



GROUP INSURANCE CONTRACT 103000

entered into by

La Capitale Civil Service
Insurer Inc.

and

Fédération interprofessionnelle
de la santé du Québec–FIQ

EXPERIENCE LA CAPITALE'S CARING APPROACH

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La Capitale
Insurance and
Financial Services

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GROUP INSURANCE CONTRACT

No. **103000**

ENTERED INTO BY

LA CAPITALE CIVIL SERVICE INSURER INC.

(the Insurer)

AND

FÉDÉRATION INTERPROFESSIONNELLE DE LA SANTÉ DU QUÉBEC–FIQ

(the Policyholder)

In consideration of payment of the applicable premiums, the Insurer agrees to pay the insurance and benefit amounts in accordance with this contract.

Effective date of the insurance: This contract comes into force on April 14, 2019.

Renewal date: April 1, 2021 for the health insurance and dental care plans, April 1, 2022 for the long-term disability insurance plan, and April 1, 2024 for the life insurance plan. Thereafter, this contract is renewable on April 1 of each following year. It is understood that, following each renewal, the new premiums apply beginning with the first complete pay period after April 1.

Time at which the insurance comes into effect, is changed or terminated: All insurance comes into effect, is changed or terminated at 12:01 a.m. in the insured person's province of residence.

This group insurance contract must be interpreted in conjunction with the information provided in the *Schedule of Benefits* for each of the plans described herein.

The Insurer agrees to collect and use the participants' relevant personal information, solely for the purposes of this contract. The Insurer agrees to take reasonable security measures to protect the personal information it collects, uses, communicates, stores or destroys, in view of the sensitivity of that information, the purpose of its use, its quantity, its distribution and its medium.

To this end, only representatives, proxies, agents, subcontractors, reinsurers, employees, brokers, officers, directors, executives, partners, assigns and any other parties that are responsible with, for or to the Insurer, as well as parties authorized by the insured person and by law, will have access to the participant's personal information, and this, solely to the extent that this information is necessary for the fulfilment of their duties or mandate.

Any communication of a participant's personal information to a third party will require the explicit prior consent of the Policyholder in accordance with the rules set out by the *Act respecting the protection of personal information in the private sector* and with the provisions stipulated in the Civil Code of Québec.

For the interpretation of this contract, the feminine form
refers to both women and men.

TABLE OF CONTENTS

SECTION	PAGE
SCHEDULE OF BENEFITS.....	1
GENERAL DEFINITIONS.....	1
INSURANCE TERMS AND CONDITIONS	5
1. Definition.....	5
2. Eligibility.....	5
3. Participation.....	6
4. Enrolment	8
5. Exemption Privilege	12
6. Evidence of Insurability	12
7. Effective Date of Coverage	13
8. Coverage Status Changes for In-Force Coverage Following a Life Event	14
9. Retroactive Salary Adjustments	15
10. Continuity of Coverage in the Event of a Work Stoppage.....	15
11. Termination of Coverage.....	19
12. Provisions Pertaining to the Change in Insurers.....	20
WAIVER OF PREMIUMS.....	22
1. Participants' Eligibility Conditions for a Waiver of Premiums	22
2. Termination of a Waiver of Premiums	22
3. Temporary Assignments and Waivers.....	23
4. Gradual Return to Work or Temporary Assignment and End of the Maximum Waiver of Premium Period	23
5. Limitations and Exclusions.....	23

LIFE INSURANCE PLAN	24
1. Definitions	24
2. Purpose of the Coverage	24
3. Participant's Basic Life Insurance	24
4. Spouse's and Dependent Children's Life Insurance	24
5. Participant's Optional Life Insurance (maximum: \$100,000).....	25
6. Participant's Optional Life Insurance (over \$100,000)	25
7. Advance benefit payment in the event of terminal illness for the participant	25
8. Spouse's Optional Life Insurance.....	26
9. Advance benefit payment in the event of terminal illness for the spouse	26
10. Participant's Basic and Optional AD&D Insurance	27
11. Beneficiaries	27
12. Conversion Privilege	28
HEALTH INSURANCE PLAN.....	30
1. Definitions	30
2. Purpose of the Coverage	30
3. Reimbursement Terms and Conditions	31
4. Hospital and Transportation Expenses.....	31
5. Prescription Drug Expenses.....	31
6. Travel Insurance and Assistance	33
7. Extended Health Care Expenses	38
8. Limitations and Exclusions.....	42
9. Conversion Privilege	43
DENTAL CARE PLAN.....	44
1. Definitions	44
2. Purpose of the Coverage	44
3. Reimbursement Terms and Conditions	44
4. Dental Care Expenses	44

5.	Rates and Notes	49
6.	Limitations and Exclusions.....	49
7.	Conversion Privilege	50
LONG-TERM DISABILITY INSURANCE PLAN		51
1.	Definitions	51
2.	Purpose of the Coverage	51
3.	Amount	51
4.	Duration of Benefits	52
5.	Integration.....	52
6.	Indexation	53
7.	Payment Frequency.....	53
8.	Rehabilitation.....	53
9.	Modification.....	53
10.	Limitations and Exclusions.....	53
CLAIMS.....		54
1.	General Provisions.....	54
2.	Life Insurance Plan	54
3.	Health Insurance and Dental Care Plans	55
4.	Long-Term Disability Insurance Plan.....	56

SCHEDULE OF BENEFITS

This summary table provides a brief description of the benefits included in your group insurance plans. For a complete description of each plan, please refer to the relevant pages.

Classes of eligible employees	
Class 1	Employees working full-time or 70% or more of a full-time schedule in a permanent position
Class 2	Employees working full-time or 70% or more of a full-time schedule on a temporary assignment
Class 3	Part-time employees working less than 70% of a full-time schedule but more than 25%
Class 4	Part-time employees working 25% or less of a full-time schedule
Eligibility period	
Class 1	After one month of continuous service for all insurance plans
Classes 2, 3 and 4	After one month of continuous service for the Bronze module of the health insurance plan and after three months of continuous service for the other insurance plans, including the choice of a higher health insurance module

LIFE INSURANCE PLAN

Participant's Basic Life Insurance	
Insurance amount	\$5,000
Start of waiver of premiums	<p>Participants with a status of permanent full-time employee: The waiver begins on the 6th workday of a disability period.</p> <p>Participants with a status other than permanent full-time employee: The waiver begins on the 8th calendar day following the first day on which the employee is scheduled to work, or on the first day following the first 12 weeks of disability, whichever occurs first.</p>

Spouse's and Dependent Children's Life Insurance	
Insurance amounts	
Spouse	\$3,000
Dependent child (24 hours old or more)	\$3,000
Start of waiver of premiums	Same as for the participant's basic life insurance

Participant's Optional Life Insurance (maximum: \$100,000)	
Insurance amount	Choice of a fixed amount: \$5,000, \$10,000, \$15,000, \$25,000, \$50,000, \$75,000 or \$100,000
Evidence of insurability	If the application is made within 30 days from the start date of the participant's eligibility, evidence of insurability is only required for the amount of \$100,000. After that time frame, evidence of insurability is required for any insurance amount.
Start of waiver of premiums	Same as for the participant's basic life insurance

Participant's Optional Life Insurance (over \$100,000)	
Insurance amount	Participants who have opted for optional life insurance for themselves in the amount of \$100,000 (maximum amount) may add: 1 to 16 units of \$25,000
Evidence of insurability	Always required
Start of waiver of premiums	Same as for the participant's basic life insurance

Advance benefit payment in the event of terminal illness (for the participant's basic and optional life insurance (maximum: \$100,000) and participant's optional life insurance (over \$100,000))	50% of the life insurance amount, with a minimum of \$2,500
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Spouse's Optional Life Insurance	
Insurance amount	1 to 20 units of \$25,000
Evidence of insurability	Always required
Start of waiver of premiums	Same as for the participant's basic life insurance

Advance benefit payment in the event of terminal illness (for spouse's optional life insurance)	50% of the life insurance amount
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Participant's Basic AD&D Insurance	
Insurance amount	Same amount as for the participant's basic life insurance
Start of waiver of premiums	Same as for the participant's basic life insurance

Participant's Optional AD&D Insurance	
Insurance amount	Same amount as for the participant's optional life insurance (maximum: \$100,000)
Start of waiver of premiums	Same as for the participant's basic life insurance

HEALTH INSURANCE PLAN

The amounts indicated below are maximum reimbursement amounts per insured person, unless otherwise specified.

No annual deductible.

Coverage	Bronze Module	Silver Module	Gold Module
Hospital and Transportation Expenses			
Hospitalization	Not covered	100%, semi-private room (two beds)	100%, semi-private room (two beds)
Ambulance	100%	100%	100%
Air or train transportation	100%	100%	100%
Prescription Drug Expenses			
Percentage of reimbursement	80%, up to a maximum annual disbursement of \$800 per certificate and 100% of any excess	80%, up to a maximum annual disbursement of \$800 per certificate and 100% of any excess	80%, up to a maximum annual disbursement of \$800 per certificate and 100% of any excess
Automated payment service	Direct	Direct	Direct
List of medications	Standard	Standard	Standard
Generic substitution	Mandatory	Mandatory	Mandatory
Preventive vaccines	Not covered	Not covered	\$500 per calendar year
Travel Insurance and Assistance			
Percentage of reimbursement	100%	100%	100%
Lifetime maximum	\$5,000,000	\$5,000,000	\$5,000,000

Coverage	Bronze Module	Silver Module	Gold Module
Extended Health Expenses (including health professional fees)			
Artificial limb or eye, or breast prosthesis	Not covered	80%	80%
Compression stockings	Not covered	80%, maximum 3 pairs per calendar year	80%, maximum 3 pairs per calendar year
Dental care following an accident and cosmetic surgery following an accident	Not covered	80%	80%
Detoxification	Not covered	80%, maximum \$60 per day, \$3,000 lifetime	80%, maximum \$80 per day, \$3,000 lifetime
Glucometer	Not covered	80%, maximum \$300 per period of 60 consecutive months	80%, maximum \$300 per period of 60 consecutive months
Hearing aid	Not covered	80%, maximum \$400 per period of 36 consecutive months	80%, maximum \$600 per period of 36 consecutive months
Intraocular lenses	Not covered	Not covered	80%
IUD (unmedicated)	Not covered	Not covered	80%, maximum \$40 per IUD
Nursing and respiratory therapy care	Not covered	80%, maximum \$160 per day, \$4,000 per calendar year for all of these services	80%, maximum \$160 per day, \$4,000 per calendar year for all of these services
Orthopaedic equipment and supplies	Not covered	80%	80%
Orthopaedic shoes	Not covered	80%, maximum 1 pair per calendar year	80%, maximum 1 pair per calendar year
Podiatric orthotics	Not covered	80%, maximum \$240 per pair, 1 pair per calendar year per adult and 2 pairs per calendar year per child under age 13	80%, maximum \$240 per pair, 1 pair per calendar year per adult and 2 pairs per calendar year per child under age 13
Post-operative bra	Not covered	Not covered	80%, maximum \$200 per period of 24 consecutive months

Coverage	Bronze Module	Silver Module	Gold Module
Rehabilitation centre or convalescent home	Not covered	Not covered	80%, maximum \$80 per day, 60 days per calendar year
Sclerosing injections (drug)	80%, maximum: \$16 per visit	80%, maximum \$16 per visit	80%, maximum \$16 per visit
Sclerosing injections (fees)	Not covered	80%, maximum \$16 per visit	80%, maximum \$40 per visit
Therapeutic devices (e.g. insulin pump, TENS)	Not covered	80%	80%
Therapeutic supplies	Not covered	80%	80%
Treatment outside the area of residence (transportation and accommodation)	80%, maximum \$1,000 per calendar year	80%, maximum \$1,000 per calendar year	80%, maximum \$1,000 per calendar year
Wheelchair and hospital bed	Not covered	80%	80%
Wig (capillary prosthesis)	Not covered	Not covered	80%, maximum \$300 per period of 60 consecutive months

Coverage	Bronze Module	Silver Module		Gold Module	
Health Professionals					
Occupational therapist	Not covered	Not covered		80%, maximum \$50 per treatment or visit, up to \$750 per calendar year for all of these professionals	
Dietitian and nutritionist					
Social worker					
Acupuncturist					
Chiropractor					
Kinesitherapist					
Massage therapist					
Naturopath, naturotherapist		80%, maximum \$28 per treatment or visit, up to \$500 per calendar year for all of these professionals			
Orthotherapist					
Osteopath					
Physiotherapist and physical rehabilitation therapist					
Podiatrist		80%		80%	
Audiologist or hearing therapist					
Speech therapist					
Fees for the drafting of an assessment report	80%		80%		
Psychologist and registered psychotherapist	50%	Maximum \$1,000 per calendar year	80%	Maximum \$1,500 per calendar year	
Fees for the drafting of an assessment report	50%		80%		
Chiropractor X-rays	80%, maximum \$32 per calendar year		80%, maximum \$32 per calendar year		
Start of waiver of premiums	<p>Participants with a status of permanent full-time employee: The waiver begins on the 6th workday of a disability period.</p> <p>Participants with a status other than permanent full-time employee: The waiver begins on the 8th calendar day following the first day on which the employee is scheduled to work, or on the first day following the first 12 weeks of disability, whichever occurs first.</p>				

DENTAL CARE PLAN

The amounts indicated below are maximum amounts per insured person, unless otherwise specified.

No annual deductible.

Automated payment service	Included
Reimbursement based on fees	For the current year
Frequency of periodic and recall examinations, polishing, scaling and fluoride treatment	1 examination every 9 months
Diagnostic and preventive care	100%
Basic services	80%
Extended care	50%
Orthodontics (for insured persons under age 21)	50%
Maximum reimbursement	\$1,000 per year for all basic and extended dental care combined, with the exception of orthodontics Orthodontics: \$1,000 lifetime
Start of waiver of premiums	Participants with a status of permanent full-time employee: The waiver begins on the 6 th workday of a disability period. Participants with a status other than permanent full-time employee: The waiver begins on the 8 th calendar day following the first day on which the employee is scheduled to work, or on the first day following the first 12 weeks of disability, whichever occurs first.

LONG-TERM DISABILITY INSURANCE PLAN

Waiting period	<p>Participants with a status of permanent full-time employee: 5 working days plus 104 weeks of the same disability period</p> <p>Participants with a status other than permanent full-time employee: 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 of the same disability period</p>
Amount	<p>Participants with a status of full-time employee: - 100% of the net salary insurance benefit received from the employer for the 104th week of disability</p> <p>Participants with a status other than full-time employee: The greater of the following amounts: - 100% of the net salary insurance benefit received from the employer for the 104th week of disability; or - 100% of the net salary insurance benefit received from the employer based on 80% of a presumed annual salary of \$12,000</p>
Duration of benefits	Up until age 65
Indexation of benefits	Yes, to Retraite Québec's Pension Index, up to 5%
Taxable benefits	No
Start of waiver of premiums	<p>Participants with a status of permanent full-time employee: The waiver begins on the 6th workday of a disability period.</p> <p>Participants with a status other than permanent full-time employee: The waiver begins on the 8th calendar day following the first day on which the employee is scheduled to work, or on the first day following the first 12 weeks of disability, whichever occurs first.</p>

GENERAL DEFINITIONS

For the purposes of this contract, some of the terminology used in the description of the insurance terms and conditions and plans, as well as that of the general provisions, is defined in this section. Additional definitions are also found in the sections concerning the insurance plans to which they specifically apply.

1. **Accident:** A sudden and unforeseeable event resulting exclusively from an external cause that, directly and independently of any other cause, results in bodily injury that is confirmed by a physician. Attempted suicide is not considered to be an accident, whether or not it results in bodily injury.
2. **Age:** The age of the person in question on their last birthday at the time it is calculated or on the day that an event covered by this contract occurs.
3. **Calendar year:** The period beginning January 1 of a given year and ending on December 31 of the same year.
4. **Collective agreement:** 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*.
5. **Contract:** This master contract, the *Schedule of Benefits*, the appendices to the contract, any endorsements between the Policyholder and the Insurer, the specifications, the Insurer's quote, subsequent agreements, participants' enrolment applications and any required evidence of insurability constitute the entire contract between the contracting parties.
6. **Contract year:** The period between the contract effective date and the renewal date that immediately follows, as well as any 12-month period between two renewal dates, subject to an alternative agreement in that regard between the Insurer and the Policyholder.
7. **Coverage status:**
 - a) Individual coverage: Participant with no dependents;
 - b) Family coverage: Participant with dependents (spouse only or spouse and children);
 - c) Single-parent coverage: Participant with dependent children only. Only participants with no spouse, as defined in this section, can opt for the status of single-parent coverage for the associated insurance plans.
8. **Deductible:** The portion of eligible expenses for which the insured person is not entitled to any reimbursement from the Insurer.
9. **Dentist:** A person who is member of a professional dental association recognized by the competent authorities in the province where the person practices.

10. Dependents:

10.1 Spouse

Spouses are understood as people living in Canada:

- a) who are married and cohabitating;
- b) who are cohabitating in a conjugal relationship and are the mother and father of the same child;
- c) who are opposite-sex or same-sex couples and have been cohabitating 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 of their civil union. 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 three months.

A married participant who is not cohabitating with her spouse may designate that person as her spouse to the Insurer. She may also designate any other person in lieu of her legal spouse, if that person fits the definition of a spouse, as stated above.

At any one time, only the spouse last designated as such is recognized by the Insurer.

10.2 Dependent child

A dependent 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 her support and who meets one of the following conditions:

- a) is under 18 years of age; or
- b) is 25 years of age or under and is a full-time student at a recognized educational institution; or
- c) irrespective of the child's age, if the child became totally disabled while meeting one of the conditions mentioned above and has remained continuously disabled since that date.

10.3 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 *Act respecting prescription drug insurance* adopted by the Quebec government. The impairment must have existed when the person's status fit the definition of paragraph (a) or (b) of the previous section, 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 insured participant or the participant's spouse, who would exercise parental authority over the impaired person if she were a minor.

11. **Disability:** A state of incapacity resulting from an 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 professional, or resulting from a stable condition that:

- During an initial period of five working 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. In the case of a participant who does not have permanent, full-time status, the period of "five working days" mentioned above is replaced by "seven 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.

12. **Disability period:**

- During the first five working days plus 156 weeks: any continuous period of disability or succession of consecutive periods separated by fewer than 15 days of full-time active employment or 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 accident or illness entirely unrelated to the previous cause of disability. In the case of a participant who does not have permanent, full-time status, the period of "five working days" mentioned above is replaced by "seven 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, any continuous period of disability or succession of consecutive periods separated by fewer than six calendar months during which the participant has not been totally disabled. Any disability period resulting from an illness or accident which is entirely unrelated to the cause of the previous disability is considered to be a new disability period, except if the new disability occurs during a disability period.

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

Restriction

A disability period resulting from alcoholism, drug addiction, active participation in a riot or insurrection, or as a 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 disability period resulting from alcoholism or drug addiction during which the participant receives treatment or care in view of rehabilitation.

13. **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. **Retired employees who come back to work after May 14, 2006, as well as any students, or nursing or respiratory therapy externs, are excluded from this definition.**
14. **Employer:** Any institution governed by the collective agreement, as well as any other group approved by the Policyholder and the Insurer.
15. **Illness:** An alteration of the physical or mental state of health, considered within the context of its evolution, which must be confirmed by a physician, including any complication resulting from a pregnancy.
16. **Insured person:** A participant or dependent covered under this contract.
17. **Participant:** An employee insured under this contract.
18. **Physician:** Any physician who is duly authorized to practice medicine.
19. **Previous contract:** Any group insurance contracts in force immediately prior to the effective date of this contract that covered the employer's employees and their dependents, if any.
20. **Province:** Any province or territory of Canada.
21. **Salary:** The salary paid to the employee in accordance with her echelon in the scale for her job title plus, if applicable, any premiums, supplements and other additional remuneration provided for under the relevant collective agreement and which are included in the calculation of the salary insurance benefits paid by the employer.
22. **Schedule of Benefits:** A summary of the insurance benefits included in the Policyholder's group insurance contract. The *Schedule of Benefits* specifies certain insurance terms and conditions, the insurance plans provided under this contract and the payable insurance and benefit amounts applicable to each class of eligible employees.

A full description of the insurance plans and their exclusions, restrictions, terms and conditions are found in the following sections of this contract.

INSURANCE TERMS AND CONDITIONS

1. Definition

In addition to the definitions in the *General Definitions* section, the following definition applies specifically to the insurance terms and conditions, where appropriate.

- a) **Reference year:** The period extending from November 1 to October 31 of the previous year, for purposes of calculating the work schedule as of January 1 of each year.

2. Eligibility

2.1. Employees

Any employee is eligible for group insurance at the end of the eligibility period indicated in the *Schedule of Benefits*, whether or not she has completed her probation period.

2.2. Job security plan

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 application of the eligibility period.

The employee does not have to complete a new eligibility period 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 departure;
- b) when the employee is relocated to another job under the job security plan of the collective agreement;
- c) when the employee joins the bargaining unit while continuing to work for the same employer.

2.3. Dependents

Any dependent of an employee is eligible for insurance, either on the same date as the employee, if she is already a dependent, or on the date on which she becomes a dependent, whichever comes last.

2.4. Provisions regarding eligibility

The eligibility of an employee and her dependents, if any, for the dental care plan is conditional on their eligibility for the health insurance plan. Likewise, the eligibility of an employee and her dependents, if any, for the life and long-term disability insurance plans is conditional on their eligibility for the health insurance plan.

3. Participation

3.1. Health insurance plan

Participation in the health insurance plan is mandatory for all eligible employees and their eligible dependents, subject to the exceptions stipulated in the *Quebec Act respecting prescription drug insurance* and the exemption privilege provided under this contract.

Provisions applicable to insured persons aged 65 or older:

There are no changes to the health insurance plan of a participant once she reaches the age of 65. That participant retains all of the coverage offered by the health insurance plan, including the reimbursement of prescription drug expenses, and this, without altering the premium. The same terms and conditions apply to the spouse of an insured participant under this contract's health insurance plan, who has reached the age of 65.

However, according to the rules of the *Régie de l'assurance maladie du Québec* (RAMQ), a person turning 65 is automatically covered under the Basic Prescription Drug Insurance Plan (RGAM) for the reimbursement of prescription drugs covered by that plan. Any insured person who reaches the age of 65 must therefore withdraw from the RAMQ to avoid paying the premium for the RGAM.

If, however, an insured person decides to remain enrolled in the RGAM, that decision is irrevocable. In addition, no dependent may remain insured for prescription drug reimbursement under this contract, customarily covered by the RGAM, if the participant herself does not remain enrolled.

3.2. Dental care plan

Participation in the dental care plan is optional for the employee and her eligible dependents.

3.3. Life and long-term disability insurance plans

With the exception of optional insurance benefits, participation in the life and long-term disability insurance plans is mandatory for all eligible employees.

Furthermore, spousal and dependent children's life insurance is mandatory for employees who choose family or single-parent coverage under the health insurance plan or who use their exemption privilege to opt out of this plan and who have dependents, as defined in this contract.

Lastly, enrolment in participant's basic life insurance is inseparable from participation in participant's basic AD&D insurance. Likewise, enrolment in participant's optional life insurance (maximum: \$100,000) is inseparable from participation in participant's optional AD&D insurance.

3.4. Employees working 25% or less of a full-time schedule

- a) At the end of the eligibility period of three months of continuous service described in the *Schedule of Benefits*, a newly eligible employee who works 25% or less of a full-time schedule is automatically insured under all of the insurance plans' mandatory coverage.
- b) On January 1 of each year, a participant whose work schedule has been reduced to 25% or less of a full-time schedule during the reference period may ask to switch to a lower-level health insurance module, even if the minimum period of participation in that module is not completed.

The participant must make this request within 10 days of receipt of the written notice from her employer, indicating her percentage of time worked
- c) On January 1 of each year, a participant whose work schedule has been reduced to 25% or less of a full-time schedule during the reference period may request that she no longer be covered under the dental care plan, even if the minimum period of participation in that plan is not completed.

The participant must make this request within 10 days of the receipt of written notice from her employer, indicating her percentage of time worked.
- d) A participant who works 25% or less of a full-time schedule and who has decided, by virtue of the above paragraphs, to change her health insurance module or terminate her coverage under the dental care plan, may then only change that decision on January 1 of each year.
- e) A participant who is absent between the end of the reference period and December 31 of a year, due to an authorized leave of absence of more than four weeks, may exercise the rights described in the preceding paragraphs upon her effective return to work.
- f) A participant who works 25% or less of a full-time schedule and who has decided to maintain her coverage under the insurance plans may not subsequently take advantage of the provisions stipulated in paragraphs (b) and (c) above, so long as her work schedule remains the same. The participant will need to wait for the end of the applicable minimum period of participation to switch to a lower-level health insurance module or terminate her participation in the dental care plan.

3.5. Special participation provisions

3.5.1 Employees who work for more than one employer

Employees covered by the FIQ's collective agreement with each of their employers

The employee must be covered under the health insurance and dental care plans of only one employer, of her choosing, and use her exemption privilege under the other employer's health insurance plan.

In addition, the employee must be covered by all mandatory benefits of the life and long-term disability insurance plans of both employers. It should be noted that the total optional life insurance amounts for all of her employers, combined, may not exceed \$100,000 of participant's optional life insurance (maximum: \$100,000) or \$400,000 of participant's optional life insurance (over \$100,000).

Employees covered by the FIQ's collective agreement with one employer

The employee must be covered under the health insurance and dental care plans of just one employer, of her choosing, and use her exemption privilege under the other employer's group insurance contract, if any.

In addition, the employee must be covered under all mandatory benefits of the life and long-term disability insurance plans of the employer where the FIQ is present.

3.5.2 Employees who work in more than one employment category for the same employer or for more than one employer

The employee must be covered under the health insurance and dental care plans of only one employer and under one employment category of her choosing and use her exemption privilege under the other employer's or the other employment category's group insurance contract, if any.

In addition, an employee who works in the category of nursing and cardiorespiratory care personnel and who also works in another employment category that is not subject to the collective agreement of the FIQ, must be covered under all mandatory benefits of the life and long-term disability insurance plans of the employer or in the employment category covered by the FIQ's collective agreement. For the purpose of the administration of the long-term disability insurance plan, only the category of nursing and cardiorespiratory care personnel is considered.

4. Enrolment

4.1. Health insurance plan

4.1.1 General provisions

All eligible employees must complete an application for enrolment in the health insurance plan within 30 days following the start date of their eligibility. Each employee must indicate their choice of module, as well as their coverage status, on the application.

4.1.2 Choice of coverage status

The following coverage statuses are available for the health insurance plan:

- Individual coverage;
- Family coverage;
- Single-parent coverage.

4.1.3 Absence of application

An eligible employee who refuses or omits to complete an application is automatically insured under the health insurance plan's Bronze module, with individual coverage, subject to exercising her exemption privilege.

The same provisions apply to an employee who is unable to complete an insurance application, but in this case, the coverage type is established based on her marital status.

Any later request to change modules or coverage status takes effect on the date the request is signed.

4.2. Health insurance plan – Provisions applicable to the modular plan

4.2.1 Description of the modules

The health insurance plan offers the following three modules:

- Bronze module;
- Silver module;
- Gold module.

4.2.2 Minimum period of participation

This modular plan stipulates a minimum period of participation of 24 months before the participant can switch to a lower-level module, whether or not she has a life event leading to a change in her family situation. Participants may switch to a higher-level module at any time.

However, the 24-month minimum period of participation is considered to be completed on this contract's effective date for participants who had the basic prescription drug plan and the extended plan III under the previous contract and who are maintaining equivalent coverage, i.e. the Silver module, under this contract.

4.2.3 Participants who are totally disabled or temporarily absent from work

A participant who is totally disabled or temporarily absent from work on this contract's effective date will automatically be assigned one of the following modules, depending on her situation:

- Bronze module, if the participant only had the basic prescription drug plan under the previous contract; or
- Silver module, if the participant had the basic prescription drug plan and the extended health III under the previous contract.

If the participant wants to switch modules at the end of her period of total disability or temporary absence from work, she must fill out a request to that effect within 30 days from the date of her effective return to work. In that case, the change in module takes effect on the date of her effective return to work.

If the request is not submitted within the required time frame, the change in module takes effect on the date the request is signed.

4.2.4 Effective date of a change in module at the end of a minimum period of participation

If the participant wants to switch to a lower-level module at the end of a minimum period of participation, she must fill out a request to that effect within 30 days of the period's end date. In that case, the change in module takes effect on the end date of the minimum period of participation.

If the request is not submitted within the required time frame, the change in module takes effect on the date the request is signed.

If the participant wants to switch to a higher-level module, the change takes effect on the date the request submitted by the participant to that effect is signed.

4.3. Dental care plan

4.3.1 General provisions

Any eligible employee can complete an application for enrolment in the dental care plan at any time. On that application, the employee must indicate her choice of coverage status.

4.3.2 Choice of coverage status

The coverage statuses available for the dental care plan are the same as the ones for the health insurance plan.

The coverage status chosen for the dental care plan may, however, be different from the one chosen for the health insurance plan. The possible combinations of coverage statuses for the health insurance and dental care plans are as follows:

Situations	Possible combinations ¹						
	1	2	3	4	5	6	7
Health insurance plan	E	E	I	SP	SP	F	F
Dental care plan	I	F	I	I	SP	I	F

1. I = Individual coverage, SP = Single-parent coverage, F = Family coverage, E = Exemption

4.3.3 Minimum period of participation

This dental care plan has a minimum period of participation of 36 months, whether or not there is a life event leading to a change in the participant's family situation.

However, the 36-month minimum period of participation is considered to be completed on this contract's effective date for participants who had the extended plan I under the previous contract.

4.3.4 Participants who are totally disabled or temporarily absent from work

A participant who is totally disabled or temporarily absent from work on this contract's effective date will automatically be assigned the dental care plan only if she had the extended plan I under the previous contract.

If the participant wants to enrol in the dental care plan at the end of her period of total disability or temporary absence from work, she must fill out an application to that effect within 30 days of the date of her effective return to work. In that case, the dental care plan takes effect on the date of her effective return to work.

If the application is not submitted within the required time frame, the dental care plan takes effect on the date the application is signed.

4.3.5 Termination of participation in the dental care plan after a minimum period of participation

If the participant wants to terminate her participation in the dental care plan at the end of a minimum period of participation, she must fill out a request to that effect within 30 days from that period's end date. In that case, participation in the dental care plan terminates on the end date of the minimum period of participation.

If the request is not submitted within the required time frame, participation in the dental care plan terminates on the date the request is signed.

4.4. Life and long-term disability insurance plans

4.4.1 General provisions

All eligible employees must complete an application for enrolment in the life and long-term disability insurance plans within 30 days of the date on which she becomes eligible. Employees must indicate their choice of optional life insurance coverage amounts, if applicable, on the application.

In addition, an employee exercising her exemption privilege to opt out of the health insurance plan and who does not participate in the dental care plan must also provide information about her dependents, as defined in this contract, if any.

4.4.2 Absence of application

An eligible employee who refuses or omits to complete an application is automatically insured under the participants' basic life insurance and basic AD&D insurance and the long-term disability insurance plan.

The same provisions apply to an employee who is unable to complete an insurance application, but in this case, the spouse's and dependent children's life insurance is granted based on her marital status.

Any later request to add coverage takes effect on the date the request is signed or on the date of the Insurer's approval of the evidence of insurability for the relevant insurance coverage.

5. Exemption Privilege

An employee may, after giving written notice to her employer, be exempted from coverage under the health insurance plan, if she proves that she and any dependents are covered under another group insurance that includes similar coverage.

An employee who opted to waive coverage under the health insurance plan, in accordance with the above paragraph, may later enrol in in these plans at a later date, pending the following conditions:

- a) She must:
 - i) establish that she and any dependents were previously insured under this group insurance plan or under any other plan that provided similar coverage;
 - ii) establish that it has become impossible for her and any dependents to continue to be insured;
 - iii) apply 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 not submitted within the required time frame, this plan takes effect on the date the application is signed.
- b) Notwithstanding what is stated in paragraph (a) above, if an employee wishes to reinstate this health insurance plan without terminating the insurance that entitled her to the exemption, she may enroll in the requested module and coverage status, effective on the date the application is signed.

6. Evidence of Insurability

Evidence of insurability deemed satisfactory by the Insurer must be submitted under the following circumstances:

- a) For participant's optional life insurance (maximum: \$100,000) in the amount of \$100,000, requested within 30 days of the date on which she becomes eligible for that benefit;

- b) For any amount of participant's optional life insurance (maximum: \$100,000), requested more than 30 days from the date on which she becomes eligible for that benefit or for any additional amount of in-force participant's optional life (maximum: \$100,000);
- c) For any amount of participant's optional life insurance (over \$100,000);
- d) For any amount of spouse's optional life insurance;
- e) For the addition of any further units of in-force participant's optional life insurance (over \$100,000) or spouse's optional life insurance.

The Insurer reviews the evidence of insurability on an individual basis for each insured person. It reserves the right to decline coverage to the participant or her spouse after reviewing the evidence.

Lastly, when evidence of insurability must be submitted to the Insurer for an optional insurance benefit, any omission, non-disclosure or misrepresentation by the person concerned at the time of enrolment in this insurance benefit could nullify it and void the payment of the applicable insurance amount. Similarly, any omission, non-disclosure or misrepresentation by the person concerned at the time additional units of insurance are requested under this insurance benefit could nullify the additional units.

7. Effective Date of Coverage

7.1. Employees

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

- a) For the health insurance plan, if the employee has recently become eligible and has not exercised her exemption privilege: on the date on which she becomes eligible, whether or not she is at work on that date;
- b) For the health insurance plan, if the employee has obtained an exemption and submits her request to terminate the exemption within the required time frame: on the date on which the insurance entitling her to an exemption terminates;
- c) For the health insurance plan, if the employee has obtained an exemption and submits her request to terminate the exemption after the required time frame: on the date the request to terminate the exemption is signed;
- d) For the dental care plan, if the employee has recently become eligible and submits her insurance application within the required time frame: on the date on which she becomes eligible;
- e) For the dental care plan, if the employee submits her insurance application more than 30 days after the date on which she becomes eligible: on the date the enrolment application is signed;
- f) For the life and long-term disability insurance plans: on the start date of the employee's eligibility, provided that she is at work or fit for work on that date; otherwise, on the date of her effective return to work at the end of the disability period;

- g) On the date when the Insurer approves the evidence of insurability for the concerned insurance benefits, provided that the employee is at work or fit for work on that date; otherwise, on the date of her effective return to work at the end of the disability period;
- h) For the health insurance and dental care plans, as well as for AD&D coverage: on the date of the employee's effective return to work, after having had her participation in the coverage terminated upon expiration of the maximum waiver of premium period;
- i) For an employee whose work schedule has been increased to more than 25% of a full-time schedule: on January 1 of the year following the reference period;
- j) For an employee working 25% or less of a full-time schedule, who decides to enroll in the insurance plans after having used the provisions specific to part-time employees working 25% or less of a full-time schedule: on January 1 of the year.

7.2. 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 becomes eligible: on the date of the life event justifying the application;
- c) If the person is the first dependent for whom the participant applies for insurance and if that person was previously eligible but not insured and the insurance application is not submitted within the required time frame: on the date the application is signed;
- d) For spouse's optional life: on the date when the Insurer approves the evidence of insurability.

Under no circumstances will coverage of a dependent begin before that of the employee.

8. Coverage Status Changes for In-Force Coverage Following a Life Event

For the purposes of this contract, the following life events may give entitlement to a change in coverage status:

- a) birth or adoption of a child;
- b) marriage, civil union or cohabitation, in accordance with the criteria set out in the definition of spouse under this contract;
- c) divorce, marriage annulment, dissolution of the civil union or de facto separation, in accordance with the criteria set out in the definition of spouse under this contract;

- d) termination of the dependent's eligibility, in accordance with the criteria set out in the definition of dependent under this contract.

The participant must complete a request for a coverage status change within 30 days from the date of the life event leading to a change in her family situation. In that case, the coverage status change takes effect on the date of that event.

If the request is not submitted within the required time frame, the change in coverage status takes effect on the date the request is signed.

When a coverage status is changed, any minimum period of participation in progress for the participant's health insurance module and dental care plan, if any, continues.

9. Retroactive Salary Adjustments

Should any retroactive adjustments be made as a result of changes to a participant's salary, the Insurer retroactively adjusts the benefits paid under the long-term disability insurance plan. The corresponding premiums must also be paid on the change in salary.

10. Continuity of Coverage in the Event of a Work Stoppage

Participation in insurance plans may be maintained during certain temporary work stoppages in accordance with the following terms and conditions. These terms are applicable subject to any legal provisions governing temporary absences.

Payment of the applicable premiums is required to maintain coverage under insurance plans during a temporary absence.

10.1. Types of temporary absences from work

10.1.1 Protective reassignment and maternity leave

In the event of protective reassignment or maternity leave, the participant's coverage under all of the plans in which the participant was enrolled before the start of her temporary absence is automatically maintained.

However, the participant may suspend her coverage under those plans, keeping only the Bronze module of the health insurance plan. In that case, any minimum period of participation in progress for the health insurance module and the dental care plan, if any, is likewise suspended.

In addition, a participant suspending her participation in her insurance plans at the start of or during a temporary work stoppage may not subsequently reinstate it during that same absence.

The employer and the participant continue to pay their respective premiums.

10.1.2 Leave with or without pay of four weeks or less

In the event of leave with or without pay lasting four weeks or less, coverage under all of the plans in which the participant was enrolled before the start of her temporary leave of absence is automatically maintained.

The participant continues to be covered, as do any dependents.

The employer and the participant continue to pay their respective premiums.

10.1.3 Leave without pay of more than four weeks

In the event of leave without pay lasting more than four weeks, coverage under all of the plans in which the participant was enrolled before the start of her temporary leave of absence is automatically maintained.

However, the participant may suspend her coverage under those plans, keeping only the Bronze module of the health insurance plan. In that case, any minimum period of participation underway for the health insurance module and the dental care plan, if any, is likewise suspended.

In addition, a participant suspending her participation in her insurance plans at the start of or during a temporary leave of absence may not subsequently reinstate it during that same absence.

The participant pays the full premium (for the employer and participant) through her employer. However, if the temporary leave of absence is for family or parental reasons, as stipulated by the *Act respecting labour standards*, the employer and the participant continue to pay their respective premiums.

10.1.4 Part-time leave without pay

In the event of part-time leave without pay, coverage under all of the plans in which the participant was enrolled before the start of her temporary leave of absence is maintained.

The participant continues to be covered, as do any dependents.

The employer and the participant continue to pay their respective premiums.

The premium and the amount of long-term disability insurance coverage are calculated based on the salary that would be paid if the participant were 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. If the participant does not use that option at the beginning of her part-time leave without pay, she cannot do so at a later date during her part-time leave without pay.

During part-time leave without pay, the participant may not take advantage of the particular provisions applicable to part-time employees working 25% or less of a full-time schedule.

10.1.5 Leave with a deferred pay plan

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

During the contribution period, coverage under all of the plans in which the participant was enrolled before the start of her temporary leave of absence is maintained.

The participant continues to be covered, as do any dependents.

The employer and the participant continue to pay their respective premiums.

The premium and the amount of long-term disability insurance coverage are calculated based on the salary the participant would have received if she were not taking a deferred pay leave or on the reduced salary if the participant chooses this option before the beginning of her participation in this plan. If the participant does not use that option at the beginning of her participation in the deferred pay leave plan, she cannot do so at a later date during her participation in that plan.

During the period of leave, the participant is considered to be on leave without pay and the provisions for leave without pay for more than four weeks apply.

If the participant has chosen to maintain coverage under all of the plans in which the participant was enrolled before the start of her temporary leave of absence, the premium and the amount of long-term disability insurance coverage are the same as those she chose at the beginning of her participation in the leave with deferred pay plan.

10.1.6 Suspension

During a period of suspension of four weeks or less, the provisions are those described for a leave with or without pay of four weeks or less.

During a period of suspension of more than four weeks, the provisions are those described for leave without pay of more than four weeks.

10.1.7 Temporary layoff

In the event of a temporary layoff, coverage under all of the plans in which the participant was enrolled before the start of her temporary absence is maintained.

The participant continues to be covered, as do any dependents.

The employer and the participant continue to pay their respective premiums.

10.1.8 Dismissal contested by grievance

A participant who contests her dismissal by way of a grievance or arbitration under the terms of the Labour Code, may either maintain her coverage under all of the plans in which she was enrolled before the start of her temporary absence or suspend that coverage, continuing only with the health insurance plan's Bronze module.

In that case, any minimum period of participation underway for the health insurance module and the dental care plan, if any, is likewise suspended.

The participant must notify the employer of her choice in this respect within 30 days of filing the grievance. She and any dependents may continue to be insured until the final decision, including any appeals, has been rendered.

The participant pays the full premium (for the employer and participant) through her employer.

If the dismissal is settled between the parties, the participant's coverage under the insurance plans ceases on the date the settlement is signed, unless there is an effective return to work.

10.1.9 Strike or lockout

During a strike or lockout, coverage under all of the plans in which the participant was enrolled before the start of her temporary absence is maintained.

The participant continues to be covered, as do any dependents.

The employer and the participant continue to pay their respective premiums.

10.2. General provisions on temporary absences

10.2.1 Suspension of coverage under insurance plans during a temporary absence and effective return to work

When a participant suspends insurance coverage under the plans during a temporary absence, coverage under those same plans automatically resumes upon her effective return to work.

The participant is insured again, as are any dependents, with the same benefits, module and coverage status as before the beginning of the temporary absence.

In addition, any minimum period of participation underway before the beginning of the temporary absence for the health insurance module and the dental care plan, if applicable, resumes where it left off.

10.2.2 Change in insurance plans during a temporary absence

A participant whose family situation changes during a temporary absence may request a change in coverage status for the relevant benefits, as per the same provisions as those in place before the beginning of the temporary absence.

However, only a participant who maintains her coverage in all of the plans in which she was enrolled before the beginning of her temporary absence may change her health insurance module or enrol in or terminate the dental care plan during the temporary absence. The participant may then make those changes as per the same provisions as those in effect before the beginning of the temporary absence.

10.3. Disability beginning during a temporary leave of absence

Unless otherwise stated, when a disability period begins during one of the temporary absences described in sections 10.1.1, 10.1.2, 10.1.3, 10.1.5 and 10.1.6 above, and if the participant has maintained coverage in the long-term disability insurance plan, for purposes of administration of the waiver of premiums and of the long-term disability insurance plan, the start of the disability period is defined as the date she is scheduled to return to work.

A participant who does not effectively return to work at the end of the maximum waiver of premium period cannot maintain her coverage under her plans during a leave without pay.

10.4. Special provisions for participants who work part time

For a participant who works part-time and has maintained her coverage under the long-term disability insurance plan during a temporary leave, the premium 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 temporary leave, during which no period of disability, parental leave, leave without pay, annual vacation or union leave has been authorized.

Should a participant who works part time become disabled during such a period, the benefits payable are based on her annualized salary on the day the waiting period ends, 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).

11. Termination of Coverage

11.1. Participants

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

- a) the date on which the participant retires;
- b) for participant's optional life insurance (over \$100,000): the date on which the participant turns 65;
- c) for travel insurance and assistance: the date on which the participant turns 75;
- d) for the long-term disability insurance plan: the date on which the participant turns 63;
- e) the date on which the participant ceases to be eligible, subject to the conversion privilege provisions, if applicable. If a union disaffiliates from the FIQ, all of the participants' insurance will terminate no later than the 45th day following the date of the Insurer's receipt of written notice from the Policyholder, informing the Insurer of the disaffiliation;
- f) the date on which this contract terminates, subject to the premium waiver conditions;

- g) for the dental care plan: January 1 following the date on which the participant uses the provisions specific to part-time employees working 25% or less of a full-time schedule;
- h) the date of the participant's death;
- i) the date on which the Insurer receives written notice from the participant wishing to cease participation in an optional insurance benefit, subject to the minimum period of participation in the dental care plan;
- j) the final due date of any unpaid premium, if not paid to the Insurer before expiration of the grace period stipulated in this contract and after all the required legal notices have been sent within the allotted time frames;
- k) for health insurance and dental care plans, as well as for AD&D insurance benefits: the date on which the maximum waiver of premium period ceases, subject to the premium waiver conditions set out in this contract.

11.2. Dependents

The dependents' coverage terminates at midnight on the earliest of the following dates:

- a) the date on which the participant's insurance plan terminates, subject to the conversion privilege provisions, if applicable;
- b) for spouse's optional life insurance: the date on which the spouse turns 65;
- c) the date on which this contract terminates, subject to the premium waiver conditions;
- d) the date on which they cease to be dependents;
- e) the date on which the Insurer receives written notice from the participant wishing to terminate participation of one or all dependents in an insurance benefit.

12. Provisions Pertaining to the Change in Insurers

The Insurer guarantees continuity between this contract and the previous contract for participants and their dependents who were covered under the previous contract.

As a result, the participant and dependents who were covered under the previous contract cannot be denied enrolment or benefit payments by the Insurer due solely to pre-existing conditions that did not apply or that were not included in the previous contract or because the participant was not actively at work on the effective date of this contract.

Participants and their dependents who were covered under the previous contract are automatically covered under this contract as of the cancellation date of the previous contract, if termination of the participant's coverage is due solely to the cancellation of the contract, and the participant belongs to a class of eligible employees under this contract.

Subject to any legal provisions, the Insurer is not liable for the payment of insurance and benefit amounts which may be owed to a participant covered under the clauses of a previous contract pertaining to extension of coverage, recurrence of total disability, waiver of premiums, the conversion privilege or any other provision provided for in that previous contract.

WAIVER OF PREMIUMS

1. Participants' Eligibility Conditions for a Waiver of Premiums

If a participant is recognized as totally disabled by the Insurer while covered under this contract, her coverage continues without payment of premiums as of the expiration of the period indicated in the *Schedule of Benefits* for any insurance benefit subject to the waiver of premiums.

2. Termination of a Waiver of Premiums

2.1. Health insurance and dental care plans

The waiver of premiums terminates on the earliest of the following dates:

- a) the date of the end of the participant's disability period;
- b) the date of the end of a maximum period of 36 months, if the employment relationship is not maintained after that period;
- c) the date of the end of a maximum period of 48 months, if the employment relationship is maintained after a 36-month period of waiver of premiums;
- d) the date on which this contract terminates;
- e) the date on which the participant retires.

However, when a disability is recognized under the *Act respecting industrial accidents and occupational diseases*, the waiver of premiums continues to apply until the participant receives full income replacement benefits under the aforementioned act.

2.2. Life and long-term disability insurance plans

The waiver of premiums terminates on the earliest of the following dates:

- a) the date of the end of the participant's disability period;
- b) the date on which the participant turns 65.

However, if the disability begins at age 62 or later, the premiums for participant's basic life insurance, participant's optional life insurance (maximum: \$100,000), participant's basic and optional AD&D coverage and spouse's and dependent children's life insurance may continue to be waived beyond age 65, subject to a maximum period of 36 months, but not beyond the date on which the participant turns 71.

In all cases, the maximum duration for the waiver of premiums for participant's basic and optional AD&D insurance is 36 months and may not exceed the date on which the participant turns 71.

However, when a disability is recognized under the *Act respecting industrial accidents and occupational diseases*, the waiver continues to apply for participant's basic life insurance, participant's optional life insurance (maximum: \$100,000) and spouse's and dependent children's life insurance, for as long as the participant is entitled to full income replacement benefits under the aforementioned act.

3. Temporary Assignments and Waivers

The provisions for the waiver of premiums in the event of disability do not apply during a temporary assignment if the participant receives the same salary as before the start of her disability.

4. Gradual Return to Work or Temporary Assignment and End of the Maximum Waiver of Premium Period

In the case of a gradual return to work or of a full-time or reduced-time temporary assignment, and so long as the employment relationship exists at the end of the maximum waiver of premium period, the participant's coverage under the health insurance and dental care plans is maintained, and the premiums are again paid as usual to the Insurer.

5. Limitations and Exclusions

No waiver of premiums is granted during a disability period:

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

LIFE INSURANCE PLAN

1. Definitions

In addition to the definitions in the *General Definitions* section, the following applies specifically to the life insurance plan, where appropriate.

- a) **Non-smoker:** A person who meets the Insurer's conditions for non-smoker status at the time the Status Statement is completed.
- b) **Loss:**
 - For a hand or foot: Total, permanent and irrecoverable loss of use, or amputation at or above the wrist or the ankle joint;
 - For a digit: Irrecoverable loss of use, or amputation at the first joint between the digits and the hand or foot;
 - For an eye: Total, permanent and irrecoverable loss of vision in that eye;
 - For hearing: Total, permanent and irrecoverable loss of hearing;
 - For speech: Total, permanent and irrecoverable loss of speech.
- c) **Advance benefit payment value:** The total payments made for an advance benefit payment in the event of terminal illness, plus the related interest accrued from the payment date to the date of the death of the totally disabled participant or spouse.

2. Purpose of the Coverage

In the event of the death of a participant covered under one or more life insurance plans, the Insurer pays the insurance amount to the participant's beneficiary.

In the event of the death of a participant's dependent covered under one or more life insurance plans, the Insurer pays the insurance amount to the participant.

3. Participant's Basic Life Insurance

In the event of the participant's death, the Insurer pays the amount indicated in the *Schedule of Benefits*.

4. Spouse's and Dependent Children's Life Insurance

The life insurance amount payable in the event of the death of the participant's spouse or dependent child is indicated in the *Schedule of Benefits*.

5. Participant's Optional Life Insurance (maximum: \$100,000)

In the event of the death of the participant, the Insurer pays the insured amount chosen by the participant (maximum: \$100,000). The available insurance amounts are indicated in the *Schedule of Benefits*.

Exclusion: No benefits shall be paid for participant's optional life insurance (maximum: \$100,000) 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 the participant dies within the 12 months following the application.

6. Participant's Optional Life Insurance (over \$100,000)

In the event of the death of the participant, the Insurer pays the insured amount chosen by the participant (over \$100,000). The available insurance amounts are indicated in the *Schedule of Benefits*.

At no time may the total insurance amounts payable under the participant's optional life insurance benefits exceed \$500,000.

Exclusion: No benefits are payable for participant's optional life insurance (over \$100,000) if the participant commits suicide in the first 12 months that this coverage is in effect.

7. Advance benefit payment in the event of terminal illness for the participant

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 basic and optional life insurance benefits payable upon the participant's death.

The advance benefit payment is limited to the percentage indicated in the *Schedule of Benefits*. This percentage applies to the amount of life insurance (basic and optional) held by the participant at the time the request is made, without going below the minimum amount indicated in the *Schedule of Benefits*.

At the death of the participant, the value of the advance benefit payment is 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.

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 interest rate will be the one established immediately after the payment of the advance benefit payment, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

Exclusion: The advance benefit payment 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 advance benefit payment is paid, the value of the advance benefit payment will be repaid to the Insurer by the recipient of the advance benefit payment.

8. Spouse's Optional Life Insurance

In the event of the death of the spouse, the Insurer pays the insured amount chosen by the participant. The available insurance amounts are indicated in the *Schedule of Benefits*.

At no time may the total amounts payable under the spouse's optional life insurance benefits exceed \$500,000.

Exclusion: No benefits are payable for spouse's optional life insurance if the spouse commits suicide in the first 12 months that this coverage is in effect.

9. Advance benefit payment in the event of terminal illness for the spouse

Subject to the approval of the Insurer, any totally disabled spouse whose life expectancy is less than 12 months may apply for payment of a portion of the sum insured under spouse's optional life insurance benefits payable upon the spouse's death.

The advance benefit payment is limited to the percentage indicated in the *Schedule of Benefits*. This percentage applies to the amount of optional life insurance held by the participant for her spouse at the time the request is made.

At the death of the spouse, the value of the advance benefit payment 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.

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 interest rate will be the one established immediately after the payment of the advance benefit payment, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

Exclusion: The advance benefit payment 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 advance benefit payment is paid, the value of the advance benefit payment will be repaid to the Insurer by the recipient of the advance benefit payment.

10. Participant's Basic and Optional AD&D Insurance

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 a loss occurs within 365 days of the accident, the Insurer pays the participant or her beneficiary, as the case may be, the percentage corresponding to the sum of the amounts insured under the participant's basic life insurance and optional life insurance (maximum: \$100,000), as indicated in the *Schedule of Losses and Benefits*.

Schedule of Losses and Benefits	
Loss	Percentage
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%.	

Limitations and exclusions related to participant's AD&D

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.

11. Beneficiaries

On the effective date of this contract or of the participant's coverage, if later, the beneficiary of the life insurance plan is "her legal heirs," unless the participant sends written notice to the Insurer's head office designating one or several beneficiaries.

Subject to any legal provisions, the participant may designate, revoke or change one or more beneficiaries at any time by submitting a written request to the Insurer's head office. The rights of a beneficiary who dies before the participant revert to the participant.

The Insurer is not responsible for verifying the validity of any designation, revocation or change of beneficiary.

If the participant does not make a specific designation, any insurance amount that is payable at the death of a participant is paid to her successors.

If more than one beneficiary is designated with no indication of their respective interests, the payable insurance amounts are divided between the beneficiaries in equal proportions.

Any insurance amount payable at the death of an insured dependent is paid to the participant if she is still living. If the participant is deceased, that amount is paid:

- to the spouse, if she is alive;
- otherwise, to the legal heirs of the concerned dependent.

The participant's basic and optional AD&D insurance amount that is payable for a loss other than loss of life is paid to the participant.

12. Conversion Privilege

All life insurance benefits held by a participant include a conversion privilege applicable in the situations described below, according to the conditions set out for each.

The conversion privilege enables the participant to convert all or a portion of the participant's group life insurance amounts, or that of any dependents, into an individual life insurance amount.

The premiums of the individual life insurance contract are established according to applicable legal provisions. The first premium must be paid within 31 days after occurrence of the situation that allows the conversion privilege to be exercised.

12.1. Termination of the participant's eligibility under the group insurance contract

Participants who are no longer eligible under the group insurance contract may use the conversion privilege without having to present evidence of insurability.

A written application for conversion must be submitted to the Insurer within 31 days of the date of conversion eligibility in order to convert for the value of their life insurance or that of their dependents.

The insurance amount available for conversion to an individual life insurance contract is the lesser of the following amounts:

- a) the total of the participant's or spouse's and dependent children's life insurance amounts on the date the conversion privilege is exercised; or
- b) \$400,000; or
- c) the amount set out in any legal provisions, if this amount is higher than the amount above; or
- d) the difference between the participant's total life insurance amounts at the time the conversion privilege is exercised and the amount obtained under the group insurance plan of the retirees offered by the Insurer (RIIRS).

The participant's or spouse's and dependent children's life insurance amounts remain in force until the date the conversion privilege is exercised, up to the 31-day time frame set out above.

Participants cannot exercise their conversion privilege with regard to any amount of life insurance for themselves or their dependents that has been lost as a result of a reduction due to a change in age or a transfer from one class of eligible employees to another.

12.2. Termination of this contract or the life insurance benefit

Participants whose group insurance contract or life insurance benefit terminates and is not replaced, or whose new contract provides a lower insurance amount than the one provided by this contract, may convert their life insurance amount without having to provide evidence of insurability.

In order to exercise this privilege, a participant must have been covered under this contract for a continuous period of five years immediately prior to the date the contract or life insurance benefit terminates. In addition, the participant must submit a written request to the Insurer within 31 days after the termination date.

The insurance amount available for conversion to an individual life insurance contract is the greater of the following amounts:

- a) 25% of the total life insurance amounts held by the participant on the date the conversion privilege is exercised; or
- b) \$5,000.

HEALTH INSURANCE PLAN

1. Definitions

In addition to the definitions in the *General Definitions* section, the following applies specifically to the health insurance plan, where appropriate.

- a) **Commercial activity:** An assembly, conference, convention, exhibition, show or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legal provisions, regulations and policies of the region where it will be held. It must also be the sole reason for the planned trip.
- b) **Travel assistance firm:** The travel assistance service provider designated by the Insurer. The Insurer reserves the right to modify the travel assistance services available or replace the travel assistance firm without notice.
- c) **Hospital centre (hospital):** A hospital centre as defined by the *Act respecting health services and social services* (R.S.Q., c. S-4.2, c. S-5); outside Quebec, “hospital centre” refers to any facility which meets the same criteria.
- d) **Travel companion:** The person with whom the insured person shares accommodation or transportation expenses.
- e) **Prior authorization drug list:** A list of prescription drugs for which the insured person must obtain prior authorization before they are eligible under this contract. The Insurer establishes this list and may revise it at any time.
- f) **Equivalent drug:** A brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.
- g) **Immediate family member:** The spouse, child, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, brother-in-law, sister-in-law, stepdaughter, daughter-in-law, stepson, son-in-law, grandparents and grandchildren of the insured person.
- h) **Trip:** Travel for the purposes of tourism, leisure, business or participating in a commercial activity requiring the insured person’s absence from the province of residence.

2. Purpose of the Coverage

The Insurer reimburses the reasonable and customary expenses for services, care, treatment and supplies that are medically required and necessary for treatment of the insured person as the result of an illness, accident, pregnancy or complication of pregnancy or surgical procedure related to family planning, or the donation of an organ or bone marrow subject to medical follow-up.

3. Reimbursement Terms and Conditions

Eligible expenses for services, care, treatment and supplies are reimbursed according to the terms and conditions indicated in the *Schedule of Benefits*, **depending on the chosen module**.

4. Hospital and Transportation Expenses

4.1. Hospitalization

Hospital expenses incurred in Quebec, up to the cost stipulated in the *Schedule of Benefits*, with no limit as to the 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.

4.2. Ambulance

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 or immediately before transportation.

4.3. Air or train transportation

As medically prescribed, transportation by air or by train for a bedridden patient, when such transportation is required for part of the trip; transportation by air or by train 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; and 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.

5. Prescription Drug Expenses

5.1. Eligible prescription drug expenses

The Insurer reimburses the following products, as per the *Schedule of Benefits* and the **chosen module**:

- a) Prescription 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 by medical prescription from a physician or a dental surgeon 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 by prescription, for which the therapeutic indication 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 by prescription may be reimbursed under certain conditions;
- d) preventive vaccines, i.e. the cost of the substance, administered by a physician or a nurse, the purpose of which is to prevent or treat an illness.

5.2. Prior authorization drug list

Drugs on the prior authorization drug list must meet the criteria determined by the Insurer. To this end, the required form must be completed by a health professional at the insured person's expense. This form may be obtained from the Insurer.

5.3. Mandatory substitution of the least expensive drug for the prescribed drug

Only expenses for purchasing the least expensive drug equivalent to the prescribed drug are eligible, even if the health professional has indicated on the prescription that there is to be no substitution.

An insured person wishing to obtain reimbursement of the cost of a prescribed drug must have the required form completed by a health professional, at the insured person's own expense, and submit it to the Insurer for review. This form may be obtained from the Insurer.

5.4. Limitations and exclusions applicable to prescription drug expenses

Reimbursements made by the Insurer are reduced by the payments made under another public or private plan. No reimbursement shall be made for:

- a) shampoos and hair growth products;
- b) expenses incurred as a result of an accident or illness contracted while the insured person is in the service of the armed forces;

- c) 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;
- d) products for cosmetic or aesthetic care;
- e) so-called "natural" products;
- f) infertility treatments;
- g) drugs prescribed for the treatment of erectile dysfunction;
- h) expenses incurred as a result of the insured person's active participation in an insurrection, a riot, a war (whether declared or not) or a civil war;
- i) drugs or products used as smoking cessation aids that are not covered under the Basic Prescription Drug Insurance Plan (RGAM) and expenses in excess of the maximum provided for smoking cessation aids under that same plan;
- j) services, treatments or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If that 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 and restrictions 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 (RGAM) in terms of benefits.

Finally, subject to any legal provisions applicable in the insured person's province of residence, the Insurer reserves the right to adopt measures which exclude, limit or terminate reimbursement of the expenses for a prescription drug or change the eligibility criteria. Furthermore, the Insurer reserves the right to exclude a drug when its cost could significantly affect the risk covered under this insurance benefit or to modify the rates applicable to it. The above notwithstanding, any changes made to the plan require an agreement between the Policyholder and the Insurer.

6. Travel Insurance and Assistance

The reasonable and customary expenses and services described below are eligible for reimbursement if an insured person, covered under public health and hospital insurance plans for her province of residence, incurs emergency expenses as a result of an accident or illness that occurs during a stay outside her province of residence.

These benefits are awarded in addition to, not in lieu of the benefits offered by government programs.

The lifetime maximum reimbursement is \$5,000,000 per insured person.

All benefit amounts are indicated in Canadian dollars.

6.1. Eligible expenses

6.1.1 Hospital, medical and paramedical expenses

- a) Expenses for hospitalization in a semi-private or private room, in excess of those reimbursed or reimbursable by public hospital insurance and health insurance plans in the province of residence of the insured person.
- b) The expenses inherent to hospitalization (telephone, television, parking, etc.), on presentation of receipts, up to a maximum of \$200 per hospitalization per insured person.
- c) The professional fees of a physician for medical or surgical care or anaesthesia, other than fees for dental care; only that portion of the expenses incurred that exceed the benefits payable under public hospital insurance and health insurance plans in the insured person's province of residence are payable.
- d) The cost of drugs obtained by prescription from a physician as part of an emergency service.
- e) The professional fees of a registered nurse for private care received in a hospital, when medically required and prescribed by the attending physician. The nurse must be a member in good standing of a professional association recognized by the competent authorities in the place where care is provided. The maximum reimbursement is \$3,000 per insured person. The nurse must not however be related to the insured person or be her travel companion.
- f) The rental of therapeutic equipment and the purchase of hernia trusses, corsets, crutches, splints, casts and other orthopaedic appliances when prescribed by the attending physician.
- g) The professional fees of a dental surgeon for accidental damage to natural, healthy living teeth, caused by an accident occurring outside the province of residence of the insured person. The maximum reimbursement is \$1,000 per accident per insured person. In addition, the covered expenses must be incurred within 12 months of the accident.

6.1.2 Transportation expenses

- a) Transportation expenses by air or surface ambulance for taking the insured person to the nearest appropriate medical institution. Expenses for transfers between hospitals are also covered when the attending physician and the travel assistance firm deem that the establishment where the insured person is hospitalized cannot adequately treat or stabilize the insured person's condition.

- b) 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. If required by her condition, the travel assistance firm sends a medical attendant to accompany the insured person during repatriation. Repatriation must be approved and arranged by the travel assistance firm.
- c) If the insured person is transported home or to a hospital, the travel assistance firm organizes and pays for a public carrier ticket to transport the insured person's dependents or travel companion, as applicable, to their province of residence, if the means of transport initially planned cannot be used, up to the price of a regular flight, train or bus ticket.
- d) If the insured person's state of health precludes their medical repatriation and compels their out-of-province hospitalization for more than seven days, the travel assistance firm arranges and pays for an economy fare for round-trip air, bus or train transportation by the most direct route for one immediate family member, living in the insured person's province of residence, to visit the insured person in hospital. 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 or if the visit is not approved and arranged by the travel assistance firm.
- e) The travel assistance firm makes the necessary arrangements to return any children under the age of 18 and accompanying the insured person to their homes if, after the insured person's accident or illness, she or any other accompanying adult is unable to look after them.
- f) If an insured person is unable to drive the motor vehicle used during a trip, after an illness or accident occurred during that trip, and if no other person accompanying her is able to drive that vehicle, the travel assistance firm pays for the expenses incurred by a commercial agency to return the insured person's personal or rented vehicle to her home or to the car rental agency's closest branch to the site of the event. The maximum reimbursement is \$1,000 per insured person.
- g) If the insured person should die, the travel assistance firm will, when necessary, arrange and pay for 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, provided that the insured person was not accompanied by an immediate family member aged 18 or over.

- h) If the insured person should die, the travel assistance firm pays for the costs of preparation and the return of the body or ashes to the place of burial in the province of residence. The cost of the burial coffin is not covered. The maximum reimbursement is \$5,000, or up to \$3,000 for the cost of cremation or burial on-site.

6.1.3 Daily allowance

The cost of accommodation and meals incurred in a commercial establishment 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. The maximum reimbursement is \$150 per day per insured person, for a maximum of eight days.

6.2. Travel assistance service

The travel assistance firm provides travel assistance services 24 hours a day, 365 days a year, to any insured person making such a request, anywhere in the world, except in countries at war or covered by a warning to travellers making it materially impossible for the travel assistance firm to intervene.

- a) Cash advances for expenses covered by travel insurance. Thereafter, the travel assistance firm claims reimbursement of the incurred expenses from the public hospital insurance and health insurance plans of the province of residence of the insured person and from the Insurer.
- b) In the event of accident or illness abroad, the travel assistance firm provides any necessary medical information in the form of simple advice and information, as well as the contact details for a medical facility. If necessary, the travel assistance firm facilitates the insured person's admission into an appropriate clinic or hospital.
- c) Subject to this contract, in the event that the insured person has an accident or contracts an illness outside her province of residence and as soon as it receives notice thereof, the travel assistance firm arranges the necessary contacts between its medical service, the attending physician and the family physician, if applicable, in order to make the best decisions for the situation.
- d) The travel assistance firm transmits urgent messages when the insured person is unable to do so herself.
- e) As far as possible, the travel assistance firm sends prescription drugs that are essential to the continuation of a treatment in progress, if they or their equivalent cannot be obtained on-site. In any case, the insured person pays for the prescription drugs, which are then reimbursed by the Insurer, if eligible.
- f) On presentation of receipts, the travel assistance firm reimburses the insured person for telephone and other communication expenses incurred to gain access to its services in the event of difficulties encountered abroad.

- g) At the request of the insured person, the travel assistance firm provides all necessary information, in the case of major problems during the insured person's trip, as a result of loss of her passport, visa, credit card, etc.
- h) The travel assistance firm offers a multilingual telephone interpreting service to the insured person encountering difficulties abroad.
- i) If the insured person is the subject of legal proceedings as a result of a traffic accident, a violation of any road safety code or any other civil offence, the travel assistance firm helps by providing lawyers' names.

6.3. Obligations of the insured person

- a) **NOTIFICATION:** The insured person must notify the travel assistance firm, as soon as possible, of the occurrence of the incident, accident or illness.
- b) **RESTRICTION:** As soon as she is able to do so, the insured person must obtain the travel assistance firm's prior agreement before taking any initiative or incurring any expense. If the insured person fails to meet this obligation, the travel assistance firm will be relieved of its obligations toward her.
- c) **UNUSED TICKETS:** When an insured person has been repatriated under the terms of her travel insurance coverage, the travel assistance firm reserves the right to claim the ticket in her possession that went unused as a result of the services provided by the travel assistance firm.
- d) **SUBROGATION:** For the purpose of this protection and for any sums advanced or reimbursed by the travel assistance firm, the insured person assigns and subrogates to the travel assistance firm all her rights and recourse to any reimbursement to which she is or may be entitled under any public or private insured service plan that are similar to those for which the travel assistance firm paid advances or expenses. The insured person agrees to sign any documents and perform any actions required by the travel assistance firm in order for this assignment and subrogation to take full force and effect, and specially appoints the travel assistance firm for those purposes as her proxy and representative in filing any claims and collecting any reimbursements.

6.4. Exclusions and reduction applicable to travel insurance and assistance

In addition to the exclusions and the reduction mentioned in the health insurance plan, no amounts are paid and no assistance is given to the insured person by the Insurer or the travel assistance firm in the following cases:

- a) if the claim event occurs in the province of residence of the insured person;
- b) if the insured person refuses, for no valid medical reason, to follow the recommendations of the travel assistance firm regarding her repatriation, the choice of hospital or the required care; "required care" refers to the treatment needed to stabilize the insured person's medical condition;
- c) if the insured person fails to communicate with the travel assistance firm as soon as possible in the case of a medical consultation or hospitalization after an accident or a sudden illness;

- d) if hospital expenses are incurred at hospital facilities for chronic illnesses, or in a chronic illness ward of a hospital centre, or for patients in extended care homes or spas;
- e) for elective or non-emergency surgery or treatment, or if the trip is undertaken with the aim of obtaining or the intention of receiving medical treatment or hospital services, whether or not the trip was recommended by a physician;
- f) for repatriation and travel assistance services, if the claim event takes place in a country at war (whether declared or not) or covered by a warning to travellers, during a riot, civil unrest, retaliations, restrictions to free movement, strike, explosion, nuclear activity, radioactivity or other force majeure events making it materially impossible for the travel assistance firm to intervene.

6.5. Coordination of benefits

This insurance is “second payer” insurance. The Insurer reimburses eligible expenses, subject to the exclusions and reductions of coverage under this contract, in excess of the benefits first paid under any public or private insurance plan, group or individual. It is understood that the rules for the coordination of benefits under different plans is done within the guidelines issued by the Canadian Life and Health Insurance Association.

7. Extended Health Care Expenses

7.1. Eligible extended health care expenses

The expenses indicated below are reimbursed as per the terms and conditions set out in the *Schedule of Benefits* and **based on the chosen module**.

a) **Artificial limb or eye, or breast prosthesis**

The purchase of artificial limbs, including an artificial eye, and other external prostheses and supplies prescribed by the attending physician, provided that such items are required for the treatment of the insured person.

Limitation: the reimbursement could be limited to customary expenses. Before purchasing any of these supplies, the insured person is advised to submit a quote to the Insurer.

b) **Compression stockings**

The purchase of compression stockings, mid-range or high compression (over 20 mm/hg), supplied by a pharmacy or a medical facility.

c) **Dental care following an accident and cosmetic surgery following an accident**

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 to repair cosmetic damage following an accident and performed within three 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.

- d) **Detoxification**
Expenses (including room and board) for the treatment of alcoholism and other drug addictions provided in a private facility under medical supervision.
- e) **Glucometer**
The cost of purchase, adjustments and repairs of a glucometer prescribed by a physician for insulin-dependent or uncontrolled diabetes.
- f) **Hearing aid**
Expenses for the purchase, replacement, rental, adjustment and repair of hearing aids.
- g) **Intraocular lenses**
Expenses for the purchase of intraocular lenses required to correct the effects of an eye condition, namely cataracts, which cannot be sufficiently corrected by contact lenses or eyeglasses.
- h) **IUD (unmedicated)**
The purchase of an IUD.
- i) **Nursing and respiratory therapy care**
Professional services of a nurse, a licensed practical nurse or a respiratory therapist.
- j) **Orthopaedic equipment 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.
- k) **Podiatric orthotics and orthopaedic shoes**
The purchase of podiatric orthotics 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.
Exclusion: Deep shoes are not considered orthopaedic shoes.
- l) **Post-operative bra**
The purchase of a post-operative bra required following a mastectomy that can only be obtained from a specialized laboratory.

m) **Rehabilitation centre or convalescent home**

Expenses for occupying a room in a rehabilitation centre during a necessary period of convalescence following hospitalization.

Expenses are eligible if all of the following conditions are met:

- i) Occupancy must begin within 14 days following the insured person's discharge from hospital;
- ii) Occupancy must be for a minimum period of 12 hours.

n) **Sclerosing injections – drug**

Sclerosing injections administered for medical reasons.

o) **Sclerosing injections – fees**

Professional fees for varicose vein treatment incurred for medical but not aesthetic reasons.

p) **Therapeutic devices (e.g. insulin pump and TENS)**

The rental, or purchase when more economical, of therapeutic devices. The Insurer covers expenses for the following, for example:

- aerosol therapy equipment, which may be used for treating, among other things, severe emphysema, chronic bronchitis or chronic asthma (e.g. Maximist, Medi-pump);
- nonunion bone stimulators (e.g. EBI);
- respiratory monitoring instruments in the event of respiratory arrhythmia (e.g. apnea monitor);
- intermittent positive pressure breathing machine (e.g. volumetric ventilator);
- insulin pump;
- percutaneous neurostimulators (e.g. TENS).

q) **Therapeutic supplies**

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

r) **Treatment outside the area of residence**

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 need for a consultation or treatment with a specialist must be sent to the Insurer. The report must state that the consultation or treatment with the specialist 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 based on the following provisions:

- Transportation for a trip 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 be 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;
- Accommodation in a hotel, up to \$60 per day following a trip of at least 400 km (round trip) 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;
- For an insured child under age 18 who requires treatment, the transportation expenses of one accompanying parent are eligible for reimbursement.

s) **Wheelchair and 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.

t) **Wig (capillary prosthesis)**

The purchase of a capillary prosthesis (wig) required following chemotherapy treatment.

7.2. Health professionals

The expenses indicated below are reimbursed as per the terms and conditions set out in the *Schedule of Benefits* and **based on the chosen module**.

All of the health professionals mentioned in this document must be members in good standing with their professional corporation or association or be recognized by the Policyholder and the Insurer and must practice within their competence, as defined by law.

For each of the health professionals listed below, only one session of care or treatment per day for the same patient is eligible for benefits:

- a) Fees of an **acupuncturist**
- b) Fees of an **audiologist** or a **hearing therapist**
Exclusion: Any tests that may be necessary are not eligible
- c) Fees of a **chiropractor** and **chiropractor X-rays**
- d) Fees of a **dietician** or a **nutritionist**
- e) Fees of an **occupational therapist**
- f) Fees of a **kinesitherapist**
- g) Fees of a **massage therapist**
- h) Fees of a **naturopath** or a **naturotherapist**
- i) Fees of a **speech therapist**
Fees for the drafting of an **assessment report** by a speech therapist are also eligible.
Exclusion: Any tests that may be necessary are not eligible.
- j) Fees of an **orthotherapist**
- k) Fees of an **osteopath**
- l) Fees of a **physiotherapist** or of a **physical rehabilitation therapist** under the supervision of a physiotherapist, when the treatment is given outside a hospital facility
- m) Fees of a **podiatrist**
- n) Fees of a **psychologist** or a **registered psychotherapist**
Fees for the drafting of an **assessment report** by a psychologist or a registered psychotherapist are also eligible.
- o) Fees of a **social worker**

8. Limitations and Exclusions

Benefits payable by the Insurer are reduced by the benefits payable under another public or private plan.

No reimbursement shall be made for:

- a) medical examinations for a third party (insurance, education, employment, etc.) or trips for health reasons;
- b) examinations for the evaluation of eyesight and hearing, as well as for eyeglasses and contact lenses;

- c) cosmetic surgery, when not provided following an accident;
- d) expenses incurred as a result of an accident or illness contracted while the insured person is in the service of the armed forces;
- e) home equipment such as whirlpool baths, air filters, humidifiers or similar devices and control devices such as stethoscopes, sphygmomanometers or similar devices;
- f) dental prostheses, unless natural teeth are replaced as a result of an accident;
- g) expenses resulting from active participation in an insurrection, a riot, a war (whether declared or not) or a civil war;
- h) care and services administered by a member of the insured person's family or by a person who resides with the insured person;
- i) 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.

9. Conversion Privilege

An insured person who is no longer eligible for coverage under this plan may obtain, without evidence of insurability, an individual health insurance contract, provided a written request is sent to the Insurer within 60 days following the date eligibility expires. Evidence of insurability is required for applications submitted after this deadline.

The individual health insurance contract of an insured person who exercises their conversion privilege within the required time frame takes effect on the date their eligibility expires under this contract's health insurance plan. If evidence of insurability is required, insurance becomes effective as of the date the Insurer approves the evidence.

DENTAL CARE PLAN

1. Definitions

In addition to the definitions in the *General Definitions* section, the following applies specifically to the dental care plan, where appropriate.

- a) **Fee Guide:** The annual Fee Guide and description of dental treatment services published by the *Association des chirurgiens dentistes du Québec (ACDQ)*.
- b) **Sextant:** Division of the dentition in six parts.

2. Purpose of the Coverage

The Insurer reimburses expenses for services, care, treatment and supplies that are recommended by a dentist and justified by current dental practice.

The description of eligible dental care expenses below is based on the Fee Guide in force at the time of the most recent update of the Insurer's contractual documents. However, for administration purposes, when applying the description of these expenses, the Insurer considers any changes to dental practice and updates to the guide.

3. Reimbursement Terms and Conditions

Eligible expenses for services, care, treatment and supplies are reimbursed according to the terms and conditions indicated in the *Schedule of Benefits*.

These expenses are eligible up to a maximum of the suggested fees in the Fee Guide for the reference year specified in the *Schedule of Benefits*.

Treatment plan

Before starting a major treatment, it is recommended that the insured person submit a detailed treatment plan to the Insurer before beginning treatment. After reviewing the treatment plan, the Insurer informs the insured person of the reimbursement amount available in accordance with the provisions of this contract.

4. Dental Care Expenses

4.1. Diagnostic and preventive care: 100% coverage

- a) **Diagnostic services**
 - i) Clinical oral examination
 - Mixed dentition oral examination (once per five years)
 - Complete oral examination, permanent dentition (once per five years)
 - Recall or periodic oral examination (once per nine months)
 - Dental examination for dependent children under the age of 10, if the examination is not payable under the public health insurance plan
 - Emergency examination (once per year)
 - Specific oral examination (once per year)

- Complete periodontal examination (once per five years)
- Specific orthodontic examination and diagnosis
- ii) X-rays
 - Intraoral X-rays
 - Extraoral X-rays
 - Sinus examination, sialography
 - Use of radiopaque dyes to demonstrate lesions, X-ray of the temporomandibular joint
 - Panoramic X-ray (one film per five years)
- iii) Tests and laboratory examinations
 - Pulpal test
 - Histological test
 - Cytological test
 - Local anaesthesia
- b) **Preventive services**
 - Prophylaxis (polishing of coronal portion of teeth, once per nine months)
 - Topical application of fluoride (once per nine months and depends under the age of 12 only)
 - Removal of subgingival filling material when local anaesthetic is needed, without flap, per tooth
 - Pit and fissure sealants (permanent teeth for dependent children aged 13 or younger)
 - Interproximal disking of teeth
 - Enameloplasty
- c) **Endodontics**
 - Endodontic emergency
- d) **Oral surgery**
 - Surgical incision and drainage
 - Post-surgical treatment without anaesthesia (e.g. alveolitis, 1st visit)

4.2. Basic services: 80% coverage

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

a) Restorations

- i) Primary teeth
 - Amalgam restoration, non-bonded
 - Amalgam restoration, bonded
 - Composite restoration
- ii) Permanent teeth
 - Amalgam restoration, non-bonded
 - Amalgam restoration, bonded
 - Composite restoration
 - Retentive pins
 - Veneer applications and diastema closure
- iii) Caries / trauma / pain control
 - Sedative filling / indirect capping
 - Recontouring and polishing of traumatized tooth

b) Endodontics

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

c) Periodontics

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

d) Oral surgery

- Tuberoplasty
- Removal of hyperplastic tissue
- Removal of excess mucosa

4.3. Extended care: 50% coverage

a) Restorations

- i) 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

b) Periapical endodontic surgery

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

c) Periodontics

- i) Non-surgical periodontal services
 - Periodontal emergencies
 - Desensitization
- ii) Preliminary treatments
 - Occlusal equilibration
- iii) Surgical periodontal services
 - Root planing and curettage (once per year, except if more than one sextant is required and proven to the Insurer's satisfaction)
 - Periodontal surgery, including graft and free connective tissue
- iv) Adjunctive periodontal procedures
 - Subgingival periodontal irrigation
 - Intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents

d) **Prosthodontics**

Reimbursement for any type of prosthesis (removable or fixed) includes follow-up examinations and adjustments for the three-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. Unless otherwise specified, any type of prosthesis is reimbursed only once per five-year period.

i) Removable prostheses

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

ii) Fixed prosthodontics and bridges (one procedure per tooth per five-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

e) **Oral surgery**

f) **Orthodontics**

Orthodontics expenses (for insured persons under age 21 only)

5. Rates and Notes

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

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:
 - the replacement is necessary because of the extraction of natural teeth while the insured person is covered under this contract, or that
 - the fixed or removable denture was installed at least five years before its replacement and that the current fixed or removable denture cannot be repaired, or that
 - 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 contract, that the replacement by a bridge or permanent denture is necessary and that it occurs within six months of the installation date of the temporary prosthesis.

6. Limitations and Exclusions

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

No reimbursement shall be made for:

- a) Dental care expenses that are covered under the health insurance plan
- b) 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 plan

7. Conversion Privilege

An insured person who is no longer eligible for coverage under this plan may obtain, without evidence of insurability, an individual dental care insurance contract, provided a written request is sent to the Insurer within 60 days following the date eligibility expires. Evidence of insurability is required for applications submitted after this deadline.

The individual dental care insurance contract of an insured person who exercises their conversion privilege within the required time frame takes effect on the date their eligibility expires under this contract's dental care insurance plan. If evidence of insurability is required, insurance becomes effective as of the date the Insurer approves the evidence.

LONG-TERM DISABILITY INSURANCE PLAN

1. Definitions

In addition to the definitions in the *General Definitions* section, the following applies specifically to the long-term disability insurance plan, where appropriate.

- a) **Waiting period:** A continuous period of total disability that must elapse before the participant is entitled to long-term disability benefits. The length of this period is indicated in the *Schedule of Benefits*.
- b) **Net benefit:** The benefit payable under the salary insurance provided by the employer, less federal and provincial taxes, and less contributions to the Québec Pension Plan, to unemployment insurance and to the Québec Parental Insurance Plan (QPIP).

2. Purpose of the Coverage

Upon receipt and approval by the Insurer of proof establishing that a participant under this contract has become totally disabled as defined herein, and after the waiting period expires, the Insurer pays a monthly benefit to the participant, the amount of which is determined below.

3. Amount

The benefit amount is equal to 100% of the net benefit established on a monthly basis and payable by the employer for the 104th week of benefit payment under the salary insurance provided by the employer, whether the benefit is actually paid or not.

The basic salary used to calculate the minimum benefit is \$12,000. It is also used to calculate the benefits of all part-time employees, 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 has jobs in more than one job category as covered in the collective agreement for the same employer, the amount of the benefit is based on the total salary earned for all jobs combined, and the minimum salary (\$12,000) applies to all jobs combined.

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

- a) 100% of the net salary 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 salary insurance benefits 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 that she would have received from the employer for the 104th week of benefits under the salary insurance plan offered by the employer.

4. 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, or until the participant's 65th birthday.

5. Integration

The benefit is reduced by the initial disability benefit payable by the following sources:

- the Teachers' Pension Plan (RRE);
- the Public Sector Superannuation Plan (RRF);
- the Pension Plan of Management Personnel (PPMP);
- the Government and Public Employees Retirement Plan (RREGOP);
- any other public and para-public sector pension plans;
- under the *Quebec Automobile Insurance Act*;
- under the *Act respecting industrial accidents and occupational diseases*;
- the Québec Pension Plan;
- any other social legislation respecting the disability which entitles the participant to receive benefits under this long-term disability plan.

Any lump sum payment or special agreement with respect to the disability, as agreed with one of the agencies mentioned above, is considered when calculating the amount of disability benefits and integrated, as applicable, to the benefit payable under this plan.

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

If the insured does not receive payments from the sources of income mentioned previously, it is the insured's obligation to prove that she is not entitled to benefits from these sources.

The benefit is not reduced by any sums paid by the employer for balances accrued in the employee's various banks, particularly for sick-leave days, vacation and statutory holidays.

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

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 an employment relationship.

6. Indexation

When benefits have been paid by the Insurer for a period of 12 full months, whether consecutive or not, over the same disability period, the net benefit then paid is indexed on January 1 of each year according to the terms and conditions set out in the *Schedule of Benefits*.

7. Payment Frequency

The benefit is paid on a monthly basis, with the first payment made one month after expiration of the waiting period.

8. 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.

9. Modification

Any modifications made to the employer's disability income benefits under the collective agreement, which would modify the premiums for this contract's long-term disability insurance plan, is considered nonexistent until the Policyholder and the Insurer reach an agreement to modify either the premiums for that plan or the benefits under that same plan.

10. Limitations and Exclusions

This insurance does not cover any period of disability:

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

CLAIMS

1. General Provisions

All insurance and benefits payable under the insurance coverage of this contract are paid to the participant. In the event of the participant's death, any insurance amounts are paid to the designated beneficiary.

Before paying an insurance or benefit amount, the Insurer reserves the right to have the insured person or the body examined and request that an autopsy be performed, unless prohibited by any legal provisions. In addition, the Insurer may require submission of all medical information and files regarding the diagnosis, treatment or services received by an insured person, before or after the effective date of insurance.

1.1. Subrogation of the participant's rights to the Insurer

The Insurer is subrogated to all rights of the participant against a third party that is liable for an event giving rise to a claim under this contract, up to a maximum of the amount paid to the participant by the Insurer.

1.2. Termination of this contract or cancellation of an insurance benefit

Subject to the provisions regarding a change of insurers, the termination of this contract or the cancellation of an insurance benefit covering an insured person is not enforceable against any claim related to:

- a) death occurring while this contract was in force;
- b) death due to a total disability occurring while this contract was in force;
- c) death or dismemberment due to an accident occurring while this contract was in force;
- d) total disability or illness occurring while this contract was in force.

The Insurer must continue paying disability insurance benefits in the event that the participant's total disability, for which she is receiving such benefits under this contract, extends beyond the termination of this contract.

1.3. Non-assignability of insured persons' rights

An insured person's rights under this contract may not be assigned or seized, and no assignment by an insured person of entitlement to benefits or to payment of a benefit under this contract is binding on the Insurer.

2. Life Insurance Plan

Benefits are based on the insurance amount in force at the time of the insured person's death or dismemberment.

The claimant must submit to the Insurer the claim and any supporting documents required by the Insurer within 10 years following the date of the insured person's death or the accident causing the dismemberment.

3. Health Insurance and Dental Care Plans

All claims must be submitted to the Insurer within 12 months following the date expenses are incurred. If the contract or the insurance benefit is terminated, claims must likewise be submitted within 12 months following the termination date.

The aforementioned time frames are firm. However, the insured person does not lose her entitlement to benefits under the health insurance and dental care plans if she is able to prove, to the Insurer's satisfaction, that she was unable to take action any sooner.

Official receipts or paid invoices must be enclosed with the claim. Expenses are considered as being incurred on the date the services, care, treatment, or supplies were provided. For certain expenses, the insured person is required to enclose the medical prescription with the claim.

3.1. Prescription drugs, extended health care and dental care

a) Claims submitted by a health professional

In some cases, insured persons may have their claims submitted by certain health professionals who have been pre-approved by the Insurer, such as pharmacists and dentists. The Insurer pays the covered portion of eligible expenses to the health professional at the time of the transaction. The insured person must pay the portion of expenses for which the insured person is responsible to the health professional, according to the provisions of this contract.

b) Claims submitted to the Insurer

The insured person may pay the total expenses incurred for the services of the health professional. The insured person may then use one of the following methods to forward the claim to the Insurer:

- i) mobile app;
- ii) online from the secure site;
- iii) by mail, by sending the completed form.

3.2. Travel insurance and assistance

The insured person pays the supplier for the total cost of services, care, treatment or supplies. The travel assistance firm reimburses eligible expenses upon receipt of the required official and supporting documents.

In some cases, and subject to the travel assistance firm's prior authorization, the travel assistance firm may reimburse incurred expenses directly to the supplier.

4. Long-Term Disability Insurance Plan

4.1. Claims

Three months before the end of payment of the salary insurance benefits by the employer, the Insurer sends an initial claim form to the participant for the long-term disability insurance plan under this contract.

The claim form must be completed by the participant and her attending physician and then returned to the Insurer along with the required documents.

The Insurer then requests additional information from the employer.

4.2. Evidence

Evidence of disability must be submitted whenever requested by the Insurer. The participant's failure to supply the Insurer with all additional evidence, or to submit to a medical examination on the date communicated by the Insurer in its written request, will suspend the participant's entitlement to disability insurance benefits, with regard to the disability in question, for a period extending from the end of a 31-day period beginning with the written request to the Insurer's effective receipt of such additional evidence or of the requested medical examination report.

However, if the participant does not submit to such a request from the Insurer within a period of six months, she automatically loses her entitlement to disability insurance benefits, related to such disability, applicable retroactively from the end of the 31-day period following the date of the initial request to this effect, communicated by the Insurer.

Failure to submit a claim form, evidence or information within the allotted time frames will not entail rejection of the claim, provided that the participant is able to demonstrate, to the Insurer's satisfaction, that legitimate reasons prevented her from doing so.

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