Benefit Summary

This Benefit Summary forms part of this booklet and should be read with the information in the rest of this booklet. Please see the related benefit sections for more detailed information and any conditions, limitations or exclusions that could apply to your plan.

The booklet is a summary of your group contract. If there are discrepancies between the group contract and the information in this booklet, the group contact will take priority as permitted by law.

Best Doctors

Benefit	Every Chambers Plan program also includes Best Doctors services that help you make medical decisions with confidence. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction with the following services: • Expert Medical Opinion • Best Doctors 360º • Find a Best Doctor / FindBestCare
Termination	This benefit terminates on the Plan Anniversary Date following the Certificate holder's 75th birthday.

Employee Life Insurance (Option: 1X)

Benefit	1 times annual earnings rounded to the next higher $1,000 to a maximum benefit of $300,000. Provides 24-hour coverage of death at any time or place, from any cause.
No-Evidence Maximum	$150,000
Living Benefit	Disabled individuals suffering from a terminal illness may be eligible for payment of a Living Benefit equal to the lesser of $25,000 or 50% of their Life Benefit.
Reduction	Coverage will reduce at age 65 to 25% of the face value.
Termination	Insurance will terminate on the Plan Anniversary Date following your 75th birthday.

Accidental Death & Dismemberment (Option: 1X)

Benefit	1 times annual earnings rounded to the next higher $1,000 to a maximum of $300,000.

Accidental Dismemberment	A benefit is paid if you suffer a loss (or use) of limb and/or sight as listed below: • 200% of Principal Sum for: Paraplegia, Quadriplegia, Hemiplegia • 100% of Principal Sum for loss of: Life, Both hands or feet or entire sight of both eyes, One hand and one foot, One hand and entire sight of one eye, One foot and entire sight of one eye, Speech and/or hearing, Use of both arms or both hands, One arm or one leg or use thereof, Use of one hand or one foot • 50% of Principal Sum for loss of: Hearing in one ear • 33% of Principal Sum for loss of: Thumb and index finger of one hand or four fingers of one hand • 25% of Principal Sum for loss of: All toes of one foot
Additional Provisions	You may also be entitled to additional benefits including: • Day Care Benefit • Education costs for Dependent Children (up to $10,000/year) • Home Alteration and Vehicle Modification • In Hospital Benefit (up to $2,500/month) • Psychological Therapy (up to $5,000) • Rehabilitation costs for re-training (up to $15,000) • Repatriation costs (up to $15,000) • Seat Belt Benefit (an additional 10% of the principal sum) • Spousal Education Benefit (up to $15,000)
Reduction	Coverage will reduce at age 65 to 25% of the face value.
Termination	This benefit terminates on the Plan Anniversary Date following your 75th birthday.

Long Term Disability (Option: L3)

Benefit	Plans with 100% employee-paid premiums pay non-taxable monthly benefits equal to **67% of the first $2,000 of monthly earnings, and 50% of any balance**. Plans with any employer-paid premium pay taxable monthly benefits based on **66 2/3% of monthly earnings**. All benefits are rounded to the next $50 to a maximum of $6,000.
No Evidence Maximum	$3,500
Benefit Period	From the 121st day of a disability up to age 65.
Definition Of Disability	You are considered to be totally disabled if you are unable, as a result of illness or injury, to perform the whole duties of your regular occupation. After 24 months of such disability, you are considered to be totally disabled if the disability prevents you from engaging in any gainful occupation for which you are or may reasonably become qualified based on their training, education or experience. No benefits are payable for partial disabilities.

Pre-Existing Condition	Benefits are not payable for any disability which begins within your first 12 months of coverage, if that disability is due to a pre-existing condition. That is, any condition for which you were treated or attended by a physician or were prescribed drugs that were taken during the 3 month period immediately prior to the effective date of coverage.
Offsets	LTD benefits are reduced (offset) by any amount payable to you because of the disability from Workers' Compensation, the Canada Pension Plan, the Quebec Pension Plan and any other similar legislated program. The benefits you receive as a result of your disability should be in proportion to your normal earnings. As such, benefits are limited to 85% of your gross monthly earnings if your monthly income under this benefit is to be included in determining your income tax, or 85% of your take-home pay if your monthly income under this benefit is to be excluded in determining your income tax.
Termination	Coverage terminates on the earliest of the date your employment ends or your 65th birthday.

Extended Health (Option: E83)

Reimbursement	80% coverage of prescription drugs listed on the ASSURE National Formulary 50% coverage of prescription drugs NOT listed on the ASSURE National Formulary 100% coverage of all other eligible benefits
Coverage	There is no overall maximum though specific benefits may have annual or lifetime limits.
Prescription Drugs	Up to **$50,000 per person per calendar year**. Fertility drugs; smoking cessation aids; erectile dysfunction drugs/items; travel vaccines; and drugs, injections or products for treatment of obesity are not covered. The plan substitutes generic equivalents whenever possible. (In Quebec, prescription drug coverage will meet provincial plan requirements) Prescription drug purchases are processed at the pharmacy using the ASSURE card.

Paramedical services	Up to **$500 per specialty per person per calendar year** for the following paramedical specialists: • acupuncturists • audiologists • chiropractors • clinical dieticians • massage therapists/Registered Kinesiotherapists (RKT)/Kinesiologists • naturopaths • osteopaths • physiotherapists/athletic therapists • podiatrists/chiropodists Up to **$600 per specialty per person per calendar year** for the following paramedical specialists: • psychologists/social workers • speech therapists
Eye exams	Up to **$75 per adult** every 24 months; **$75 per child** every 12 months.
Hospital	Semi-private / convalescent hospital.
Nursing care	Up to **$25,000 per person** every 24 months.
Hearing aids	Up to **$700 per person** every 60 months.
Ambulance	**Transport** as a result of emergency or in-patient treatment
Dental Accidents	Dental repairs as a result of an accident while insured.
Other services and equipment	Medical Equipment including: • wheelchairs, hospital beds, up to **$5,000 each per insured,** • respirators and oxygen (including CPAP and sleep apnea appliances), up to **$1,000 per insured,** • breast prosthesis, artificial limbs, eyes, • braces for limb truss, walking aids, • wigs as a result of chemotherapy, up to **$1,000 per insured.** Diabetic, colostomy and ileostomy supplies. Orthotics up to **$200 per person** per calendar year. Orthopaedic shoes (custom designed).
Medical Travel Benefit	Travel costs for medically necessary treatments, up to **$750 per person** every 24 months.

Medical Emergency Assistance / Travel Health Benefits	24 hour emergency assistance finding medical help abroad, including emergency medical payments and evacuation, where required. Hospital and physician charges for emergency treatment outside Canada. The Plan covers the first number of days of a trip based on the age of the certificate holder, as follows: • up to age 65 - 180 days; • age 65 to 69 - 90 days; • age 70 to 74 - 60 days; and • age 75 to 80 - 30 days.
Survivor Benefit	24-month Survivor Benefit for a deceased employee's insured spouse and dependents.
Teladoc	Your Extended Health Care benefit under Chambers Plan includes free access for you and your insured dependents to Teladoc® – a global service providing convenient access to high-quality care to millions of people in more than 130 countries. Teladoc telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference or by phone, from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.
Termination	All health benefits will cease at the end of the month following the date of termination, but no later than the Anniversary Date following your 80th birthday.

Dental (Option: D21)

Reimbursement	80% coverage of Basic, Endodontic and Periodontal services
Deductible	Nil
Fee Guide	Benefits are based on your Province's current Dental Fee Guide.
Maximums	$2,000 maximum per person per calendar year (plans for 1 & 2 person firms have a $2,500 per calendar year family maximum).

Coverage	***Basic*** services covered: • Recall Exams (Check-up) - 2 times per calendar year • Complete Exams (Dental history) - once every 3 years • Tests, lab exams, treatment planning • Fluoride treatments - 2 times per calendar year • Polishing - 1 unit, 2 times per year • Scaling • X-rays including 1 full mouth series and panoramic film every 24 months • Consultations / Pit and fissure sealants • Space maintainers for children • Fillings (nonbonded, composite, acrylic & silicate) • Extractions of impacted teeth and simple extractions • Oral surgery and general anaesthesia • Relining and rebasing of dentures • Repairs to dentures / fixed bridgework ***Endodontic and Periodontal*** *services* covered: • Treatment of disease of the pulp chamber and canals of the teeth (root canals, pulpectomy) • Treatment of the gums and bones supporting teeth (major scaling, periodontic surgery & appliances) • Additional scaling units (to a reasonable and customary amount)
Survivor Benefit	24-month Survivor Benefit for a deceased employee's insured spouse and dependents.
Termination	All dental benefits will cease at the end of the month following the date of termination, but no later than the Anniversary Date following your 80th birthday.

Best Doctors

General description of coverage

Every Chambers Plan program also includes Best Doctors services. Best Doctors provides access to expert medical specialists who help you understand your medical condition and treatment options, so you make the right decisions about your care.

As long as you are insured under the Chambers of Commerce Group Insurance Plan, you and your dependents will have unlimited access to the following Best Doctors services:

Expert Medical Opinion	More than a second opinion regarding a medical diagnosis or treatment plan, Best Doctors experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written summary of their findings, which includes a diagnosis and treatment recommendations that you can share with your doctor.
Best Doctors 360°	Best Doctors 360° can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Best Doctors provides you with a variety of tools and resources when you're facing medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your healthcare.
Find a Best Doctor	If you're searching for a local specialist let Best Doctors do the work for you. They will search their database of top Canadian specialists and take into account your unique medical history and geographic location, matching you with the right physician for your condition.
FindBestCare	If you need a specialist outside of Canada they can make it possible through their FindBestCare service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility.

Accessing Best Doctors Services

Contact Best Doctors directly at **1 877 419 2378**. Please have your Firm and Certificate numbers ready to identify yourself as a Chambers of Commerce Group Insurance Plan member. When you contact Best Doctors, you will be assigned a Member Advocate (a Registered Nurse) who will assess your medical issue, answer your questions, determine what service would best meet your needs and keep you informed about the progress of your case

Best Doctors services are available without charge to all Chambers Plan insureds and their dependents as defined in your benefit plan as well as your parents and parents-in-law. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging. Best Doctors does not make referrals or appointments for members.

Employee Life Insurance

General description of coverage

The amount of your coverage is shown on the *Certificates of Insurance*. This is called the face amount. Life insurance coverage decreases to 25% of the face amount on the Policy Anniversary (April 1) on or after your 65th birthday.

Benefit

Group Life provides 24-hour coverage of death at any time or place, from any cause. If your insurance ends and you die within 31 days, benefits are payable equal to the amount of life insurance you were entitled to under the *Conversion Option*.

Beneficiary	A beneficiary is the person assigned to receive the Group Life benefit in the event of your death. If there is no living beneficiary when you die, the life insurance proceeds are payable to your estate. Life insurance benefits are not taxable. However, the beneficiary or the estate is responsible for tax on any interest which accrues on the benefit, from the date of your death to the date the funds are paid by the Insurance Company. With regards to life insurance only and subject to legal provisions, you may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice. The rights of a beneficiary who dies before you reverts to the latter.
Change of Beneficiary	You can change the beneficiary at any time, subject to any limits set by law. To do so, complete an *Employee Change Request* and mail the completed request to the Plan Administrator.
Waiver of Premium	If you become totally disabled before age 65 and while insured for this benefit, you keep this life insurance coverage (subject to any age limit reduction) as long as you remain disabled. If your plan includes Long Term Disability coverage, you will be considered totally disabled as defined under your Long Term Disability benefit. While you are receiving monthly income payments, no further life insurance premiums are required. If your plan does not include Long Term Disability coverage, to be considered totally disabled, you must be unable, as a result of sickness or injury, to engage in any gainful occupation for which you may become reasonably qualified by training, education, or experience. Proof of continuous total disability will be required periodically. After 6 months of continuous total disability, and on approval from the Insurance Company, no further life insurance premiums are required. Partial disability does not qualify you for any waiver of premium.

Living Benefit	A terminally ill employee may request an advance of life insurance benefits equal to the lesser of $25,000 or 50% of the face amount. You must provide satisfactory evidence to the Insurance Company that death will most likely occur within 12 months, be totally disabled for at least six months and be approved for Life Waiver of Premium. The employer and any designated beneficiary must consent to the payment. At your death the advanced funds plus interest are deducted from the face amount.
Conversion Option	Life insurance ends 31 days after the date of termination of coverage. An employee under the age of 66 may apply to the Insurance Company to convert the group life coverage to an individual policy. No medical evidence is required as long as written application is submitted and the first premium is paid within 31 days of the date of termination. If you are converting this insurance due to the firm's termination, you and the firm must have been insured continuously with this plan for five years prior to termination.
Extension of Benefit	If you die within 31 days of the termination of the insurance under this benefit, the amount of life insurance you were eligible to convert will be payable.

Claims

A completed claim form must be submitted to the Plan Administrator within 90 days of death. Before settling any claim, written proof of the occurrence, cause and circumstances of the death will be required. Written proof means a completed claim form accompanied by either an original funeral director's statement or original death certificate. Notarized copies of the funeral director's statement or death certificate will be accepted if originals cannot be submitted.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Accidental Death & Dismemberment (AD&D)

General description of coverage

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

You are automatically covered for a Principal Sum equal to the amount of insurance shown on your *Certificate of Insurance*. Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents. Your coverage is in force around-the-clock, at work, at home or at play, anywhere in the world.

Beneficiary Designation

For your accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation then the benefit will be paid to your estate. All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use	If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the *Benefit Summary*. If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.
Permanent and Total Disability Indemnity	If you suffer injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the table of losses which have been paid or which are payable for the same loss. Permanent and Total Disability means as a result of an injury, you are unable to perform at least two of the *Activities of Daily Living* described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible. *Activities of Daily Living* are: • Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters; • Transferring: moving between a bed and a chair, or a bed and a wheelchair; • Dressing: putting on and taking off all necessary items of clothing;

	• Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; • Eating: performing all major tasks of getting food into the body; and • Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.
Rehabilitation Benefit	Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within three years of and as a result of an injury for which you receive a benefit under the Plan.
Home Alteration and Vehicle Modification Benefit	Pays a benefit of up to the greater of $10,000 or 10% of the Principal Sum to a maximum of $50,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.
Workplace Modification and Accommodation Benefit	Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.
Psychological Therapy	Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.
In-Hospital Benefit	Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.
Family Transportation	Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.
Repatriation Benefit	Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.
Identification Benefit	Pays a benefit of up to $15,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
Seat Belt Benefit	Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.
Day Care Benefit	Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a commercial and licensed day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit	Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $10,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years. If you do not have a Dependent Child eligible for this benefit, an amount of $1,500 will be paid to your beneficiary following your covered accidental death.
Spousal Educational Benefit	Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.
Funeral Expense	Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.
Bereavement Benefit	Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require grief counselling within one year of the accident.
Felonious Assault Benefit	Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, other than an act of a fellow employee or a member of your family or household.
Serious Illness Benefit (Non-Cancer)	Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness: • Major Burns (3rd degree) • Multiple Sclerosis • Necrotizing Fasciitis • Parkinson's Disease • Major Organ Failure Requiring Transplant • Motor Neuron Disease • Major Organ Transplant You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This benefit is payable only once even if you are diagnosed with more than one covered serious illness.
Coma Benefit	Pays a monthly benefit of 1% of the difference between the Principal Sum and any other amount payable under the Plan in connection with the injury for up to 100 months, if you suffer an injury for which you receive a benefit under the Plan, and within 90 days of the date of the covered accident are disabled by coma which lasts for at least 6 consecutive months and is then determined by a physician to be permanent.

Disfigurement Benefit

If an Insured Person suffers Injury resulting in the destruction of his or her skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with Loss of fluid (3rd degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation, the Company will pay, up to $25,000 per Insured Person, based on a percentage of the Insured Person's Principal Sum, provided that the Insured Person survives for a period of at least 30 days after the date of the accident causing the burn. The Company will pay depending on the area of the body which is burned and determined in accordance with the table below.

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the Insured Person's Body Part that is burned and then multiplying the resulting percentage (not to exceed the Maximum Percentage for that Body Part (B)) by the Principal Sum for such Insured Person.

The maximum amount payable for this benefit for all Injuries resulting from any 1 accident is $25,000 per Insured Person.

Body Part	(A) Body Classification	(B) Maximum % for that Body Part
Face, Neck, Head	11	99%
Hand & Forearm	5	22.5%
Either Upper Arm	3	13.5%
Torso (front or back)	2	36%
Either Thigh	1	9%
Either Lower Leg (below knee)	3	27%

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance benefit.

Conversion Privilege Benefit

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

Policy Exclusions

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

- suicide or any attempt thereat by you while sane;
- self inflicted injury or any attempt thereat by you while sane or insane;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
- mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

- stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    - riding as a passenger in an aircraft owned or leased by the Policyholder;
- infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
- injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 milliliters of blood; and
- natural causes.

Claims

A completed claim form must be submitted to the Plan within 90 days of death or dismemberment. Before settling any claim, written proof of the occurrence, cause and circumstances of the death will be required.

All benefits described here are governed by the Master Contract underwritten by Chubb Life Insurance Company of Canada.

Privacy

At Chubb Life Insurance Company of Canada, we are committed to protecting our customers' privacy. Chubb Life Insurance Company of Canada's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers.

For these purposes, we, our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb Life Insurance Company of Canada may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

Long Term Disability (LTD)

General description of coverage

Upon approval by the Insurance Company, the Long Term Disability (LTD) pays a regular monthly income, subject to the Elimination and Benefit Period shown on the *Certificate of Insurance*, if you are absent from work for long periods as a result of illness or injury. Benefits are available if you become totally disabled, provided you are under the regular and personal care of a physician. No benefits are payable for partial disabilities and dependents are not eligible for coverage.

Definition of Total Disability

You are considered to be totally disabled if you are unable, as a result of illness or injury, to perform the whole duties of your regular occupation, and do not work at any other compensatable job.

After 24 months of such disability, you are considered to be totally disabled if the disability prevents you from engaging in any gainful occupation for which you are or may reasonably become qualified based on your training, education or experience.

Benefit	The LTD benefit is based on a percentage of your gross monthly earnings subject to benefit maximums. **If the benefit is a Taxable Benefit (i.e. your employer pays any portion of the LTD premium), the benefit will be calculated at 66 2/3% of the monthly income. If the benefit is a Non-Taxable Benefit (i.e. you pay the entire LTD premium), the benefit will be calculated at 67% of the first $2,000 of salary and 50% of the excess.** The amount payable is the lower of the insured amount or the percentage of your monthly earnings at the date of disability. Any payment for a period of less than one month will be at a daily rate of one-thirtieth of the monthly payment.
Offsets	LTD benefits are reduced (offset) by any amount payable to you because of the disability from Workers' Compensation, the Canada Pension Plan, the Quebec Pension Plan and any other similar legislated program, except for CPP/QPP dependents' benefits and cost of living increases.
All Source Maximum	All the benefits you receive as a result of your disability should be in proportion to your normal earnings. Therefore, if your disability income from all sources exceeds the applicable limit below, the monthly income under this benefit will be further reduced so that your total disability income from all sources equals such limit. • If your monthly income under this benefit is to be included in determining your income tax, the limit is 85% of your gross monthly earnings at the time you became disabled. • If your monthly income under this benefit is to be excluded in determining your income tax, the limit is 85% of your take-home pay at the time you became disabled. Your disability income from all sources will include: • any monthly income payment from this benefit; • any earnings or payments from your employer;

	• any disability benefits payable under the Canada/Quebec Pension Plans, excluding dependents' benefits and cost of living increases; • any disability benefits payable under any *Workers' Compensation Act* (or similar legislation) or any other government plan excluding benefits payable under the U*nemployment Insurance Act*; • any disability benefits payable under any other group, association or franchise insurance plan; • any benefits payable from a retirement or pension plan; • any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.
Date of Disability	The date of disability and the Elimination Period begins the date you visit your physician who certifies that you are totally disabled. You must then serve a continuous waiting period of 120 days, referred to as the Elimination Period, during which time no benefits are payable. Benefits will commence once the waiting period has been satisfied and you remain totally disabled, up to the maximum Benefit Period according to the guidelines set by the Insurance Company. The Benefit Period is the length of time during which benefits are payable, but not beyond your 65th birthday.
Pre-existing Conditions	No payments will be made for any period of Total Disability commencing during the first 12 months of coverage if such disability was directly or indirectly the result of a sickness or injury that was treated or attended by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.
Rehabilitation	For up to two years, you may take part in rehabilitative employment approved by the Insurance Company and still be considered totally disabled under this benefit. Monthly benefit payments will continue, reduced by the ratio of rehabilitative earnings to former earnings. Total income from all sources, however, must not exceed 100% of former earnings.
Recurrent Disability	If your disability recurs within 6 months of returning to work after a period in which benefits were paid, is due to the same or related cause, and upon submission of medical evidence, LTD payments will resume immediately for the balance of the benefit period. This is in accordance with the guidelines set by the Insurance Company.
Waiver of Premium	If you become totally disabled before your 65th birthday and if the total disability has existed continuously for 180 days, the Insurance Company will waive all disability premiums after that time, during the term of the total disability.
Termination	If you are totally disabled and receiving LTD benefits on the date this group insurance ends, LTD coverage will continue as if the benefit were still in force, provided your disability remains continuous. All LTD benefits terminate on the earliest of the date on which payments have been paid up to the end of the Benefit Period or your 65th birthday.

Exclusions

Disability benefits are not payable under any of the following circumstances:

- intentionally self-inflicted injuries while sane or insane;
- war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit, a criminal offence, including driving while impaired;
- medical or surgical care which is cosmetic (except cosmetic care provided as a result of an accident);
- disabilities as a result of excessive use of alcohol or drugs, unless you take active part in a continuous, medically supervised recovery program beginning within the first 120 days of total disability.

Disability payments will not be made for a period of disability during

- which you are not under the regular care and personal attendance of a Physician for the sickness or injury causing the disability,
- a formal maternity and/or parental leave taken by an employee,
- the imprisonment of an employee due to conviction of an offence,
- which you are resident outside of Canada or the United States of America.

Claims

A completed claim form must be received by the Plan Administrator within five months of the date of total disability. Proof of a continuing total disability will be required periodically. In the case of owners and employees whose income is derived in whole or in part from commissions, the insuring company will require financial information for the two years prior to total disability. Charges incurred for the completion of claim forms are your responsibility.

Please read *Understanding Your Chambers of Commerce Group Insurance Plan® Long Term Disability Claim* which explains the steps involved in making a disability claim. It can be found at *www.chamberplan.ca > Plan Members > Making a Claim*

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Extended Health Care

General description of coverage

This plan covers reasonable and customary charges for supplies and services used to treat injury or illness. There is no overall lifetime maximum benefit, but certain types of expenses are subject to limits and conditions. Any benefit maximum applies to a calendar year (January through December).

To receive benefits, employees and dependents must be registered with their provincial health plan. If an employee or dependent is hospitalized before the effective date of this coverage, no benefits are payable for any charges during the hospitalization and coverage will begin the first of the month following the date of discharge.

Your plan has a coinsurance amount which is shown on the *Certificate of Insurance* and *Benefit Summary*.

Benefits

Prescription Drugs	Coverage includes drugs approved in Canada, available only by prescription and administered for medical necessity. Oral contraceptives are considered eligible drugs. All drugs must be prescribed by a physician, surgeon, dentist or dental surgeon or, where legal, by a licensed, certified or registered health practitioner. The drug must be dispensed by a licensed organization or registered pharmacist.
	Coverage also includes serums, vaccines (not for travel purposes) and injectables. These items are not available through the Assure card, and must be submitted for reimbursement.
Drug Card	Prescription drug expenses will be handled on a card system referred to as the Assure Card.
Maximum	**The maximum limit available per person is $50,000 per calendar year**. Prescriptions are limited to a one month supply, except for "maintenance prescriptions" such as oral contraceptives which are limited to a three month supply.
Coverage does not include	This coverage does not include proprietary or patent medicines, drugs available over-the-counter or off-the-shelf, experimental drugs, vaccines for travel purposes, drugs used in the treatment of infertility and hair loss, dietary or health foods, vitamins, nutritional products, nicotine patches or smoking cessation drugs and programs, and charges for the administration of drugs, serums or vaccines. **Injections normally administered to patients admitted to hospital for treatment are ineligible**.
National Formulary	Your Plan reimburses prescription drug purchases on a two tier system. If the DIN (Drug Identification Number) is on the National Formulary, coverage will be at the reimbursement percentage shown on the Benefit Summary. Eligible prescription drugs not on the Formulary will be covered at 50%.

	If the drug your physician prescribes is not on the Formulary, a 'therapeutic alternative' providing similar treatment likely will be. With your doctor's advice, you have two options: • you can ask your doctor to prescribe a drug that is on the Formulary, covered at the higher reimbursement percentage, or • you can fill the unlisted prescription and be reimbursed 50% of the eligible cost. For more information on the National Formulary, visit www.chamberplan.ca > Plan Members > Forms and Recourses > Your Health Coverage
Generics	The Plan uses Generic substitution whenever possible. Where there is a Generic drug that is considered interchangeable with a Brand drug, only the cost of the lowest price Generic will be reimbursed. Though the Plan substitutes Generic equivalents wherever possible, a Brand drug will be dispensed if the Generic is unacceptable. Your physician need only specify "No Substitution" on the prescription. If your plan includes a tiered formulary, the Plan will reimburse the eligible Brand cost, based on the reimbursement percentage of the tier in which the DIN is found.
Quebec residents	If you are a resident of Quebec, this plan will reimburse you for all drugs normally provided under the Quebec Universal Drug Plan. If a brand name drug is purchased where a generic substitute is available, the plan will cover the cost of the brand name drug up to the maximum coinsurance currently allowed under the Quebec Universal Drug Plan.
Paramedical Services	The plan will cover the costs for the paramedical specialists listed on the *Benefit Summary* up to reimbursement levels indicated provided the practitioner is operating within the scope of their licence. Charges for group sessions are not eligible expenses. Services of a chiropractor include one diagnostic x-ray per year and charges for the x-ray are combined in the maximum. Services of a naturopath exclude food supplements or vitamins. Services of a registered dietician exclude fees for weight loss programs and require a written referral from a physician.
Eye Exams	Eye exams are covered to **$75 per person** when performed by a qualified ophthalmologist or licensed optometrist. Adults are covered for one such exam in any 24 month period while dependent children are covered once in any 12 month period.

Other Services and equipment

Ambulance	This benefit allows charges for licensed **ground ambulance** service when used to transport an insured person as a result of emergency or in-patient treatment: • from the place the insured suffers injury or illness to the nearest hospital where adequate treatment is available; • from one hospital to another; • from a hospital to the insured's residence when condition of patient warrants it. Proof of the medical necessity of an ambulance may be required from the attending physician.
Emergency Air Transportation	Emergency transportation by a licensed **air ambulance** is covered to the nearest hospital qualified to provide the necessary treatment when certified as essential by the attending physician.
Cardiac Rehabilitation	When prescribed by their attending physician, cardiac patients may participate in a recognized rehabilitation program after a heart attack, bypass surgery, valve replacement or management of angina pectoris. The benefit has a lifetime maximum of **$300 per individual**.
Dental Accidents	The services of a dentist required for the repair and replacement of sound natural teeth injured by an accidental blow to the insured's mouth while insured under this benefit. This coverage does not include damage resulting from an object wittingly or unwittingly placed in the mouth. Treatment must begin or a treatment plan must be sent to the Plan Administrator within 90 days of the injury. No benefits are payable for treatment more than 2 years after the date of the accident. An *Accidental Dental* claim form must be submitted. Benefits paid by the Plan are based on the last approved Fee Guide established by the Provincial Dental Association.
Hearing Aids	The plan allows for the purchase and installation of, but not batteries for or repair of, hearing aids on the written recommendation of a physician. The benefit is limited to **$700 per person** in any 5 year period.
Hospital	This plan pays the additional cost charged by the hospital for a **semi-private room** over a standard public ward. It will also cover the additional cost of a private room, if the attending physician provides a written recommendation of its medical necessity. Coverage does not include care or treatment for substance abuse.
Convalescent/Rehabilitation Hospital	The benefit provides **$30 per day for up to 180 days** per confinement for the cost of room and board in a convalescent hospital approved by a province's appropriate hospital authority. The insured must be admitted to the convalescent facility within 14 days of discharge as an in-patient at a hospital. Coverage excludes nursing homes, homes for the aged and chronically ill, homes for the mentally ill, rest homes, or any place for the care or treatment of substance abusers.

Hostel Accommodation	The plan pays the reasonable and customary charges in the province of residence for the patient's hostel accommodation associated with the hospital performing diagnostic testing or treatment and recommended by a physician up to 180 days. The hostel must be in the province of residence and located more than 60 km from the insured's home.
Medical Equipment	This group plan includes charges for: • purchase, but not repair, of a **spinal brace** (at the discretion of the Insurance Company) or **artificial limb or eye** where the loss occurs while the individual is insured; replacement is covered only when required because of changes to the insured's body; Artificial limbs require a Doctor's letter and are limited to reasonable and customary charges. • purchase or rental, but not repair or replacement, of a brace (at the discretion of the Insurance Company) for a **limb truss or crutch**. Braces prescribed solely for athletic purposes are not covered; Claims for braces require a written medical necessity from your medical provider (MD). • rental, purchase or repair of a **wheelchair**; rental or purchase of a **hospital bed** up to a lifetime maximum of $5,000 each (at the discretion of the Insurance Company); Hospital beds require a physician letter and are defined to have adjustable head, foot and height levels and guardrails. • **respirator and oxygen** purchase or rental to a lifetime maximum of $1,000 per person (including CPAP and sleep apnea appliances); • purchase of **colostomy, ileostomy** or **uretherostomy** supplies; • purchase of one **glucometer** on the written recommendation of a physician; • purchase of reagent strips and other eligible **diabetic supplies**; • purchase of a **breast prosthesis** as a result of a total or radical mastectomy performed while the patient is insured, to a maximum of $200 per person every calendar year; • purchase of two **surgical brassieres** each calendar year when required as a result of a total or radical mastectomy; • purchase of an **aerochamber inhaler**; • purchase of two pair of **surgical elastic stockings** per year, on the written recommendation of a physician; The Plan only covers medically necessary surgical stockings with a compression factor of 20 mmHg or higher. • **plasma, blood** or blood substitutes and their administration; • purchase of **wigs required as a result of chemotherapy** or accidental injury to a lifetime maximum of $1,000 per person; • rental or purchase of other prescribed, approved, **medical equipment** up to a lifetime maximum of $250 per person.

Medical Travel	The benefit will provide up to **$750 per person** each 24 months to transport an insured from their normal place of residence to a medical facility (in Canada) for medically necessary treatment under the following conditions: • The treatment cannot be available in the normal place of residence and must be ordered by a physician; • The treatment must take place within 60 days from the date of the physician's referral; and • The round trip distance must be 300 kilometers or more. Covered expenses include: • Expenses for the person requiring the treatment and one traveling companion; • Cost of transport including economy class of a scheduled flight, rail, bus or ferry, or automobile fuel expenses; and • Cost to accommodate the patient in a commercial facility for up to $75 per day for a maximum of 5 days either before or after medical treatment. Telephone and meal expenses are not covered.
Orthopaedic Supplies	Coverage includes: • purchase, but not repair of, one pair of **custom designed orthopaedic shoes** from a recognized orthopaedic supplier each calendar year. This does not include off-the-shelf, regular stock shoes or shoes for athletic purposes. The Plan requires written medical necessity (condition/diagnosis) from your medical provider and a detailed description from the manufacturer of the shoes to confirm how the shoes are/have been made. • purchase of a **custom-made foot orthotic** or arch support, to a maximum of $200 per person per calendar year. A custom made foot orthotic is specifically made for the individual and fabricated from a three-dimensional model/cast of the foot which captures the foot alignment and shape. A biomechanical assessment by a physician, chiropractor, podiatrist, chiropodist, pedorthist, or orthotist is required.
Private Duty Nursing	On the written recommendation of the insured's doctor, charges will be covered for nursing visits in the insured's home. They must be provided by a professional nurse who is not related by blood, or connected by marriage, not a close friend or does not normally reside in the insured's home. Nursing services must be consistent with the insured's diagnosis and treatment of the condition and not primarily for custodial care. A *Nursing Care Questionnaire* is required and approval is at the discretion of the Insurance Company. Maximum payment is **$25,000 per insured** in any consecutive 24 month period.

Out-Of-Province/Out-Of-Country

Coverage	An insured and eligible dependents including students, who incur charges for emergency medical treatment outside their province of residence, are covered. An individual must be covered under their government health and hospital insurance plans to be eligible for coverage and the individual's provincial health plan must be prepared to pay a portion of any claim. Coverage for an insured and any dependents is based on the age of the certificate holder. The Plan covers the first: • 180 days of a trip for certificate holders up to age 65, • 90 days of a trip for certificate holders age 65 to 69, • 60 days of a trip for certificate holders age 70 to 74, and • 30 days of a trip for certificate holders age 75 to 80. All totally disabled employees who qualify for Waiver of Premium under the life insurance benefit will not be covered for any Out-of-Province/Out-of-Country expenses. The emergency expenses must be reasonable and customary for the area in which they are charged. This plan will pay for eligible expenses that exceed the provincial health insurance plan schedule in the insured's home province. Covered services include: • semi-private hospital room; • hospital medical services and supplies; • physicians' services; • prescription drugs; • licensed ground or air ambulance to the **nearest** hospital equipped to provide the required treatment. If you have a medical emergency, you must contact Voyage Assistance immediately to receive benefits. They will confirm your coverage and help connect you to eligible services. You'll find the toll-free emergency numbers on the back of your Chambers Plan wallet card. Inside Canada or U.S. 1 800 465.6390 Outside Canada or U.S. 1 514 875.9170
Voyage Assistance	Contacting the Voyage Assistance Centre will not only confirm your eligibility for coverage, but it will also make the following services available to you or any Dependent insured under the Extended Health Care benefit of this policy: *After Hospital Convalescence* | *Bedside Visit* *Emergency Medical Payments* | *Legal Assistance* *Lost Luggage and Documents* | *Meals and Accommodation* *Medical Assistance and Consultation* | *Medical Evacuation* *Return of Deceased* | *Return of Dependent Children* *Return of Vehicle* | *Telephone Interpretation Services* *Trip Interruption* | *Urgent Messages* Please read the Voyage Assistance brochure for full details of these services. It can be found at *www.chamberplan.ca > Plan Members > Your Coverage.*

Excluded Services	Chambers Plan coverage does not pay for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of either the employee and any of his dependents without endangering his life or health, even if such service is provided as a result of a sudden illness or an accident requiring emergency treatment, or if the purpose of the trip is to obtain medical services for which the either the employee or any of his dependents was advised as necessary, but not readily available in the province of residence.
Travel Claims	Claims for hospital and medical expenses incurred while travelling must be submitted to the Plan Administrator. Complete a *Travel Health* claim form and send it along with itemized receipts for all services received. The insurance company will coordinate payments on your behalf with your provincial government plan. The provincial health plan must be prepared to pay a portion of any claim. All foreign bills must be translated prior to submission. Eligible claims are payable on a reimbursement basis in Canadian currency at the conversion rate in force on the date the claim is paid.

Exclusions and Limitations

Extended Health benefits are not payable under any of the following circumstances:

- experimental services, treatments or supplies;
- drugs, injections or products for treatment of obesity;
- travel vaccines;
- services or treatment provided by anyone related by blood or marriage or living in the employee's residence (this might come up, for example, if an insured lives with a dentist or pharmacist);
- services, treatment or supplies provided to the employee by the employer;
- services, treatment or supplies not included in the list of eligible expenses;
- expenses as a result of intentionally self-inflicted injuries while sane or insane;
- cosmetic treatment expenses, except as a result of an accidental injury;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- personal comfort items and erectile dysfunction drugs/items;
- patent medicines;
- general health exams;
- physicians' fees;
- services, treatment or supplies which the individual received without charge;
- charges for services which are not medically necessary;
- travel time, broken appointments, transportation costs, telephone or other indirect consultations;
- amounts in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate;
- expenses related to temporomandibular joint dysfunction;
- out of province referrals.

Survivors' Benefit

There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured.

- the end of a 24 month period following the death of the Employee,
- the date on which the spouse remarries,
- the date on which the spouse becomes an employee or dependent under this or any other group plan,
- the date on which the Member Firm is no longer insured under this benefit,
- the date on which this benefit terminates.

Claims

All claims should be sent to the Plan Administrator and signed by the employee. Completed claim forms must be submitted within one year from date of service. Original receipts are required. Upon termination, claims must be submitted within 120 days after the termination date.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Teladoc

General Description of Coverage

Your Extended Health Care benefit under Chambers Plan includes free access for you and your insured dependents to Teladoc® – a global service providing convenient access to high-quality care to millions of people in more than 130 countries. Teladoc telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference or by phone[1], from wherever you are in Canada or the United States[2], 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.

Convenience	• You have confidential access to a doctor via app or telephone[1] who is available anytime. • You get treated for non-emergency conditions like the flu, bronchitis, and much more. • When necessary, prescriptions are sent directly to your pharmacy of choice.
Greater Access	• Visits occur within an hour of contact, so you get the care you need when you need it, without the wait. • The service is even available when you travel to the United States[2].
Clinical Quality	• Each doctor is board-certified by the College of Family Physicians of Canada to ensure the highest standards of quality. • Every visit provides the opportunity for a copy of your visit to be sent to your family physician.

Accessing Teladoc

Simply download the Teladoc app from Apple or Google Play (icons), complete the registration, and request a consultation either, by video conference or by phone[1], at **1-888-983-5236**.

Prior to your first consultation, you must complete an electronic health record for the doctor to review.

For more information visit **teladoc.ca**.

Teladoc services are available without charge to all insureds and their dependents holding a Chambers Plan Extended Health benefit. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.

[1] In Quebec, telemedicine services must be offered by video conference.

[2] Teladoc Health services in the U.S. can only be accessed by telephone.

Teladoc is a registered trademark of Teladoc Health, Inc.

Dental

General description of coverage

Dental benefits paid by the plan are based on the last approved Fee Guide established by the Provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the Fee Guide. If the dentist charges more than the Fee Guide, you are responsible for the excess charges.

The maximum benefit is $2,000 per person per calendar year (January through December) for all services combined based on reasonable and customary charges (plans for 1 & 2 person firms have a $2,500 per calendar year family maximum). *Late Entrants* have a maximum benefit of $250 per person for their first 12 months of coverage.

A deductible is the dollar amount for which you are responsible. Your plan deductible and/or coinsurance percentage is on the *Certificate of Insurance*. This amount is applied to eligible expenses incurred each calendar year prior to reimbursement by the plan.

If you or a dependent needs more than $500 of treatment at one time, you should send the dentist's Treatment Plan, to the Plan Administrator for review by the Insurance Company. The Insurance Company will confirm how much the plan will pay and what your share of the expenses will be, if any. Treatment Plan decisions will not be given verbally over the phone. These Treatment Plans are only valid for 90 days.

Benefits

This plan is primarily designed to cover dental expenses that occur most often. Dental services are categorized as Basic, Major and Orthodontic services. **Please note your plan covers Basic services only**.

Basic services, covered at the coinsurance level shown on the *Certificate of Insurance*, include:	
Oral examinations	• two recall oral exams (check-ups) in any calendar year • one complete oral exam (exam and medical and dental history) once every three years • emergency or specific oral exams
X-rays	• one complete series of periapical films and panoramic film in any 24 month period • bitewing films and x-rays, excluding duplicate x-rays and x-rays for temporomandibular joint procedures
Consultations and Special Visits	• consultations with another dentist • house or hospital call and after-hours office visit

Preventive	• one unit of polishing, scaling twice each calendar year • topical application of fluoride twice each calendar year • pit and fissure sealants • space maintainers for missing primary teeth (except when used for orthodontic purposes)
Restorative services	• amalgam, acrylic, silicate or composite restorations • duplicate fillings on the same tooth will not be covered within one year • repair, rebasing and relining of partial or complete dentures, not including the replacement of teeth on a denture • repair of fixed bridgework
Endodontic	• treatment of disease of the pulp chamber and canals (root canal therapy)
Periodontal	• treatment of the soft tissue (gums) and bone supporting the teeth • additional scaling units above those provided in preventive services, to a reasonable and customary amount
Oral surgery	• including uncomplicated removal of erupted or impacted teeth or residual roots

Other Services	• Laboratory examinations
	• Anaesthesia (if performed in conjunction with oral surgery)
	  o general anaesthesia
	  o neuroleptanalgesic
	  o conscious sedation

Exclusions

Dental benefits are not payable under any of the following circumstances:

- charges for services not previously listed;
- charges for services that are not reasonable and customary;
- treatment for full mouth reconstruction, vertical dimension correction, occlusion restoration, temporomandibular joint (TMJ) correction or permanent splinting of teeth;
- any dental treatment which is not yet approved by the Canadian Dental Association or which is experimental in nature;
- replacement of lost, stolen or mislaid dentures and appliances;
- oral hygiene instruction, plaque control programs, nutritional counselling, chlorzoin treatment and sterilization of equipment;
- implant expenses or services related to implant procedures;
- non-emergency dental treatment provided outside of Canada;
- treatment for cosmetic purposes, i.e. veneers, bleaching, etc.;
- services or treatment provided by anyone related by blood or marriage or living in the employee's residence (this might come up, for example, if the insured lives with a dentist);
- services, treatment or supplies provided to the employee by the employer;
- expenses as a result of intentional self-inflicted injuries while sane or insane;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;

- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- services, treatment or supplies which the individual received without charge;
- travel time, broken appointments, transportation costs, charges for completion of claim forms, telephone or other indirect consultations;
- facility fees.

Limitations

Reimbursement will not be made over the suggested charge in the appropriate Fee Guide for the least expensive treatment that will provide a professional result.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services. Total reimbursement will not exceed 60% of the suggested fee in the appropriate Fee Guide.

Survivors' Benefit

There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured:

- the end of a 24 month period following the death of the employee;
- the date on which the spouse remarries;
- the date on which the spouse becomes an employee or dependent under this or any other group plan;
- the date on which the Member Firm is no longer insured under this benefit;
- the date on which this benefit terminates.

Claims

Completed claim forms must be submitted within one year of the date the expense was incurred. Upon termination, claims must be submitted within 120 days after the termination date. All claims must be sent to the Plan Administrator and signed by the employee.

Eligible expenses will be based on the date the service or supply was provided. For bridges, crown or dentures, the date the appliance was inserted will be the date of service. For root canal therapy, the date of the final treatment will be the date of service.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.