 12-month period ending 6 months prior to the date the indexation applies.

9. Claims

9.1. Claims and proof of total disability must be submitted to SSQ within 90 days following the end of the elimination period. Proof of recurring total disability and related claims must be submitted within 90 days following the date the total disability recurs. If you fail to meet these deadlines, you must prove that you were unable to submit your application and supporting documents earlier: otherwise SSQ may decline your claim or interrupt payment of benefits.

9.2. For a claim or request to be approved, all required documents must in all cases be submitted to SSQ no later than 12 months following the end of the elimination period. The insurer reserves the right to require proof or additional information and have the insured person examined by a physician of its choice.

PLAN H – YOUR BUSINESS OVERHEAD EXPENSES INSURANCE

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Elimination period

Period of total disability that must elapse before you are entitled to benefits under this insurance coverage. The duration of the elimination period appears in the "**Schedule of Insurance**".

2. Coverage

Subject to the other provisions of the contract, and to the indications of the "**Schedule of Insurance**", SSQ agrees to pay you an amount of monthly benefits during your total disability, if you become totally disabled while insured under this benefit and your total disability continues after the elimination period.

3. Claims

3.1 Amount and duration

The amount and duration of benefits payable under this insurance coverage are established in accordance with the "**Schedule of Insurance**", the contract's provisions in effect at the onset of disability, as well as the category of eligible individuals to which you belong.

Benefits under this insurance coverage are payable at the end of the period to which they apply.

If necessary, the initial and final payment pertaining to the same total disability period are fractionated, on a basis of 1/30 per day of total disability in the month during which the entitlement to benefits begins or ends.

If the fees incurred in a month are less than the amount of insurance, the duration of benefit payments may be extended until the maximum amount of benefits is reached, subject to the maximum monthly amount of benefit payment indicated in the "**Schedule of Insurance**".

If the fees incurred in a month are more than the amount of insurance, the difference between the fees incurred may be carried over to the next months, subject to the maximum monthly amount of benefit payments.

The maximum amount of benefit payable is equal to the monthly insurance amount multiplied by the maximum amount of months, which is 18.

3.2 Calculation of benefit payments

The amount and duration of benefit payments under this insurance coverage are determined in accordance with the "**Schedule of Insurance**", the contract provisions in force at the onset of disability and the class of participants to which you belong at that time.

Benefits under this insurance coverage are payable at the end of the period to which they apply.

4. Eligible business expenses

This benefit covers the portion of business expenses pertaining to your doctor's office that remain payable and for which you are responsible. The following recurring expenses are eligible under this benefit, provided approval of submitted documents by SSQ:

a) rent, water, power and other public utilities;

b) the salary of employees and your contribution as employer to the group insurance plan, to the employee pension plan, to the Quebec Pension Plan (RRQ), to Employment Insurance, to the Régie de l'assurance maladie du Québec (RAMQ), and to the Quebec Parental Insurance Plan;

c) professional accounting services for your office;

d) rental of equipment, including automobiles;

e) your dues to various organizations regulating the medical profession and relevant professional associations;

f) other recurring fees having to be paid out.

5. Exclusions, limitations and restrictions

5.1. No benefits under the Business Overhead Expenses Insurance shall be payable for a period during which:

a) you are not under the care of a physician other than yourself, except if your total disability, as defined in the contract, is a condition that is declared stable by a physician, to the satisfaction of SSQ;

b) you fail to participate in a rehabilitation program recommended by SSQ;

c) you fail to undertake a gradual return to work recommended by SSQ.

5.2. This benefit does not cover:

a) disabilities for which you fail to undergo, when requested to do so by SSQ, any examination with a health care professional or any treatment or program likely to favour recovery of your health;

b) disabilities eligible for benefits under a comparable insurance benefit that was effective before the date this benefit became effective;

c) disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:

i) a criminal act that you commit or attempt to commit;

ii) your active participation in a riot or insurrection;

iii) war, whether declared or undeclared;

iv) your active service in the armed forces;

v) aesthetic or cosmetic treatments;

vi) intentional self-inflicted injuries, regardless of your state of mind.

d) disabilities stemming from alcoholism or substance abuse, if you do not receive treatment or medical care aimed at rehabilitation.

5.3. The following are not eligible under this benefit: your income, the income of your replacement, the cost of goods and pharmaceutical products, and fees that are not included in the list of eligible expenses to the present benefit.

5.4. In the following cases, periods of disability due to pregnancy, childbirth, miscarriage or any other complication related directly or indirectly with one of these causes are not eligible under this benefit:

a) during a maternity leave taken in accordance with a provincial or federal law;

b) during periods when maternity leave benefits are payable under the Employment Insurance Act or the Quebec Parental Insurance Plan (RQAP).

6. Claims

6.1. Claims and proof of total disability and the accident or illness you have suffered must be submitted to SSQ within 90 days following your total disability but no later than within 15 days following your return to your professional duties. After that, proof of the continuation of your total disability must be submitted to SSQ on demand.

6.2. If you fail to meet these deadlines, your entitlement to benefits will not begin before reception of the proof of total disability.

6.3. If you fail to submit additional evidence required by SSQ or if you fail to undergo medical examination within 31 days of a request to do so by SSQ, you will not be entitled to benefits under this coverage between the end of the 31-day deadline and the date the additional evidence or the medical report is received by SSQ.

6.4. From the time SSQ notifies you that your claim has been declined or payment of benefits is to be terminated, you have 90 days in which to provide additional proof justifying your continued entitlement to benefits or request that your file be reviewed.

6.5. If you fail to submit claims or requests for review and the evidence required by SSQ within the deadlines provided for under this benefit, your entitlement to benefits will not apply to any period prior to their date of reception by SSQ.

6.6. For a claim or request to be approved, all required documents must in all cases be submitted to SSQ no later than 12 months following the end of the elimination period and no later than 12 months after termination of this insurance benefit. In addition, in the event that a claim is declined or payment of benefits is terminated, no new benefits may be paid with regard to your disability if all documents required are not submitted to SSQ at the latest 12 months after the date on which notice of refusal or termination is issued.

PLAN L – DENTAL CARE INSURANCE

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Close relative

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Deductible

The amount of eligible dental care expenses that you must pay each year before being entitled to any reimbursement.

Eligible expenses

Dental care expenses eligible for inclusion in the calculation of reimbursements, taking into account any deductible, percentage of reimbursement and other maximum provided for under the contract.

2. Coverage

2.1. If an insured incurs expenses that are eligible under this benefit, SSQ agrees to reimburse such expenses as indicated in the "**Schedule of Insurance**", subject to the provisions of the contract.

2.2. Eligible expenses for Dental Care Insurance are grouped together by type of service as follows:

- Diagnostic and Preventive Services
- Basic Dental Care
- Major Restorative Services (Prosthodontics)

3. General conditions for eligibility of expenses

In all cases, to be considered eligible, expenses and services must meet the following conditions:

a) services must be obtained while the individual is insured under this benefit;

b) treatment must be provided by an accredited dentist, denturist or dental hygienist working under supervision of a dentist;

c) treatment must be administered in compliance with current dental practice standards;

d) Services must be provided by an individual who does not reside with the insured and who is not a close relative of the insured.

Treatment Plan

When expenses are expected to exceed $800, a detailed written treatment plan and appropriate X-rays should be submitted to SSQ prior to the start of treatment. This allows insureds to be informed in advance of the portion of expenses covered under their insurance.

4. General exclusions, limitations and restrictions

4.1. For insureds who are not covered under the public health insurance plan of their province of residence, any amounts paid by SSQ are limited to the amounts that would have been payable had the insured been covered under the relevant plan.

4.2. Expenses are eligible up to the amount of the fees recommended in the following professional association's fee guide for the year specified in the "**Schedule of Insurance**": For services of a general dental practitioner or dental specialist, the fee guide for general dental practitioners of the dentist's province of practice; For services of a denturist, the fee guide for denturists of the denturist's province of practice. However, eligible laboratory expenses are limited to 50% of the fees detailed in the fee guide for the orodental act in question. In the absence of fees recommended by an appropriate professional association, eligible expenses are limited to reasonable amounts that uninsured individuals would normally have to pay for the services in question, taking into account standards that SSQ deems applicable to the dentist's or denturist's province of practice.

4.3. In the event that a less expensive treatment than that received by the insured would have given the appropriate results, eligible expenses are calculated based on the fee provided for the less expensive treatment, taking into account, however, the applicable fees provided for above.

4.4. When the word "sextant" or "quadrant" is used in the description of a treatment, the code or codes for insured services corresponding to such treatment are limited to 6 different sextants per calendar year, per insured or 4 different quadrants per calendar year, per insured.

4.5. When a fee based on units of time is provided, expenses recognized for insurance purposes are limited to the recommended fee covering the maximum number of units of time for the treatment or service in question. Expenses for additional units are not considered when calculating eligible expenses.

4.6. Installation of gold foil, inlays or replacement prostheses (individual crowns, veneers, cast posts, prefabricated posts, removable dentures, fixed bridges) is not considered a service covered under this benefit if installed within 60 months of the previous one. However, expenses for replacing partial or complete permanent removable dentures may be 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).

4.7. Dental Care Insurance provides for no reimbursement in the following cases:

a) expenses incurred due to self-inflicted injuries, regardless of the state of mind of the person;

b) expenses payable by the government or by another insurer;

c) expenses for which a third party is liable, except in the case of subrogation;

d) expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract; for example, transformation, extraction or replacement of healthy teeth to modify their appearance are considered treatment for aesthetic purposes;

e) expenses that you are unable to prove were incurred by the insured;

f) expenses incurred for treatments or services of an experimental nature or at the medical research stage;

g) expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes;

h) expenses incurred in relation to services that are not provided while the individual is insured;

i) expenses regarding implants and any implant-related treatment or prosthesis;

j) expenses regarding an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction or vertical dimension correction; however, a portion of the expenses incurred for an intra-oral appliance is eligible, i.e. an amount equal to the amount specified in the fee guide for the dentist's professional association for bruxism appliances;

k) expenses regarding the replacement of appliances or dentures that are lost or stolen;

l) expenses in relation to appointments not kept, filing claims, treatment plans, written reports, travelling expenses, correspondence expenses, legal identification, and appearance in court as an expert witness or telephone consultations;

m) expenses for mouth guards;

n) expenses that the insured would not have had to pay if uninsured;

o) expenses regarding a dental appliance for treatment of snoring or sleep apnea;

p) expenses regarding transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort;

q) expenses regarding transitional pontics or abutments;

r) expenses related to microbiological tests or analyses;

s) expenses regarding diagnostic photographs.

5. Multiple coverage and coordination of benefits

5.1. Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not you have submitted a claim for such benefits.

5.2. If you are entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

5.3. If you and your spouse each have group health insurance coverage, each of you should first submit your own claims to your own group insurance plan.

5.4. If you and your spouse each have family coverage status for your group dental care insurance, 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 children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

6. Claims

6.1 If the dentist uses electronic claim submission

When the insured incurs dental expenses, he or she must present the dental claim card to the dentist and pay only the portion of the expenses not covered by the insurance. SSQ will reimburse the insured portion of the expenses directly to the dentist.

6.2 If the dentist does not use electronic claim submission

You may file your claim by completing and returning to SSQ the dental claim form provided by the dentist.

Claims should be submitted to SSQ no later than 90 days following the date expenses are incurred. SSQ declines all claims submitted more than 12 months after the date expenses are incurred and all claims submitted more than 12 months after termination of coverage under the benefit.

Diagnostic and Preventive Services (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "**Schedule of Insurance**".

Eligible expenses are provided under this contract for the following diagnostic and preventive services:

a) Diagnostic services

1) Clinical oral examination

- for Quebec residents: Dental examination for children under age 10, if not covered under public plan: one examination per period of 12 months
- Recall or periodic oral examination: one examination per period of 6 months
- Complete oral examination: one examination per period of 36 months
- Complete periodontal examination: one examination per period of 36 months
- Emergency examination: 2 examinations per calendar year
- Specific oral examination: 2 examinations per calendar year

2) X-rays

a) Intra-oral X-rays

- Periapical film
- Occlusal film
- Bitewing film
- Soft-tissue film

b) Extra-oral X-rays

- Extraoral film
- Sinus examination
- Sialography
- Use of radiopaque dyes to demonstrate lesions
- Temporomandibular joint
- Panoramic film: one film per period of 36 months
- Cephalometric film

c) Other

- Duplicate radiograph: 2 times per calendar year

3) Laboratory tests and examinations

- Pulpal tests: 3 times per period of 12 months
- Bacteriologic tests
- Histological tests: Biopsy of soft tissue, biopsy of hard tissue
- Cytological tests

- Diagnostic casts (excluded if associated to restorative treatment)
- Case presentation / treatment plan
- Consultation with patient
- Vitality test

b) Preventive services

1) Routine preventive services

- Polishing of coronal portion of teeth: one visit per period of 6 months
- Scaling: once per period of 6 months
- Topical application of fluoride*: once per period of 6 months
- Diet assessment: one visit per lifetime
- Oral hygiene instruction: once per lifetime
- Plaque control program: 5 times per calendar year
- Finishing restorations
- Pit and fissure sealants, including prophylactic odontotomy and acid etch preparation* (only on occlusal surfaces of premolar and permanent molar teeth): once per period of 36 months per tooth
- Removal of subgingival filling material requiring anesthesia, without flap
- Interproximal discing *
- Enameloplasty (recontouring of natural tooth for non-aesthetic reasons)

2) Space maintainers: one visit per period of 24 months*

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

4) Appliance for bruxism

- One appliance per period of 60 months
- Repair: one visit per calendar year
- Adjustment: one visit per calendar year

5) Occlusal equilibration

- 8 units of time per calendar year or one major and 3 minor occlusal equilibrations per calendar year

* Expenses for these services may only be considered eligible when provided for children under age 16.

Basic Dental Care (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "**Schedule of Insurance**".

Eligible expenses are provided under this contract for the following basic dental care:

a) Minor restorative services

- Sedative filling
- Smoothing of traumatized tooth
- Recementation of a broken tooth fragment
- Resin, amalgam or composite restorations*
- Retentive pins

* Restoration treatment for the same surface or class of the same tooth may be considered eligible for reimbursement only 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

c) Periodontics

- Non-surgical treatment
- Periodontal surgery
- Gingival curettage and root planing (maximum 6 units of time per calendar year or maximum one visit per tooth per period of 24 months)
- Splinting (excluding Maryland type)
- Periodontal irrigation

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

- Rebase, reline
- Repairs with or without impression
- Palatal lift: one per period of 60 months
- 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 / rebonding of bridges, inlays, onlays, crowns, posts or veneers: 2 visits per calendar year for the same tooth or abutment
- Supplement for acid-etch restoration: 2 times per calendar year
- Immobilization, sectioning
- Post removal

f) Oral surgery

- Removal of erupted teeth, complex or uncomplicated
- Removal of impacted teeth, roots and tooth fragments
- Surgical exposure of tooth, including orthodontic attachment: once per lifetime per tooth
- Transplantation of tooth: once per lifetime per tooth
- Surgical repositioning of tooth: once per lifetime per tooth
- Enucleation of an unerupted tooth and follicle: once per lifetime per tooth
- 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) General additional services

- Local anesthesia
- Conscious sedation
- Home, hospital or dental office visit outside normal office hours

Major Restorative Services (Prosthodontics) (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "**Schedule of Insurance**".

Eligible expenses are provided under this contract for the following prosthodontic services:

a) Major restorative services and fixed prostheses

- Gold foil: once per period of 60 months for the same tooth
- Inlays: once per period of 60 months for the same tooth
- Retentive pins for inlays and onlays
- Metal cast retainer, Maryland type: once per period of 60 months for the same 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
- Prefabricated post
- Tooth reconstruction (core build up) in preparation for crown
- Supplement for restoration

b) Removable dentures

- Complete dentures*
- Partial dentures*

* Expenses for equilibrated dentures are reimbursed based on the cost of the equivalent standard dentures .

c) Fixed bridges

- Pontics
- Metal cast retainer (inlay) for Maryland, Rochette or Monarch bridge
- Abutment
- Retention bar for attachment to coping crowns
- Abutments, inlays or onlays: metal, porcelain, ceramic or resin
- Precision attachments
- Supplement for preparation of crown under existing partial denture clasp

APPENDIX A - GARANTEED INSURABILITY OPTION - LONG TERM DISABILITY INCOME REPLACEMENT INSURANCE (PLAN G)

1. Option description

The participant who chooses the garanteed insurability option is allowed to increase the monthly sum insured without having to submit evidence of insurability. The additional sum insured can be obtained during the period of option, provided the garanteed insurability option is in force and you exercise your garanteed insurability right.

2. Eligibility

Any individual under age 45 is eligible for this option on the date they become insured under the Long Term Disability Income Replacement Insurance benefit (Plan G).

3. Application to the option and evidence of insurability

Application to this option is optional and conditional to application to the Long Term Disability Income Replacement Insurance benefit (Plan G). Evidence of insurability satisfactory to the insurer must be solely submitted at the time of application to the option, for the potential total amount the participant may receive.

4. Effective date of the option

Subject to any other provisions of the Long Term Disability Income Replacement Insurance benefit (Plan G), a member's garanteed insurability option is effective on the date the insurer approves their insurability, provided that the additional premium applicable to this option is paid.

5. Sum insured

Under this option, the sum insured of your Long Term Disability Income Replacement Insurance benefit is increased by $1,000 per year if you request it during an option period. You may exercise the option during 10 consecutive years from the effective date of the option, up to a cumulative maximum of $10,000. However, in any circumstances can the total sum insured you own exceed the maximum provided for under the Long Term Disability Income Replacement Insurance benefit. A participant under age 40 who chose the garanteed insurability option waives their right to the 10% increase of the initial sum insured offered each January 1 under the Long Term Disability Income Replacement Insurance benefit (paragraph ''3.3 Increase of the monthly sum insured'' of provision ''3. Benefits'')

6. Garanteed insurability exercise right

You must inform the administrator in writing of your choice to exercise your garanteed insurability right during each annual period of option. The annual period of option is from December 1 to 31 of each year.

To exercise your right, you must prove that your monthly net income justifies the increase of the sum insured, by also taking into account of any other individual or group disability insurances you own. The garanteed insurability then becomes effective on January 1 immediately following the period of option during which you exercise your right, provided that:

i) the required additional premium is paid;

ii) you are at work or were at work on the last scheduled work day, on a full-time basis;

iii) you perform the main duties of your usual professional occupation, or if not at work, are able to perform the main duties of your usual professional occupation.

The increase is applied to your single sum insured or only one of the sum insured owned by you.

If you choose not to exercise your right during a given annual period of option, the increase for this period is forfeited. You may however exercise your right for future increases, provided you continue to pay the additional premium applicable to these increases, and you request them during the annual period of option.

The monthly sum insured may be increased only once during a single period of disability, provided that you exercised your right during the year preceding disability. This increase will only apply during the next period of disability.

This right to exercise this option ends on January 1 following your 45th birthday.

7. Additional premium

The premium applicable to this option is payable as long as you are covered under the option, whether or not you exercised your garanteed insurability rights.

The first additional premium applicable to this option must be paid prior to the end of the annual period of option during which you exercised your garanteed insurability rights.

The additional premium is based on the shortest elimination period you have chosen and your choice of whether or not to apply benefit indexation to the sum(s) insured you hold.

8. Conditions, provisions, limitations and exclusions

This option is subject to the conditions, provisions, limitations and exclusions provided for under the Long Term Disability Income Replacement Insurance benefit (Plan G).

9. Waiver of premium

This option is subject to the waiver of premium provision provided for under the Long Term Disability Income Replacement Insurance benefit (Plan G), subject to the provisions of the **Waiver of premiums in the event of total disability** section.

10. Termination of the garanteed insurability option

The garanteed insurability option ceases at midnight, on the earliest of the following dates:

a) the date this contract terminates;

b) the due date of the additional premium, if such premium is not paid before the end of the grace period;

c) January 1 following the participant's 45th birthday;

d) the date the Long Term Disability Income Replacement Insurance benefit (Plan G) ceases;

e) the date on which 10 years have elapsed since the guaranteed insurability option came into effect;

f) the date the participant's total sum insured reaches the maximum provided for under the Long Term Disability Income Replacement Insurance benefit (Plan G).

The insurance outlined in the following section is underwritten by the contract of SSQ, Insurance Company Inc. If there is any conflict between this booklet and the applicable contract, the terms and conditions of the contract will govern. SSQ Life Insurance Company Inc.'s liability is limited to the insurance coverage governed by its own contracts.

SSQ INSURANCE COMPANY INC.

CRITICAL ILLNESS INSURANCE

for Insured Members of

LA FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

Provisions in force July 1, 2017

POLICY No. 1HB60

This Booklet/Certificate is an important document.

Please keep it in a safe place.

This booklet is an outline of SSQ Insurance Company Inc. Critical Illness Insurance Plan offered to the Members of LA FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC and their dependent (Spouses). It is designed to help you learn more about the coverage offered under this Plan. This booklet should be retained for reference.

The Critical Illness Insurance Group Policy no. 1HB60, its master application endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", sets forth the terms and conditions of the Insurance Plan. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

NOTICE OF NEW FILE

File and Personal Information

In order to maintain the confidentiality of information concerning the persons it insures, the Insurer 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 members, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to reinsurers and any other person you may authorize. The Insurer keeps these insurance files in its offices.

All persons insured with SSQ Insurance Company Inc. 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 the Insurer's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, the Insurer 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

The Insurer may exchange information of a personal and confidential nature with its reinsurers, legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned. The Insurer'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 the Insurer can offer you.

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

INTRODUCTION

What is Critical Illness Insurance?

Critical Illness Insurance can provide the funds and means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

It is designed to provide a lump sum payment in the event that the individual is diagnosed for the first time with a given covered Critical Illness while the insurance is in force and survives at least 14 days following the diagnosis. Among the many advantages of this coverage, payment of benefits is not limited by your ability to work or even by a full recovery. Should you receive a critical illness diagnosis, the benefit is paid directly to you and you are free to choose how to use the amount you receive.

Why is Critical Illness Insurance important?

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

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

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

Critical illnesses are diagnosed everyday. Although healthy lifestyle choices can help protect against some health risks, a critical illness or condition can strike anyone at any time. Thanks to advances in modern medicine however, Canadians are enjoying longer and healthier lives. As survival rates improve, the need for Critical Illness Insurance, to help provide financial support throughout the recovery process is becoming more and more important.

A Critical Illness Insurance benefit can help you:

- obtain the appropriate care where and when you decide
- cover medical expenses not covered under your provincial health care plan
- focus on your recovery process by funding a leave of absence or time off to take care of a family member
- compensate for reduced family earnings and face increased costs, by using the benefit to pay for:
  - medical bills or private nursing care
  - mortgage payments or rent

- debt or other financial liabilities
- child care
- hired domestic help
- home or vehicle modifications

What are the advantages of your coverage?

With your Critical Illness Insurance, you benefit from:

- affordable coverage thanks to our competitive group rates;
- premium payments by way of payroll deductions;
- continued protection even if your health has diminished while covered under the Plan – even after having received a critical illness benefit, you and your insured spouse may still be covered under the Insurer's Critical Illness Insurance

GENERAL DEFINITIONS

"Critical Illness" means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

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 or repair
18. Hip replacement surgery
19. Kidney failure
20. Knee replacement surgery
21. Liver failure of advanced stage
22. Loss of independent existence
23. Loss of limbs
24. Loss of speech
25. Major organ failure on waiting list
26. Major organ transplant

27. Motor neuron disease
28. Multiple sclerosis
29. Muscular dystrophy
30. Occupational HIV infection
31. Paralysis
32. Parkinson's disease and specified atypical Parkinsonian disorders
33. Primary pulmonary hypertension
34. Progressive systemic sclerosis
35. Severe burns
36. Severe rheumatoid arthritis
37. Stage 1A malignant melanoma
38. Stage A (T1a or T1b) prostate cancer
39. Stroke
40. Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present document is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"Diagnosis" or "Diagnosed" refers to the determination by a Specialist, using tests or other diagnostic methods, that the Insured Person has a specific illness covered under the Policy. The Diagnosis of any covered illness must be made in Canada or the United States by a Specialist licensed to practice in Canada or the United States. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

"Member" means all Physicians and their spouses, the employees of Physician member and/or their spouses, Medical Students and Medical residents of the Policyholder who is under the age of seventy (70).

"Insured" means an insured Member and their spouse whose coverage under the Policy is in force, except where otherwise specified under the policy.

"We", "us", "the Insurer" means SSQ Insurance Company Inc.

"Irreversible" means a condition of the Insured where the prognosis cannot be improved by medical or surgical treatment at the time of Diagnosis. However, when the prognosis could be improved by medical or surgical treatment but would impose, in the opinion of the Insured's Physician, a risk to the Insured's health that would outweigh the expected benefit(s) of such treatment, the condition is then also considered as Irreversible for the purpose of this definition.

"Life Support" means the Insured is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

"Policy" means Policy n° 1HB60 as well attached Master Application, any endorsements and attached papers, if any.

"Physician" means an individual who is legally licensed to practice medicine in Canada or the United States and provides treatment within the scope of his licence. The Physician must not ordinarily reside with the Insured. The Physician must not be the Insured, a relative of or business associate of the Insured.

"Pre-existing Condition" means:

- the existence of symptom(s) within a twenty-four (24) month period preceding the Insured's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or
- an illness or condition for which the Insured, during twenty-four (24) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

"Principal Sum" means the amount of insurance applicable to the Insured and stated under the section Coverage Amount of the booklet.

"Specialist" means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practising in Canada or the United States. The Specialist must not ordinarily reside with the Insured. The Specialist must not be the Insured, a relative of or business associate of the Insured.

"Spouse" means an individual under the age of seventy (70) who resides in Canada and:

(a) who is legally married to or in a civil union with the Insured Member; or

(b) with whom the Insured Member has continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, if an individual is the biological or adoptive mother or father of at least one of the children of the Insured Member and is cohabiting with the Insured Member, the individual shall be deemed to be a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one (1) year of cohabitation.

Only one (1) individual qualifies as the Spouse of any Insured Member. If the Insured Member is legally married or in a civil union but is also cohabiting with an individual as described under Item (b) above, the Insured Member may elect in writing which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Member is legally married or in a civil union.

"Surgery" means that the Insured undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada or the United States.

"Survival Period" means the fourteen (14) days following the date of Diagnosis or fourteen (14) days following the date of Surgery if applicable, except where otherwise specified under the present document. The Survival Period does not include days on Life Support as defined in this section. The Insured must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain.

For those conditions which have a qualifying period, for example ninety (90) days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

ENROLMENT

Enrolment in this plan is on a voluntary basis.

ELIGIBILITY

The Critical·Choice·Care insurance program is available to the Insured Person of La Fédération des médecins omnipraticiens du Québec and their dependents (Spouse).

As an active Member (hereinafter individually called "Insured Person") of La Fédération des médecins omnipraticiens du Québec, you are eligible under the Critical·Choice·Care program if you are residing in Canada. If you are absent from active work for any reason other than bona fide vacation, you will only become eligible upon return to active work.

Your spouse is eligible for coverage if he or she resides in Canada and meets the Spouse definition as presented under the "Definitions for a better comprehension of this booklet" section.

Note: Your Spouse under the Critical·Choice·Care program will be the person whom you designate as your spouse under the group benefit program of La Fédération des médecins omnipraticiens du Québec.

COVERAGE AMOUNTS

Critical Illness Insurance is a voluntary group coverage for you or your Spouse.

You have the option to buy an amount of principal sum in units of $5,000 up to a maximum of $500,000, subject to the terms of premium payment indicated in the "Coverage Payment" section.

Your Spouse has option to buy an amount of principal sum in units of $5,000 up to a maximum of $500,000, subject to the terms of premium payment indicated in the "Coverage Payment" section.

Note: Your Spouse may not request an amount of coverage greater than your amount of coverage.

With respect to new graduate physicians:

An enrollment period of ninety (90) days, on the date the new graduate Physician is admitted to the College des Médecins:

Guaranteed Issue Amount (new insured graduate Physician): $40,000

Guaranteed Issue Amount (Spouse of new insured graduate Physician): $20,000

EVIDENCE OF INSURABILITY AND EFFECTIVE DATE OF INSURANCE

Required evidence of insurability

Evidence of insurability to the satisfaction of the Insurer is required for any Amount.

With respect to new graduate physician

Evidence of insurability to the satisfaction of the Insurer is required when the requested amount exceeds the Guaranteed Issue Amount.

It is also required when the request is received by the Policyholder more than thirty-one (31) days after one of the following events:

1. the Effective Date of the Policy;
2. the person's date of eligibility;
3. a Life Event.

Life Events

At the time of any Life Event listed hereafter, the eligible persons may enrol in the plan subject to the provisions of this "Evidence of Insurability and Effective Date of Insurance" section. For the purposes of this insurance, Life Events that give rise to a new eligibility period without evidence of insurability are the following: marriage; civil union; cohabitation for one year; birth or adoption of a first child.

For coverage that can be obtained only upon approval of evidence of insurability by the Insurer

Coverage as to each eligible person becomes effective on the later between the Effective Date of the Policy and the first day of the month coincident with or next following the date of approval of evidence of insurability, if approved by the Insurer.

DEFINITIONS OF COVERED ILLNESSES

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

Aortic Surgery

means the undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

Aplastic anemia

means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one (1) of the following:

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

Bacterial meningitis

means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the date of Diagnosis.

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

Benign brain tumour

means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s).

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

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by its treatment.

Blindness

means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes; or the field of vision being less than 20 degrees in both eyes.

Cancer (life-threatening)

means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusion: No benefit will be payable under this condition for any of the following:

- lesions described as benign, pre-malignant, uncertain, borderline or non-invasive, carcinoma in situ (Tis) or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of cancer (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. Also for the purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Coma

means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

Exclusion: No benefit will be payable under this condition for any of the following:

- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a Diagnosis of brain death.

Coronary artery bypass surgery

means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

Deafness

means a definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Dementia, including Alzheimer's disease

means the definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects);
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour) which is affecting daily life.

The following is also required:

- dementia of at least moderate severity, which must be evidenced by a Mini State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and;
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six (6) month period.

Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

Dilated cardiomyopathy

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

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

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

Fulminant viral hepatitis

means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

- a rapidly decreasing liver size as confirmed by abdominal ultrasound;
- necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
- rapidly deteriorating liver function tests;
- deepening jaundice.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

Heart attack

means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Exclusions: No benefit will be payable under this condition for any of the following:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart valve replacement or repair

means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

Kidney failure

means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis or peritoneal dialysis is required, or renal transplantation initiated.

Liver failure of advanced stage

means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice;
- Ascites;
- Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

Loss of independent existence

means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

Activities of Daily Living are:

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

Loss of limbs

means a definite Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

Loss of speech

means a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

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

Major organ failure on waiting list

means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and for which transplant must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrollment in the transplant centre.

Major organ transplant

means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver or bone marrow, and limited to these entities.

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

Motor neuron disease

means a definitive Diagnosis of one (1) of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy.

Multiple sclerosis

means a definite Diagnosis of at least one (1) of the following:

- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

Muscular dystrophy

means a definite Diagnosis of all of the following:

- Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- Characteristic electromyography changes;
- Muscle biopsy confirming Diagnosis of muscular dystrophy.

Occupational HIV infection

means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

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

- The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
- A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;

- A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

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

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

Paralysis

means a definite Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

Parkinson's disease and specified atypical Parkinsonian disorders

Parkinson's disease means a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Exclusion: No benefit will be payable under this condition for any other type of Parkinsonism.

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

Primary pulmonary hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)

means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment-39th Edition) states the following about Class IV:

> "Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

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

Progressive systemic sclerosis

means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

Severe burns

means a definite Diagnosis of third degree burns over at least 20% of the body surface.

Stroke

means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination;

persisting for more than thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Exclusion: No benefit will be payable under this condition for any of the following:

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

COMPLEMENTARY BENEFIT IN CASE OF CERTAIN ILLNESSES (APPLICABLE TO AN INSURED MEMBER AND INSURED SPOUSE)

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

1. Coronary angioplasty
2. Crohn's disease requiring surgery
3. Ductal carcinoma in situ of the breast
4. Hip or knee replacement surgery
5. Severe rheumatoid arthritis
6. Stage A (T1a or T1b) prostate cancer
7. Stage 1A malignant melanoma
8. Systemic lupus erythematosus

Coronary angioplasty

means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

Crohn's disease requiring surgery

means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the Insured must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non-surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

Ductal carcinoma in situ of the breast

means the Diagnosis of this illness, as confirmed by biopsy.

Hip or knee replacement surgery

means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

(a) For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).

(b) For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

Severe rheumatoid arthritis

means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

Stage A (T1a or T1b) prostate cancer

means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma

means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

Systemic lupus erythematosus

means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Member or Insured Spouse is Diagnosed with one of the illnesses indicated previously in this section while his coverage is in force and subject to the conditions of the "Survival Period" section and the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Member or the Insured Spouse:

(1) 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:

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

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(2) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:

- Crohn's disease requiring surgery
- Severe rheumatoid arthritis
- Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(3) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:

- Hip replacement surgery
- Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

CANCER RECURRENCE BENEFIT (APPLICABLE TO AN INSURED MEMBER AND INSURED SPOUSE)

The Insurer will pay a Principal Sum amount if the Insured Member or Insured Spouse is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor). The subsequent Diagnosis must be made while coverage is in force.

MULTIPLE EVENT COVERAGE (APPLICABLE TO AN INSURED MEMBER AND INSURED SPOUSE)

If an Insured Member or Insured Spouse is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

SECOND MEDICAL OPINION SERVICE

Any Insured who is Diagnosed with a covered Critical Illness while enrolled in the insurance program is offered access to AXA Assistance's Second Medical Opinion program.

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

If you or your insured Spouse have been Diagnosed with a covered Critical Illness, simply call: 1-877-266-6550 in order to benefit from AXA Assistance's Second Medical Opinion program.

RE-ENTRY CONDITIONS (APPLICABLE TO AN INSURED MEMBER AND INSURED SPOUSE)

If a benefit amount has already been received for a covered Critical Illness of an Insured Member or Insured Spouse, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the "Re-entry Exclusions Appendix" of this insurance.

CONDITIONS FOR PAYMENT

When an Insured is Diagnosed with a covered Critical Illness and the required Survival Period is completed, the Insurer shall pay the Principal Sum, unless otherwise provided under the contract and subject to all of the conditions and limitations of this Policy.

BENEFICIARY

Amounts payable under this Critical Illness benefit will be payable to the Insured Member or to the Insured Spouse if the latter is the one who is Diagnosed with the Critical Illness.

However, accrued benefits, if any, unpaid at the time of the beneficiary becoming unable to legally receive payment of benefits will be paid to the beneficiary's estates.

TERMINATION OF COVERAGE

Coverage of an Insured will immediately terminate on the earliest of the following dates:

A) With respect to an Insured Member:

1. the date the Policy is terminated;
2. the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
3. the premium due date coincident with or following the date the Insured Member reaches seventy (70) years of age;
4. the premium due date coincident with or following the date the Insured Member ceases to be an active Member of the Policyholder on account of leave of absence, lay-off, maternity or parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:
   - Waiver of Premium
   - Continuation of Coverage during Approved Leaves
   - Extension of Coverage

5. the date the Insured Member dies;
6. the premium due date coincident with or following the date the Insured Member gives notice of cancellation to the Policyholder.

B) With respect to an Insured Spouse:

1. the date such person ceases to satisfy the criteria for definition of "Spouse" as presented in the Policy;
2. the premium due date coincident with or following the date the Insured Spouse reaches seventy (70) years of age;
3. the date the Insured Member's insurance coverage is terminated.

CONVERSION OF GROUP COVERAGE TO AN INDIVIDUAL INSURANCE CONTRACT

In the event an Insured Member's or Insured Spouse's coverage is terminated because:

(a) the Insured Member ceases to be an active Member of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or

(b) the Insured Member ceases to be an eligible person under the plan; or

(c) the period of extension of coverage ends,

the Insured Member or Insured Spouse who has not yet reached the age of sixty-five (65) may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual Critical Illness policy to the applicant that will consist of 4 illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Member or Insured Spouse may only convert if he has never received a benefit payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

The amount of insurance that may be converted will not exceed the lesser of:

(a) the amount of insurance then in effect on the date of termination; or

(b) a total aggregate amount of one hundred thousand dollars ($100,000) for all such conversions by any Insured.

Premiums for such individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates in force for the attained age of such Insured at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

WAIVER OF PREMIUM

The Insurer will waive the Insured Member's premium in the following circumstances:

A) If the Insured Member has Life Insurance with waiver of premium provisions or Long Term Disability (LTD) Insurance and becomes totally disabled while covered under both this Critical Illness Insurance and the Life or LTD Insurance:

From the first day of the month following the date the Insured Member becomes entitled to waiver of premium under the Life or LTD Insurance.

B) If the Insured Member has no Life Insurance with waiver of premium provisions and no Long Term Disability (LTD) Insurance and becomes totally disabled while covered under this Critical Illness Insurance:

From the first day of the month following six (6) consecutive months during which injury or sickness totally disables and prevents this Insured Member from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience.

Notice of such disability must be submitted to the Insurer within twelve (12) months of the onset of total disability and due proof of disability must be submitted to the Insurer within three (3) months following the date notice was given.

Premiums with respect to the Critical Illness Insurance of the Insured Spouse will also be waived whenever the Insured Member's premiums for Critical Illness Insurance are waived.

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

1. the date the Critical Illness Insurance is terminated;
2. the date the Insured Member reaches sixty-five (65) years of age;
3. the date the Insured Member ceases to be totally disabled; or
4. the date the Insured Member fails to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuses to submit to examination.

The coverage which is continued under this clause will be subject to the terms and provisions of this document in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this document, in no event will benefits payable for any Diagnosis which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to the Insured at the date of commencement of disability.

The Insurer will have the right to request proof of the continuance of total disability, and may also require the disabled Insured Member to submit to examination by the Insurer's medical advisor from time to time, as the Insurer may reasonably require.

CONTINUATION OF COVERAGE DURING APPROVED LEAVES

Coverage under the Policy will be continued for an Insured Member and his Insured Spouse during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave of the Insured Member, provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

(1) with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

(2) with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

(3) with respect to strike, on the thirty-first (31st) day following the commencement of the strike, or later if approved by the Policyholder;

(4) with respect to any maternity/parental leave approved by the Policyholder, on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment; and

(5) with respect to any disability leave approved by the Policyholder, on the date the Insured Member reaches seventy (70) years of age, qualifies for a waiver of premium or returns to work in any capacity, whichever is earlier.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable at the date of commencement of the leave of the Insured Member.

EXTENSION OF COVERAGE

Individual coverage will be continued for a period of up to twelve (12) months for an Insured Member whose employment has been terminated by the Policyholder, provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement received by the Insured Member from the Policyholder and payment of premium in accordance with the Master Application is continued. Under such conditions, individual coverage for the Insured with respect to the Insured Spouse will also continue, provided payment of the appropriate premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date the Insured Member returns to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable at the date of termination of employment.

EXCLUSIONS

No indemnity will be paid if a Critical Illness results directly or indirectly from any one or more of the following causes or situations:

1. Within ninety (90) days following the effective date of the Insured's coverage:

   a. Diagnosis of Cancer is made; or

   b. The Insured has any signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made.

2. Within ninety (90) days following the effective date of the Insured's coverage:

   a. Diagnosis of Benign Brain Tumour is made; or

   b. The Insured has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.

3. The Insured does not satisfy the Survival Period limitations.
4. The Insured suffers a self-inflicted injury, Sickness or Disease, whether the Insured was sane or insane at the time of such infliction.
5. The Insured Person has used illicit drugs, or any drug other than as prescribed, recommended or administered by or in accordance with the instruction of a Physician, whether or not such drugs are available only by prescription.
6. The Insured has any cancer that manifests itself prior to the Insured's effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
7. The Insured operated a motor vehicle while concentration of alcohol in his blood exceeded the applicable legal limit where the events causing the Critical Illness occurred.
8. The Insured committed or attempted to commit a criminal offense or provoked an assault.
9. The Critical Illness results from an abuse of alcohol.

10. The Insured participated in any riot, war or any civil strife.
11. A Pre-existing Condition, except if the Critical Illness being claimed for is Diagnosed at least twenty-four (24) months after the Insured's effective date of coverage and subject to all other provisions of the "Pre-existing Condition Exclusion" section.
12. Any exclusion stipulated on the certificate of the insured Member becomes part of the Exclusions section of this booklet on the effective date of the certificate.

PRE-EXISTING CONDITION EXCLUSION

This Pre-existing Condition Exclusion applies to all portions of the Principal Sum that are obtained without evidence of insurability, as well as all Critical Illnesses newly covered without evidence of insurability.

If the Critical Illness Insurance directly replaces one with the insurer or another insurer providing similar benefits and that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy, an Insured who has satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be deemed to have satisfied the time period under the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

An Insured who has not satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be allowed to apply any amount of time satisfied under the Pre-existing Condition Exclusion of the previous policy toward the satisfaction of the time period requirement of the Pre-existing Condition Exclusion of the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy and provided that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

COVERAGE PAYMENT

Monthly premium

Monthly rates for each $1,000 of Principal Sum (provincial taxes not included):

	Premium Rates ($)			
	Male		**Female**	
AGE	Non-Smoker	Smoker	Non-Smoker	Smoker
15-19	$0.144	$0.164	$0.125	$0.144
20-24	$0.152	$0.173	$0.118	$0.137
25-29	$0.205	$0.248	$0.196	$0.242
30-34	$0.221	$0.281	$0.254	$0.344
35-39	$0.253	$0.365	$0.304	$0.473
40-44	$0.356	$0.608	$0.390	$0.721
45-49	$0.595	$1.205	$0.568	$1.183
50-54	$0.934	$2.152	$0.773	$1.700
55-59	$1.602	$3.942	$1.048	$2.256
60-64	$2.729	$6.602	$1.553	$3.078
65	$3.629	$8.786	$2.066	$4.096
66	$3.991	$9.665	$2.272	$4.505
67	$4.391	$10.632	$2.500	$4.955
68	$4.830	$11.695	$2.748	$5.449
69	$5.312	$12.864	$3.023	$5.993

To calculate your monthly premium or your Spouse's monthly premium, use the table above to find the unit rate that applies (based on age, gender and smoker status). Multiply the unit rate found by the number of $1,000 units of principal sum selected.

PREMIUM PAYMENT

Premiums for your coverage or your Spouse's coverage are paid by you, using the means of payroll deductions.

LIMITATION OF CONTRACTUAL LIABILITY

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

AREA OF DIAGNOSIS

Should an Insured claim for a Critical Illness which occurred or was diagnosed outside of Canada or the United States, such Insured may be eligible to receive indemnity under this section upon that person's return to Canada. Prior to determining eligibility, however, the Insurer will have the right to require that the Insured obtain, on his return to Canada, a Diagnosis by a Physician in Canada.

CLAIMS PROVISIONS

Notice of Claim

Written notice of Critical Illness on which claim is based must be given to the Insurer within thirty (30) days after the date of the Diagnosis resulting in such Critical Illness. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 1225, Saint-Charles Street West, Suite 200, Longueuil (Quebec), J4K 0B9, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose Critical Illness is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Claim Forms

The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of Critical Illness. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such Critical Illness upon submitting, within the time fixed in the Policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Proof of Critical Illness

Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis resulting in such Critical Illness. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Physical Examination and Autopsy

The Insurer will have the right and opportunity to confirm the Diagnosis at its own expense by appointing a medical practitioner to examine the Insured whose Critical Illness is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims

All indemnities provided in the Policy for Critical Illness will be paid after customary proof of Critical Illness satisfactory to the Insurer has been given in accordance with the requirements of the Policy. All moneys payable under the Policy are payable in the lawful money of Canada.

RE-ENTRY EXCLUSIONS APPENDIX

This appendix provides for all Critical Illnesses that may be included in all of the Insurer's Critical Illness insurance packages so that the policyholder and the participants are informed that these exclusions shall continue to apply even when the policyholder or participant has chosen any new Critical Illness insurance package offered by the Insurer. Please refer to the provisions of the Critical Illness benefit to know what Critical Illnesses and Surgeries are actually covered under your policy.

After benefit has been claimed and adjudicated as payable for an individual other than a child with respect to a first event mentioned in the columns at the right of this schedule, no benefits can be paid for the same individual with respect to subsequent events mentioned on the lines of the left column hereunder, if the cell they have in common is marked with an X. Also, for an event to give rise to benefits, it must be included in the list of Covered Illnesses of the Insured's coverage or under the "Complementary Benefit in Case of Certain Illnesses" section, if any.

After benefit has been claimed and adjudicated as payable for a child with respect to a covered event, no benefits can be paid for the same child with respect to any subsequent event.

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event						
	Aortic surgery	Aplastic anemia	Bacterial meningitis	Benign brain tumour	Blindness	Cancer (life threatening)	Coma
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia		X				X	
Bacterial meningitis			X	X			
Benign brain tumour				X			
Blindness			X	X	X		X
Cancer (life threatening)		X				X *	
Coma	X		X	X			X
Coronary angioplasty	X						
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery							
Deafness			X	X			X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast		X				X	
Fulminant viral hepatitis							
Heart attack	X						
Heart valve replacement or repair	X						
Hip replacement							
Kidney failure	X						
Knee replacement							
Liver failure of advanced stage	X					X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech			X	X			X
Major organ failure	X						
Major organ transplant	X						
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV							
Paralysis			X	X			X
Parkinson's disease or SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X				X	
Stage A (T1a or T1B) prostate cancer		X				X	
Stroke	X		X	X			X
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ of the breast
No claim can be paid for this subsequent event							
Aortic surgery		X				X	
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty	X	X				X	X
Coronary artery bypass surgery		X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement							
Kidney failure		X	X			X	
Knee replacement							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV							
Paralysis							
Parkinson's disease or SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event						
	Fulminant viral hepatitis	Heart attack	Heart valve replacement or repair	Hip replacement	Kidney failure	Knee replacement	Liver failure of advanced stage
No claim can be paid for this subsequent event							
Aortic surgery		X	X				X
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							X
Cancer (life threatening)	X						X
Coma		X	X		X		X
Coronary angioplasty		X	X				X
Coronary artery bypass surgery		X	X				X
Crohn's disease requiring surgery					X		
Deafness							
Dementia, including Alzheimer's disease		X	X				
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis	X						
Heart attack		X	X		X		X
Heart valve replacement or repair		X	X				
Hip replacement				X		X	
Kidney failure		X	X		X		X
Knee replacement				X		X	
Liver failure of advanced stage	X	X	X		X		X
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech							
Major organ failure	X	X	X		X		X
Major organ transplant	X	X	X		X		X
Motor neuron disease							
Multiple sclerosis							X
Muscular dystrophy							
Occupational HIV							
Paralysis							X
Parkinson's disease or SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							X
Severe burns							
Severe rheumatoid arthritis				X	X	X	
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X	X		X		X
Systemic lupus erythematosus					X		

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event						
	Loss of independent existence	Loss of limbs	Loss of speech	Major organ failure on waiting list	Major organ transplant	Motor neuron disease	Multiple sclerosis
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia	X			X	X		
Bacterial meningitis	X						
Benign brain tumour	X						
Blindness	X					X	X
Cancer (life threatening)	X			X	X		
Coma	X			X	X	X	X
Coronary angioplasty							
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery	X						
Deafness	X					X	X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy	X						
Ductal carcinoma in situ of the breast				X	X		
Fulminant viral hepatitis	X						
Heart attack	X			X	X	X	
Heart valve replacement or repair	X						
Hip replacement	X						
Kidney failure	X			X	X		X
Knee replacement	X						
Liver failure of advanced stage	X			X	X		
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs	X	X					
Loss of speech	X		X			X	X
Major organ failure	X			X	X		
Major organ transplant	X			X	X		
Motor neuron disease	X					X	
Multiple sclerosis	X						X
Muscular dystrophy	X						
Occupational HIV	X						
Paralysis	X					X	X
Parkinson's disease or SAPD	X						
Primary pulmonary hypertension	X						
Progressive systemic sclerosis	X						
Severe burns	X						
Severe rheumatoid arthritis	X						
Stage 1A malignant melanoma				X	X		
Stage A (T1a or T1B) prostate cancer				X	X		
Stroke	X			X	X	X	X
Systemic lupus erythematosus	X						

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event						
	Muscular dystrophy	Occupational HIV	Paralysis	Parkinson's Disease or SAPD	Primary pulmonary hypertension	Progressive systemic sclerosis	Severe burns
No claim can be paid for this subsequent event							
Aortic surgery					X		
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness	X	X					
Cancer (life threatening)		X					
Coma	X	X	X	X	X	X	
Coronary angioplasty							
Coronary artery bypass surgery					X		
Crohn's disease requiring surgery							
Deafness	X	X					
Dementia, including Alzheimer's disease							
Dilated cardiomyopathy	X				X		
Ductal carcinoma in situ of the breast		X					
Fulminant viral hepatitis							
Heart attack	X				X	X	
Heart valve replacement or repair	X				X		
Hip replacement							
Kidney failure	X	X			X	X	
Knee replacement							
Liver failure of advanced stage	X	X				X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech	X	X	X	X			
Major organ failure	X				X	X	
Major organ transplant	X				X	X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy	X						
Occupational HIV		X					
Paralysis	X	X	X	X			X
Parkinson's disease or SAPD				X			
Primary pulmonary hypertension					X		
Progressive systemic sclerosis						X	
Severe burns							X
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X					
Stroke	X	X			X	X	
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (cont'd)

	If a claim has been paid for this event				
	Severe rheumatoid arthritis	Stage 1A malignant melanoma	Stage A (T1a or T1B) prostate cancer	Stroke	Systemic lupus erythematosus
No claim can be paid for this subsequent event					
Aortic surgery				X	
Aplastic anemia					
Bacterial meningitis					
Benign brain tumour					
Blindness					
Cancer (life threatening)					
Coma				X	
Coronary angioplasty		X	X	X	
Coronary artery bypass surgery				X	
Crohn's disease requiring surgery	X				X
Deafness					
Dementia, including Alzheimer's disease				X	
Dilated cardiomyopathy					
Ductal carcinoma in situ of the breast		X	X		
Fulminant viral hepatitis					
Heart attack				X	
Heart valve replacement or repair				X	
Hip replacement	X				
Kidney failure	X			X	X
Knee replacement	X				
Liver failure of advanced stage	X			X	X
Loss of independent existence	X			X	X
Loss of limbs					
Loss of speech					
Major organ failure	X			X	X
Major organ transplant	X			X	X
Motor neuron disease					
Multiple sclerosis					
Muscular dystrophy					
Occupational HIV					
Paralysis					
Parkinson's disease or SAPD					
Primary pulmonary hypertension					X
Progressive systemic sclerosis					
Severe burns					
Severe rheumatoid arthritis	X				X
Stage 1A malignant melanoma		X	X		
Stage A (T1a or T1B) prostate cancer		X	X		
Stroke				X	X
Systemic lupus erythematosus	X				X

* Following a life threatening Cancer claim, the Insured cannot claim again for Cancer, except for plans with a "Cancer Recurrence Benefit" section, when all of its requirements have been met.

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SSQ Customer Service
Toll free: 1-888-651-8181

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