360° GROUP INSURANCE

Your Group Insurance Plan

west vancouver

THE CORPORATION OF THE DISTRICT OF WEST VANCOUVER

Plan No. 647208 and Policy No. 647215

Library Staff

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Desjardins Insurance
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This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective January 1, 2016. Only the Group Insurance Policy may be used to settle legal matters.

Information on benefits that are not insured by Desjardins Financial Security Life Assurance Company (hereinafter referred to as Desjardins Financial Security) has been inserted in this booklet for convenience and reference purposes only. Inclusion of such wording does not imply nor impart any liability upon Desjardins Financial Security for these coverages.

This electronic version of the booklet has been updated on August 1, 2016. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

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BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory
Eligibility Requirements	
Number of hours worked per week:	A minimum of 21 hours per week
Eligibility Period:	As provided by the Employer
Waiver of Premium	
Benefits for which premiums are waived in the event of Total Disability:	• Basic Participant Life Insurance Benefit • Participant Long Term Disability Benefit.
Beginning of Waiver of Premium:	At the end of the Elimination Period of the Participant Long Term Disability Benefit.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Underwritten by Desjardins Financial Security under policy number 647215

Amount of Insurance:	* 2 times annual Earnings, rounded to the next higher $1,000, if not already a multiple, up to a maximum of $210,000.
Non-Evidence Maximum of Insurability:	$210,000
*** Reduction of Amount:**	None

Benefit Termination

Age Limit:	The last day of the month during which the Participant reaches Age 65 or retires, whichever occurs first.

PARTICIPANT LONG TERM DISABILITY BENEFIT

Underwritten by Desjardins Financial Security under policy number 647215

Percentage and Maximum of Benefit:	50% of gross monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $5,000.
Non-Evidence Maximum of Insurability:	$5,000
Elimination Period:	180 days or upon expiration of accumulated sick leave credits, at the Employer's discretion
Maximum Benefit Period:	To age 65
Taxability of Benefits:	Taxable

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

Self-Insured under Plan 647208 by The Corporation of the District of West Vancouver and administered by Desjardins Financial Security

Deductible Amount

Hospitalization Expenses:	Nil
Travel Coverage:	Nil
Other Expenses:	$100 per single coverage or $100 per family coverage each Calendar Year.
Drug Payment Card:	Direct

Percentage of Reimbursement *

Drugs: *	1) Generic drugs: 80% of the lowest priced equivalent drug available on the market 2) Brand name drugs: • 80% of the brand name drug if no equivalent drug is available on the market • 80% of the lowest priced equivalent drug available on the market
Travel Coverage:	100%
Other Expenses: *	80%

* *After $1,000 has been paid by Desjardins Financial Security for a Covered Person in a Calendar Year, further Eligible Expenses incurred by or on behalf of that Covered Person within the Calendar Year will be reimbursed at 100%.*

Limits for Eligible Expenses

Overall maximum for all Extended Health Care expenses, including Travel Coverage:	Lifetime payable amount of $1,000,000 per Covered Person.
Drugs:	
• mark-up:	15%
• dispensing fee:	Covered
Short-Term Hospitalization Expenses:	The cost of a private room for each day of Hospitalization with no limit as to the number of days.
Nursing Care:	Payable amount of $50,000 per Covered Person each Calendar Year.
Paramedical Services:	
• acupuncturist	Payable amount of $300 per Covered Person each Calendar Year.
• chiropractor • naturopath	Payable amount of $600 for all specialists combined per Covered Person each Calendar Year.
• massage therapist • physiotherapist or physiatrist	Payable amount of $800 for all specialists combined per Covered Person each Calendar Year.
• podiatrist or chiropodist	Payable amount of $500 for all specialists combined per Covered Person each Calendar Year.
Orthopaedic supplies:	
• Orthopaedic shoes	Covered

Orthesis and Prosthesis:

• Podiatric Orthesis or arch support	Payable amount of $300 per Covered Person for any period of 5 consecutive Calendar Years.
• External breast Prosthesis	Payable amount of $200 per Covered Person for any period of 24 consecutive months.
• Hearing aids	Payable amount of $750 per Covered Person for any period of 5 consecutive Calendar Years.
• Wigs	Payable amount of $1,000 per Covered Person for any period of 2 consecutive Calendar Years, including the purchase of surgical brassieres.

Medical supplies:

• Stump socks	Payable amount of $250 per Covered Person each Calendar Year.

Vision Care:

• Eye examination	Payable amount of $100 per Covered Person under age 65, for any period of 24 consecutive months.
• Eyeglasses, Lenses and Eye surgery	Payable amount of $400 per Covered Person once in any 24 month period.
• Contact Lenses (special conditions)	Payable amount of $250 per Covered Person per period of 24 consecutive months.

<u>Benefit Termination</u>

Age Limit:	The date of retirement.

DENTAL CARE BENEFIT

Self-Insured under Plan 647208 by The Corporation of the District of West Vancouver and administered by Desjardins Financial Security

Fee Guide Year:	The current Calendar Year Dental Association Fee Guide for General Practitioners or Specialists of the Province in which the Covered Person is a resident.
Deductible Amount:	Nil
Percentage of Reimbursement	Reimbursement of Eligible Expenses is limited to the fees recommended by the Fee Guide specified above.
PLAN A - Preventive Services, Basic Services, Endodontics and Periodontics:	80%
PLAN B - Major Restorative Services:	50%
PLAN C - Orthodontics:	50%
	Eligible Expenses for adults and children.
Maximum Benefit	
PLANS A AND B - Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Unlimited
PLAN C - Orthodontics:	Lifetime Maximum of $3,000 per Covered Person.
Frequency:	For recall oral examination, polishing, light scaling and fluoride treatment: 9 months for adults and twice a year for Children

Limitations:	Reimbursement of fees for composite restorations performed on posterior teeth are limited to the fees for amalgam restorations.
Payment Card:	Yes

Benefit Termination

Age Limit:	The date of retirement.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is under 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Covered Person means the Participant or one of his covered Dependents, as the case may be.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, but excluding bonuses, dividends, profit sharing, overtime pay and any non regular form of remuneration.

Effective Date means January 1, 2016.

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time or part-time basis for not less than the number of hours specified in the Benefit Schedule. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Plan means The Corporation of the District of West Vancouver’s Extended Health Care and Dental Care Plans.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

1) is legally married to or living in a civil union with the Participant; or

2) has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

1) the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

When a Participant retires while covered under the Extended Health Care and Dental Care Benefits, he may remain covered under these Benefits for one of the periods specified below:

1) until the end of the month during which he retires; or

2) until the end of the month following the month during which he retires.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EXEMPTION PRIVILEGE

A Participant may decline to be covered under the Extended Health Care Benefit or Dental Care Benefit, if such Participant is covered as a Dependent under the Plan or another similar group insurance plan. However, if the other plan terminates or the Spouse ceases to be a member of an eligible class, the Participant will be eligible for coverage under the Benefit he previously opted out of as of the date of such termination, provided written application is made within 6 months of such eligibility.

If the written application is received more than 6 months after the eligibility date, the following conditions apply:

1) the Covered Person will have to submit evidence that he may be covered for the Extended Health Care Benefit and coverage will not take effect until the date on which such evidence is approved by Desjardins Financial Security;

2) the Dental Care Benefit will be effective on the date on which the written application is signed by the Participant and limited as indicated in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under the Dental Care Benefit.

EVIDENCE OF INSURABILITY

The following terms:

1) evidence of insurability,

2) evidence, and

3) evidence that one may be covered,

are defined as any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer:

    a) on or before that date, for Extended Health Care and Dental Care Benefits,

    b) within 180 days of his date of eligibility, for all other Benefits,

3) the date on which his written application for the Extended Health Care and Dental Care Benefits, completed using the form required by Desjardins Financial Security, is signed by him, provided this application is received by Desjardins Financial Security within 6 months of his date of eligibility,

4) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days (6 months for Extended Health Care and Dental Care Benefits) after the date of his eligibility.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

With respect to the Dental Care Benefit, if the Employee applies more than 6 months after the date of his eligibility, his dental coverage will be limited as set forth in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS section of the Dental Care Benefit.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days (6 months for Extended Health Care and Dental Care Benefits) of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days (6 months for Extended Health Care and Dental Care Benefits) after the date he became eligible,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days (6 months for Extended Health Care and Dental Care Benefits) after the Participant first became eligible for such insurance.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital. This does not apply to the Extended Health Care Benefit, for a Covered Person domiciled in Quebec.

WAIVER OF PREMIUM

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

    a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

b) the date on which the Participant ceases to be Totally Disabled,

c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

d) the date on which the Participant attains Age 65 or retires, if earlier.

2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

a) the Participant became Totally Disabled while insured under this Benefit,

b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

c) the Participant dies within 12 months from the onset of his Total Disability,

d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 12 months of his death.

5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability and satisfactory proof of Total Disability within 12 months of the date the Participant becomes Totally Disabled.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date the Participant retires,

6) the date the Participant ceases to be Actively At Work,

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date the insurance of the Participant terminates,

2) the date the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

With regard to life insurance only and subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, in the event of the Spouse's death, the death benefit is paid to the Spouse's legal heirs.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

CO-ORDINATION OF BENEFITS

If an individual, who is covered for a Benefit that is subject to the CO-ORDINATION OF BENEFITS provision, is also insured under another Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated.

Coordination of benefits under the Plan will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association so that the total payments under all Plans will not exceed the individual's total incurred eligible expenses.

As used in this provision, "Plan" means the Plan and any plan providing benefits or services under

1) other group insurance programs;

2) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

3) government programs or any insurance required by statute.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) the maximum amount applicable in the province of residence of the Participant; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice and the written proof of claim must be submitted to the Insurer within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Net Monthly Earnings means the gross monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada Pension Plan and Employment Insurance payable thereon, or any other contribution to a public income replacement plan.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

1) during the Elimination Period and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered Totally Disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of the contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

1) the end of Elimination Period;

2) the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each monthly period of Total Disability, commencing on the date the Elimination Period is completed.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Direct Offset

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

b) any disability benefit the Participant is eligible to receive under the Canada Pension Plan excluding

i) benefits payable on behalf of his Dependents; and

ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and

c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;

d) any disability benefit payable by a private pension plan. However, Long Term Disability Benefits payable under this Benefit are not reduced by any benefit payable by an individual disability insurance plan.

2) Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

a) 80% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

b) 80% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

a) any Long Term Disability payments under this Benefit;

b) any monthly Earnings or payments from the Employer;

c) any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

e) any disability benefits payable under any other group or association insurance plan;

f) any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

g) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

3) In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

4) Limitations

No benefits are payable for a period of Total Disability

a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

b) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a total disability occurring during this period;

c) during a Parental or Family-related Leave taken by a Participant, as provided for under provincial or federal legislation, for Total Disability occurring during this period;

d) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

e) during the imprisonment of the Participant due to conviction of an offence;

f) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

5) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

a) intentionally self-inflicted injuries while sane or insane;

b) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

c) committing, or attempting to commit a criminal offence;

d) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;

e) 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, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

f) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

1) 30 consecutive days of active full-time employment during the Elimination Period; or

2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work,

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Monthly Income earned from any rehabilitative activity

B = Monthly Earnings of the Participant immediately prior to the commencement of Total Disability

C = Long Term Disability Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

1) the date the Participant ceases to be Totally Disabled;

2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date set by the Insurer the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

4) the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date the Participant attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

If a Participant is not Totally Disabled on the date this Benefit terminates but was receiving Long Term Disability Benefits under this Benefit less than 6 months prior to such date, such Participant will be eligible to a resumption of Long Term Disability Benefits if he again becomes Totally Disabled from the same or related causes prior to

1) 90 days after the termination of this Benefit; or

2) 180 days after the last day he was Totally Disabled.

The reinstated Long Term Disability Benefits will be equal to those which the Participant was previously eligible to receive and will continue for the remainder of the Maximum Benefit Period.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim and initial written proof must be submitted to the Insurer within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period extending from January 1st to December 31st inclusive.

Day Surgery means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Drugs available on prescription means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.

Equivalent drug means a brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

Hospitalization means

1) to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or

2) any Hospital stay in order to receive Day Surgery.

In-patient means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.

Medical Emergency means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.

Medical Recommendation means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of his profession.

Orthesis means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Period Of Hospitalization means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Covered Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.

Prosthesis means an appliance used to replace all, or part, of a limb or organ.

Reasonable and Customary Charges means the charges generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration that requires the same skill and is performed by a provider of similar training and experience.

Sound Tooth means a natural tooth that is not afflicted with any pathology either itself or in the adjacent structures. In addition, a tooth that has been treated or repaired and restored to normal function will be considered sound.

Stable refers to the health condition of a Covered Person who, within 30 days prior to the trip departure date, is not affected by any medical condition, or is affected by a medical condition that:

1) does not require a change or for which no change was recommended in the treatment or dosage of prescribed drugs; and

2) does not demonstrate any symptoms that would indicate a deterioration of the medical condition in the course of the trip.

Vehicle means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to Desjardins Financial Security that a Participant, or one of his Dependents, while covered under this Benefit, incurred Eligible Expenses, Desjardins Financial Security will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and the Plan.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1) which is medically necessary to treat the Covered Person;

2) which is generally provided for an Illness or injury of similar type or seriousness; and

3) which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the reasonable and customary charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

COMMENCEMENT OF DEPENDENT COVERAGE

If a Dependent is hospitalized on the day his coverage would normally become effective, the effective date of coverage will be delayed, and his coverage will commence 24 hours after his discharge from the hospital. However, the newborn Child of a Participant, with Dependents who are already covered, will become covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

Eligible Expenses incurred during the last 3 months of a Calendar Year and used to satisfy all or part of the annual Deductible are also deducted from the Deductible for the following year.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by Desjardins Financial Security, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA – EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

1) in the Participant's province of residence; and

2) outside the Participant's province of residence, for any reason other than a Medical Emergency.

HOSPITALIZATION EXPENSES

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

DRUGS

1) Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

   cardiac problems;

   pulmonary problems;

   diabetes;

   arthritis;

   Parkinson’s disease;

   epilepsy;

   cystic fibrosis;

   glaucoma.

2) Anaesthetic administered during surgery that is not performed in a Hospital, up to a payable amount of $20 per surgery per Covered Person.

3) Products and drugs used in the treatment of obesity and that are available only on prescription, up to a payable amount of $1,000 per Insured Person each Calendar Year.

PRIOR AUTHORIZATION DRUGS

Prior authorization by Desjardins Financial Security is required for certain drugs. The prior authorization process is used to collect the medical information necessary to confirm that the prescribed drug is being used for its intended purposes and meets Desjardins Financial Security's prior authorization criteria.

A special authorization form completed by the Physician and the Covered Person must be submitted to Desjardins Financial Security, either before or after the prescription is filled.

HEALTH PROFESSIONALS

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the payable amount specified in the Benefit Schedule per Covered Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the Participant or to any of his Dependents by birth or marriage, and must not ordinarily reside in his or his Dependent's home.

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified, provided that the practitioner is operating within his recognized field. He must be a member in good standing of his professional association that must be recognized by Desjardins Financial Security. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

AMBULANCE

In the event of a Medical Emergency, or if the Covered Person must be transferred to another Hospital, transportation by a licensed ground ambulance

1) from the place of the Accident or Illness to the nearest Hospital where adequate medical treatment is available;

2) between Hospitals; and

3) from the Hospital to the place of residence of the Covered Person, when his condition warrants it.

Medical Emergency transportation by a licensed air ambulance to the nearest Hospital where adequate treatment is available, or to another Hospital when certified as medically necessary by the attending Physician.

MOBILITY AIDS

Wheelchair: Rental or purchase, at the discretion of Desjardins Financial Security, of a conventional wheelchair. However, an electric wheelchair may be covered up to one wheelchair per Covered Person for any period of 5 consecutive Calendar Years, if the Covered Person is unable to operate a conventional wheelchair.

Walkers or crutches: Purchase or rental, at the discretion of Desjardins Financial Security.

ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase.

Brace for a limb, truss and plaster: Purchase.

Hospital bed: Purchase or rental, at the discretion of Desjardins Financial Security, of a conventional Hospital bed or electric Hospital bed, if the Covered Person is unable to operate a conventional Hospital bed, up to one bed per Covered Person for any period of 5 consecutive Calendar Years.

Orthopaedic shoes: Purchase, as provided for in the Benefit Schedule, on the prior recommendation of the attending Physician or a chiropractor. Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces. The cost of modifications or adjustments to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded.

ORTHESIS AND PROSTHESIS

Expenses incurred for Orthesis are eligible, provided they are purchased on the prior recommendation of the attending Physician, a chiropractor or physiotherapist, including an in-person biomechanical assessment.

Podiatric Orthesis or arch support: Purchase of custom-made podiatric Orthesis or arch support, as provided for in the Benefit Schedule.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Covered Person.

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy that has been performed while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, as provided for in the Benefit Schedule.

Surgical brassieres: Purchase, when required because of total or radical mastectomy that has been performed while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, as provided for in the Benefit Schedule.

Hearing aids: Purchase on the written prescription of a licensed otolaryngologist, as provided for in the Benefit Schedule. However, speech processors and headsets are covered when required for profound deafness, up to one device per Covered Person for any period of 5 consecutive Calendar Years.

Wigs: Purchase of wigs required as a result of chemotherapy, as provided for in the Benefit Schedule.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of Desjardins Financial Security.

Apnea monitor: Purchase or rental, at the discretion of Desjardins Financial Security.

Drainage pump and chest percussion accessories: Purchase.

TENS nerve stimulators: Purchase or rental, at the discretion of Desjardins Financial Security, up to a lifetime payable amount of $700 per Covered Person.

Insulin pumps: Purchase or rental, at the discretion of Desjardins Financial Security, up to a maximum of one device per Covered Person for any period of 5 consecutive Calendar Years.

Other therapeutic equipment: Purchase or rental, at the discretion of Desjardins Financial Security, of equipment that is not listed above, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of $25,000 per Covered Person. This category of equipment includes, for example, non-union bone stimulators, aerosol therapy equipment and intermittent positive pressure breathing machines.

MEDICAL SUPPLIES

Colostomy, ileostomy or uretherostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (over 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to a payable amount of $500 each Calendar Year, per Covered Person.

Stump socks: Purchase, as provided for in the Benefit Schedule.

Supplies for paraplegics: Purchase, provided such supplies are required for the treatment and the care of a paraplegic Covered Person.

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

DENTAL TREATMENT DUE TO AN ACCIDENT

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in his mouth. Dental services must be rendered within 12 months of the accident; otherwise, a treatment plan deemed satisfactory by Desjardins Financial Security will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

VISION CARE

Eye examinations: Including eye refraction, provided they are performed by a qualified ophthalmologist or a licensed optometrist, as provided for in the Benefit Schedule.

Eyeglasses or contact lenses and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or surgery to correct myopia, hypermetropia and astigmatism, as provided for in the Benefit Schedule.

Contact lenses (special conditions): Purchase of one pair, as provided for in the Benefit Schedule, provided that they are required as a result of cataract surgery and that vision can be improved to at least 20/40.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day enabling the Covered Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Covered Person with information on the following topics:

- health
- nutrition
- physical fitness
- availability of local resources
- immunization
- lifestyle
- child care

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the regular health care provider of the Covered Person, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

The Insured Person may contact HEALTH ASSISTANCE at any time.

Calls from	**Dial**
Anywhere in Canada	1 877 875-2632

ELIGIBLE EXPENSES - TRAVEL COVERAGE

If a Covered Person incurs Medical Emergency expenses during the first 90 days of a stay outside his province of residence, Desjardins Financial Security will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

1) the Covered Person must be covered under government health and hospital insurance plans;

2) expenses must be eligible under the Extended Health Care Benefit; and

3) expenses must be related to a Stable health condition prior to the trip departure date.

The Participant must contact Desjardins Financial Security if the duration of the stay outside the province of residence is, or may be, longer than 90 days. Otherwise the Covered Person may not be covered under the Travel Coverage benefit.

1) Eligible Health Care Expenses

   a) Hospital services and room and board charges in a semi-private room until the Covered Person is discharged from the Hospital;

   b) Services of a Physician, a surgeon and an anaesthetist;

   c) All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Covered Person, excluding Hospital and Convalescent Care Eligible Expenses, if covered.

2) Eligible Transportation Expenses

a) Expenses incurred for the repatriation of the Covered Person to his place of residence by a suitable means of public transportation to receive appropriate care as soon as his state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Covered Person declines, his coverage under the Travel Coverage provision will terminate.

b) Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member covered under this Benefit, if he cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".

c) Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".

d) Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Covered Person must be confined for at least 7 days (expenses will be reimbursed only if the Covered Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Covered Person is not accompanied by an Immediate Family member age 18 or over. The cost of meals and accommodation for the Immediate Family member up to $500 are also covered. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".

e) Cost of returning the personal or rented Vehicle of the Covered Person if the Covered Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to $1,000 per Participant.

f) If the Covered Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Covered Person was accompanied by an Immediate Family member age 18 or over.

g) If the Covered Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".

3) Eligible Daily Allowance

The cost of meals and accommodations for a Covered Person who must delay his return because of an Illness or bodily injury suffered by the Covered Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Covered Person. Eligible Expenses are limited to $200 per day per Participant for a maximum of 10 days and the Illness or injury must be certified by a Physician.

4) Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Covered Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Covered Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

5) Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

6) Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Covered Person who requires them:

a) 24 hour toll-free telephone assistance;

b) referral to Physicians or health-care facilities;

c) assistance for Hospital admission;

d) cash advances to the Hospital when required by the facility;

e) repatriation of the Covered Person to his home city, as soon as his state of health permits it;

f) establishing and staying in contact with Desjardins Financial Security;

g) handling arrangements in the event of death;

h) repatriation of the Children of the Covered Person, if the Covered Person cannot be moved;

i) delivery of medical assistance and drugs to a Covered Person who is too far from health care facilities to be transported there;

j) arrangements to bring a member of the Immediate Family to the bedside of the Covered Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;

k) assistance in replacing lost or stolen travel documents so that the Covered Person can continue his trip;

l) referral to lawyers if legal problems arise;

m) translation services for emergency calls;

n) transmission of urgent messages to close friends or family in case of emergency; or

o) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the insured must contact the travel assistance firm immediately.

Calls from	**Dial**
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

1) Eligible Expenses are subject to the limitations and maximums indicated in the Benefit Schedule or this Benefit.

2) No reimbursement will be made under this Benefit for the following:

   a) services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;

   b) services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, Desjardins Financial Security will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Covered Person's province of residence;

   c) services, treatment or supplies which are experimental in nature;

   d) expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under the Plan;

   e) services, treatment or supplies provided to the Participant by the Employer;

   f) wheelchairs adapted or designed for sports activities;

   g) monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;

   h) equipment such as "Obus form" type;

   i) training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

   j) diapers for incontinence;

   k) dental services, except those provided for in this Benefit;

   l) dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;

   m) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;

   n) expenses incurred for genetic testing;

o) services, treatment or supplies not included in the list of Eligible Expenses;

p) Eligible Expenses which result directly or indirectly from the following:

i) intentionally self-inflicted injuries while sane or insane;

ii) cosmetic treatment;

iii) committing, or attempting to commit a criminal offence;

iv) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

v) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

vi) driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment are not subject to this exclusion;

q) imaging techniques ordered by a chiropractor, a podiatrist, an osteopath or chiropodist;

r) services, treatment or supplies for the treatment of alcoholism and drug addiction;

s) services, treatment or supplies for fertility treatment;

t) sunglasses, except those provided for in this Benefit;

u) safety glasses.

3) Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

a) contraceptives (prophylactics and contraceptive jellies and foams);

b) the following products, whether or not prescribed:

i) shampoos and other scalp care products, including hair growth products;

ii) beauty-care products;

iii) cosmetics;

iv) so-called "natural" products and homeopathic preparations;

v) sun-tan emulsions (sunscreens);

vi) soaps;

vii) over-the-counter laxatives;

viii) over-the-counter antacids;

ix) skin softeners;

x) disinfectants and ordinary dressings;

xi) mineral water;

xii) any infant milk formulas;

xiii) proteins and food supplements (i.e. products used to supplement or complement a diet);

c) preventive vaccines;

d) sclerosing injections;

e) products and drugs used in the treatment of sexual dysfunctions;

f) products used as smoking cessation aids;

g) products used in fertility treatment.

4) Exclusions applicable to drugs requiring prior authorization

No reimbursement will be made under this Benefit for drugs that do not meet Desjardins Financial Security's prior authorization criteria on the date the expenses were incurred.

5) Drug restrictions

Any one prescription for drugs or medicines must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

6) Exclusions and limitations applicable to Travel Coverage

If a Covered Person fails to contact "Voyage Assistance" immediately when he requires Medical Emergency services that require Hospitalization outside the country, Desjardins Financial Security may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that Desjardins Financial Security is not responsible for the availability or quality of such services.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Coverage provision. Furthermore, Desjardins Financial Security will not pay any of the benefits provided for under the Travel Coverage provision in the following circumstances:

a) if the Covered Person is not covered under government health and hospital insurance plans;

b) if the purpose of the trip is to receive medical or paramedical treatment or Hospital services, even if the trip was recommended by a Physician;

c) for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Covered Person without endangering his life or health, even if such service is provided as a result of a Medical Emergency;

d) if the Covered Person does not agree to repatriation as recommended by "Voyage Assistance";

e) for health care and Hospital expenses incurred for a Covered Person who cannot be repatriated in his province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";

f) for any Medical Emergency incurred in a country or region for which the Canadian government issued, prior to the trip departure date, one of the following travel warnings:

   i) avoid non-essential travel; or

   ii) avoid all travel.

   The Covered Person who is in the country or region for which a travel warning is issued during his trip is not subject to this exclusion. However, he must make the necessary arrangements to leave the country or region as soon as possible;

g) if the Covered Person refuses to disclose to Desjardins Financial Security necessary information regarding other insurance plans under which he also has travel insurance coverage, or if he refuses the use of such information by Desjardins Financial Security;

h) if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date.

Travel Coverage benefits are limited to the maximum specified in the Benefit Schedule.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT COVERAGE and TERMINATION OF DEPENDENT COVERAGE provisions.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to Plan provisions, coverage under this Benefit will continue for covered Dependents until the earliest of the following dates:

1) 3 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent coverage would have terminated if the Participant had not died;

4) the date on which this Benefit or Plan terminates.

NOTICE AND PROOF OF CLAIM

All claims, other than drug claims, must be submitted to Desjardins Financial Security along with any receipts within 12 months of the date the expense was incurred.

In the event of an Accident for which the Participant must submit a claim, written notice must be sent to Desjardins Financial Security within the 30 days immediately following the Accident.

DRUG CLAIMS

When incurring drug expenses, the Covered Person must show his payment card to the pharmacist. With this method of payment, which is referred to as “direct”, the Covered Person only pays the pharmacist for the uncovered portion of the drug expenses incurred and, therefore, the Participant is not required to submit a claim to Desjardins Financial Security.

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period from January 1st to December 31st inclusive.

Dental Hygienist means a person licensed by an accredited dental faculty to perform dental prophylaxis.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Fee Guide means the Dental Association Fee Guide for General Practitioners or Specialists of the Province in which the Covered Person is resident, for the Calendar Year mentioned in the BENEFIT SCHEDULE.

LATE APPLICATION

With respect to this Benefit, if the Participant applies for coverage for himself or his Dependents more than 31 days after the date of his eligibility, Desjardins Financial Security will limit the amount of Eligible Expenses in accordance with the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under this Benefit.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to Desjardins Financial Security that a Covered Person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a Dentist, Desjardins Financial Security will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable Plan provisions.

To be eligible, the expenses must have been performed

1) by a Dentist; or

2) by a Dental Hygienist under the supervision of a Dentist; or

3) by a licensed denturist when such services are within the scope of his licence.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

COMMENCEMENT OF DEPENDENT COVERAGE

If a Dependent is hospitalized on the day his coverage would normally become effective, the effective date of coverage is delayed, and his coverage will commence 24 hours after his discharge from the Hospital. However, the newborn Child of a Participant with Dependents who are already covered becomes covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by Desjardins Financial Security, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA

PLAN A - PREVENTIVE SERVICES, BASIC SERVICES, ENDODONTICS AND PERIODONTICS

EXAMINATIONS

- Complete oral examination, once every 24 months
- Recall oral examination, according to the frequency specified in the Benefit Schedule
- Specific oral examination, once every 6 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

- Complete series of periapical films or panoramic radiographs, limited to one series in any 24 months
- Intra oral films, including bitewing films, and radiographs to diagnose a symptom or examine progress of a particular course of treatment
- Interpretation of radiographs from another source
- Photography
- Radiograph of the hand and wrist as a diagnostic aid for dental treatment

LAB TESTS AND EXAMINATIONS

- Bacteriologic cultures/smears to determine pathological agents
- Biopsies
- Pulp vitality tests
- Unmounted diagnostic casts

CASE PRESENTATION AND EXPLANATION

- Consultation with a patient (a day other than the examination date)

PREVENTIVE SERVICES

- Oral hygiene instruction (once in a lifetime)
- Polishing, according to the frequency specified in the Benefit Schedule
- Light scaling for preventive purposes rather than therapeutic, according to the frequency specified in the Benefit Schedule
- Topical application of fluoride, according to the frequency specified in the Benefit Schedule
- Finishing restorations
- Pit and fissure sealants, for Children under Age 16
- Interproximal discing
- Space maintainers for missing primary teeth, for Children under Age 16
- Prophylactic odontotomy/enameloplasty

RESTORATIONS

- Amalgam (silver)
- Composite restorations in accordance with the LIMITATIONS provision of the Dental Care section in the Benefit Schedule
- Retentive pins for amalgam and composite restorations
- Preformed stainless steel and polycarbonate crowns, for Children under Age 16
- Caries / trauma / pain control, separate procedure from restoration

ENDODONTICS

- Treatment of disease of the pulp chamber and pulp canals (root canal therapy)

PERIODONTICS

Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited:

a) post-operative visits, 4 visits per Calendar Year

b) curettage performed by a Dentist, once per period of 60 months

c) scaling for therapeutic purposes limited to a maximum of 13 units per Calendar Year

d) adjustments to periodontal appliance to control bruxism only, limited to one adjustment per Calendar Year

e) occlusal equilibration, limited to 8 units per period of 12 months or one major and 3 minors per period of 12 months

MAINTENANCE OF REMOVABLE DENTURES

- Repair
- Structure addition (to an existing removable dentures)
- Relining
- Rebasing
- Adjustments to dentures, 3 months after insertion
- Denture adjustments including minor adjustments, once every 6 months.

ORAL SURGERY

- Extractions - uncomplicated and complex
- Removal of residual roots
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty
- Alveolar ridge reconstruction
- Extension of mucous folds
- Excisions

- Incisions
- Frenectomy
- Miscellaneous surgical procedures

OTHER SERVICES

Only general anaesthesia and conscious sedation are covered. These expenses are eligible if they are administered in conjunction with extractions.

PLAN B - MAJOR RESTORATIVE SERVICES

PROSTHODONTICS

Expenses incurred for a permanent initial prosthodontic appliance, such as partial or full removable denture or fixed bridge, are covered if such appliance was necessary because of the extraction of at least one natural tooth.

Replacement of an existing denture or bridge by a permanent denture or bridge:

a) if the replacement was necessary because of the extraction of one or more natural teeth, or

b) if the existing denture or bridge is at least 5 years old; or

c) if the existing denture or bridge is temporary and is being replaced with a permanent denture or bridge within 12 months of the installation of the temporary appliance. With respect to a permanent appliance that replaces a temporary one, the amount eligible for reimbursement will be reduced by the amount previously reimbursed by Desjardins Financial Security for the temporary appliance.

A temporary appliance which is at least 12 months old will be considered to be a permanent denture or bridge for the purposes of this provision.

REMOVABLE DENTURES

- Complete denture
- Immediate complete denture
- Complete or partial overdenture
- Transitional denture
- Partial denture including cast in chrome (but not in gold)

- Partial denture remake
- Remount with occlusal equilibration
- Therapeutic tissue conditioning

FIXED PROSTHODONTICS (bridges)

- Abutments and pontics
- Repairs
- Bridge removal
- Recementation

OTHER SINGLE RESTORATIONS

- Onlays, veneers applications, inlays, crowns

    a) for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite

    b) temporary crowns are considered to be part of the final restoration

    c) replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old

    d) only metal crowns on molars are reimbursed

- Porcelain repair
- Retentive pins, pivots, cast posts
- Recementation
- Removal of an inlay or crown

PLAN C - ORTHODONTICS

If a Covered Person, while Covered under this Benefit, incurs Eligible Expenses that are for necessary dental treatment, which has as its objective the correction of malocclusion of the teeth, as listed below, Desjardins Financial Security will reimburse such expenses, in accordance with the provisions of the Plan and subject to any maximum specified in the Benefit Schedule.

- services for diagnostic purposes
- preventive orthodontic treatment
- comprehensive orthodontic treatment
- appliances to control harmful oral habits

ELIGIBLE EXPENSES OUTSIDE CANADA

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this Benefit if such treatment had been rendered in the normal province of residence of the Covered Person.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

In the event of late application of the Participant or his Dependents, in accordance with the Late Application provision under this Benefit, reimbursement will be limited to $250 per Covered Person for the first 12 months of coverage and Orthodontics will not be covered during the first 24 months of such coverage.

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule.

When there are two or more courses of treatment available to adequately correct a dental condition, the Plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care. Bridgework is not subject to this limitation.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 50% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

Reimbursement of fees for composite restorations performed on posterior teeth may be limited to the fees for amalgam restorations as specified in the LIMITATIONS provision of the Dental Care section in the Benefit Schedule.

No reimbursement will be made under this Benefit for the following:

1) any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;

2) charges for nutritional counselling;

3) any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction, for the correction of temporomandibular joint dysfunction or for permanent splinting of teeth;

4) charges levied by a Dentist for broken appointments, completion of claim forms or advice by telephone;

5) expenses incurred for bacteriologic cultures/smears followed by a Chlorzoïn treatment;

6) expenses incurred for implants;

7) expenses incurred for duplicate diagnostic casts (unmounted);

8) expenses incurred for anaesthesia administered by acupuncture;

9) any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;

10) dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;

11) services, treatment or supplies provided to the Participant by the Employer;

12) dental services and supplies not included in the list of Eligible Expenses;

13) Eligible Expenses that result directly or indirectly from the following:

    a) intentionally self-inflicted injuries while sane or insane;

    b) committing, or attempting to commit a criminal offence;

    c) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

    d) war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

EXCLUSIONS RELATED TO PROSTHESES AND CROWNS (PLAN B)

No reimbursement will be made under this Benefit for the following:

1) expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen;

2) prosthetics with precision attachments or stress breakers;

3) precision attachments and telescoping crown units for fixed bridgework;

4) preformed stainless steel or polycarbonate crowns, except in the case of primary teeth;

5) transfer coping for crowns.

EXCLUSIONS RELATED TO ORTHODONTIC TREATMENT (PLAN C)

No reimbursement will be made under this Benefit for the following:

1) myofunctional therapy;

2) replacement or repair of an orthodontic appliance;

3) patient motivation (psychological evaluation and progress, per visit);

4) procedure requiring the insertion of an adjustable orthodontic appliance before the person is covered under this Benefit.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for a Covered Person is expected to exceed $500, the Participant should submit a detailed treatment plan to Desjardins Financial Security before treatment commences. Desjardins Financial Security will then advise the Participant of the amount of reimbursement for which the Covered Person is eligible in accordance with the provisions of the Plan. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the Dentist who first proposed the treatment, otherwise the Participant will be required to submit a new treatment plan to Desjardins Financial Security for re-assessment.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant reaches the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT COVERAGE and TERMINATION OF DEPENDENT COVERAGE provisions.

No benefits are payable for expenses incurred after the date the coverage of the Participant terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by Desjardins Financial Security prior to such termination date.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to Plan provisions, coverage under this Benefit will continue for covered Dependents until the earliest of the following dates:

1) 3 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent coverage would have terminated if the Participant had not died;

4) the date on which this Benefit or Plan terminates.

PROOF OF CLAIM

The Covered Person domiciled in Quebec must show his government health card and payment card to a Dentist participating in the payment card program to be reimbursed for dental expenses. A simple telephone call allows the Dentist to validate the payment card, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Dentist by Desjardins Financial Security and the amount payable by the Covered Person. The Dentist submits the benefit claim to the service provider and gives a copy to the Covered Person who only pays the uncovered portion of the dental expenses incurred. In the case of a Dentist who is not participating in the payment card program, the Covered Person must pay all treatment charges and submit a benefit claim to Desjardins Financial Security.

For a Covered Person domiciled outside Quebec or if the Dentist uses the Electronic Data Interchange (EDI), the Participant is not required to submit a claim to Desjardins Financial Security. EDI allows the Dentist to validate the Covered Person's eligibility, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Participant, or the Dentist, by Desjardins Financial Security, and the amount payable by the Covered Person. The Dentist submits the benefit claim through EDI and gives a copy of the confirmation to the Covered Person. If the Dentist does not use the Electronic Data Interchange (EDI), the Covered Person must submit a benefit claim to Desjardins Financial Security.

All claims must be submitted to Desjardins Financial Security along with any receipts within 12 months of the date the expenses were incurred.

Desjardins Financial Security reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

PAYMENT OF ORTHODONTIC CLAIMS (PLAN C)

Notwithstanding anything to the contrary under the PAYMENT OF BENEFIT provision of the Plan, the payment of orthodontic claims will be made on one of the following bases:

1) If a single charge is estimated for the entire course of treatment and the Covered Person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, Desjardins Financial Security will reimburse the Participant each time he submits a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or

2) If in lieu of a single charge, a charge is made for each treatment as it is performed, Desjardins Financial Security will reimburse the Participant as each charge is incurred.

Our Commitment to Our Plan Members

As one of our valued Plan Members, you are entitled to our attention and respect. We make it a point to be available to provide you with any assistance you may require. You can rely on our knowledgeable team that is committed to settling your claims objectively and diligently, thereby delivering the kind of service you have come to expect.

At Desjardins Insurance, the needs of the Plan Members are at the heart of the organization. Your financial security is vital to us and, as such, we will provide financial support in the event of illness, an accident or death.

Please accept this brochure which summarizes our financial obligations toward you.

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