360° GROUP INSURANCE

FÉDÉRATION
INTERPROFESSIONNELLE
DE LA SANTÉ DU QUÉBEC

Your Group Insurance Plan

Policy No. F001

Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

Cooperating in building the future

Your Group Insurance Plan

FÉDÉRATION INTERPROFESSIONNELLE DE LA SANTÉ DU QUÉBEC

Policy No. F001

This document is an integral part of the Insurance Certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on April 1, 2017. 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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TO ALL MEMBERS OF THE FIQ

This booklet explains the main provisions and conditions of your group insurance plan.

This plan is designed to meet your principal needs, while taking into account the benefits payable under various government plans.

So please read this booklet carefully, to familiarize yourself with all of the insurance coverage to which you are entitled.

Please note that the feminine gender used throughout this text designates men as well as women.

PLANNING AHEAD REDUCES COSTS

To take out insurance is to pool the contributions made by each participant and use them for those who need the benefits provided for under the contract, either to maintain an acceptable standard of living or to help them pay the cost, usually high, of medical and paramedical services that they need. On the whole, group insurance is an act of solidarity among members of the Federation.

YOUR PERSONAL RESPONSIBILITIES

Each of you can do your part to keep insurance costs low. Please make sure to:

- send your claims to the appropriate organization (Desjardins Insurance, CSST or SAAQ), as the case may be;

- only take medication that you really require;

- pay attention to the cost of medication in order to pay the best possible price;

- develop a healthier lifestyle that includes exercise and a balanced diet.

MONEY DOESN'T GROW ON TREES!

Benefits are not paid with dollars picked from the money tree, but by an insurance company that is using your premiums.

In a large group such as yours, the premiums for one year depend on the benefits paid during the previous year. If, in the course of one year, there is a surplus of premiums, the surplus is returned to the plan. Likewise, if there is deficit for one year, premiums of the subsequent year must be raised in order to prevent future deficits.

SUMMARY SCHEDULE OF HEALTH CARE AND DENTAL CARE REIMBURSEMENTS

For a complete description of each benefit as well as the details on exclusions and limitations, please refer to the relevant pages.

BASIC PLAN

BASIC DRUG PLAN

Drug Expenses	
Percentage of Reimbursement	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 or if an equivalent drug is available on the market and the Physician provides the required form indicating a valid reason, in the Insurer's opinion, for which the drug cannot be substituted • 80%* of the lowest priced equivalent drug available on the market and the Physician did not provide the required form indicating a valid reason, in the Insurer's opinion, for which the drug cannot be substituted * The percentage indicated applies to the first $3,750 of Eligible Expenses incurred by the Participant and her Dependents, if any, each Calendar Year and becomes 100% for the balance of Eligible Expenses incurred during the Calendar Year.
Eligible Maximum Amount	Nil
Sclerosing injections	
Percentage of Reimbursement	80%
Eligible Maximum Amount	$20/visit[(1)]

BASIC EXTENDED HEALTH PLAN III

List of Eligible Expenses	Eligible Maximum Amount	Percentage of Reimbursement
Hospital expenses incurred in Quebec	Semi-private room	100%
Ambulance	Nil	100%
Travel insurance	$5,000,000	100%
Audiologist or hearing therapist	Nil	100%
Speech therapist	Nil	100%
Varicose vein treatment	$20/visit(1)	80%
Artificial limbs	Nil	80%
Therapeutic equipment	Nil	80%
Wheelchair, hospital bed	Nil	80%
Orthopaedic appliances	Nil	80%
Glucometer	$300/5 years	80%
Foot orthoses	$300/pair, maximum 1 pair/calendar year(1)	80%
Elastic support stockings (over 20 mm/hg)	3 pairs/calendar year	80%
Nurse, nursing assistant and respiratory therapist	$200/day, maximum $4,000/calendar year	80%

BASIC EXTENDED HEALTH PLAN III (CONTINUED)

List of Eligible Expenses	Eligible Maximum Amount	Percentage of Reimbursement
Physiotherapist, podiatrist, naturopath, chiropractor, osteopath, acupuncturist, massage therapist, kinesiologist, orthotherapist	$35/treatment[(1)] Overall maximum of $500/calendar year for all these specialists combined	80%
X-ray examinations by a chiropractor	$40/calendar year[(1)]	80%
Psychologist and registered psychotherapist	$1,000/calendar year	50%
Treatment of alcoholism and drug addiction	$75[(1)]/day, lifetime maximum of $3,000	80%
Hearing aids	$500[(1)]/3 years	80%
Dental surgeon to repair accidental damages	Nil	80%

[(1)] Eligible amount must be multiplied by 0.80

EXTENDED PLAN I – DENTAL CARE INSURANCE

Fee Guide Year (ACDQ): Current year

Frequency: For recall oral examination, polishing, light scaling and fluoride treatment every: 9 months

Deductible Amount: Nil

List of Eligible Expenses	Payable Maximum Amount	Percentage of Reimbursement
Preventive services:	Nil	100%
Basic services, endodontics and periodontics:	Combined maximum of $1,000 per calendar year per insured person	80%
Major restorative services:		50%
Orthodontics:	Lifetime maximum of $1,000 per insured person	50%

DESCRIPTION OF BENEFITS

BASIC PLAN

BASIC DRUG PLAN
(compulsory)

For any calendar year, the maximum reimbursement the insurer will make for eligible drug expenses incurred by a participant or one of her insured dependents as a result of an illness, an accident, a pregnancy or complications during a pregnancy, a surgical procedure related to family planning or an organ donation or bone marrow donation for which a medical follow-up is provided, is:

1) for generic drugs: 80% of the lowest priced equivalent drug available on the market

2) for brand name drugs:

   - 80%* of the brand name drug if no equivalent drug is available on the market or if an equivalent drug is available on the market and the Physician provides the required form indicating a valid reason, in the Insurer's opinion, for which the drug cannot be substituted

   - 80%* of the lowest priced equivalent drug available on the market and the Physician did not provide the required form indicating a valid reason, in the Insurer's opinion, for which the drug cannot be substituted

* The percentage indicated applies to the first $3,750 of Eligible Expenses incurred by the Participant and her Dependents, if any, each Calendar Year and becomes 100% for the balance of Eligible Expenses incurred during the Calendar Year.

The following products are reimbursed:

a) Drugs and other products provided for under the List of Medications covered by the Basic prescription drug insurance plan (RGAM).

b) Therapeutic drugs that are not covered under the List of Medications covered by the RGAM, and **which can only be obtained on medical prescription** from a physician or a dental surgeon [medication coded "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialities] and dispensed by a pharmacist or a physician where there is no pharmacist, or prescribed and dispensed by a nurse authorized to do so in remote areas.

c) 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 Specialities is directly linked to the treatment of the following pathological conditions:

- cardiac disorders;
- pulmonary disorders;
- diabetes;
- arthritis;
- Parkinson's disease;
- epilepsy;
- cystic fibrosis;
- glaucoma.

If the condition is considered and identified as a serious illness by medical opinion, some non-prescription drugs obtained on prescription may be reimbursed under certain conditions.

d) Sclerosing injections administered for medical reasons, up to an eligible amount of $20 per visit.

e) Insulin, syringes, needles, and reactive sticks.

Exclusions applicable to the Basic Drug Plan

a) Reimbursements made by the insurer will be reduced by the payments made under another public or private plan.

b) No reimbursement shall be made for the following:

- shampoos and hair growth products;
- expenses incurred as a result of an accident or illness contracted while the insured person is in the service of the armed forces;
- products used to complete, supplement or replace food, with the exception of medication to treat a clearly identified metabolic disorder for which a full medical report describing, to the insurer's satisfaction, all the conditions justifying the prescription of an otherwise excluded product, is submitted;
- products for cosmetic or aesthetic care;
- so-called "natural" products;
- infertility treatments;
- drugs prescribed for the treatment of erectile dysfunction;
- expenses incurred as a result of a participation in an insurrection, a riot, a war (whether declared or not) or a civil war;
- drugs or products used as smoking cessation aids that are not covered under the Basic prescription drug insurance plan and expenses in excess of the maximum provided for smoking cessation aids under the Basic prescription drug insurance plan;
- services, treatments 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 such laws, the insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the insured person's province of residence.

The exclusions stipulated above do not apply if they make coverage under the insurer's plan less extensive than that of the Basic prescription drug insurance plan in terms of benefits.

BASIC EXTENDED HEALTH PLAN III
(compulsory)

When a participant incurs eligible expenses for herself or for her insured dependents as the result of an illness, an accident, a pregnancy or complications due to pregnancy, a surgical procedure related to family planning or an organ donation or bone marrow donation for which a medical follow-up is provided, she is entitled to the reimbursement of the following eligible expenses:

A) Expenses reimbursed at 100%

a) Hospital expenses incurred in Quebec, up to the rate of a semi-private room for each day of hospitalization, for an unlimited number of days. Since some participants live in remote areas and the nearest hospital is located in another province, hospital expenses in excess of ward accommodation are covered, up to the daily rate of a semi-private room as established by the *ministère de la Santé et des Services sociaux* (MSSS), provided the hospital is located in Canada.

b) Expenses incurred by an insured person for transportation to or from the hospital by ambulance, including transportation by air in the event of an emergency, as well as the cost of oxygen therapy treatments received during transportation or immediately before transportation.

c) On medical prescription, transportation by air for a bedridden patient, when such transportation is required for part of the trip; transportation by air of an insured person for immediate hospitalization as an inpatient at the closest hospital that can provide the medical or surgical care prescribed by the physician; transportation to return the insured person to her place of residence, immediately following such hospitalization. Reimbursement is limited to expenses incurred for the use of the most economical means of transportation, considering the insured person's medical situation and the means of transportation available.

d) Professional fees of an audiologist or hearing therapist and of a speech therapist. Tests which may be required are not covered.

B) Expenses reimbursed at 80%

a) Professional fees for varicose vein treatment: expenses incurred for medical but not aesthetic reasons, up to an eligible maximum of $20 per visit per insured person.

b) Artificial limbs: the purchase of artificial limbs, including an artificial eye, if the event causing the loss of use of the limb or natural organ occurs while the insurance is in effect, and other external prostheses and supplies prescribed by the attending physician, provided that such items are required for the treatment of the insured person.

c) Therapeutic equipment: the rental, or purchase when more economical, of therapeutic equipment. This category of equipment includes, for example:

   i) aerosol therapy equipment, which may be used for treating, among other things, severe emphysema, chronic bronchitis or chronic asthma (e.g. Maximist, Medi-pump);

   ii) non union bone stimulators (e.g. EBI);

   iii) respiratory monitoring instruments in the event of respiratory arrhythmia (e.g. apnea monitor);

   iv) intermittent positive pressure breathing machine (e.g. volumetric ventilator);

   v) insulin pump;

   vi) percutaneous neurostimulator (e.g. TENS).

d) Therapeutic supplies: the purchase of incontinence pads, sounds, catheters and other such hygiene-related items, needed as a result of total and irreversible loss of an organ or limb; the term "loss" also means the loss of use.

e) Wheelchair or hospital bed: the rental, or purchase when more economical, of a conventional wheelchair or hospital bed when prescribed by a physician. In order to be eligible for reimbursement, the hospital bed must be similar to what is commonly used in a hospital.

f) Orthopaedic devices and supplies: the purchase of hernia trusses, corsets, crutches, splints, casts (including fibreglass casts), burn garments, and other orthopaedic appliances when prescribed by a physician.

g) Glucometer: the cost of purchase, adjustments and repairs of a glucometer prescribed by a physician for insulin-dependent or uncontrolled diabetes. The reimbursement is limited to one apparatus per insured person and is subject to a maximum of $300 per 5-year period for all those expenses combined.

h) Foot orthoses: the purchase of foot orthoses, up to $300 of eligible expenses per pair, for a maximum of one pair per calendar year (2 pairs for children under age 13), and the purchase of orthopaedic shoes. Orthopaedic shoes are defined as custom-moulded shoes designed for the insured person to correct a foot defect. Open-toe shoes, flared or straight-last shoes, and shoes required for Denis Browne braces are also covered.

   Furthermore, the cost of additions or modifications to stock-item footwear is also eligible but deep shoes are not considered orthopaedic shoes.

i) Elastic support stockings: the purchase of elastic support stockings, mid-range or high compression (over 20 mm/hg), supplied by a pharmacy or a medical facility, up to 3 pairs per calendar year, per insured person.

j) Nursing and respiratory therapist services: professional services of a nurse, a nursing assistant or a respiratory therapist, up to an eligible amount of $200 per day, subject to a $4,000 maximum per calendar year per insured person, for all these specialists combined.

k) Dental surgeon for accidental damages: professional fees of a dental surgeon for the treatment of a broken jaw or to repair accidental damage to natural teeth, and cosmetic surgery required as a result of an accident and performed within 3 years of the date of the accident, provided that the insurance was in effect on the date of the accident and that the treatment begins within 12 months of that date.

l) Health care professionals: physiotherapy treatment provided outside a hospital by a **physiotherapist** or by **physical rehabilitation therapist**, up to an eligible amount of $35 per treatment; the services of a **podiatrist**, a **naturopath**, a **chiropractor**, an **osteopath**, an **acupuncturist**, a **massage therapist**, a **kinesiologist** or an **orthotherapist**, up to an eligible amount of $35 per treatment; the expenses are limited to one treatment per day per insured person and to a maximum reimbursement of $500 per calendar year per insured person, for all of these specialized treatments combined. X-ray examinations by a chiropractor are eligible, up to a $40 maximum reimbursement per calendar year, per insured person.

m) Psychologist: professional fees of a psychologist (or a nurse specialized in psychotherapy for services rendered exclusively in a private clinic, provided this is her main occupation and professional fees of a psychotherapist who has a permit delivered by the Ordre des psychologues); such eligible expenses are **reimbursed at 50%**, up to a maximum of $1,000 per calendar year per insured person, for all these services combined.

n) Treatment of alcoholism and drug addiction: expenses (including room and board) for the treatment of alcoholism and other drug addictions provided in a private facility under medical supervision, subject to a maximum amount of $75 per day and up to a lifetime overall reimbursement of $3,000 per insured person.

o) Hearing aids: expenses for the purchase, replacement, rental, adjustment and repair of hearing aids, up to an eligible amount of $500 per insured person per period of 3 years.

p) Transportation and accommodation expenses for medical treatment outside the area of residence: expenses for transportation and accommodation incurred in Quebec for the consultation of a specialist or to receive specialized treatment that is not available in the area in which the insured person resides. A report signed by the insured person's attending physician demonstrating the necessity of a specialist consultation or treatment must be sent to the insurer. The report must state that the specialist consultation or treatment took place or was administered at the place where the specialist provides the treatment or consultation, and that this place is the closest to the area in which the insured person resides.

Costs are considered eligible for reimbursement as follows:

i) Transportation for a journey of at least 200 km (one-way only) from the insured person's place of residence by the most direct route. Transportation by a common carrier (the cheapest method) is reimbursed. If the insured person uses her own vehicle, the expenses reimbursed will the same as the cheapest means of transportation by carrier to the same destination. Proof confirming the use of a private vehicle (gas receipt) must be enclosed with the claim for reimbursement;

ii) Accommodation in a hotel, up to $60 per day (reimbursable at 80%) following a journey of at least 400 km (return journey) to and from the insured person's place of residence by the most direct route. The need to make an overnight stay must be demonstrated to the insurer's satisfaction. Receipts of these expenses must be enclosed with the claim for reimbursement;

iii) For an insured child of under age 18 who requires treatment, the transportation expenses of one accompanying parent are eligible for reimbursement.

The reimbursement of transportation and accommodation expenses must not exceed $1,000 per calendar year per insured person.

C) Travel insurance expenses

If an insured person, living in Canada and insured under public health and hospital insurance plans, incurs emergency expenses as a result of an accident or illness that occurs during a stay outside her province of residence, the insurer reimburses 100% of eligible expenses incurred for herself or one of her insured dependents, if any, up to a lifetime maximum reimbursement of $5,000,000 per insured person, provided these expenses are not reimbursed by a government agency or under another private insurance plan.

Eligible expenses

a) Hospital, medical and paramedical expenses:

1) hospital room and board and other hospital charges for necessary treatment of the insured person. The insured person must contact the travel assistance firm as soon as she is hospitalized, otherwise, certain expenses may not be reimbursed. If the expenses are incurred in Canada, they are limited to the daily cost of a semi-private room;

2) services of a physician, a surgeon and an anaesthetist;

3) services of a private nurse, when prescribed by the attending physician, not exceeding C$1,000. Charges are limited to the amount normally charged for the same services in the insured person's province of residence.

b) Transportation expenses:

1) expenses incurred for the repatriation of the insured person to her place of residence by a suitable means of transportation in order to receive appropriate care as soon as her state of health allows, and in so far as the means of transportation initially arranged for the return trip cannot be used. Repatriation must be approved and arranged by the travel assistance firm. Furthermore, if the travel assistance firm recommends repatriation and the insured person declines, her coverage under the travel insurance benefit terminates;

2) expenses incurred for the repatriation of a member of the insured person's immediate family, if that person is unable to return to the point of departure by the means of transportation initially arranged for the return trip. Repatriation must be approved and arranged by the travel assistance firm;

3) round-trip economy fare 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 the travel assistance firm;

4) economy fare for round-trip air, bus or train transportation by the most direct route for one immediate family member to visit the insured person in hospital where the insured person must be confined for at least 7 days (expenses will be reimbursed only if the insured person remains in hospital for at least 7 days). However, this visit is not eligible for reimbursement if the insured person was already accompanied by a family member aged 18 or over, and if the necessity for the visit is not confirmed by the attending physician beforehand;

5) the cost of returning the insured person’s personal or rented vehicle if the insured person is impaired, as certified by a physician, and thus prevented from driving the vehicle and none of the family members accompanying her are able to return it. A commercial agency may be hired to return the vehicle, but the return must be approved and arranged by the travel assistance firm. The maximum reimbursement is C$750 per participant. "Vehicle" means a car, a motor home, or a small truck or van with a maximum load capacity of 1,000 Kg;

6) if the insured person should die, round-trip economy air, bus or train transportation by the most direct route for one member of the insured person's immediate family to identify the body before repatriation (the trip must be approved and arranged by the travel assistance firm beforehand). These expenses are not reimbursed if the insured person was accompanied by an immediate family member aged 18 or over;

7) if the insured 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 C$3,000; the cost of the burial coffin is not covered. The return must be approved and arranged by the travel assistance firm beforehand. If the insured person is also covered by the trip cancellation insurance offered by the insurer, eligible expenses under this section are limited to those that are not reimbursed under the trip cancellation insurance.

c) Daily allowance:

The cost of meals and accommodation for an insured person who must delay her return because of illness or bodily injury suffered by the insured person herself, an accompanying member of her immediate family or a travelling companion, as well as additional child care expenses for children not accompanying the insured person. The maximum reimbursement is C$100 per day per participant for a maximum of 7 days. The illness or injury must be confirmed by a physician.

d) Long-distance charges:

Charges incurred for long-distance telephone calls made to reach a member of the immediate family if the insured person is hospitalized, provided that the transportation allowance to visit that person is not used and that the insured person is not accompanied by an immediate family member aged 18 or over, up to C$50 per day, for an overall maximum of C$200 per hospitalization.

Travel assistance service

The travel assistance firm will take the necessary steps to provide the following services to any insured person who requires them:

a) 24-hour toll-free telephone assistance;

b) referral to physicians or health-care facilities;

c) assistance with hospital admission;

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

e) repatriation of the insured person to her home city, as soon as her state of health permits;

f) establishing and staying in contact with the insurer;

g) handling arrangements in the event of death;

h) repatriation of the insured person's children if the insured person cannot be moved;

i) sending medical assistance and drugs to an insured person who is too far from health-care facilities to be transported;

j) arrangements to bring a member of the immediate family to the insured person's bedside if the insured person must be confined to hospital for at least 7 days, provided that this visit is ordered by the physician;

k) assistance in obtaining temporary documents to replace lost or stolen identification papers for the insured person to pursue the trip;

l) referral to lawyers if legal problems arise.

Travel assistance is provided by "**Voyage Assistance**" 24 hours a day, year round.

In the event of a medical emergency, and before incurring expenses, you should contact the travel assistance service immediately at one of the following numbers:

Calling from	**Number to call**
Montréal area	(514) 875-9170
Canada and United States	(toll-free) 1 (800) 465-6390
Elsewhere in the world (Excluding North and South America)	(toll-free) international code of the country + 800 29485399
Everywhere in the world	(collect call) (514) 875-9170

Exclusions applicable to the Basic Extended Health Plan III

a) Benefits payable by the insurer are reduced by the benefits payable under any other public or private plan.

b) No reimbursement shall be made for:

- medical examinations for a third party (insurance, education, employment, etc.) or trips for health reasons;
- examinations for the evaluation of eyesight and hearing, as well as for eyeglasses and contact lenses;
- cosmetic surgery;
- expenses incurred as a result of an accident or illness by an insured person who is serving in the armed forces at the time of the accident or illness;
- home equipment such as whirlpool baths, air filters, humidifiers or similar devices and control devices such as stethoscopes, sphygmomanometers or similar devices;
- wigs, dental prostheses, unless natural teeth are replaced as a result of an accident and in accordance with the provisions set forth in paragraph k) of subsection B) Expenses reimbursed at 80%;

- expenses resulting from active participation in an insurrection, a riot, a war (whether declared or not) or a civil war;
- care and services administered by a member of the insured person's family or by a person who resides with the insured person;
- services, treatments or supplies that a person receives free of charge or that are reimbursed under a provincial or federal law. If a person is not covered under such laws, the insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the insured person's province of residence.

c) Exclusions applicable to travel insurance

Exclusions applicable to the health insurance (Basic Drug Plan and Basic Extended Health Plan III) also apply to the travel insurance.

When an insured person is required to contact the travel assistance firm but fails to do so, the reimbursement of certain expenses may be reduced or refused. Contacting the travel assistance firm not only prevents this kind of annoyance, it also enables the insured person to obtain information on the restrictions and limitations of her travel insurance.

The insurer pays none of the benefits provided for under the travel insurance coverage if the purpose of the trip is to receive medical or paramedical treatment or hospital services, even if the trip is made on the recommendation of a physician.

EXTENDED PLAN I

DENTAL CARE INSURANCE
(compulsory following a vote in favour)

This section presents a summary of eligible dental services. For more information on dental treatment services covered under this plan, please contact our customer service representatives. The phone numbers are listed at the end of this booklet.

When the cost of any dental treatment exceeds $300, it is recommended to submit to the insurer an estimate of cost completed by the dentist before treatment commences in order to determine which benefits may be payable.

When a participant incurs expenses related to the following services, for herself or one of her insured dependents, the insurer reimburses:

A. Diagnostic and Prevention Dental Care: 100% coverage

DIAGNOSTIC SERVICES

Clinical oral examination

- Mixed dentition oral examination (once per 5 years)
- Complete oral examination, permanent dentition (once per 5 years)
- Recall or periodic oral examination (once per 9 months)
- Dental examination for children under the age of 10, if the examination is not payable under the Quebec health insurance plan
- Emergency examination (once per year)
- Specific oral examination (once per year)
- Complete periodontal examination (once per 5 years)
- Specific orthodontic examination and diagnosis

Radiographs

- Intraoral radiographs
- Extraoral radiographs
- Sinus examination, sialography
- Use of radiopaque dyes to demonstrate lesions, radiograph of the temporomandibular joint
- Panoramic radiograph (one film per 5 years)

Tests and laboratory examinations

- Pulpal test
- Histological test
- Cytological test
- Local anesthesia

PREVENTIVE SERVICES

- Prophylaxis (polishing of coronal portion of teeth – once per 9 months)
- Topical application of fluoride (once per 9 months and for children under the age of 12 only)
- Removal of subgingival filling material when local anesthetic is needed, without flap, per tooth
- Pit and fissure sealants (permanent teeth for children aged 13 or younger)
- Interproximal disking of teeth
- Enameloplasty

ENDODONTICS

- Endodontic emergency

ORAL SURGERY

- Surgical incision and drainage
- Post-surgical treatment without anesthesia (example: Alveolitis, 1st visit)

B. Basic Dental Care: 80% coverage

The same surface or class on the same tooth is reimbursed once a year.

RESTORATIONS

Primary teeth

- Amalgam restoration, non-bonded
- Amalgam restoration, bonded
- Composite restoration

Permanent teeth

- Amalgam restoration, non-bonded
- Amalgam restoration, bonded
- Composite restoration
- Retentive pins
- Veneer applications and diastema closure

Caries/trauma/pain control

- Sedative filling/indirect capping
- Recontouring and polishing of traumatized tooth

ENDODONTICS

- Pulpotomy, primary teeth (for children under the age of 12)
- Root canal treatment
- Apexification
- Apicoectomy and root canal treatment performed jointly
- Perforation repair
- General treatments

PERIODONTICS

- Splint and removal of splint
- Periodontal scaling supra and subgingival (once per 9 months)
- Periodontal appliances
- Intraoral appliance for TMJ

ORAL SURGERY

- Tuberoplasty
- Removal of hyperplasic tissue
- Removal of excess mucosa

C. Complementary Dental Care: 50% coverage

RESTORATION

Permanent teeth

- Recementation of broken tooth chip
- Inlays and onlays, metal
- Inlays, porcelain, resin or ceramic
- Retentive pins for inlays and onlays
- Prefabricated post with buildup through existing crown or abutment
- Preformed crown

PERIAPICAL ENDODONTIC SURGERY

- Apicoectomy
- Apicoectomy and retrofilling
- Root amputation
- Intentional reimplantation
- Hemisection

PERIODONTICS

Non-surgical periodontal services

- Periodontal emergencies
- Desensitization

Preliminary treatments

- Occlusal equilibration

Surgical periodontal services

- Root planning and curettage (once per year, except if more than one sextant is required and proven to the insurer's satisfaction)
- Periodontal surgery, including Graft, free connective tissue

Adjunctive periodontal procedures

- Subgingival periodontal irrigation
- Intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents

PROSTHODONTICS

Reimbursement for any type of prosthesis (removable or fixed) includes follow-up examinations and adjustments for the 3-month period following the date on which the prosthesis is fitted. For the laboratory expenses included in a procedure, the eligible maximum is 50% of the dental surgeon's fee for the dental procedure code at issue and in accordance with the maximum set forth in the Fee Guide of the *Association des chirurgiens dentistes du Québec* (ACDQ). Unless otherwise specified, any type of prosthesis is reimbursed only once per 5-year period.

Removable Prosthodontics

Complete dentures

- Standard complete dentures
- Equilibrated complete dentures
- Immediate complete dentures (once in a lifetime)
- Immediate complete dentures (transitional) (once in a lifetime)
- Dentures, complete, overdenture, standard
- Dentures, complete, overdenture, equilibrated
- Partial dentures, acrylic (immediate, transitional or permanent) (once in a lifetime)
- Partial dentures, cast
- Complete denture with partial denture (opposing arch) with cast (standard and equilibrated)
- Removable cast partial dentures with precision attachments or semi-precision cast partial dentures
- Hybrid partial dentures, cast
- Dentures, complementary services
- Dentures supported by implants, up to the fee for an equivalent standard denture

Fixed prosthodontics and bridges
(One procedure per tooth per 5-year period)

Fixed prosthodontics

- Individual crown
- Cast post
- Crown or veneer repair, chairside
- Recementation or removal of inlay, onlay, non-prefabricated crown, veneer or post
- Prefabricated post with buildup
- Pontics
- Fixed bridges, complementary services
- Abutments

ORAL SURGERY

ORTHODONTICS

Orthodontics expenses (for insured persons under age 21. Treatment plan to be submitted beforehand.)

NOTES:

Expenses for permanent prosthesis are considered provided the fitting occurred within 6 months of the installation date of the temporary prosthesis.

Eligible expenses for each service rendered are based on the suggested rates of the *Association des chirurgiens dentistes du Québec* (ACDQ) for the period during which expenses are incurred.

THE FOLLOWING EXPENSES ARE ELIGIBLE:

- initial prosthodontic appliances (fixed prosthodontics, permanent or temporary removable prosthodontics, complete or partial) made necessary by the extraction of natural teeth;

- replacement of an existing denture, fixed or removable, temporary or permanent, partial or complete, only if proven to the insurer in a satisfactory manner that:

  i. the replacement is necessary because of the extraction of natural teeth while the insured person is covered under this benefit, or that

  ii. the fixed or removable denture was installed at least 5 years before its replacement and that the current fixed or removable denture cannot be repaired, or that

  iii. the current prosthesis is a temporary denture that replaces one or more natural teeth that were extracted while the insured person was covered under this benefit, that the replacement by a bridge or permanent denture is necessary and that it occurs within 6 months of the installation date of the temporary prosthesis.

1) Maximum Reimbursement

For diagnostic, preventive and emergency procedures, no maximum applies.

The maximum reimbursement for all other services is $1,000 per calendar year per insured person, except orthodontic expenses which are limited to a lifetime maximum of $1,000 per insured person.

2) Limitations and Exclusions

a) Dental care benefits are reduced by benefits payable under any other public or private plan.

b) Dental care expenses that are covered under the Basic Extended Health Plan III are not eligible under this dental care benefit.

c) No benefits are payable for dental care expenses incurred:

- for cosmetic services, surgery or care;
- while the insured person is serving in the armed forces;
- for services that the insured person would not be required to pay if she did not have this coverage;
- for services related to implants, except those covered under this benefit.

EXTENDED PLAN II

The Extended Plan II includes the following 5 benefits:

1. Participant basic life insurance;
2. Participant additional life insurance;
3. Participant basic and additional accidental death and dismemberment (AD&D) insurance;
4 Dependent life insurance;
5. Long term disability insurance.

Coverage under the life insurance benefit (including AD&D insurance) and long term disability insurance benefit is compulsory for all eligible employees. Furthermore, the dependent life insurance is compulsory for participants who choose family or single-parent coverage under the Extended Plan I or under the Basic Extended Health Plan III section of the Basic Plan. The participant who has opted out of these plans may enrol under the dependent life insurance benefit if she specifically requires it when she becomes eligible.

All employees must complete an application form and indicate the amount of additional life and AD&D insurance chosen. If an employee fails to complete the application form within 30 days of the day on which she becomes eligible, the insurer shall conclude that the participant does not wish to enrol in additional life and AD&D insurance plans.

1) PARTICIPANT BASIC LIFE INSURANCE

In the event of the participant's death, the insurer will pay $5,000 to the last beneficiary designated by the participant.

The benefits payable are not subject to limitations or exclusions, even in the event of suicide.

2) PARTICIPANT ADDITIONAL LIFE INSURANCE

In the event of the participant's death, the insurer will pay to the last beneficiary legally designated by the participant, the following amounts: $5,000, $10,000, $15,000, $25,000, $50,000, $75,000 or $100,000 depending on the personal choice of each participant. Evidence of insurability is required by the insurer for the sums of $75,000 and $100,000, and for any increase in the amount of additional life insurance.

If an employee works for more than one employer, the sum of all additional life insurance amounts cannot exceed $100,000 in total.

The benefits are payable without limitations or exclusions, even in the event of suicide. However, with respect to the additional life insurance benefit, no benefits shall be paid in the event of the participant's suicide for the coverage amounts requested more than 30 days after the date on which the participant became eligible if such participant dies within the 12 months following the application.

Living benefit

Subject to the approval of the insurer, any totally disabled participant whose life expectancy is less than 12 months may apply for payment of a portion of the sum insured under the life insurance and additional life insurance benefits payable upon the participant’s death.

However, the living benefit is limited to 50% of the amount of life insurance. In addition, this amount may not be less than $2,500 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 this plan.

The participant must provide the insurer with the appropriate form, duly completed and signed by the concerned persons. This form is available for the participant through the insurer.

"Value of the living benefit" means the aggregate of the payments made under the living benefit, 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. 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.

3) PARTICIPANT BASIC AD&D AND ADDITIONAL AD&D

When a participant sustains one of the losses listed below as a result of an accident that occurs while the insurance is in force, and if such loss occurs within 365 days of the accident, the insurer will pay the participant or her beneficiary, as the case may be, the percentage corresponding to the sum of the amounts insured under the basic life insurance and additional life insurance benefits in force, as indicated in the SCHEDULE OF LOSSES AND BENEFITS.

SCHEDULE OF LOSSES AND BENEFITS

Loss of life	100%
Loss of one hand	50%
Loss of one foot	50%
Loss of sight in one eye	50%
Loss of hearing	50%
Loss of speech	50%
Loss of one finger or toe	10%

The maximum percentage payable as a result of an accident that causes more than one loss is 100%.

"Loss" means:

- in the case of a hand or foot, the complete, definitive and irrecoverable loss of use of one hand or one foot, or the amputation at the wrist or ankle or above;
- in the case of a finger, the amputation of one finger at the first phalanx or the irrecoverable loss of use of one finger;
- in the case of sight, the total, definitive and irrecoverable loss of sight of an eye;
- in the case of hearing, the total, definitive and irrecoverable loss of hearing;
- in the case of speech, the total, definitive and irrecoverable loss of speech.

Limitations and Exclusions

No benefits are payable for a loss due to one of the following causes:

a) suicide, attempted suicide or voluntary self-inflicted injury;

b) active participation in a riot, an insurrection, criminal acts, a war, whether declared or not, or a civil war;

c) active service in the armed forces.

4) DEPENDENT LIFE INSURANCE

The dependent life insurance benefit applies to dependent children including, as the case may be, a person suffering from a functional impairment, as defined in subparagraph 2. of paragraph B) of the DEFINITIONS section under the GENERAL PROVISIONS.

The amount of life insurance is $3,000; the dependent child is insured as soon as he is at least 24 hours old at the time of death.

5) LONG TERM DISABILITY INSURANCE

This benefit complements the disability insurance offered by the employer and provides the participant with an income if a disability prevents her from working for an extended period of time.

Waiting period

For a participant who has a full-time employee status, the waiting period is equal to 5 working days plus 104 weeks of the same disability period. For a participant who does not have a permanent full-time employee status, the waiting period of "5 working days" mentioned above is replaced by "7 calendar days" as of the first day on which the employee is scheduled to work, or as of the first day following the first 12 weeks of disability, whichever occurs first, plus 104 weeks.

Amount

The benefit amount is equal to 100% of the net benefit established on a monthly basis [see NOTE 1] and payable by the employer for the 104th week of benefit payment under the disability insurance plan offered by the employer, whether the benefit is actually paid or not.

The basic salary used to calculate the minimum benefit is $12,000 and is the one used to calculate the benefits of a part-time employee, regardless of the percentage of time worked (25% more or less). In the case of a participant who works for more than one employer or a participant who works more than one job referred to in the collective agreement for the same employer, the amount of the benefit is based on the total salary earned on for all jobs combined, and the minimum salary ($12,000) applies to all jobs combined.

Thus for a part-time participant, the amount of benefit payable is the highest between:

a) 100% of the net disability insurance benefit received from the employer for the 104th week of disability, or

b) 100% of the net benefit based on 80% of a presumed annual salary of $12,000.

In the case of a participant who is dismissed during the period of disability insurance benefit payment provided for in the plan offered by the employer, the amount of her long term disability insurance benefit will be calculated on the basis of the net benefit [see NOTE 1] that she would have received from the employer for the 104th week of benefits under the disability insurance plan offered by the employer.

NOTE 1: The net benefit is equal to the benefit payable under the disability insurance plan offered by the employer, reduced by federal and provincial income taxes and contributions to the Québec Pension Plan, Employment Insurance and Québec Parental Insurance Plan.

Payment frequency and duration of benefits

After the waiting period has expired, the benefit is paid on a monthly basis for as long as the total disability lasts as defined in paragraph **C.** of the DEFINITIONS section under the **GENERAL PROVISIONS**, or until the participant's 65th birthday.

Indexation

When benefits have been paid by the insurer for a period of 12 full months, whether consecutive or not, the net benefit then paid is indexed on January 1st of each year according to the pension index published by the *Régie des rentes du Québec*, up to a maximum adjustment of 5%.

Integration

The benefit is reduced by the initial disability benefit payable under the Teachers' Pension Plan (RRE), the Public Sector Superannuation Plan (RRF), by the Pension Plan of Management Personnel (PPMP), by the Government and Public employees Retirement Plan (RREGOP), or by any other public and para-public sector pension plans, under the *Quebec Automobile Insurance Act* or the *Act respecting industrial accidents and occupational diseases*, by the Québec Pension Plan or any other social legislation respecting the disability which entitles the participant to receive benefits under this long term disability insurance plan. Any lump sum payment or special agreement respecting the disability, as agreed with one of the agencies mentioned above, is considered when calculating the amount of disability benefits and integrated, as the case may be, to the benefit payable under this plan.

However, only the initial amounts payable under each of the other sources are considered, regardless of their indexation after the date the benefits set forth under this plan become payable.

It is the participant's obligation to prove that she is not entitled to benefits from the sources mentioned previously.

For a disabled participant who is eligible, without actuarial reduction, to a pension annuity under a public and para-public sector pension plans (RREGOP, RRE, RRF, PPMP, etc.) and is no longer employed, her disability benefits will be reduced by an amount equal to 60% of said pension annuity under a public and para-public sector plan (RREGOP, RRE, RRF, PPMP, etc.).

The disabled participant who is eligible under the pension plan with actuarial reduction is not obliged to apply for her pension annuity. If she does, the pension benefit will be integrated with the disability insurance benefit.

In addition, the disabled participant who continues to accumulate years of service under the RREGOP, RRE, RRF, PPMP, etc. is not obliged to apply for her pension as long as she maintains a link of employment.

Rehabilitation

If a disabled participant accepts employment as part of a rehabilitation program approved by the insurer, the benefit payable will be reduced only by 50% of the net salary received from this employment.

Limitations and exclusions

This insurance does not cover any period of disability:

- while the participant is not under the continuous care of a physician or of a health care professional, except in the case of a stable condition certified by a physician to the satisfaction of the insurer;
- due to active participation in a war (whether declared or not), a civil war, an insurrection or a riot;
- during which the participant performs a gainful occupation (except as stipulated under the “Rehabilitation” paragraph) or as part of a rehabilitation program for which the conditions are approved by the insurer, in which case benefits are integrated and not excluded.

GENERAL PROVISIONS

DEFINITIONS

A) **<u>Collective Agreement</u>:** The collective agreement entered into by the *Comité patronal de négociation du secteur de la santé et des services sociaux* and the *Fédération interprofessionnelle de la santé du Québec*-FIQ.

B) **<u>Dependents</u>:**

1) **Dependent child:** A child of the participant, of her spouse or of both, residing or domiciled in Canada, who is not married or engaged in a civil union, who depends on the participant for his support and who meets one of the following conditions:

a) is under 18 years of age;

b) is 25 years old or under and is a full-time registered student at an educational institution recognized as such;

c) irrespective of his age, if he became totally disabled while he was satisfying one of the conditions mentioned above and has been continuously disabled since such date.

2) **Functionally Impaired Person**: A person who has reached the age of majority, has no spouse, and is suffering from a functional impairment referred to in the regulation pertaining to the Quebec Drug Insurance Act. The impairment must have existed when the person's status fit the definition of paragraph 1a) or 1b) of the definition of Dependent child, and the person must not be receiving any benefits under a last resort program provided for in the *Act Respecting Income Security*. In addition, the person must be living with the participant or the participant's spouse who would exercise parental authority over him or her if he or she were a minor.

3) Spouse: "spouses" means two persons living in Canada:

a) who are married and cohabiting;

b) who are cohabiting in a conjugal relationship and are the mother and father of the same child;

c) who are same-sex or opposite-sex couples and have been cohabiting in a conjugal relationship for at least one year.

Following the adoption in June 2002 of the *Act instituting civil unions and establishing new rules of filiation*, individuals, of the opposite or same sex, are recognized as common-law partners as of the date on which they sign the contract. These individuals are therefore subject to the same rules for participation in the group insurance plan as are married individuals.

A person ceases to be considered the participant's spouse if the marriage is dissolved by divorce or annulment or if the civil union is dissolved, or, in the case of a common-law marriage, by de facto separation of more than 3 months. The married participant who is not cohabiting with her spouse may designate this person as a spouse to the insurer. The participant may also designate another person in lieu of the legal spouse if that person fits the definition of "spouse" mentioned above. At any one time, only the spouse last designated as such will be recognized by the insurer.

C) <u>Disability</u>: A state of incapacity resulting from illness, accident, a complication of pregnancy, a tubal ligation, a vasectomy or any other surgical procedure related to family planning, organ donation or bone marrow donation and their complications and requiring medical care and/or treatment administered by a recognized health care professional, or resulting from a stable condition that:

- during an initial period of 5 work days plus 260 weeks, leaves the participant entirely incapable of performing the normal duties of her occupation or of any similar occupation with similar remuneration offered by the employer. For a participant who does not have permanent, full-time status, the period of "5 work days" mentioned above is replaced by "7 calendar days" as of the first day on which she was scheduled to work or as of the first day following the first 12 weeks of disability, whichever of these dates occurs first;

- thereafter, leaves the participant entirely incapable of performing any gainful occupation for which she is reasonably suited by education, training or experience.

D) <u>Disability Period</u>:

- during the first 5 work days plus 156 weeks, "disability period" means any continuous period of disability or succession of consecutive periods separated by fewer than 15 days of full-time active employment or by 15 days of availability for full-time employment, unless the participant proves, to the employer's or to the employer representative's satisfaction, that a subsequent disability period is attributable to an illness or accident entirely unrelated to the previous cause of disability. In the case of a participant who is not a full-time permanent employee, the above-mentioned period of "5 work days" is replaced by "7 calendar days" as of the first day on which the employee is required to attend work or as of the first day after the first 12 days of disability, whichever occurs first;

- thereafter, "disability period" means any continuous period of disability or succession of consecutive periods separated by fewer than 6 calendar months during which the participant has not been totally disabled. Any period of disability resulting from an illness or accident which is entirely unrelated to the cause of the previous disability is considered to be a new period of disability, except if the new disability occurs during a period of disability.

Any period of rehabilitation or temporary assignment occurring during the waiting period specified for the long term disability income insurance will not interrupt the disability period but can affect the administration of the waiver of premiums.

RESTRICTION – A period of disability resulting from alcoholism, drug addiction, active participation in a riot or insurrection, or which is the result of committing a criminal offence or serving in the armed forces is not recognized as a period of total disability, with the exception of a period of disability resulting from alcoholism or drug addiction during which the participant receives treatment or care in view of rehabilitation.

E) **Employee**: Unless otherwise decided by the Policyholder, any person who is gainfully employed by an Employer and who is a member of a certification unit held by a union affiliated with the FIQ and any person, whether unionized or not, who is gainfully employed by the FIQ and/or one or several of its affiliated unions. "Employee" also means an employee who is on leave for union activities. **The retired employee who comes back to work after May 14, 2006, as well as any student, or nursing or respiratory therapy extern, is excluded**.

F) **Employer**: Any institution governed by the collective agreement as well as any other group approved by the FIQ and the insurer.

G) **Equivalent drug**: A brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

H) **Health professional:**

1) Any health professional mentioned in the contract who is a member in good standing of his professional corporation or association;

2) Any other health professional that is recognized by the FIQ and the insurer, who practises within his competence, as defined by law.

I) **Hospital centre (hospital)**: A hospital centre as defined by the *Act respecting health services and social services* (R.S.Q., c. S-5, c. S-4.2); outside Quebec, "hospital centre" refers to any facility which meets these same criteria.

J) **Income from other sources**: Disability pensions payable under the Teachers' Pension Plan (RRE), Pension Plan of Management Personnel (PPMP), Public Sector Superannuation Plan (RRF) or Government and Public employees Retirement Plan (RREGOP), and the *Automobile Insurance Act*, *Act Respecting Industrial Accidents and Occupational Diseases*, Québec Pension Plan or any other social legislation with respect to disability and which entitles the participant to benefits under this long term disability insurance plan.

K) **Participant**: Employee insured under the group insurance plan.

L) **Physician**: Any physician who is duly authorized to practise medicine.

M) **Salary**: The salary paid to the employee in accordance with the applicable salary scale plus, if applicable, any incentive earnings or bonuses provided for under the relevant collective agreement and which are included in the calculation of the disability income benefits offered by the employer.

ELIGIBILITY

Any employee is eligible for group insurance as of the date indicated below, and until the effective date of her retirement, whether or not she has terminated her probation period:

1- employee working full-time or 70% or more of a full-time schedule in a **permanent position**:

- after 1 month of continuous service for the Basic Drug Plan;
- after 1 month of continuous service for the Basic Extended Health Plan III as well as for the Extended Plan I and Extended Plan II.

2- employee working full-time or 70% or more of a full-time schedule on a **temporary assignment**:

- after 1 month of continuous service for the Basic Drug Plan;
- after 3 months of continuous service for the Basic Extended Health Plan III as well as for the Extended Plan I and Extended Plan II.

3- **part-time** employee working less than 70% of a full-time schedule:

- after 1 month of continuous service for the Basic Drug Plan;
- after 3 months of continuous service for the Basic Extended Health Plan III as well as for the Extended Plan I and Extended Plan II.

The length of time the employee worked for the employer both within and outside the bargaining unit is taken into consideration for the purposes of the eligibility period of 1 or 3 months.

The employee does not have to complete a new eligibility period (1 or 3 months) in the following cases:

a) when the employee, after having definitively ceased working for her employer, starts working again for the same employer or starts working for a new employer within a period not exceeding 30 calendar days following her termination;

b) when a person is relocated in another job by virtue of the job security plan of the collective agreement;

c) when an employee joins the bargaining unit while continuing to work for the same employer.

PARTICIPATION

The criteria for participation are as follows:

Employee

Basic Drug Plan: Participation is compulsory for all eligible employees and their eligible dependents, subject to the provisions of the exemption privilege.

- Employee with one or more dependents

  If the employee has one or more dependents who are not insured under another group plan, the employee must, in conformity with the *Drug Insurance Act*, opt for the family or single-parent coverage.

- Employees aged 65 or over

  An employee who reaches age 65 is automatically covered under the Basic prescription drug insurance plan (RGAM) administered by the RAMQ and she is no longer covered under the Basic drug plan. The employee may however choose to remain covered under the group insurance plan by notifying the RAMQ and the Insurer of her choice. When an employee's spouse covered under this group insurance plan reaches age 65, he is automatically covered under the RGAM administered by the RAMQ and he is no longer covered under his spouse's group insurance plan. The spouse may remain covered under his spouse's group insurance plan provided the RAMQ and the Insurer are notified of this choice. However, a dependent may only remain insured under the employee's group insurance plan provided the employee continues membership in the plan. A person who elects to enrol in the RGAM may not choose to be insured under this plan at a later date.

In either case, the insurer must be informed of the option chosen at least 3 months before reaching age 65.

If no notice is received regarding the employee and/or her spouse choice, it will be deemed by the insurer that the automatic enrollment to the RAMQ was not cancelled and that the person chose to remain covered by the RGAM for drugs covered under this plan.

Basic Extended Health Plan III: Participation is compulsory for all eligible employees, subject to the provisions of the exemption privilege.

Extended Plan I: Participation is compulsory for all eligible employees in an institution, if a majority of the employees vote in favour of establishing the plan, subject to the provisions of the exemption privilege.

Extended Plan II: Coverage under the basic life insurance, basic AD&D and long term disability insurance benefits is compulsory for all eligible employees without right of exemption. Employees who have chosen family or single-parent coverage under the Extended Plan I and III must take out dependent life insurance.

Special provisions for part-time employees who work 25% or less of a full-time schedule

Coverage under the Basic Extended Health Plan III and Extended Plan I is optional for eligible employees who work 25% or less of a full-time schedule.

1. After the 3-month period of continuous service

   A newly hired part-time employee working 25% or less of a full-time schedule is automatically insured unless she informs the employer in writing that she is declining coverage under the plans mentioned in the previous paragraph **within 10 days** of receiving the employer's notice indicating the percentage of time she has worked during her first 3 months of employment.

2. On January 1st of each year

   An employee whose work schedule has been reduced to 25% or less of a full-time schedule during the reference period (November 1st to October 31st of the previous year) may request that she no longer be covered under the Basic Extended Health Plan III and Extended Plan I. She must make this request in writing **within 10 days** of receipt of the notice from the employer indicating the percentage of time worked during the reference period.

3. Return to participation

   Only an employee who has declined coverage or requested to terminate her coverage may change her decision on January 1st of each year.

   A person who is absent between the end of the reference period (November 1st to October 31st of the previous year) and December 31st or a year due to an authorized leave of absence of more than 4 weeks may, if applicable, exercise the right described in paragraphs 2 or 3 upon her return to work.

4. Continuation of participation

   A part-time employee working 25% or less of a full-time schedule and who has decided to be covered or to continue her coverage as described in the previous paragraphs may not change her decision for as long as she continues to work 25% or less of a full-time schedule.

Special provisions for employees who work for more than one employer

The following two situations may be encountered:

1. participant working for more than one employer and who is a member of the FIQ at both employers

   The participant must be covered under all compulsory benefits of the Extended Plan II under the group insurance plan of both employers. It should be noted that the total additional life insurance amounts may not exceed $100,000. With regards to the other plans (Basic Drug, Basic Extended Health III and Extended I), the participant is covered under only one employer's group insurance plan. The participant chooses with which employer she participates and asks for an exemption privilege under the other employer's group insurance plan.

2. participant working for more than one employer and who is a member of the FIQ at only one employer

   The participant must be covered under all compulsory benefits of the Extended Plan II under the group insurance plan of the employer where the FIQ is present. With regards to the other plans (Basic Drug, Basic Extended Health III and Extended I), the participant is covered under only one employer's group insurance plan. The participant chooses with which employer she participates and asks for an exemption privilege under the other employer's group insurance plan.

Special provisions for employees who work in more than one employment category for the same employer or for more than one employer

The participant who works in the nursing and cardio-respiratory care personnel category and who also works in another employment category that is not subject to the collective agreement of the FIQ must be covered under all compulsory benefits of the Extended Plan II of the employer or in the employment category in which the FIQ is present. With regards to the Long Term Disability Insurance benefit, only the salary of the nursing and cardio-respiratory personnel category applies. With regards to the other plans (Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I), the participant is covered under the group insurance plan of the employment category of her choice and asks in writing an exemption privilege for the other plan.

Dependents

Basic Drug Plan:

An employee with one or more dependents must select family or single-parent coverage, subject to the exemption privilege.

Basic Extended Health Plan III

An employee with one or more dependents may select coverage as a participant with no dependents (individual), as a participant with dependents (family) or as a participant with dependent children (single-parent), subject to the exemption privilege. Only participants with no spouse (by marriage, civil union or common-law marriage) may select single-parent coverage.

Extended Plan I

An employee with one or more dependents may select coverage as a participant with no dependents (individual), as a participant with dependents (family) or as a participant with dependent children (single-parent), subject to the exemption privilege. Only participants with no spouse (by marriage, civil union or common-law marriage) may select single-parent coverage.

However, the coverage type selected under Extended Plans I and III must be the same.

The combinations permitted are as follows:

PLANS	Type of coverage	Type of coverage	Type of coverage
Basic Drug	INDIVIDUAL	SINGLE-PARENT	FAMILY
Basic Extended Health III	INDIVIDUAL	INDIV./SINGLE-PARENT	INDIV./FAMILY
Extended I	INDIVIDUAL	INDIV./SINGLE-PARENT	INDIV./FAMILY

EVIDENCE OF INSURABILITY

The employee must complete an application within 30 days of the date on which she or her dependents become eligible, after which, evidence of insurability is required for dependents wishing to be insured under the extended plans I and III.

EXEMPTION PRIVILEGE

An employee may be exempted from coverage under the Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I if she proves that she and her dependents are covered under a group insurance plan that includes similar coverage and an exemption privilege.

To obtain exemption from the Basic Extended Health Plan III, the employee must also obtain an exemption from the Basic Drug Plan.

An employee aged 65 or older may be exempted from the Basic Drug Plan only, provided she is insured under the Basic prescription drug insurance plan administered by the RAMQ.

An employee who requests an exemption from the Extended Plan I must also request an exemption from the Basic Drug Plan and Basic Extended Health Plan III.

An employee may also be exempted from coverage under the Basic Drug Plan and Basic Extended Health Plan III, in conformity with the above conditions, but may enrol in the Extended Plan I, if it was selected at her institution.

Then, the exemption privilege becomes effective on the date the application was signed.

TERMINATION OF THE EXEMPTION PRIVILEGE

An employee who opted to waive coverage under the Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I in accordance with the provisions concerning the exemption privilege, may enrol in these plans at a later date, at the following conditions.

1. She must establish that:
    a) she was previously insured under this group insurance plan or under any other plan that provided similar coverage;
    b) coverage under the other plan terminated;
    c) she applies for coverage within 30 days of termination of coverage under the other plan, in which case, her coverage under this plan takes effect on the termination date of the insurance that entitled her to the exemption. If her application is submitted more than 30 days after termination of her previous insurance, the insurance takes effect on the date the application is signed.
2. In the case of an employee who, prior to her application, was not insured under the Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I, the insurer is not required to pay benefits for which the previous insurer might be responsible under an extension or conversion provision, or otherwise.

In the case of an employee who would want to resume her coverage without termination of the exemption, the plans become effective on the following date:

The Basic Drug Plan, according to the coverage type requested (individual, family or single-parent) becomes effective on the date the application is signed.

The Basic Extended Health Plan III and Extended Plan I, according to the individual coverage category, become effective at the same date as the Basic Drug Plan but the family or single-parent coverage category becomes effective on the date the insurer approves the evidence of insurability provided for the participant's spouse and dependent children.

APPLICATION

Any eligible employee, as well as an employee who wishes to participate in the insurance plan after having been exempted, must complete an application form within **30 days** of the date on which she becomes eligible or the termination date of the plan that made the exemption possible. She must indicate her choice of coverage on the application:

1. participant without dependents (individual)
2. participant with dependents (family)
3. participant with dependent children (single-parent).

ABSENCE OF APPLICATION

Notwithstanding the foregoing paragraph, an employee who refuses or omits to complete an application

. is automatically insured under the **Basic Drug Plan** with an individual coverage. The same rule applies to an employee who is unable to complete an application but in this case, the coverage type (individual, family or single-parent) is established on the basis of her marital status;

. is automatically insured under the **Basic Extended Health Plan III and Extended Plans I and II** with an individual coverage. The same rule applies to an employee who is unable to complete an insurance application but in this case, the coverage type (individual, family or single-parent) is established on the basis of her marital status. In the latter case, the employee may change her coverage type at a later time provided she sends a written notice to the employer to this effect within 30 days of the date on which she is able to do so.

EFFECTIVE DATE OF COVERAGE

A. Basic Drug Plan

Employee

Coverage for the employee becomes effective as of one of the following dates:

a) if the employee has recently become eligible and has not exercised her exemption right: on the date on which she becomes eligible, whether or not she is at work on this date;

b) if the employee has obtained an exemption and her application is submitted within 30 days of the termination of her previous coverage: on the date on which the insurance entitling that person to an exemption terminates;

c) if the employee has obtained an exemption and submits her application more than 30 days after the termination of her previous coverage: on the date the insurance application is signed;

d) if the employee has not been at work after the maximum waiver of premium period of 3 years expires: on the date of effective return to work.

Dependents

Coverage for a dependent becomes effective on one of the following dates:

a) if the participant is already insured as a participant with dependents or as a single-parent and her dependent has recently become eligible: on the date on which the dependent becomes eligible;

b) if the person is the first dependent for whom the participant applies for insurance and if that person has recently become eligible and the insurance application is submitted within 30 days of the date on which the dependent became eligible: on the date of the event giving rise to the application;

c) if the dependent was previously eligible but not insured and the application is received within 30 days of the date on which the dependent became eligible: on the date the application is signed;

d) in the case of a new participant who requests a single-parent or family coverage type and whose application is submitted within 30 days of the date on which she becomes eligible for coverage under the Basic Extended Health Plan III and Extended Plan I: the date she becomes eligible for coverage under these plans.

B. Basic Extended Health Plan III

Employee

Coverage for the employee becomes effective on one of the following dates:

a) if the employee has recently become eligible: on the date on which she became eligible, regardless of whether or not she is at work on that date;

b) if the employee, having previously obtained an exemption, submits her application within 30 days of the date on which her previous insurance terminates: on the date on which her insurance entitling her to an exemption terminates;

c) if the employee, having previously obtained an exemption, submits her application within 30 days of the date on which her previous insurance terminates: on the date the insurance application is signed;

d) if the employee's work schedule increases to more than 25% of a full-time schedule: on January 1st of the current year;

e) if the employee works 25% or less of a full-time schedule and wishes to enrol in the insurance plan: on January 1st of the current year;

f) if the employee has not been at work after the maximum waiver of premium period of 3 years expires: on the date of effective return to work.

Dependents

Coverage for a dependent becomes effective on one of the following dates:

a) if the participant is already insured as a participant with dependents or as a single parent and the dependent has recently become eligible: on the date on which the dependent becomes eligible;

b) if the insurer's approval of the application is not required and the person is the first dependent for whom insurance is requested and that person has recently become eligible: on the date of the event giving rise to the application;

c) if the insurer's approval of the application is required: on the date the insurer approves such application;

d) if the insurer's approval of the application is not required and the dependent was previously eligible but not insured: on the date of the event giving rise to the application.

Under no circumstances can a dependent's insurance take effect before that of the employee.

C. Extended Plan I

Employee

Coverage for the employee becomes effective on one of the following dates:

a) on the first day of the pay period following the date indicated in the employer's notice sent to the insurer following a majority vote in favour of Extended Plan I. The date indicated in the notice cannot precede the date on which the vote is held;

b) if the employee has recently become eligible: on the date on which she became eligible, regardless of whether or not she is at work on that date;

c) if the employee, having previously obtained an exemption, submits her application with 30 days of the date on which her previous insurance terminates: on the date on which her insurance entitling her to an exemption terminates;

d) if the employee, having previously obtained exemption, submits her application more than 30 days of the date on which her previous insurance terminates: the date the insurance application is signed;

e) if the employee's work schedule increases to more than 25% of a full-time schedule: on January 1st of the current year;

f) if the employee works 25% or less of a full-time schedule and wishes to enrol in the insurance plan: on January 1st of the current year;

g) if the employee has not been at work after the maximum waiver of premium period of 3 years expires: on the date of effective return to work.

Dependents

Coverage for a dependent becomes effective on one of the following dates:

a) if the participant is already insured as a participant with dependents or as a single parent and the dependent has recently become eligible: on the date on which the dependent becomes eligible;

b) if the insurer's approval of the application is not required and the person is the first dependent (for whom insurance is requested) and he has recently become eligible: on the date of the event giving rise to the application;

c) if the insurer's approval of the application is required: on the date the insurer approves such application;

d) if the insurer's approval of the application is not required and the dependent was previously eligible but not insured: on the date of the event giving rise to the application.

Under no circumstances can a dependent's insurance take effect before that of the employee.

D. Extended Plan II

Employee

Employee coverage takes effect on the date on which the employee becomes eligible, provided she is at work or able to work on this date; if not, when the employee's disability period terminates and she actively returns to work.

However, for any part of the additional life insurance in excess of $50,000, and for any part of the total amount of accidental death and dismemberment coverage exceeding $50,000 requested within 30 days of the date on which the employee becomes eligible, coverage takes effect on the date the insurer approves the evidence of insurability, providing the employee is at work or able to work on this date; if not, when the employee's period of disability terminates and she actively returns to work.

Furthermore, if any amount of additional life insurance or accidental death and dismemberment insurance is applied for more than 30 days after the date on which the employee becomes eligible, coverage takes effect on the date the insurer approves the evidence of insurability, provided the employee is at work or able to work on this date; if not, when the employee's period of disability terminates and she actively returns to work.

Finally, for the accidental death and dismemberment insurance benefits when an employee has not been at work after the maximum waiver of premium period of 3 years, these benefits will resume upon effective return to work.

Dependents

Coverage for a dependent becomes effective on one of the following dates:

a) if the participant is already insured as a participant with dependents and the dependent has recently become eligible: on the date on which the dependent becomes eligible;

b) if the insurer's approval of the application is not required and the person is the first dependent for whom insurance is requested: on the date of the event giving rise to the request;

c) if the insurer's approval of the application is required: on the date the insurer approves the evidence of insurability;

d) if the insurer's approval of the application is not required and the dependent was previously eligible but not insured: on the date the insurance application is signed.

WAIVER OF PREMIUMS

The insurance plans remain in effect without payment of premiums for a disabled participant as of the 6th work day of a period of disability. For a participant without permanent, full-time status, the waiver begins on the 8th calendar day following the 1st day on which she was scheduled to work or as of the 1st day following the first 12 weeks of disability, whichever occurs first.

However, the provisions regarding the waiver of premium in case of disability does not apply during a temporary assignment if the participant receives a salary equal to the salary she was receiving before the beginning of her disability.

In the case of a progressive return to work or temporary assignment on a full-time or reduced-time basis and providing the employment relation is in effect at the end of the period during which premiums are waived, the participant's coverage under the Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I is maintained and the premiums start to be paid again to the insurer as usual.

A. Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I

The maximum duration of the waiver of premiums is 3 years. However, the waiver of premiums terminates on the earliest of the following dates:

a) the date of the end of the participant's period of disability;

b) the date on which the contract terminates;

c) the date on which the participant retires.

However, when a disability is recognized by virtue of the *Act respecting industrial accidents and occupational diseases*, the waiver continues to apply for as long as the participant is entitled to full income replacement benefits under such law.

B. Extended Plan II

The waiver of life insurance and long term disability insurance premiums terminates on the first of the following dates:

a) the date on which the participant's period of disability terminates;

b) the date on which the participant attains age 65.

However, if the disability begins at age 62 or later, the waiver of premiums may continue to be waived beyond age 65, subject to a maximum period of 3 years, but not beyond the date on which the participant attains age 71.

In all cases, the maximum duration for the waiver of premiums of the AD&D insurance is 3 years and may not exceed the date on which the participant attains age 71.

Furthermore, when a disability is recognized by virtue of the *Act respecting industrial accidents and occupational diseases*, the waiver continues to apply for the basic and additional life insurance of the participant and dependents, if any, for as long as the participant is entitled to full income replacement benefits under such law.

CONTINUITY OF COVERAGE IN THE EVENT OF WORK STOPPAGE

Unless otherwise indicated, if a period of disability begins during a temporary leave of absence indicated in paragraphs A, B, C, E or F below and during which the participant is covered, the disability period for the purpose of waiver of premiums and application of the long term disability insurance will be deemed to have started on the anticipated date of return to work.

The participant who maintains her coverage during a leave of absence and whose status changes during such leave must provide the employer with an application for a change of coverage category within 30 days of the date of the event. After such delay, evidence of insurability for dependent will be required for the Basic Extended Health Plan III, Extended Plan I and Extended Plan II.

The participant who chooses not to maintain her coverage under the Basic Extended Health Plan III, Extended Plan I and Extended Plan II automatically resumes her coverage upon her effective return to work. The participant and her dependents, if any, start to be insured again with the same type of coverage that was in force before the beginning of the leave, unless her marital status changed during the leave, in which case, she has a period of 30 days from the date of her active return to work to apply for a change in her type of coverage, without evidence of insurability.

The participant's decision to maintain her coverage or not must be the same for all benefits of the Extended Plans.

The participant who decides not to maintain her coverage under the Extended Plans at the beginning of or during an absence may not resume her coverage at a later date during the same absence.

A participant who does not return to work after the maximum waiver of premium period of 3 years cannot maintain her coverage in the event of an unpaid leave of 4 weeks or less, or during a leave without pay of more than 4 weeks.

A. Protective and maternity leave

1 - The participant's coverage under the Basic Drug Plan is continued and she and her dependents, if any, continue to be insured. The employer and the participant continue to pay their respective premiums.

2 - Coverage under the Basic Extended Health Plan III, Extended Plans I and II is automatically continued during the participant's leave and she and her dependents, if any, continue to be insured, provided the premium continues to be paid. However, the participant may suspend her coverage under these Plans as of the beginning of the leave or at any time during the absence.

B. Paid or unpaid leave of 4 weeks or less

Coverage under the Basic Drug Plan, Basic Extended Health Plan III, Extended Plan I and Extended Plan II remains in force during the participant's absence and she and her dependents, if any, continue to be insured. The employer and the participant continue to pay their respective premiums.

C. Leave without pay of more than 4 weeks

1 - Coverage under the Basic Drug Plan remains in force, and the participant and her dependents, if any, continue to be insured. The participant pays to her employer the full premium stipulated in the contract (employer and participant). However, in the case of an absence or leave for family or parental reasons, as stipulated in the *Act respecting Labour Standards*, the employer and the participant continue to pay their respective premiums.

2 - Coverage under the Basic Extended Health Plan III and Extended Plans I and II is automatically suspended during her absence and the participant and her dependents, if any, cease to be insured.

3 - Notwithstanding the subsection above, a participant may maintain her coverage under the Basic Extended Health Plan III and Extended Plans I and II and continue to be insured, as well as her dependents, if any, provided she pays her employer the full premium.

D. Part-time leave without pay

1 - Coverage under the Basic Drug Plan, Basic Extended Health Plan III, Extended Plan I and Extended Plan II is maintained during the participant's absence and she and her dependents, if any, continue to be insured. The employer and the participant continue to pay their respective premiums.

2 - The premium and the amount of long term disability coverage are calculated based on the salary that would be paid if the participant was not on part-time leave without pay or on the reduced salary if the participant chooses this option before the beginning of her part-time leave without pay.

3 - A participant who does not avail herself of the provisions of the above-mentioned subsection at the beginning of her part-time leave without pay cannot do so at a later date during her part-time leave without pay.

4 - The particular dispositions applicable to a part-time employee working 25% or less of a full-time schedule do not apply to such employee simply because of her part-time leave without pay.

E. Deferred pay leave

This plan includes both a period of participation and a period of leave.

1 - During the period of participation, coverage under the group insurance plan is continued for the participant and her dependents, if any. The premium and the disability insurance amount are determined on the basis of the reduced salary or on the basis of the salary the participant would have received if she were not taking a deferred pay leave and provided she notifies her employer of her decision before the start of the deferred pay leave. The employer and the participant continue to pay their respective premiums.

2 - During the period of leave, the participant is considered to be on leave without pay and the provisions of paragraph C (Leave without pay of more than 4 weeks) apply. If the participant has chosen to maintain coverage under the various insurance plans, the premium and the amount of disability insurance coverage are the same as those she chose at the beginning of her participation in the deferred pay leave plan.

F. Suspension

1 - During a period of suspension of 4 weeks or less, the provisions are those described in paragraph B. "Paid or unpaid leave of 4 weeks or less".

2 - During a period of suspension of more than 4 weeks, the provisions are those described in paragraph C. "Leave without pay of more than 4 weeks".

G. Layoff

Coverage for the participant and her dependents, if any, under the Basic Drug Plan, Basic Extended Health Plan III, Extended Plan I and Extended Plan II is continued during the absence and she continues to be insured. The employer and the participant continue to pay their respective premiums.

H. Dismissal contested by grievance

A dismissed participant who contests her dismissal by way of a grievance or arbitration under the terms of the Labour Code, must maintain her coverage under Basic Drug Plan, and she may, if she wishes, continue her coverage under the Basic Extended Health Plan III, Extended Plan I and Extended Plan II for herself and her dependents, if any, until the final decision, including any appeal proceedings, as the case may be, has been handed down, provided she pays her employer the full premium amount. The participant must notify the employer of her intention to maintain her coverage under the Basic Extended Health Plan III, Extended Plan I and Extended Plan II within 30 days of the grievance presentation.

If dismissal is settled between parties, the participant's coverage under the Basic Drug Plan and, as the case may be, under Extended Plans I, II and III will cease on the date the settlement is signed, unless there's effective return to work.

NB: Part-time participant

The premium for a part-time participant who has continued her coverage under the Extended Plan II during a temporary leave is based on her salary calculated pro rata to the time paid compared with a full-time schedule during the 12 weeks preceding the start of the period during which no period of illness, parental leave, leave without pay, annual vacation or union leave has been authorized.

Should a part-time participant become disabled during such period, the benefits payable are based on her annualized salary on the day the waiting period terminates multiplied by the percentage of her time actually paid compared with a full-time schedule during the 12 weeks preceding the start of her temporary leave during which no period of disability, parental leave or leave without pay has been authorized (minimum salary of $12,000).

GENERAL LIMITATIONS

Should an addition or amendment be made to the current tax legislation, social legislation, to a government plan or collective agreement, the provisions of this plan continue to apply as if the addition or amendment had not taken place, until the parties agree to adjust the premium rate in effect under this plan accordingly.

TERMINATION OF COVERAGE

The participant's insurance terminates at midnight on the earliest of the following dates:

1. the date on which the contract terminates, subject to the **premium waiver** provisions;
2. the date on which the participant ceases to be eligible, subject to the **conversion privilege** provisions;
3. the date on which the participant ceases to participate in the Basic Drug Plan, Basic Extended Health Plan III and Extended Plan I by exercising her **exemption privilege**;
4. January 1st of the year in which the participant indicates her wish to cancel her coverage under the Basic Extended Health Plan III and Extended Plan I, since the percentage of time she works is reduced to 25% or less of a full-time schedule;
5. the date on which she attains age 63, in the case of long term disability insurance;
6. for the purpose of the Basic Drug Plan, the date on which the participant becomes insured under the Basic prescription drug insurance plan;
7. for the purpose of the Extended Plan I, January 1st following the date on which employees, working for one employer, vote not to participate in such plan;
8. the date of retirement;
9. for the purpose of the Basic Drug Plan and the Basic Extended Health Plan III, the date on which the maximum waiver of premium period of 3 years ceases, unless the participant is on temporary assignment or progressive return to work;
10. for the purpose of the Extended Plan I, the date on which the maximum waiver of premium period of 3 years ceases, unless the participant is on temporary assignment or progressive return to work;

11. for the purpose of the participant accidental death and dismemberment insurance benefit, the date on which the maximum waiver of premium period of 3 years ceases without exceeding the age of 71 if the disability commenced at age 62 or after. It is understood that this benefit is continued if the participant is on temporary assignment or progressive return to work.

The dependent's insurance terminates at midnight on the earliest of the following dates:

1. the date on which the contract terminates, subject to the **premium waiver** provisions;
2. the date on which the participant's insurance plan terminates, subject to the **conversion privilege** provisions;
3. the date on which the dependent ceases to be eligible (see the definition of "dependent" in the General Provisions section);
4. the date on which the participant applies for individual insurance, without dependents or for single-parent insurance;
5. for the purpose of the Basic Drug Plan, the date on which the participant becomes insured under the Basic prescription drug insurance plan.

INSURANCE PROGRAM FOR RETIREES

At the time of retirement, two individual insurance policies are offered to the participant.

For the members of the *Regroupement interprofessionnel des intervenants retraités des services de la santé* (RIIRS), a life insurance policy is available.

An individual health insurance policy proposed by Desjardins Insurance for individuals who are no longer eligible for group insurance coverage is also offered to participants at the time of retirement. This individual health insurance policy complements the Public Prescription Drug Insurance Plan provided for by the RAMQ and includes an extended health plan, travel insurance and trip cancellation insurance.

For more information regarding these individual insurance plans, please call 1 877 385-3033 or consult the pamphlet available at your employer's office.

CONVERSION PRIVILEGE

The participant may exercise her conversion privilege only once under any contract issued by the insurer.

A) Basic Extended Health Plan III

The conversion privilege enables the insured person (participant and dependent) who is no longer eligible for coverage, to obtain health insurance coverage without drug insurance coverage in the form of a separate contract, without having to provide evidence of insurability. The premium rates and conditions are determined by the insurer and are those in effect at the time for the same type of coverage, provided she applies in writing to the insurer's head office within 31 days of one of the following events:

a) the insured person ceases to be eligible for coverage before the contract terminates; this conversion privilege may then be exercised by the participant for herself and her dependents, if they were in her care;

b) a dependent ceases to be a dependent under the terms of the contract;

c) the participant dies.

B) Participant life insurance

If the participant's life insurance terminates, the participant may convert, without providing evidence of insurability, all or part of her life insurance coverage then in force under the Extended Plan II to an individual whole or term life insurance policy, with a one-year term insurance option for the first year.

A written application for conversion must be submitted to the insurer within 31 days of the date of conversion eligibility, during which period the life insurance coverage under the Extended Plan II remains in force. The new policy becomes effective on the 31st day after this date, provided that the initial premium is paid.

The new policy's premium is calculated in accordance with the rates then in effect for the age of the insured person on the date of conversion. The new policy does not include a waiver of premium benefit or other additional privileges unless agreed to by the insurer.

However, notwithstanding any other provision of the Extended Plan II policy, any retiree who enrols in the group insurance plan of the *Regroupement interprofessionnel des intervenants retraités des services de la santé* (RIIRS) may only convert into individual insurance an amount that is equal to or less than the difference between the life insurance coverage she already holds under the Extended Plan II and that which she obtains under the retirees' plan.

Two documents will allow the participant to fully understand and to exercise her conversion privilege: the "Conversion Privilege" request Form No. 14141E and the pamphlet called "Your life insurance conversion privilege". Both documents have been posted on the secure website for participants under I want Information > Forms > Administrative Forms or on the Desjardinslifeinsurance.com website under: Group Plans > Employee departure or retirement.

HOW TO SUBMIT A CLAIM?

HEALTH INSURANCE

1) Hospital expenses

Simply present your insurance certificate at the hospital.

2) Drugs

Direct payment

Reimbursement of eligible drug expenses may be claimed through the direct payment service, by presenting the insurance certificate card bearing your identification number to the pharmacist.

This service gives immediate authorization at the drugstore for your reimbursement. Moreover it saves having to fill out claim forms, the inconvenience of lost receipts and postal charges.

When you purchase medication, you must present your card and pay the pharmacist for the uninsured portion of the drug expenses incurred. Therefore, you are not required to submit a claim to the Insurer.

Note that you cannot use the payment service to claim for medication purchased outside the province of Quebec or for other expenses provided for under the contract; please refer to the paragraph "Other ways to claim" below.

Other ways to claim

When a participant purchases medication eligible for reimbursement in a pharmacy which does not offer the direct payment service, and when she incurs other insured health expenses, she must complete a claim form (#19-132A) and enclose the original receipts. The name of the insured person, the nature, date and cost of the service should be written on all receipts.

All claims, evidence and information must be received by the insurer within 12 months of the date on which the expenses were incurred.

Reimbursement of brand name drugs

If the attending physician judges that the brand name drug he prescribes should not be substituted, it could be reimbursed provided that:

a) the appropriate form is completed by the physician and submitted to the insurer;

b) the medical reason for which the drug must not be substituted is valid in the Insurer's opinion.

This form is available in the website desjardinslifeinsurance.com. To access it:

- in the *Group plans* tab, choose *Group insurance forms* under *Group insurance*;
- click on the *Medical expenses* button;
- select the form **Request for Reimbursement of Brand Name Medications – Plan member – 12126E**.

3) Hospital or medical expenses resulting from a work-related accident or illness

All medical or hospital expenses incurred by an employee as a result of an occupational injury or illness (industrial accident, occupational disease or employment hazard), will be reimbursed by the CSST. The receipts must be sent to the CSST and not to Desjardins Financial Security Life Assurance Company.

4) Dental care expenses

The payment of dental care expenses is made by using the payment card at participating dentist's offices. If the dentist does not participate, the claim form, evidence and information must be sent to the insurer within 12 months of the date these expenses were incurred.

Treatment plans may be sent by fax at 418-835-5346.

5) Long term disability insurance

Claims for disability benefits must be submitted, using the form that can be obtained from the person responsible for group insurance at your place of work, 90 days prior to the benefit payment date.

6) Life insurance

The claim form for life insurance benefits can be obtained directly from Desjardins Financial Security Life Assurance Company.

Please write your contract number on all claim forms and correspondence and send to:

DESJARDINS INSURANCE
P. B. 3950
Lévis, Québec
G6V 6R2

For any additional information about **health, travel or dental care insurance claims**, please call the head office at one of the following numbers:

Québec City area: (418) 838-7843

Other areas: 1-800-463-7843 (toll-free)

You can consult this booklet on our internet site at the following address: www.dfs.ca.

To access your booklet, follow these steps:

1) In the “Log on” drop-down menu, select “Group insurance” in the “For individuals” zone.
2) If it is your first visit, click the “Register now” button and follow the instructions.
3) If you already registered, enter your User ID and password and click the “Confirm” button.
4) In the welcome page, select “Insurance booklet” in the “Your account” drop-down menu.

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 any assistance you may require. You can rely on our knowledgeable team who 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.

desjardinslifeinsurance.com

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Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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