GROUP INSURANCE CONTRACT

NUMBER **001008 - 001010**

LA CAPITALE INSURANCE AND FINANCIAL SERVICES

Hereinafter the "Insurer"

Issues contract number 001008 - 001010 (hereinafter the "Contract") for participants affiliated with the:

FÉDÉRATION NATIONALE DES ENSEIGNANTES ET DES ENSEIGNANTS DU QUÉBEC-CSN

Hereinafter the "Policyholder"

THE INSURER AGREES, in consideration of the payment of the stipulated premiums, as they fall due and subject to the clauses and conditions of this contract, to pay the benefits provided for under this contract.

Terms and provisions specified in the following pages, including the premium tables and Schedules I to V, are an integral part of this contract as if they appeared above the affixed signatures.

Any modification made to the contract must be accepted by the Insurer and the Policyholder and be notified through an endorsement signed by the authorized representatives of both parties.

Effective date: This contract becomes effective on January 1, 2017.

Year of insurance: The period between the effective date of the contract and the date of renewal that immediately follows, and any 12-month period between 2 renewal dates.

Date of renewal: January 1, 2018 and January 1 of each subsequent year.

Effective time: Any insurance benefit becomes effective, is modified or ends at 12:01 a.m. local time at the Policyholder’s head office on the date on which one of the events provided for in the contract occurs.

January 1, 2017

TABLE OF CONTENTS

SECTION 1 - **DEFINITIONS**

For the interpretation of this contract, unless specified otherwise, the following terms and expressions mean:

1.1 "**Accident**": Any bodily injury confirmed by a physician and directly resulting from a sudden and unforeseeable action of an external cause, and independently of any other cause.

1.2 "**Age**": The age on the last birthday of an insured, at the time of calculation for the purposes of this contract, or at the time an event provided for under the contract occurs.

1.3 "**Assistor**": CanAssistance or any other assistance company designated by the Insurer.

1.4 "**Business partner**": A person with whom the insured is associated for business purposes as part of a company comprised of 4 shareholders or fewer, or a profit-making corporation comprised of 4 partners or fewer.

1.5 "**Care insured for inpatients**": Care that an insured person is entitled to receive free of charge under the Quebec *Hospital Insurance Act* or that is covered in accordance with the provisions of this act.

1.6 "**Close relative**": Close relative refers to the insured's spouse, children, father, mother, brother, sister, stepfather, stepmother, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

1.7 "**College**": A general and vocational college established under the *General and Vocational Colleges Act*, including private educational institutions.

1.8 "**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 legislation, regulations and policies of the region where it will be held. The commercial activity must be the only reason for the planned trip.

1.9 "**Committee**": The Union Committee in charge of group insurance plans.

1.10 "**Default**»: Insolvency or bankruptcy of the travel services provider, whether voluntary or involuntary, that prevents insureds from following through on the travel arrangements and that exposes them to a financial loss.

1.11 "**Deductible**": The portion of eligible expenses for which the insured is not entitled to any reimbursement from the Insurer.

1.12 "**Dentist**": Any individual who is a member of the *Ordre des dentistes du Québec* or a professional association recognized by the jurisdiction applicable where the dentist practices.

1.13 "**Dependent**": A participant's spouse or dependent child, as defined hereafter.

1.13.1 Spouse: The man or woman who, on the date of the event giving entitlement to benefits:

i) is married or civilly united to the participant; or

ii) is not married nor civilly united to the participant and has been cohabiting in a conjugal relationship with the participant, who is not married nor civilly united to anyone, for at least one (1) year or for less than one (1) year if he or she is the father or mother of a child of the participant; or

iii) is not married nor civilly united to the participant and has been cohabiting in a conjugal relationship with the participant, who is not married nor civilly united to anyone, and had previously cohabited with the participant for an entire period of at least one (1) year.

However, the status of spouse may be cancelled by any of the following events, as the case may be:

- in the case of a marriage, a judgment of divorce between the participant and the spouse;

- in the case of a common-law union, de facto separation for at least 90 days;

- in the case of a civil union, dissolution of the union by a notarized act or court decision.

1.13.2 Dependent child: The expression "dependent child" designates any of the following individuals:

i) a person under the age of 18 for whom the participant or the spouse exercises parental authority, including children for whom adoption procedures have been undertaken;

ii) a person age 25 or under, who has no spouse, and is attending a recognized educational institution as a duly registered full-time student, and for whom the participant or the spouse would exercise parental authority if that person was a minor;

iii) a person who has reached the age of majority, who has no spouse and is domiciled at the participant's home, for whom the participant or spouse would exercise parental authority if that person was a minor, and who is afflicted with a total disability or functional impairment, as defined in applicable legislation, that occurred while the person met any of the conditions indicated in either one of the 2 preceding paragraphs.

The concept of parental authority for a person other than the participant's or the spouse's child must be confirmed by a court judgment or by a valid will of the father or mother or by a statement on their part to such effect forwarded to the Curateur public du Québec.

1.14 "**Disability or disabled**":

1.14.1 For a disability that began before July 1, 1991

A state of incapacity, resulting from an illness or an accident which requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment during the Long Term Disability Insurance elimination period and the following 5 years, and after this period, which completely prevents the participant from carrying out any gainful employment for which he or she is reasonably qualified by education, training or experience. However, for a disability that began before January 1, 1990, the expression "5 years" is replaced by "24 months".

1.14.2 For a disability that began on or after July 1, 1991 but before July 1, 1995

A state of incapacity, resulting from an illness or an accident which requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment during the Long Term Disability Insurance elimination period and the following 5 years, and after this period, up to age 60, which completely prevents the participant from carrying out any gainful employment for which he or she is reasonably qualified by education, training or experience, and as of age 60, which completely prevents the participant from carrying out the usual duties of his or her regular employment.

1.14.3 For a disability that began on or after July 1, 1995 but before January 1, 2008

A state of incapacity, resulting from an illness, an accident or a surgical procedure directly related to family planning, which requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment during the Long Term Disability Insurance elimination period and the following 5 years, and after this period, up to age 60, which completely prevents the participant from carrying out any gainful employment for which he or she is reasonably qualified by education, training or experience, and as of age 60, which completely prevents the participant from carrying out the usual duties of his or her regular employment.

1.14.4 For a disability that began on or after January 1, 2008

A state of incapacity, resulting from an illness, an accident or a surgical procedure directly related to family planning, which requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment.

Furthermore, a disability claim cannot be denied solely because the participant, after expiry of the elimination period, is undergoing a gradual return to work or is taking part in a rehabilitation program under the terms of his or her collective agreement.

Medical care is not required when disability results from the loss of limbs or sight and that such loss can be definitively established to the Insurer's satisfaction.

1.15 "**Disability period**":

During the first 24 months of disability:

Any uninterrupted period of disability, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of less than 8 days of work[(1)], unless disability, during a given period, results from an illness or accident that is entirely independent from the illness or accident that caused the disability for the previous period, and that disability only begins upon the participant's return to work.

[(1)] should read "32 days" of work if the disability period exceeds 3 months

Afterwards:

Any uninterrupted period of disability, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of less than 180 days of work, unless disability, during a given period, results from an illness or accident that is entirely independent from the illness or accident that caused the disability for the previous period, and that disability only begins upon the participant's return to work.

1.16 "**Due date of premium**": The invoicing date coinciding with the first day of a pay period.

1.17 "**Effective date of retirement**": The date on which a participant retirement begins in accordance with the applicable retirement plans. If the date of retirement with payment of a pension is later, this date will be considered as the effective date of retirement. The term "retirement" includes gradual retirement.

However, if the participant retires because of the incapacity to carry out his or her employment due to a disability, the effective of retirement will be the first of the following dates:

- the date the participant retires with a pension;
- the date of the participant's 65th birthday.

1.18 "**Elimination period**": A period that begins at the start of a period of total disability, during which no disability benefits are payable.

1.19 "**Employee**":

- Any person hired by the employer on a full-time basis and who is covered by the bargaining certificate issued for a union affiliated with the FNEEQ-CSN and covered under this contract;

- Any person hired by the employer on a part-time basis for at least 33% of a workload and who is covered by the bargaining certificate issued for a union affiliated with the FNEEQ-CSN and covered under this contract. For colleges, the percentage of the workload is determined at the starting date of each session while for primary and secondary establishments, this percentage is determined on the 1st and the 101st days of the school year.

- Any individual or classes of individuals approved by the Policyholder and listed under Schedules I to V.

1.20 "**Employer**":

- an educational institution or related to education for which a grouping of employees are set up as unions affiliated with the FNEEQ-CSN or approved by the FNEEQ-CSN for the purposes of this contract.

- any employer accepted by the Policyholder.

1.21 "**FNEEQ-CSN**": The Fédération nationale des enseignantes et des enseignants du Québec-CSN.

1.22 "**Full-time teacher**": A teacher hired by the employer under a full-time contract in accordance with his or her collective agreement.

1.23 "**Hospital centre**": Any hospital centre, including an auxiliary residence located in Quebec, that is authorized by the Quebec *Ministère de la Santé et des Services sociaux* to register with the hospitalization insurance plan introduced under the *Hospital Insurance Act* of this province and the regulations applicable under this act, as well as the following hospital centres when located outside Quebec:

1.23.1 Any hospital centre located in Canada that is a federal hospital centre, a hospital centre holding an operating licence, or recognized as a hospital centre by the public organization in charge of issuing such operating licences in the territorial jurisdiction where the hospital centre is located, or recognized by the minister of Social Affairs when there is no public organization in charge of issuing operating licences.

1.23.2 Any hospital centre located abroad for which the minister of Social Affairs authorized payments for care given in that hospital centre, in accordance with the *Hospital Insurance Act*.

The expression "hospital centre" does not include tuberculosis hospitals, sanatoriums, homes for the mentally ills, rest homes, retirement homes, dispensaries or other institutions established to offer supervisory care.

1.24 "**Hospitalization**": The act of occupying a room in a hospital centre as an admitted inpatient.

1.25 "**Host at destination**": The person at whose principal residence the insured is planning to stay by prior agreement.

1.26 "**Illness**": Any health condition or bodily disorder diagnosed by a physician, including pregnancy and any related complication.

1.27 "**Insurance certificate**": The individual insurance certificate issued by the Insurer for the participants.

1.28 "**Insured**": A participant or one of the participant's dependents insured under this contract.

1.29 "**Invoicing period**": The period corresponding to a pay period of 14 consecutive days.

1.30 "**Net wage or salary**": The participant's wage or salary reduced by the following amounts:

- Contributions to the Quebec Pension Plan;
- Contributions to Employment and Social Development Canada (employment insurance);
- Contributions to the Quebec Parental Insurance Plan;
- Applicable federal and provincial taxes in accordance with the tax exemption form submitted to the employer;
- Health Insurance premiums payable under this contract based on the coverage held at the beginning of Long Term Disability Insurance benefit payments.

1.31 "**Participant**": An eligible employee who is insured under this contract.

1.32 "**Part-time teacher**": A teacher hired by the employer under a part-time contract in accordance with his or her collective agreement.

1.33 "**Physician**": A physician, a surgeon or a doctor of medicine duly licensed to practice medicine in accordance with regulations governing the practice of medicine in the location where services covered by this contract are provided.

1.34 "**Policyholder**": The Fédération nationale des enseignantes et des enseignants du Québec (FNEEQ-CSN).

1.35 "**Prepaid travel expenses**": Any amount paid by and for the insured to purchase a package trip, including tickets from a public carrier and rental of motor vehicles from an accredited firm. Also includes amounts paid by the insured for land arrangements usually included in a package trip, whether the reservations are made by the insured or by a travel agency, as well as amounts paid by the insured in relation to registration fees for a commercial activity.

1.36 "**Previous contract**": The group insurance contract or contracts in force immediately prior to the effective date of this contract, covering the employer's employees and their dependents, if any.

1.37 "**Public Prescription Drug Insurance Plan**": The public prescription drug insurance plan administered by the Régie de l'assurance-maladie du Québec.

1.38 "**Remission period**": A period during which a participant who was totally disabled ceases to be totally disabled.

1.39 "**Starting date of the session**": The date representing the first day of the availability period of the school calendar.

1.40 "**Teacher**": A person hired by the employer to provide education, including any dispatcher of a flying school.

1.41 "**Travel companion**": The person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the insured.

1.42 "**Travel services provider**": Travel agency, travel wholesaler, charter tour operator or air carrier holding a valid licence from the Canadian Transportation Agency and a valid operating certificate issued by Transport Canada.

1.43 "**Trip**": A trip for the purposes of tourism or recreation, a trip for the purposes of humanitarian aid or cooperative work that is supervised by an organization, a commercial activity or an occasional business trip. A business trip is considered to be occasional when carried out on an exceptional and not on a regular basis.

Any other type of trip**, including a trip during which a teacher accompanies students within the scope of his or her duties**, is not covered under this contract, unless the Policyholder and the Insurer have agreed otherwise. Furthermore, the trip must entail the insured's absence from the province of residence.

For the purposes of Trip Cancellation Insurance, the insured's trip must include a stay of at least one (1) night at the trip destination, either in or outside the insured's province of residence.

1.44 "**Wage or salary**": The participant's wage or salary for a given year excluding bonuses, overtime pay, fees, accommodation and meal allowances, isolation pay or any lump-sum payments. However, additional income such as overtime pay and other bonuses are included when calculating the wage or salary when they are part of the participant's regular remuneration.

Any lump-sum payments provided for under the collective agreement between the F.P.P.S.C.Q. and the C.P.N.C. are also considered part of the wage or salary. Salary also includes any amount paid by a college to a teacher who is in charge of a sports team.

For an employee who is eligible in accordance with article 2.1.7, the participant's salary is that used or that would have been used for the calculation of Long Term Disability Insurance benefits had she or he not been rehabilitated.

SECTION 2 - **CONDITIONS OF INSURANCE**

2.1 **Eligibility**

2.1.1 All employees hired by the employer or approved by the Policyholder are eligible as of the date they start working for that employer. However, for instructors or senior lecturers, specific provisions apply to individuals or classes of individuals approved by the Policyholder and listed under Schedules I to V attached to this contract.

Part-time teachers whose contract is lesser than 33% of a workload are not eligible for insurance. For colleges, the percentage of the workload is determined at the beginning of each session while for primary and secondary schools, this percentage is determined on the 1st and the 101st days of the school year.

However, persons who are not permanent employees are eligible for Long Term Disability Insurance subject to the provisions of article 2.2.5.

Finally, all new employees who are already considered disabled under a private or public plan (namely the QPP, SAAQ, CSST, IVAC or any other), or whose disability claim was subjected to a settlement agreement or who receives pension benefits are not eligible for Short and Long Term Disability Insurance

2.1.2 Dependents of an employee become eligible for insurance on the date on which the employee becomes eligible. For any person who becomes a dependent after the date of the employee's eligibility, he or she becomes eligible on the date on which he or she meets the definition of "Dependent".

2.1.3 Employees of the public sector are not eligible for Short Term Disability Insurance.

2.1.4 Employees who became permanent employees before August 15, 2001 and who had not applied for Long Term Disability Insurance on October 31, 2001 are not eligible for Long Term Disability Insurance.

2.1.5 Employees insured under Basic Life Insurance benefit are eligible for Optional Life Insurance benefit.

2.1.6 The employee's spouse is eligible for Optional Life Insurance if he or she is under age 65 and is insured under the Dependent's Life Insurance benefit.

2.1.7 Disabled employees who have rehabilitated in an employment whose insurance coverage does not provide for benefits similar to those they previously had remain insured for the benefits they could not otherwise keep for a maximum period of 5 year following the end of their disability. For the purposes of this contract, employees of the public sector are considered to be insured under Short Term Disability Insurance.

2.1.8 All retired teachers who are insured under the contract offered jointly by the AREF and the FNEEQ-CSN and who are rehired as employees remain insured under the plan offered to retirees.

2.2 Participation

2.2.1 Health Insurance benefit

Application for Module A (basic coverage), B (standard coverage) or C (extended coverage) of the Health Insurance benefit is mandatory for all eligible employees and their dependents, if any.

Application for this benefit may entail a minimum participation period, as indicated in article 2.5 "Change in coverage – Health and Dental Care Insurance".

a) Application form

All eligible employees must complete an application form for themselves and their dependents within 30 days following the date they become eligible. If the form is completed after this 30-day period, insurance will become effective as of the date the Insurer receives the application form.

The same provisions apply to a change in family status for participants who did not have any dependents at the time they became eligible. Participants must then complete a new application form for their dependents within 30 days following the date on which they become eligible.

b) Exemption and termination of exemption

Employees, participants or their dependents may waive or terminate coverage under the Health Insurance benefit, upon written notice sent to the employer, if they certify that they are covered under another group insurance contract offering similar benefits.

However, if coverage under the other group insurance contract terminates, employees, participants and their dependents must apply for Health Insurance coverage under this contract, or resume participation in this benefit, as of the date on which they are no longer eligible under the other group insurance contract. Provisions applicable at the time of the initial application for insurance apply again.

Finally, when obtaining a permanent status, employees or participants who refused or ceased coverage under the Health Insurance benefit may apply or resume participation, even if they are eligible under another group insurance contract. Such employees must submit their application form to the Insurer within 30 days following the date they obtain a permanent status, provided that they are actively at work at that time.

c) Provisions applicable for participants age 65 and over

Participants age 65 and over may choose to remain insured for drugs covered by the Public Prescription Drug Insurance Plan under this contract. Participants who wish to cover such drugs must send a request to the Insurer before the expiry of a 30-day period following the date of their 65th birthday. In such a case, participants must pay the additional premium indicated in the premium tables at the end of the contract. The additional premium becomes payable when participants reach age 65, in accordance with the coverage status held at that time.

2.2.2 Dental Care Insurance benefit

Participation in basic coverage (Option 1) or extended coverage (Option 2) of the Dental Care Insurance benefit is optional for all eligible employees and their dependents.

However, participation in Option 2 is only possible for employees who selected Module C for Health Insurance. Furthermore, coverage status (Individual, Couple, Single-parent or Family) for Dental Care Insurance must be identical to that requested for the Health Insurance benefit, subject to paragraph b) below.

Participation in Dental Care Insurance entails a minimum participation period of 36 months, subject to the provisions of article 2.5 "Change in coverage - Health and Dental Care Insurance."

a) Application form

Eligible employees must complete an application form for themselves and their dependents within 30 days following the date they become eligible. Otherwise, the provisions of article 2.5 "Change in coverage - Health and Dental Care Insurance" apply.

b) Exemption right for dependents

Employees, participants or their dependents may waive or terminate coverage under Dental Care Insurance upon written notice sent to the employer, if they certify that they are covered under another group insurance contract offering similar benefits. They must submit their request within 30 days following the date they become insured under the other group plan in order that the exemption becomes effective as of that date. If the request is submitted after the expiry of the 30-day period, exemption becomes effective as of the date the Insurer receives the request.

If coverage under the other group insurance contract terminates, employees, participants or their dependents may apply for Dental Care Insurance coverage under this contract or resume participation in this benefit as of the date on which they are no longer eligible under the other group insurance contract. Provisions applicable at the time of the initial application for insurance apply again.

2.2.3 Participant's Life Insurance and Critical Illness Insurance, Dependent's Life Insurance and Participant's and Spouse's Optional Life Insurance

Participation is optional for employees who meet the eligibility conditions.

Employees who wish to apply for the Basic Life Insurance benefits must complete an application form within 30 days following the date they become eligible. If the application is completed after expiry of that 30-day period, employees must submit, at their own expense, evidence of insurability deemed satisfactory by the Insurer.

However, the participant can apply for Life Insurance without evidence of insurability by completing an application form within 30 days following the adoption or the birth of a first child or the date on which the participant designates a spouse, as defined in this contract.

Application for the Participant's Basic Life Insurance entails the automatic application for the Participant's Critical Illness Insurance benefit since participation in these 2 benefits is indissociable.

Evidence of insurability deemed satisfactory by the Insurer is always required for employees or spouses when applying for Optional Life Insurance or adding Optional Life Insurance units.

2.2.4 Short Term Disability Insurance benefit

Participation is mandatory for employees of the private sector, instructors of CEGEPs covered under Schedule I of this contract, TÉLUQ tutors and Université Laval senior lecturers who meet eligibility conditions.

2.2.5 Long Term Disability Insurance benefit

a) Permanent employees

Subject to the Refusal of coverage under Long Term Disability insurance provisions, participation in the plan is mandatory as of the date a teacher obtains a permanent status. The employer must send the duly signed application form to the Insurer.

However, participants who obtained their permanent status on or before August 15, 2001 are not eligible for the Long Term Disability Insurance if they did not apply for it or if they ended participation in this benefit during the application campaign of the fall of 2001.

b) Non-permanent employees

Participation is optional for these employees. When obtaining the first three contracts of at least 33% of a workload, non-permanent employees can apply for this benefit without evidence of insurability provided the application form is submitted to the Insurer within 30 days following the date the employee becomes eligible. If the form is completed after expiry of the 30-day period, they will have to submit, at their own expense, evidence of insurability deemed satisfactory by the Insurer.

Satisfactory evidence of insurability will also have to be submitted to the Insurer, at the participant's own expense, for subsequent contracts.

This provision does not apply to employees who have been denied participation in this benefit following assessment of evidence of insurability by the Insurer.

Subject to the provisions of the refusal of coverage under Long Term Disability insurance, participation in the plan is mandatory for all teachers in college when a fourth annual contract is awarded, on a full-time basis with the same employer, whether the contracts are consecutive or not.

Specific provisions apply to employees or classes of employees approved by the Policyholder and listed in Schedules I to V.

c) Refusal of coverage under Long Term Disability insurance

All employees may exercise their Refusal of coverage under Long Term Disability insurance within 2 years preceding the date on which they become eligible for the employer's retirement pension without actuarial deduction. The employees referred to in Schedules I to III may exercise this refusal right on or after their 58th birthday or when they have attained 33 years of service.

The appropriate form must be completed and sent to the employer. Exercising of the refusal right then becomes irrevocable, as long as the employee retains the employment status under which he or she was able to exercise this right.

Coverage under the Long Term Disability insurance benefit ends on the date corresponding to the start of the first complete pay period following or coinciding with the date on which the Insurer received the refusal request.

2.2.6 Coverage status

When applying for insurance, the employee must choose one of the coverage statuses available under this contract for the Health and Dental Care Insurance benefits, if applicable, based on the employee's family status at that time. Coverage statuses available are the following:

a)	Individual coverage	Participant only
b)	Single-parent coverage	Participant with dependent children, but without a spouse
c)	Couple coverage	Participant with a spouse, but without dependent children
d)	Family coverage	Participant with a spouse and dependent children

2.2.7 Extension of benefits for dependents of a deceased participant

Upon the participant's death, dependents remain insured under the Health Insurance and Dental Care Insurance benefits, without payment of premiums, for a period of 90 days following the date of death. Furthermore, dependents may remain insured under all of the Dependents' Life Insurance benefits held by the participant if they inform the Insurer of their intention within 90 days following the date of death.

2.2.8 Rehiring or change of employer

Non-permanent employees who obtain a new teaching contract within 12 months following the date of termination of their insurance under the preceding contract must select, if they are eligible, the same module and Option they had for the Health and Dental Care Insurance benefits if the minimum participation periods were not completed.

Non-permanent employees registered on the employment priority list who are rehired by the same employer resume participation in the Life Insurance and Disability Insurance benefits held at the time their contract ended, without evidence of insurability, provided they are eligible.

Employees hired at the end of a session by another college for the following session keep the benefits they held with the previous college. However, employees of the new college must be eligible for insurance under this contract.

2.3 **Effective date of insurance**

2.3.1 Employees

2.3.1.1 Insurance becomes effective on the latest of the following dates:

a) The date on which they become eligible provided the application form is submitted to the Insurer within 30 days following that date, subject to the provisions of article 2.4.

b) The date on which the Insurer accepts any evidence of insurability, if applicable.

2.3.1.2 Long Term Disability Insurance becomes effective on the latest of the following dates:

a) For non-permanent employees

- The date they become eligible provided the application form is submitted to the Insurer within 30 days following that date, subject to the provisions of article 2.4;
- The date on which the Insurer accepts any evidence of insurability, if applicable.

b) For permanent employees

- The date they become eligible provided the application form is submitted to the Insurer within 30 days following that date.

2.3.1.3 Health Insurance becomes effective on the date on which employees become eligible. However, insurance for employees who exercised their exemption right becomes effective on the first day following the date of termination of the previous insurance.

2.3.1.4 Dental Care Insurance becomes effective on the date on which employees become eligible provided the application form is submitted to the Insurer within 30 days following that date.

2.3.1.5 Short Time Disability Insurance for employees of the private or university sector becomes effective on the date on which they become eligible.

Specific provisions apply to any individuals or classes of individuals approved by the Policyholder and listed in Schedules I to V attached to this contract.

2.3.2 Dependents

2.3.2.1 Life Insurance becomes effective on the latest of the following dates:

a) The date on which dependents become eligible provided the application form is submitted to the Insurer within 30 days following that date;

b) The date on which the Insurer accepts any evidence of insurability, if applicable.

2.3.2.2 Health Insurance becomes effective on the latest of the following dates:

a) The effective date of the participant's insurance;

b) The date on which dependents become eligible;

c) The day following the date of termination of insurance under the other contract allowing them to exercise their exemption right.

However, the Insurer must receive the application or termination of exemption form within 30 days. Otherwise, insurance becomes effective on the date the Insurer receives the form.

2.3.2.3 Dental Care Insurance becomes effective on the latest of the following dates:

a) The effective date of the participant's insurance;

b) The date on which dependents become eligible;

c) The day following the date of termination of insurance under another contract.

However, the Insurer must receive the application form within 30 days. Otherwise, a new application form will have to be submitted during the period extending from November 1 to November 30 and insurance will become effective on January 1 of the following year.

2.4 Acquisition of permanent status

Within 30 days following the date of written confirmation of the acquisition of a permanent status, employees can benefit from the following options:

a) apply for Basic Life Insurance without evidence of insurability.

b) apply for Dental Care Insurance.

c) end exemption, if applicable, under the Health Insurance.

d) cover their dependents, according to the same provisions as those applicable to new employees.

Furthermore, employees must apply for Long Term Disability Insurance.

Employees must be actively at work at the time of applying for any insurance coverage. Otherwise, they may apply within 30 days following the date they return to work.

The Long Term Disability Insurance benefit is granted retroactively to the starting date of the session while other benefits selected become effective on the date the Insurer receives the application form if this form was sent within 30 days following confirmation of the permanent status.

If the application form is submitted after this deadline, Health Insurance will become effective on the date the Insurer receives the form. For Life Insurance, employees will have to submit evidence of insurability and insurance will become effective on the date the Insurer accepts such evidence. For Dental Care Insurance, employees must submit a new application form during the next enrolment period which is from November 1 to November 30 of each year.

2.5 Change in coverage – Health and Dental Care Insurance

Any request to increase or decrease coverage must be made during the period from November 1 to November 30 of each year, and the new coverage requested will become effective on January 1 of the year following the date of the request.

This provision is also applicable for any application for Dental Care Insurance if employees did not apply for this benefit at the time they became eligible for insurance, provided employees have been covered under the Health Insurance benefit for at least 12 months, regardless of the coverage chosen.

However, disabled employees cannot benefit from this provision until they are effectively back to work, on their regular work schedule.

Any change in coverage will entail the beginning of a new 12-month or 36-month participation period. However, if there is a change in coverage status for the same benefit (Individual, Family, Couple or Single-parent), the ongoing minimum participation period (12 or 36 months) continues.

2.5.1 Increase

Participants can request the following increases in coverage after a minimum participation period of 12 consecutive months.

a) Health Insurance

- Change from Basic coverage (Module A) to Standard coverage (Module B)
- Change from Basic coverage (Module A) to Extended coverage (Module C)
- Change from Standard coverage (Module B) to Extended coverage (Module C)

b) Dental Care Insurance

- Change from Option 1 to Option 2 if the participant has Extended coverage (Module C) in Health Insurance.

When participants change for Extended coverage (Module C), they can request Option 2 in Dental Care or change from Option 1 to Option 2 if they already have Option 1.

2.5.2 Reduction

Participants can request the following reductions in coverage after a minimum participation period of 36 consecutive months.

a) Health Insurance

- Change from Extended coverage (Module C) to Standard coverage (Module B)
- Change from Extended coverage (Module C) to Basic coverage (Module A)
- Change from Standard coverage (Module B) to Basic coverage (Module A)

b) Dental Care Insurance

- Change from Option 2 to Option 1 or end participation in this benefit.

For participants who have Option 2 for Dental Care Insurance on the date they end their participation in Extended coverage (Module C), participation in Option 2 for Dental Care Insurance will also end, provided they have completed the minimum participation period of 36 months for Option 2. Otherwise, they may only terminate Extended coverage for Health Insurance once they completed the minimum participation period.

Participant who have completed the minimum participation period for Option 2 in Dental Care Insurance can end participation in this Option and apply for Option 1 if they want to.

2.5.3 Life events

Participants can request increase or reduction in coverage upon one of the following events:

- acquisition of permanent status;
- birth or adoption of a first child;
- marriage or an equivalent union;
- separation or divorce;
- death of the spouse or a dependent child.

However, none of these events entitle participants to end their participation in the Dental Care Insurance benefit.

Participants have a 30-day period as of the date of the event to change coverage. The minimum participation of 12 or 36 months does not apply. Participants can choose any coverage they want, based on their new situation, as if they were applying for the first time.

The new coverage requested becomes effective on the date of the event if the participant has submitted the request for change within 30 days following the date of the event. Otherwise, Health Insurance coverage becomes effective on the date on which the Insurer receives the request. For Dental Care Insurance, employees must submit a new application during the enrolment period from November 1 to 30 of each year and coverage will become effective on January 1 of the year following the date of the request.

2.6 Transfer provisions

2.6.1 For participants insured alone or with dependents under a previous contract, the Insurer guarantees continuity between this contract and the previous contract in compliance with the *Act respecting Insurance* and the *Regulation under the Act respecting Insurance*, to avoid participants and their dependents, if any, sustaining any harm due to a change in contract, regardless of whether they are at work.

Therefore, no participant or dependent insured under the previous contract may be excluded from the new contract or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the previous contract, or because the participant is not at work on the effective date of the new contract.

Also, every participant or dependent insured under the previous contract is covered *pleno jure* by this contract on cancellation of the previous contract if the termination of insurance is exclusively attributable to the cancellation and the participant belongs to a class of participants covered by this contract.

2.6.2 In the case of a participant who, prior to submitting an application for insurance, was insured under a previous contract, the Insurer shall not be liable for any benefits that may be payable by the previous insurer under any extension, exemption, conversion or other clause.

2.7 Maintaining of insurance during leaves

Subject to the provisions of the collective agreement, participants who are on a leave continue to be insured, with payment of premiums, under the Health Insurance and Dental Care Insurance benefits. They can also maintain participation, as of the beginning of the leave, in one or several of the other benefits by paying the full premium, including the employer's share. The amounts of Life Insurance, Disability Insurance benefits and premiums payable for these benefits are based on the participant's basic annual salary on the date of beginning of the leave. No disability benefits will be paid prior to the scheduled end date of the unpaid leave.

Participants who have not maintained all their benefits will only be entitled to resume participation in the benefits they had at the beginning of the leave when they effectively return to work. The benefits shall be reinstated without evidence of insurability if the participant submits an application within 30 days of the date he or she effectively returns to work.

In the case of a voluntary work reduction program, participants continue to be insured, with payment of premiums, under the Health Insurance and Dental Care Insurance benefits. They can also maintain participation in the Life Insurance and Disability Insurance benefits. The amounts of Life Insurance, Disability Insurance benefits and premiums payable for these benefits are based on the participant's basic annual salary payable immediately before they began to participate in such program.

2.8 Anticipated or deferred salary leave or progressive retirement

Insurance of participants who take part in an anticipated or deferred salary leave program, or in a progressive retirement program, remains in force. The amounts of Life Insurance, Disability Insurance benefits and premiums payable for these benefits are based on the basic annual salary participants would have received had they not taken part in the program. Any disability that occurs during such leave shall be deemed to begin on the same date as that used by the collective agreement to determine the salary insurance period.

2.9 Short-term layoff

Participants who have been laid off in accordance with their collective agreement, or with provisions set out by law, remain eligible for insurance. The amount of coverage to which they are entitled is based on the salary they would have received had they not been laid off. However, participants may decrease their amount of coverage based on their reduced salary following the layoff by sending a written notice to the employer within 30 days following the layoff. No other request will be accepted.

2.10 Layoff, strike, lockout or dismissal

For participants who are temporarily absent from work due to a layoff, a strike or a lockout, insurance remains in force provided the regular premiums continue to be paid. The dismissal of a participant that is contested by grievance or legally challenged shall be deemed, for the purposes of insurance, to be a temporary layoff ending on the date of final ruling on the case.

2.11 Portability of coverage

Participants who are relocated in another college following short-time layoff can apply, without evidence of insurability, for the same benefits they had with the former employer, regardless of the union membership, provided these benefits are available.

Participants who benefit from an exchange between colleges remain covered under their benefits and pay the premiums to the college from which they were exchanged for as long as this exchange remains temporary. When the exchange becomes permanent, participants must apply for the insurance benefits with the college they were exchanged to.

SECTION 3 - **LIFE INSURANCE**

3.1 **Amount of basic insurance**

3.1.1 The amount of basic insurance payable in the event of the participant's death is the following:

a) Participant under age 65 (participant's choice)

- 1 times the annual salary, rounded to the nearest $500, if death occurs before the 65th birthday or the effective date of retirement, if earlier. The minimum amount of basic Life Insurance is $35,000.

- 2 times the annual salary, rounded to the nearest $500, if death occurs before the 65th birthday or the effective date of retirement, if earlier. The minimum amount of basic insurance is $70,000.

b) Participant age 65 to 70

- 50% of the amount of Life Insurance held on the date of the 65th birthday.

c) Participant over age70

- $10,000 if death occurs on or after the 70th birthday, but before the date of retirement.

3.1.2 Change in the amount of basic insurance

If the participant's salary is modified, including in the case of a temporary assignment, the change in the amount of Life Insurance becomes effective on the latest of the date the change in salary comes into force or the date an agreement to this effect is reached between the Policyholder and the Insurer.

For disabled participants, no change will be made after a 24-month period of disability to which is added the expiry of any sick leave bank.

3.1.3 Termination of insurance

Subject to the provisions of articles 3.5 "Waiver of premiums", 3.6 "Extension" and 3.7 "Conversion privilege", a participant's insurance terminates on the first of the following dates:

3.1.3.1 The date of cancellation of this contract or benefit.

3.1.3.2 The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is with the Policyholder is not considered a termination of employment.

Non-permanent employees within the meaning of the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding a 2-month period after the contract termination date, unless they end their participation, in which case the insurance terminates on the contract termination date.

3.1.3.3 The day before the due date of any unpaid premium.

3.1.3.4 The date on which the Insurer receives written notice from a participant to terminate coverage under this benefit, or on the termination date indicated in such notice, whichever is later.

3.1.3.5 The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65.

3.1.3.6 The expiry of the 5-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

3.2 Participant's Critical Illness Insurance (benefit indissociable from the Participant's Life Insurance benefit)

3.2.1 Coverage

If a participant undergoes a surgical procedure or is diagnosed with a critical illness for the first time, the Insurer agrees to pay the percentage of the amount of insurance specified for each of the illnesses and surgeries covered under this benefit.

To be eligible for benefits, the participant must be insured under this benefit on the date of the surgical procedure or diagnosis of the illness and must survive for a minimum period of 30 days following that date, provided the diagnosis remains unchanged during that period. However, in the event that the illness or surgery results directly from an accident, the date of the accident is considered to be the date of the diagnosis or surgery.

3.2.2 Amount of insurance

The amount of insurance applicable is $25,000.

The maximum amount payable for all surgical procedures and illnesses for which the participant submits a claim is limited to a lifetime maximum of 100% of the amount of insurance.

3.2.3 Illnesses and surgeries covered

a) Multiple sclerosis – 100% of the amount of insurance

Unequivocal diagnosis of at least 2 well-defined neurological abnormalities, including one episode having lasted for a minimum period of 6 consecutive months. The diagnosis must be given by a neurologist and confirmed by medical imaging.

b) Muscular dystrophy – 100% of the amount of insurance

Degenerative hereditary disorder of the striated muscles, the unequivocal and final diagnosis of which is given by a duly qualified physician. The affliction must be severe enough that the participant is unable to carry out the activities of daily living usually associated with a person of the same age for a minimum period of 6 consecutive months. The diagnosis must be confirmed by electromyography and muscular biopsy.

c) Paralysis – 100% of the amount of insurance

Loss of motor skills of neurological origin of at least 2 limbs, resulting in the total and permanent loss of use of those limbs. The paralysis must have persisted for at least 180 days since the date of the accident or the illness at the origin of the paralysis, with no signs of improvement during that time.

d) Alzheimer's disease – 100% of the amount of insurance

Progressive neurodegenerative illness diagnosed by a neurologist or geriatric specialist, with the exception of any organic brain syndrome or psychiatric disorder. The participant must show signs of diminished intellectual faculties, especially pertaining to memory and judgment, such that his or her capacity to function in society is greatly reduced and he or she requires constant supervision.

e) Parkinson's disease – 100% of the amount of insurance

Idiopathic and degenerative Parkinson's disease diagnosed by a neurologist and characterized by at least 2 of the following symptoms:

- Rigidity
- Shaking
- Akinesia

Exclusions and reductions of coverage: Other types of parkinsonian syndromes are not covered.

f) Motor neuron disease – 100% of the amount of insurance

Unequivocal diagnosis by a neurologist of one of the following 5 illnesses:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal amyotrophy
- Progressive bulbar paralysis
- Pseudobulbar paralysis

g) Blindness – 100% of the amount of insurance

Total and irreversible loss of sight in both eyes diagnosed by an ophthalmologist. Corrected eyesight must be weaker than 20/200, or the visual fields must be less than 20 degrees, in both eyes.

h) Occupational HIV infection – 100% of the amount of insurance

Infection of the participant by the human immunodeficiency virus (HIV) occurring after the effective date of coverage under this benefit, arising from an accident or injury that happens in Canada during the course of the ordinary duties of his or her occupation, if the occupation usually exposes the participant to blood or other body fluids contaminated by HIV.

The Insurer must be notified of any accident or injury likely to lead to HIV infection within 14 days following the date of the event. The participant must have blood samples taken for HIV screening during this 14-day period, and tests must be negative. Blood samples must be retaken between 3 and 6 months following the date of the event and tests must be positive at that time. The Insurer is authorized to have blood samples analyzed by a laboratory of its choice and has the right to require additional samples to be taken.

The accident or injury must be reported, evaluated and documented according to the protocols in force for the participant's occupation.

Exclusions and reductions of coverage: This benefit does not cover any HIV infection contracted in other circumstances, including sexual activity and drug use.

No amount of insurance will be payable in the event that the participant refuses to use any vaccine affording protection against the HIV virus that was available prior to the accident or injury.

Furthermore, if a curative treatment for AIDS were to become available after the effective date of coverage under this benefit, this accidental HIV infection coverage will automatically become null and void starting on the date such treatment becomes available.

i) Cerebrovascular accident (stroke) – 50% of the amount of insurance

Cerebrovascular accident, with the exception of an ischemic accident or vertebrobasilar insufficiency, diagnosed by a neurologist and resulting from thrombosis, intracranial hemorrhage or embolism from an extracranial source. The accident must have neurological sequelae, with paralysis or any other objective and measurable neurological deficit, persisting for at least 30 consecutive days following the accident.

j) Kidney failure – 50% of the amount of insurance

Permanent and irreversible failure of both kidneys diagnosed by a nephrologist and requiring regular treatment through hemodialysis or peritoneal dialysis.

k) Severe burns – 50% of the amount of insurance

Third-degree burns diagnosed by a plastic surgeon, covering at least 20% of the body.

l) Major organ transplant – 50% of the amount of insurance

Graft of one of the following organs due to a chronic and irreversible failure:

- Heart
- Liver
- Bone marrow, excluding autografts
- Both lungs
- Both kidneys
- Pancreas

m) Myocardial infarction (heart attack) – 35% of the amount of insurance

Necrosis of part of the heart muscle as a result of the obstruction of the arteries ensuring its irrigation.

The diagnosis must be confirmed by both of the following elements:

- Presence of electrocardiographic modifications (ECG) indicating a myocardial infarction or a new clinical picture of typical pain symptoms, exclusively in cases where the electrocardiogram cannot be interpreted (complete bundle branch block, Wolff-Parkinson-White syndrome, cardiac stimulator) and;
- elevation on 2 occasions of biological markers, including cardiac enzymes, troponin, CPK or MB-CPK at a level indicative of myocardial infarction.

Exclusions and reductions of coverage: Myocardial infarction that does not meet the criteria mentioned previously or myocardial infarction occurring within 48 hours following elective revascularization, is not covered, unless accompanied by new pathological Q waves.

n) Cancer – 35% of the amount of insurance

Malignant tumor diagnosed by an oncologist, characterized by the uncontrolled development and spreading of malignant cells invading the tissue.

Exclusions and reductions of coverage: This benefit does not cover any cancer diagnosed in the first 90 days following the effective date of insurance for the participant, or if signs, symptoms or problems occur during this period.

The following types of cancer are also excluded:

- Any cancer classified as TX, TO or Tis (in situ) as per the TNMclassification, as well as T1N0M0 classification for prostate cancer
- Pre-cancerous lesions, benign tumors or polyps
- Any type of skin cancer, except for malignant melanoma invading the dermis or deeper (more than 1.0 mm)
- Any tumor diagnosed for an HIV-infected participant

o) Coma – 35% of the amount of insurance

Deep state of unconsciousness, with no reaction of the participant to any external stimulus, persisting for at least 96 consecutive hours and having been diagnosed by a neurologist.

p) Coronary bypass – 35% of the amount of insurance

Surgery recommended by an internist or cardiologist and carried out by a surgeon in order to correct the narrowing or obstruction of one or more coronary arteries by means of anastomosis or bypass grafting.

Exclusions and reductions of coverage: This benefit does not cover nonsurgical techniques such as angioplasty with a balloon-tip catheter, correction of an obstruction by laser or any other arterial technique not involving a bypass or anastomosis.

q) Deafness – 25% of the amount of insurance

Total and irreversible loss of hearing in both ears, diagnosed by an ear, nose and throat specialist, rendering the participant incapable of hearing sounds of 90 decibels or less.

r) Muteness – 25% of the amount of insurance

Total, permanent and irreversible loss of speech due to illness, bodily injury or accident which has persisted for a minimum period of 365 consecutive days. Muteness must be diagnosed by a physician duly qualified to make such a diagnosis and must not result from a psychological or psychiatric disorder.

3.2.4 Pre-existing conditions

The participant is not entitled to any amount of insurance for any critical illness or surgery resulting directly or indirectly from a pre-existing condition for which the participant consulted a physician or received treatment in the 24 months preceding the start date of his or her coverage under a critical illness insurance benefit.

However, this exclusion no longer applies if the unequivocal and final diagnosis of the critical illness is made for the first time more than 24 months after the effective date of the participant's insurance.

3.2.5 Exclusions and reductions of coverage

No amount of insurance is payable for an illness or surgical procedure that results directly or indirectly from any of the following causes:

a) Voluntarily self-inflicted injuries, self-mutilation or attempted suicide, whether or not the participant is of sound mind.

b) An injury suffered or illness contracted during a criminal act or an act deemed as such, that the participant commits or attempts to commit.

c) A condition resulting from driving any vehicle:

- while having a blood alcohol level in excess of the prescribed legal limit where the accident occurred; or

- while under the influence of drugs, or medication not taken in compliance with the physician's prescription or the manufacturer's directions for use or recommended dosage.

d) Abuse of alcohol, drug use or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

e) Injury or illness due to war, whether declared or not, or the insured's participation or attempted participation in a riot or an insurrection.

f) Refusal or omission by the participant to receive appropriate treatment for his or her condition.

g) Active service of the participant in the armed forces of any country.

3.2.6 Termination

The participant's Critical Illness Insurance benefit ends on the same date as that of the participant's Life Insurance benefit.

Furthermore, participants who have received the maximum amount of benefits payable under this coverage may terminate participation in this benefit by sending a written request to the Insurer.

3.3 Dependent's Life Insurance

3.3.1 The amount of Dependents' Life Insurance is the following:

a) Spouse:

- $10,000 if death occurs before the spouse's 65th birthday;
- $5,000 if death occurs on or after the spouse's 65th birthday, but before the date of the participant's retirement.

b) Dependent children:

- $5,000 as of 24 hours of age, as long as the child meets the definition of dependent child.

3.3.2 Termination

Subject to the provisions of articles 3.5 "Waiver of premiums", 3.6 "Extension" and 3.7 "Conversion privilege", a dependent's insurance terminates on the first of the following dates:

3.3.2.1 The date of termination of the insured participant who was covering the dependent.

3.3.2.2 The date on which the person ceases to be considered a dependent.

3.4 Optional Life Insurance

3.4.1 Amount of Optional Life

a) Participant

The participant can apply for 1 to 10 units of $25,000 of Optional Life Insurance.

The maximum amount of Optional Life Insurance is $250,000, including any amount held before January 1, 2013.

Employees who applied for this benefit before January 1, 2013 keep the amount of insurance held on that date (amount based on units of $20,000). However, if they wish to add or remove any units to or from the amount currently held, those units will be of $25,000 and the new amount will be rounded to the nearest multiple of $25,000, up to the $250,000 maximum amount.

b) Spouse

The participant can apply for 1 to 10 units of $25,000 of Optional Life Insurance for his or her spouse.

The maximum amount of Optional Life Insurance is $250,000, including any amount held before January 1, 2013.

Spouses who were covered under this benefit before January 1, 2013 keep the amount of insurance held on that date (amount based on units of $20,000). However, if they wish to add or remove any units to or from the amount currently held, those units will be of $25,000 and the new amount will be rounded to the nearest multiple of $25,000, up to the $250,000 maximum amount.

3.4.2 Termination

3.4.2.1 Subject to the provisions of articles 3.5 "Waiver of premiums", 3.6 "Extension" and 3.7 "Conversion privilege", a participant's insurance terminates on the first of the following dates:

a) The date of termination of the contract or the benefit;

b) The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is with the Policyholder is not considered a termination of employment;

Non-permanent employees within the meaning of the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding a 2-month period after the termination date of the contract, unless they end participation, in which case the insurance terminates on the termination date of the contract;

c) The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65;

d) The day before the due date of any unpaid premium;

e) The date on which the Insurer receives written notice from a participant to terminate coverage under this benefit, or on the date of termination indicated in such notice, whichever is later;

f) The date of the participant's 70th birthday;

g) The expiry date of the 5-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

3.4.2.2 Subject to the provision of articles 3.5 "Waiver of premiums", 3.6 "Extension" and 3.7 "Conversion privilege", a spouse's insurance terminates on the first of the following dates:

a) The date of termination of the participant's Basic Life Insurance;

b) The date on which the participant reaches age 70;

c) The date on which the spouse reaches age 70;

d) The date on which the person ceases to meet the definition of a spouse.

3.5 Waiver of premiums

Insurance for participants and their dependents, if any, who become disabled before the effective date of retirement is maintained in force until the first of the following dates:

a) The date on which total disability ends;

b) The date of the participant's retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65.

c) The date of the participant's 65th birthday;

d) The date of termination of the contract or the benefit for the Critical Illness Insurance benefit.

Waiver of premiums applies after expiry of a 30-day period following the onset on disability.

Evidence of disability must be submitted upon the Insurer's request who agrees not to request such evidence more than once a year.

3.6 Extension

In case of termination of this contract or benefit, the participant's Life Insurance, excluding Critical Illness Insurance, Optional Life Insurance and Dependent's Life Insurance benefits for which premiums are waived are kept in force.

3.7 Conversion privilege

Participants whose Life Insurance coverage terminates under this benefit because they cease to work for the employer for a reason other than retirement or because they cease to be eligible in accordance with article 2.1.1 can, within 31 days following the date of termination of employment and without evidence of insurability, obtain a permanent or temporary individual life insurance policy, without accessory benefits, offered by the Insurer at that time.

In case of termination of employment or the participant's death, the spouse can, within 31 days following termination of the Participant's Basic Life Insurance and without evidence of insurability, obtain a permanent or temporary individual life insurance policy, without accessory benefits, offered by the Insurer at that time.

The amount of insurance that can be converted to an individual policy must not exceed the amount of coverage that was in force.

The participant's and spouse's coverage under this benefit remains effective for the 31-day period during which they can apply for an individual life insurance policy.

3.8 Beneficiary

Participants may designate a beneficiary, change a previously designated beneficiary or specify that insurance is payable to their successors by sending a written and signed statement to the Insurer's head office, subject to provisions of the law. The Insurer shall not be liable for the legal validity of any change of beneficiary.

All amounts of Dependent's Life Insurance are payable to the participant.

The rights of any beneficiary who dies before the participant revert to the participant. If at the time of the participant's death, the participant had not designated a beneficiary in writing, the amount of insurance is payable to his or her successors.

3.9 Payment of insurance

Benefits are based on the amount of insurance held at the time of an insured's death or when the participant is diagnosed with a critical illness, as described under articles 3.1 to 3.4. In case of a participant's death, benefits are payable to the designated beneficiary or the participant's successors, if there is no designated beneficiary. In case of the death of the participant's spouse or dependent child, benefits are payable to the participant.

The claimant must provide the Insurer with the required evidence to establish, other than the claimant's rights, the death of the insured and cause of death, as well as the accuracy of the date of birth given by the participant. Benefits are payable only if insurance is effective at the time of death.

SECTION 4 - **MANDATORY HEALTH INSURANCE**

Eligible expenses are those incurred for care, supplies and services described below and are limited to the expenses reasonably justified by the seriousness of the case, current medical practice and the customary and reasonable charges in force in the area, subject to the exclusions indicated under the Quebec *Health Insurance Act*, the Quebec *Hospital Insurance Act*, or any other health or hospital insurance legislation in the insured's province of residence.

Expenses that are not medically necessary, expenses payable under any other individual or group insurance plan and expenses for which the insured is entitled to an indemnity under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, or under any other similar federal or foreign legislation are excluded.

Direct automated claims payment

When making prescription drug purchases, insureds present their service card to the pharmacist. The Insurer automatically issues payment for the insured portion of prescription drug expenses. There's no need to fill out a claim form, and insureds pay only the uninsured portion of prescription drug expenses including any applicable deductible.

4.1 Schedule of Insurance

Care, services and supplies identified with an asterik (*) require a medical prescription. The maximums indicated are per insured, unless otherwise specified.

	Basic coverage (Module A)	**Standard coverage (Module B)**	**Extended coverage (Module C)**
1. **Expenses reimbursed at 100%**			
Hospitalization in Canada	Semi-private room	Semi-private room	Semi-private room
Extended care	Semi-private room Maximum of 180 days per calendar year	Semi-private room Maximum of 180 days per calendar year	Semi-private room Maximum of 180 days per calendar year
Travel Insurance	Lifetime maximum of $2,000,000	Lifetime maximum of $2,000,000	Lifetime maximum of $2,000,000
Trip Cancellation Insurance	Maximum of $5,000 per trip	Maximum of $5,000 per trip	Maximum of $5,000 per trip

	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
2. **Prescription drugs ***			
Prescription drug clause	Regular list	Regular list	Regular list
Reimbursement	Generic: 80%* Patented: 70%* Brand name: Under the same coinsurance as the BPDIP (on the basis of the least expensive generic drug – mandatory substitution)* *of eligible expenses up to the maximum annual contribution under the BPDIP, and 100% of any excess per certificate	Generic: 90%* Patented: 80%* Brand name: Under the same coinsurance as the BPDIP (on the basis of the least expensive generic drug – mandatory substitution)* *of the first $2,500 of eligible expenses and, 100% of the excess per certificate	Generic: 100%* Patented: 90%* Brand name: Under the same coinsurance as the BPDIP (on the basis of the least expensive generic drug – mandatory substitution)* *of the first $2,500 of eligible expenses and, 100% of the excess per certificate
Annual deductible	None	None	None
Automated claims payment	Direct	Direct	Direct
Note: If the BPDIP prescription drug reimbursement coinsurance increases during the year, the brand name prescription drug coinsurance will be adjusted as of the same date. If the BPDIP prescription drug reimbursement coinsurance decreases, the coinsurance modification will become effective on January 1 of the following year.			

	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
3. **Other eligible expenses**			
Reimbursement	70%	80%	90%
Annual deductible	None	None	None
Ambulance	Covered	Covered	Covered
Artificial limbs *, prosthetic devices *, foot orthoses * and orthopaedic devices *	Covered	Covered	Covered
Blood glucose monitor *, dextrometer * or other similar device *	Maximum reimbursement of $200 per period of 60 consecutive months	Maximum reimbursement of $200 per period of 60 consecutive months	Maximum reimbursement of $200 per period of 60 consecutive months
Breast prosthesis *	Eligible maximum of $500 per calendar year	Eligible maximum of $500 per calendar year	Eligible maximum of $500 per calendar year
Capillary prothesis (wig) *	Eligible maximum of $700 per calendar year	Eligible maximum of $700 per calendar year	Eligible maximum of $700 per calendar year
Corrective footwear *	Eligible maximum of $100 per pair and 2 pairs per calendar year	Eligible maximum of $100 per pair and 2 pairs per calendar year	Eligible maximum of $100 per pair and 2 pairs per calendar year
Dentist following an accident	Covered	Covered	Covered
Eye examination	Not covered	Eligible maximum of $50 per period of 24 consecutive months	Eligible maximum of $50 per period of 24 consecutive months
Hearing aid *	Maximum reimbursement of $1,000 per period of 36 consecutive months	Maximum reimbursement of $1,000 per period of 36 consecutive months	Maximum reimbursement of $1,000 per period of 36 consecutive months

	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
3. **Other eligible expenses**			
Homeopathic medicines *	Maximum reimbursement of $400 per calendar year	Maximum reimbursement of $400 per calendar year	Maximum reimbursement of $400 per calendar year
Insulin pump *	Maximum reimbursement of $3,000 per period of 60 consecutive months	Maximum reimbursement of $3,000 per period of 60 consecutive months	Maximum reimbursement of $3,000 per period of 60 consecutive months
Intra-uterine device (IUD)	Covered	Covered	Covered
Orthopaedic shoes *	Purchase expenses, after application of a $20 deductible per pair	Purchase expenses, after application of a $20 deductible per pair	Purchase expenses, after application of a $20 deductible per pair
Oxygen therapy	Covered	Covered	Covered
Private clinic for the treatment of alcoholism, drug addiction or compulsive gambling	Maximum reimbursement of $3,500 per calendar year, up to one treatment per calendar year and 2 treatments per lifetime	Maximum reimbursement of $3,500 per calendar year, up to one treatment per calendar year and 2 treatments per lifetime	Maximum reimbursement of $3,500 per calendar year, up to one treatment per calendar year and 2 treatments per lifetime
Registered nurse * or nursing assistant *	Eligible maximum of $300 per day Maximum reimbursement of $10,000 per calendar year	Eligible maximum of $300 per day Maximum reimbursement of $10,000 per calendar year	Eligible maximum of $300 per day Maximum reimbursement of $10,000 per calendar year

	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
3. **Other eligible expenses**			
Rehabilitation centre and convalescent home	Semi-private room Eligible maximum of $75 per day and 15 days per hospitalization	Semi-private room Eligible maximum of $75 per day and 15 days per hospitalization	Semi-private room Eligible maximum of $75 per day and 15 days per hospitalization
Serums and fluids injected for curative purposes (including injections for artificial insemination) *	Covered	Covered	Covered
Support stockings	Maximum of 6 pairs per calendar year	Maximum of 6 pairs per calendar year	Maximum of 6 pairs per calendar year
Treatment from a medical specialist not available in the insured's area of residence *	Maximum reimbursement of $750 per calendar year	Maximum reimbursement of $750 per calendar year	Maximum reimbursement of $750 per calendar year
Vaccines (including preventive vaccines)	Covered	Covered	Covered
Wheelchair *, iron lung * and therapeutic devices *	Covered	Covered	Covered

	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
4. **Health Care Professionals**			
Reimbursement	70%	80%	90%
Chiropractor	Not covered	Eligible expenses of $50 per treatment, consultation or X-ray, up to a maximum reimbursement of $600 per calendar year for all of these professionals	Eligible expenses of $50 per treatment, consultation or X-ray, up to a maximum reimbursement of $900 per calendar year for all of these professionals
Acupuncturist, dietitian, homeopath, occupational therapist, osteopath, physiotherapist, podiatrist, sports therapist and physical rehabilitation therapist	Not covered		
Massage therapist *	Not covered	Not covered	
Remedial teacher and speech-language pathologist	Not covered	Eligible expenses of $50 per consultation, up to a maximum reimbursement of $600 per calendar year for all of these professionals	Eligible expenses of $50 per consultation, up to a maximum reimbursement of $900 per calendar year for all of these professionals
Guidance counsellor in private practice, psychoanalyst, psychiatrist, psychologist, psychotherapist and social worker	Not covered	Eligible expenses of $75 per consultation, up to a maximum reimbursement of $900 per calendar year for all of these professionals	Eligible expenses of $75 per consultation, up to a maximum reimbursement of $1,400 per calendar year for all of these professionals

4.2 Eligible Health Insurance expenses

4.2.1 Hospitalization

Expenses are reimbursed according to the terms indicated in the *Schedule of Insurance*, based on the module selected by the participant.

a) When an insured, upon a physician's recommendation, is admitted to a hospital centre in Canada after the effective date of his or her insurance, the Insurer pays for the insured the fees charged by the hospital for a private or semi-private room as long as the insured is eligible for insured care as an inpatient, up to the amount the hospital is authorized to directly charge the patient for a semi-private room.

b) When an insured, upon a physician's recommendation and after the effective date his or her insurance, is admitted as a chronic care inpatient to a tuberculosis hospital, a sanatorium, a home for the mentally ill, a nursing home, a retirement home or a dispensary and that this establishment is authorized by the Quebec *Ministre de la Santé et des Services sociaux* to belong to the hospital insurance plan under the *Hospital Insurance Act* of this province, the Insurer pays for the insured the fees charged by the facility for the stay, up to the amount the said facility is authorized to directly charge the patient for a stay in a semi-private room.

4.2.2 **Prescription drugs**

Expenses are reimbursed according to the terms and conditions indicated in the *Schedule of Insurance*, based on the module selected by the participant.

The Insurer reimburses the participants for expenses incurred for themselves or their insured dependents for the purchase of prescription drugs that can be obtained only by prescription from a health care professional legally authorized to prescribe such drugs. Prescription drugs means any products included in the most recent drug formulary of the Régie de l'assurance maladie du Québec (RAMQ) or in the drug formulary of the Association québécoise des pharmaciens propriétaires (AQPP), with the exception of drugs coded "V" or "Z".

However, pharmaceutical services and prescription drugs that are covered under the Basic Prescription Drug Insurance Plan (BPDIP) as established under the Act respecting prescription drug insurance (R.S.Q., c. A-29.01) are not covered for participants age 65 or over and their dependents unless the participant has requested otherwise in accordance with the provisions specified in the section regarding insurance application. If the participant chooses to insure prescription drugs with the RAMQ, only the portion not eligible for reimbursement (deductible and coinsurance) is eligible under this contract.

The Insurer also reimburses drugs obtained by medical prescription and whose therapeutic indication is directly related to treatment of the following medical conditions:

- Cardiac disorders
- Pulmonary disorders

- Diabetes
- Arthritis
- Parkinson's disease
- Epilepsy
- Cystic fibrosis
- Glaucoma

For any new drug approved after January 1, 1997, the Insurer reserves the right, upon agreement with the Committee:

- to limit the reimbursement according to the criteria stipulated by the regulation regarding the Act respecting prescription drug insurance, if it is registered as an exception drug on the list under section 60 of the act;
- to exclude it or establish reimbursement criteria, if this drug is not included on the said list.

Notwithstanding any of the definitions or exclusions of this contract, all prescription drugs that must be covered under the group insurance contract in accordance with the *Act respecting prescription drug insurance* are considered to be eligible expenses

If there are medical contraindications preventing the insured from purchasing a generic drug, the brand name drug can be reimbursed in accordance with the percentage indicated for a patented drug. The insured must then submit to the Insurer a document specifying the contraindications signed by the physician who prescribed the drug. If the Insurer accepts the request, no other medical document will be required for the renewal of the approved prescription drug.

4.2.3 **Other eligible expenses**

Expenses are reimbursed according to the terms indicated in the *Schedule of Insurance*, based on the module selected by the participant.

a) Expenses for transportation by ambulance, including round trip air or train transportation, in case of an emergency.

b) Expenses for the purchase of an artificial limbs for a loss occurring while insurance is in force, prosthetic devices excluding dental prostheses, foot orthoses, casts and orthopaedic devices except for orthopedic shoes. Expenses for the repair of such devices are also covered if the cost is less expensive than the purchase cost.

c) Expenses for the purchase of a blood glucose monitor, a dextrometer or any other device of a similar nature and the travel case, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of this device.

d) Expenses for the purchase of a capillary prosthesis (wig) following chemotherapy treatments.

e) Expenses for corrective footwear purchased from a specialized establishment.

f) The professional services of a dentist to repair accidental damage to natural teeth occurring after the effective date of insurance, provided that the treatment takes place within one (1) year of the date of the accident.

g) Expenses for the purchase of an external breast prosthesis following a mastectomy, in excess of the amount payable by the RAMQ.

h) Professional fees for an eye examination carried out by an ophthalmologist or an optometrist for insureds age 18 to 64.

i) Expenses for the purchase or repair of a hearing aid.

j) Expenses for homeopathic medicines available only on prescription by a duly authorized homeopath or physician and that are dispensed by a licensed pharmacist.

k) Expenses for the purchase of an insulin pump used to manage diabetes, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of such device.

l) Expenses for the purchase of orthopaedic shoes (moulded shoes).

m) Oxygen therapy services administered under the supervision or upon prescription of a physician. However, the professionals who provide such services must be registered with the organization governing their profession.

n) Expenses incurred within or outside of Canada for a program in a recognized private clinic specializing in the treatment of alcoholism, drug addiction (excluding addiction to smoking) or compulsive gambling.

o) The professional services of a registered nurse or nursing assistant, excluding any person who usually resides in the insured's home or is a member of the insured's family.

p) Expenses for occupying a room, including meals, for at least 12 consecutive hours in a rehabilitation centre or a convalescent home, as defined by the *Act respecting health services and social services*, in excess of the expenses payable under any government insurance plan, provided that the insured is admitted to the centre or home immediately following hospitalization and that hospitalization lasted at least 3 days and began while insurance was in force.

q) Expenses for serums and fluids injected for curative purposes, including injections for artificial insemination.

r) Expenses for the purchase of support stockings.

s) Expenses incurred by insureds who must travel outside of their area of residence in order to consult a specialist or receive specialized treatment not available in their area of residence. The following expenses are eligible:

- If the situation requires travel of at least 280 kilometres (total round trip distance) from the insured's place of residence, expenses for travel with a public carrier (bus, plane, boat or train) or by automobile. However, when travelling by automobile, eligible expenses are equal to those that would have been incurred had the trip been made by bus.

- Accommodation expenses incurred in a public establishment, provided that the consultation or the treatment requires an overnight stay.

Eligible expenses must be incurred for consultations or treatments in the province of Quebec and are reimbursed upon presentation of paid invoices, except if the means of transport used is an automobile.

Eligible expenses must be incurred by and for the participants if they have Individual coverage. If participants have Family or Single-Parent coverage, eligible expenses must be incurred by and for the participants or their dependents. This benefit also covers expenses for a person accompanying the insured, when required.

t) Expenses for vaccines, including preventive vaccines, which are administered by a physician or a nurse.

u) Expenses for the rental of a wheelchair, an iron lung or other therapeutic devices.

4.2.4 **Health care professionals**

Expenses incurred for treatments or consultations with one of the following health care professionals are reimbursed according to the terms indicated in the *Schedule of Insurance*, based on the module selected by the participant.

The health care professionals must be members in good standing of a professional corporation recognized by the competent authorities or, failing the existence of such corporation, of a professional association recognized by the Insurer.

Insureds cannot receive or obtain more than one treatment or one consultation per day from or with the same health care professional, regardless of the number of specialities the professional practises.

a) Acupuncturist

b) Chiropractor, including X-rays

c) Dietitian

d) Guidance counselor in private practice

e) Homeopath

f) Massage therapist

g) Occupation therapist

h) Osteopath

i) Physiotherapist, sports therapist and physical rehabilitation therapist

j) Podiatrist

k) Psychiatrist. Fees for marital therapy for both spouses are also covered. Furthermore, for expenses to be eligible, the psychiatrist must be a member of the Canadian Psychoanalytic Society.

l) Psychoanalyst in an outpatient clinic. Fees for marital therapy for both spouses are also covered.

m) Remedial teacher

n) Psychologist. Fees for marital therapy for both spouses are also covered.

o) Psychotherapist

p) Social worker

q) Speech-language therapist

4.3 Travel Insurance

The customary and reasonable expenses described hereafter are eligible for reimbursement, if incurred following an emergency situation resulting from an accident or illness occurring while the insured person is temporarily outside the province of residence, provided the insured person is covered under the government health insurance plan of the province of residence.

Benefits are granted over and above and not in replacement of any benefits provided under government programs.

The maximum reimbursement per insured is indicated in the *Schedule of Insurance*.

IMPORTANT – EXCLUSION AND REDUCTION OF COVERAGE

To be covered under this benefit, insured persons who have a known illness or condition must ensure before departure that their health condition is stable and under control, that they can carry out usual daily activities and that they are experiencing no symptoms that may reasonably suggest that any complications may arise or that medical care may be required during the planned stay outside the province of residence.

An illness or condition is considered to be stable in the absence of any:

- deterioration;
- relapse;
- diagnosis of terminal phase;
- chronicity likely to lead to deterioration or complications during the planned trip outside the province of residence.

Insured persons with a known illness or condition who are unsure about their health condition or who are awaiting diagnosis must contact the Assistor at least 15 days before departure to obtain confirmation of insurance coverage under this benefit.

4.3.1 Hospitalization, medical and paramedical expenses

a) Expenses for hospitalization in a semi-private room or private room, in excess of the amounts paid or payable under the government health insurance plan of the insured's province of residence.

b) Incidental expenses (telephone, television, parking, etc.) related to hospitalization, upon presentation of supporting documents, up to a maximum of $100 per hospitalization.

c) Professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care; expenses incurred are payable only for the portion of expenses in excess of the benefits payable under the government health insurance plan of the insured's province of residence.

d) The cost of drugs obtained on prescription by a physician in an emergency treatment situation.

e) Professional fees of a registered nurse, who is a member in good standing of a recognized professional order, for private nursing care dispensed exclusively in a hospital centre, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $3,000 per hospitalization period. The nurse must not be related to the insured nor be a travel companion.

f) Rental of therapeutic devices and purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices, when prescribed by the attending physician.

g) Professional fees of a dentist for treatment of accidental injury to natural teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident; to be covered, expenses must be incurred within 12 months following the accident.

4.3.2 **Eligible transportation expenses**

a) Expenses for transportation of the insured by air or surface ambulance to the nearest medical centre where adequate medical care is available. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing the patient's condition.

b) Repatriation expenses for the insured to return to the place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as the insured's health condition so allows and insofar as the means of transport initially planned for the return cannot be used. If required by the insured's health condition, the Assistor will send a medical escort on site to accompany the insured on the return trip. Repatriation must be approved and planned by the Assistor.

c) When the insured is repatriated or transported, the Assistor organizes and pays expenses for the insured's spouse and dependent children or the insured's travel companion, as applicable, to return to the insured’s province of residence, up to the cost of a regularly scheduled airline flight, train or bus ticket, if the means of transport initially planned for the return cannot be used.

d) When the insured’s health condition does not allow medical repatriation and hospitalization outside the province must extend beyond 7 days, the Assistor will organize and pay round-trip transportation expenses to enable a close relative of the insured, residing in the insured's province of residence, to be at the bedside of the insured. The maximum reimbursement is $1,500.

However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative age 18 or over, if the necessity of a visit is not confirmed by the attending physician, or if the visit is not approved in advance and planned by the Assistor.

e) The Assistor will make necessary arrangements to return home any children under age 18 accompanying the insured if, following the insured's accident or illness, the insured or another accompanying adult is unable to do so personally.

f) If the insured is unable to drive the automobile used for a trip following an illness or accident that occurs during the trip and no other accompanying person is able to drive the vehicle, the Assistor will pay the expenses incurred by a commercial agency to return the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency, subject to a maximum reimbursement of $1,000.

g) In the event of the insured's death, when necessary, the Assistor will organize and pay expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing that no close relative age 18 years or over is accompanying the insured on the trip. The maximum reimbursement is $1,500.

h) In the event of the insured's death, the Assistor will pay for the cost of preparing and returning the remains of the insured (excluding the cost of the coffin or casket) to the place of burial in the province of residence, subject to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

4.3.3 Eligible living expenses

Expenses for accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home due to an illness or bodily injury suffered by the insured, a close relative accompanying the insured or a travel companion, subject to a maximum reimbursement of $150 per day for a maximum of 8 days.

4.3.4 Travel Assistance Service

On request, the Assistor will provide insureds with worldwide travel assistance service 24 hours a day, 365 days a year, excluding countries at war or known to be in a state of political instability, making any intervention by the Assistor physically impossible.

a) Advances for expenses covered under the Travel Insurance benefit. The Assistor then files a claim for reimbursement of expenses covered under the government health insurance plan of the insured's province of residence and with the Insurer.

b) In the event of illness or accident abroad, the Assistor will provide straightforward medical advice and information as to the location of an appropriate medical centre. If necessary, the Assistor will help coordinate the insured's admission to an appropriate clinic or hospital.

c) Subject to the provisions herein, once notified of an illness or accident suffered by the insured outside the province of residence, the Assistor will coordinate communication between its medical service, the attending physician, and ultimately the insured's family doctor, in order to ensure any decisions made are best adapted to the situation.

d) The Assistor will take charge of transmitting any urgent messages when the insured is personally unable to do so.

e) The Assistor will ensure, insofar as possible, the dispatch of any drugs that are indispensable for the ongoing treatment of the insured in the event that it is impossible to obtain such drugs or equivalent drugs on site. In all cases, drugs must be paid for by the insured and then, if eligible, reimbursed by the Insurer.

f) Upon presentation of supporting documents, the Assistor will reimburse the insured for any telephone and other communication expenses incurred by an insured in distress abroad in order to gain access to covered services.

g) Upon request by the insured, the Assistor will provide any information required in the event of major problems occurring during the trip following the loss of the insured's passport, visa or credit card, etc.

h) The Assistor will provide insureds in distress abroad with telephone access to a multilingual interpretation service.

i) In the event that an insured is involved in legal proceedings following a traffic accident, highway code violation or any other civil offence, the Assistor will provide assistance by recommending names of lawyers. This service is only applicable in Canada and the United States.

4.3.5 **Obligations of the insured**

a) NOTICE: Insureds must notify the Assistor of any incident, accident or illness as soon as possible.

b) RESTRICTION: As soon as they are able to do so insureds must obtain the prior approval of the Assistor before taking any initiative or incurring any expenses. If the insured fails to fulfill this obligation, the Assistor will be relieved of its obligations to the insured.

c) UNUSED TICKETS: When an insured has benefited from repatriation under the terms of this Travel Insurance benefit, the Assistor reserves the right to

claim any ticket held by the insured that was not used due to services provided by the Assistor.

d) SUBROGATION: For the purposes of this benefit and with regard to any funds advanced or reimbursed by the Assistor, the insured hereby assigns and subrogates the Assistor in all of his or her rights and recourses to any reimbursement from which he or she benefits or claims to benefit in accordance with any public or private plan providing insured services similar to those for which advances or expenses have been incurred by the Assistor. Insureds shall agree to sign any document and execute any deed required by the Assistor in order to give full and complete effect to this assignment and subrogation and specifically mandate the Assistor for this purpose as attorney and representative for submitting any claim and collecting any reimbursement.

4.3.6 Exclusions and reduction of Travel Insurance coverage

In addition to the exclusions and reduction specified in section 4.5, the Insurer and the Assistor will issue no reimbursement nor provide any assistance to the insured in the following cases:

a) When the loss occurs in the insured's province of residence.

b) When the insured refuses without any valid medical reason to comply with the Assistor's recommendations with regard to repatriation or the choice of hospital or required care; by required care is meant the treatment needed to stabilize the insured’s medical condition.

c) If the insured fails to contact the Assistor in the event of a medical consultation or hospitalization following an accident or sudden illness.

d) When expenses are incurred due to pregnancy, and any related complications, within 8 weeks preceding the expected date of delivery.

e) When the expenses incurred outside the insured's province of residence could have been incurred in the province of residence, without danger to the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from an accident or sudden illness. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province does not constitute a danger for the insured's life or health.

f) When expenses are incurred for insureds in hospitals for the chronically ill, services for the chronically ill in public hospitals, extended care homes or thermal spas.

g) For elective or non-emergency surgery or treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.

h) For an accident occurring while the insured is practising any sporting activity involving remuneration, motor vehicle competition or any speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity. Activities other than those previously listed that are offered to the general public in resort areas are not considered dangerous activities.

i) When the loss occurs in a country that is at war, whether declared or not, is known to be experiencing political instability during a riot, an uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving an Act of God making any intervention by the Assistor physically impossible. This exclusion only applies for the travel assistance services.

The Insurer may, at any time and at its sole discretion, change the Assistor for the purposes of this Travel Insurance benefit.

4.4 Trip Cancellation Insurance

The Insurer will pay, in accordance with the terms and conditions specified hereunder, 100% of the expenses incurred by the insured following the cancellation or interruption of a trip, insofar as the expenses incurred are related to travel expenses paid in advance by the insured while this benefit is in force and, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip. The maximum reimbursement per insured is indicated in the *Schedule of Insurance*.

4.4.1 Eligible causes of cancellation or interruption

The trip must be cancelled or interrupted due to one of the following causes:

a) An illness or accident preventing the insured, the insured's travel companion, a close relative of either, or a business partner of the insured from performing his or her usual activities, which is sufficiently serious to justify the cancellation or interruption of the trip.

b) Death of the insured, the insured's spouse, the insured's child or spouse's child, or the insured's travel companion or business partner.

c) Death of a close relative of the insured, other than the insured's spouse or child, or a close relative of the travel companion if the funeral is scheduled to take place during the trip or the preceding 14 days.

d) Death or emergency hospitalization of the host at destination.

e) The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the planned trip, provided the person involved is not a party to the litigation and has taken all necessary measures to have the hearing postponed.

f) Quarantine of the insured or travel companion, provided that quarantine ends 7 days or fewer prior to the scheduled date of departure.

g) Hijacking of the airplane on which the insured is travelling.

h) Damage rendering the principal residence of the insured's travel companion or of the host at destination uninhabitable, provided the residence remains uninhabitable 7 days or fewer prior to the scheduled date of departure, or the damage occurs during the time of the trip.

i) Transfer of the insured or travel companion, by the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required within the 30 days preceding the scheduled date of departure.

j) Terrorism or any other situation in the country to which the insured is travelling, provided the Government of Canada issues a warning that Canadians should not travel in that country during the time of the planned trip and that the warning was issued after travel expenses were incurred.

k) Missed departure due to a delay in the means of transportation used to reach the point of departure, provided that the means of transportation used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure, or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by weather conditions, mechanical problems (except for a private automobile), a traffic accident or an emergency road closure, each of the latter 2 causes requiring confirmation by a police report.

l) Weather conditions such that the departure of the public carrier used by the insured, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip, or preventing the insured after departure from making a scheduled connection with another carrier, provided the scheduled connection after departure is delayed for at least 30% (minimum 48 hours) of the planned duration of the trip.

m) Damage occurring to a commercial establishment or location where a commercial activity is scheduled to be held, preventing the activity from taking place, provided that a written cancellation notice is issued by the organization officially responsible for the activity.

n) Involuntary loss of employment of the insured or the insured's spouse, provided the person in question has been working for the employer for at least one year.

o) Default by the travel services provider.

4.4.2 Expenses covered

The following expenses are covered, provided they are incurred by the insured.

a) In the event of cancellation prior to departure:

- The non-refundable portion of prepaid travel expenses;
- Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the eligible reasons for cancellation provided hereunder and the insured decides to proceed with the trip as initially planned; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel;
- The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the insured decides not to proceed with the trip.

b) In the event of missed departure, at the beginning of or during the trip, due to one of the reasons provided hereunder, the additional cost charged by a scheduled public carrier for economy class travel, via the most direct route, to the initially-planned trip destination.

c) If the return is earlier or later than planned:

- The additional cost of a one-way economy class ticket, by the most direct route to the point of departure, by the means of transportation initially planned, or if the initially-planned means of transportation cannot be used, the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure; these expenses must be pre-approved by the Insurer.

  However, if the insured’s return is delayed by more than 7 days due to an accident or illness suffered by the insured or travel companion, expenses incurred are eligible provided the person in question was admitted to a hospital as an inpatient for more than 48 hours within the 7-day period.

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

d) In the event of default by the travel services provider:

Subject to the following provisions and subrogation in favour of the Insurer for any amount reimbursed, the Insurer will cover the financial loss incurred due to default by the service provider:

- If default occurs before departure, the Insurer will reimburse the non-refundable portion of prepaid travel expenses;

- If default occurs after departure, the Insurer will reimburse the unused and non-refundable portion of prepaid travel expenses.

The Insurer's liability is limited to $500,000 for all claims due to any travel services provider's default, and to an overall maximum of $1,000,000 per calendar year for all travel services providers.

4.4.3 Exclusions of Trip Cancellation Insurance coverage

This benefit does not cover losses due to the following causes or to which such causes have contributed:

a) An illness or condition that was not stable at the time the insured finalized travel arrangements. Criteria used to define a stable illness or condition are specified in article 4.3.

b) Any trip taken for the purpose of medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.

c) Any trip taken to visit a person who is ill or has suffered an accident and that cancellation or interruption of the trip results from the death or a change in the medical condition of such person.

d) War, whether declared or not, or active participation in an insurrection, whether real or apprehended.

e) Active participation of the insured or travel companion in a criminal act or deemed as such.

f) Pregnancy, and any related complications, within 8 weeks preceding the expected date of delivery.

g) Voluntary injury the insured or travel companion inflected to themselves, suicide or attempted suicide, whether or not the person is of sound mind.

h) Voluntary abusive consumption of medication, drugs or alcohol and the resulting consequences.

i) Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity. Activities other than those previously listed that are offered to the general public in resort areas are not considered dangerous activities.

j) A medical condition for which the insured or travel companion has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date on which travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the person in question is stable at the time expenses are incurred. Any change in medication, including use and dosage, is considered to be a medical treatment.

k) Any loss related to a known condition of the insured or travel companion that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.

4.4.4 Deadline to request cancellation

In the event of an incident that results in trip cancellation prior to departure, the trip must be cancelled within a maximum period of 48 hours or on the next business day, if the incident occurs on a statutory holiday. The Insurer must be notified at the same time. The Insurer's liability is limited to the cancellation costs that, as provided for in the travel contract, apply for 48 hours following the incident that resulted in the cancellation or the following business day, if the incident occurs on a statutory holiday.

4.4.5 Coordination of benefits

Any amounts payable hereunder are reduced by any amounts payable under another individual or group insurance plan. Any expenses that insureds would not have had to pay had they not been covered under this benefit are also excluded.

4.4.6 Trip Cancellation benefit claims

When filing a claim, insureds must provide the following supporting documents:

- Unused travel tickets.
- Official receipts for additional transportation expenses.
- Receipts for ground travel arrangements and other expenses paid. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation. Written proof that the insured has requested a reimbursement of travel expenses must be forwarded to the Insurer, along with the reply received as to the outcome of such request.
- Official documents certifying the reason for cancellation. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip.

- An official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure.

- An official report issued by the appropriate authorities pertaining to weather conditions.

- Written proof issued by the official organizer of a commercial activity confirming that the event is cancelled and the specific reasons of cancellation.

- Any other report required by the Insurer to support the insured's claim.

4.5 Exclusions and reduction of the Health Insurance coverage

Without further limitation to care, supplies and services described under eligible health insurance expenses, and subject to the provisions of the *Act respecting prescription drug insurance*, the Insurer will not reimburse the following expenses:

a) For eye and hearing examinations, except if required following an accident. However, this exclusion does not apply for eye examinations covered under the Standard (Module B) or Extended (Module C) coverage.

b) For dental prostheses, eyeglasses or contact lenses, except if required following an accident.

c) That insureds would not be required to pay if they had invoked the provisions of any public plan for which they were eligible.

d) For treatments, surgery or prostheses provided for aesthetic purposes, except following an accident.

e) Treatment or services provided by a close relative of the insured or by a person who resides with the insured.

f) For periodic medical examinations for the purposes of employment or insurance.

g) While the insured is on active duty with armed ground, sea or air forces.

h) As a result of any war, whether declared or not, or active participation in an insurrection.

i) As a result of active participation in a criminal act.

j) For dietetic substances or foods.

k) After termination of this contract, subject to article 4.10 "Extension".

l) For drugs or substances used for the treatment of impotence.

m) For any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this benefit, except for the deductible and coinsurance required by the RAMQ.

Exclusions and reduction in coverage listed in the Travel Insurance benefit apply in addition of those listed in this article.

For the Trip Cancellation Insurance benefit, only exclusions and reduction in coverage listed in article 4.4.3 apply.

4.6 Pre-existing conditions

Benefits related to causes that existed before the effective date of this contract shall not be excluded solely for this reason.

4.7 Benefit claims

The Insurer shall be liable for the reimbursement of claims under this benefit only if such claims are submitted within the 12 months following the date on which eligible expenses were incurred. Expenses are considered to be incurred on the date services or supplies are provided.

If the participant demonstrates that it was impossible to submit the claim within this deadline and that such claim was submitted as soon as the participant was able to do so, the claim will then be eligible under this benefit.

4.8 Information

The Insurer may require any information, including details, files and case histories regarding the diagnosis, treatment or services provided to each insured, either before or after the effective date of insurance for the insured. The insured hereby agrees, as a condition of the Insurer's liability under this benefit, to disclose or have disclosed all required information, and authorizes any person providing or having provided such services to disclose such information directly to the Insurer. All information is considered strictly confidential by the Insurer.

4.9 Waiver of premiums

Insurance for participants (and their dependents, if applicable) who become disabled before the effective date of retirement is maintained in force without payment of premiums for as long as disability lasts, provided the contract remains in force and that disabled participants have not reached age 65.

However, waiver of premiums applies only once the participant becomes eligible for Long Term Disability Insurance benefits, that is to say after the 104-week elimination period which is extended, if applicable, by any unused credits in the participant's sick leave bank.

4.10 Extension of coverage

Upon termination of a participant's insurance and for the 3-month period immediately following the termination date, the Insurer reimburses, for a disabled participant or an insured dependent who is hospitalized when insurance ends, eligible expenses incurred for the illness or the accident that entailed the disability or hospitalization provided that:

a) The participant incurred eligible expenses for the illness or accident that entailed the participant's disability or the insured dependent's hospitalization before the termination date of the insurance.

b) Disability or hospitalization is ongoing without interruption.

4.11 Conversion privilege

Insureds who are no longer eligible for coverage under this benefit for a reason other than retirement may apply, without evidence of insurability, for an individual health insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within 60 days following the date of termination of insurance. Evidence of insurability will be required for applications submitted after this deadline. For insureds who exercise their conversion privilege within the specified deadline, their individual health insurance policy will be effective as of the date of termination of their group insurance. If evidence of insurabililty is required, insurance will become effective as of the date the Insurer accepts such evidence.

4.12 Termination of insurance

4.12.1 Participant

Subject to the provisions of articles 4.9 "Waiver of premiums" and 4.10 "Extension", a participant's insurance terminates on the earliest of the following dates:

a) The termination date of the contract;

b) The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant to a college whose insurance contract comes under the Committee is not considered a termination of employment;

For non-permanent employees, insurance remains in force until the first day of the following session, without exceeding a 2-month period from the termination date of the contract;

c) The effective date of retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65;

d) In the case of unpaid premium, 30 days after the date on which a written notice to that effect is sent by the Insurer to the participant's last known address.

4.12.2 Dependent

Subject to the provisions of articles 4.9 "Waiver of premiums" and 4.10 "Extension of coverage", a dependent's insurance terminates on the earliest of the following dates:

a) The date of termination of the insured participant who was covering the dependent.

b) The date on which the person ceases to meet the definition of dependent under this contract.

SECTION 5 - **DENTAL CARE INSURANCE**

5.1 **Eligible expenses**

Eligible expenses are expenses that are reasonably incurred, recommended by a dentist and justified by current dental practice, for the treatments described below, up to the amount of the fees specified in the fee guide approved by the *Association des chirurgiens dentistes du Québec* at the time services are rendered.

Expenses payable under any other individual or group plan and expenses for which the insured is entitled to an indemnity under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, or under any other similar federal or foreign law are excluded.

The codes used in the description of eligible expenses come from the document entitled "2014 Fee Guide and Description of Dental Treatment Services", approved by the *Association des chirurgiens dentistes du Québec*. For subsequent years, these codes will be replaced by their equivalents from later documents approved by the Association. All new dental procedure codes related to the following expenses, added while the contract is in force, are considered an integral part of the description of eligible expenses under this contract.

If more than one type of treatment exists for the insured's dental condition, the Insurer reimburses expenses based on the least expensive normal and appropriate treatment.

Expenses are reimbursed in accordance with the terms indicated in the *Schedule of Insurance*, based on the Option selected by the participant.

5.2 Schedule of Insurance

The minimum participation period for both of these options is 36 months, subject to the provisions of article 2.5 "Change in coverage – Health and Dental Care Insurance".

Extended coverage (Option 2) is only available for participants who selected Module C for the Health Insurance benefit.

The maximums indicated are per insured.

	Basic coverage (Option 1)	Extended coverage (Option 2)
Preventive services	80% 1 examination per period of 9 consecutive months	80% 1 examination per period of 9 consecutive months
Basic restorative services	80%	80%
Major restorative services	Not covered	80%
Maximum reimbursement	$1,000 per calendar year	$1,000 per calendar year
Annual deductible	None	None
Reimbursement based on	Fee guide of current year	Fee guide of current year

5.3 Description of preventive services

5.3.1 Diagnosis:

– clinical oral examination :

a) complete examination: one examination per period of 9 consecutive months (01110, 01120, 01130)

b) recall or periodic examination: one examination per period of 9 consecutive months (01200)

c) dental examination for dependent children under age 10 not reimbursed by the Quebec public health insurance plan: one examination per period of 12 consecutive months (01250)

d) emergency examination (01300)

e) specific oral examination: one examination per period of 9 consecutive months (01400)

f) complete periodontal examination: one examination per period of 24 consecutive months (01500)

Limitation: Only one recall, periodic, complete or specific oral examination is covered per period of 9 consecutive months.

– radiographs :

a) intraoral radiographs:

i) radiograph, periapical (02111 to 02116)

ii) occlusal film (02131, 02132)

iii) bitewing film (02141 to 02144);

b) extraoral radiographs

i) extraoral film (02201, 02202)

ii) radiograph, sinus (02304)

iii) radiograph, sialography (02400)

iv) radiopaque dyes (02430)

v) radiograph, temporomandibular joint (02504)

c) Tomography (02920, 02929)

Limitation: Only one series of radiographs is eligible for reimbursement per period of 9 consecutive months, except for a series of radiographs taken during an emergency examination. Furthermore, a complete series of periapical and bitewing films is only eligible for reimbursement once per period of 36 consecutive months.

5.3.2 Preventive services :

– polishing of coronal portion of teeth (prophylaxis): one treatment per period of 9 consecutive months (11100, 11200, 11300)

– periodontal scaling: one treatment per period of 9 consecutive months for all related dental procedures (43411 to 43414, 43417, 43419)

– topical application of fluoride for dependents age 16 and under: one treatment per period of 9 consecutive months (12400)

- finishing restorations (13300)
- removal of surplus subgingival filling material, when local anesthetic is required, without flap, per tooth (13301)
- pit and fissure sealants for dependents age 14 and under (13401, 13404)
- teeth recontouring
    a) interproximal disking of teeth (13700)
    b) enameloplasty, per tooth (13715)

5.4 Description of basic restorative services

5.4.1 Restoration:

- primary teeth :
    a) non-bonded amalgam, anteriors or posteriors (21101 to 21105)
    b) bonded amalgam, anteriors or posteriors (21121 to 21125)
    c) bonded composite anteriors (23311 to 23315)
    d) bonded composite posteriors (23411 to 23415)
- permanent teeth :
    a) non-bonded amalgam, anteriors or bicuspids (21211 to 21215)
    b) non-bonded amalgam, molars (21221 to 21225)
    c) bonded amalgam, anteriors and bicuspids (21231 to 21235)
    d) bonded, amalgam molars (21241 to 21245)
    e) bonded, composite anteriors (23111 to 23115, 23118)
    f) veneer application - chairside (anteriors and bicuspids) (23122)
    g) bonded composite bicuspids: up to the amount payable for bonded amalgam bicuspids (23211 to 23215)
    h) bonded composite molars: up to the amount payable for bonded amalgam molars (23221 to 23225)

– Retentive pins (amalgam or composite) (21301 to 21304)

– Supplement for restoration (amalgam or composite) under an appliance or supporting an existing removable partial denture (21601)

5.4.2 Oral surgery :

– removal of erupted teeth (uncomplicated) (71101, 71111)

– surgical excision :

a) erupted teeth (complex) (72100, 72110)

b) impacted tooth (72210, 72220, 72230, 72240)

c) residual roots (72300, 72310, 72320)

d) tooth fragment, removal (72350)

e) surgical exposure of teeth (72410 à 72412)

f) surgical movement of teeth (72430, 72440)

g) enucleation of teeth (72450)

– remodelling and recontouring of oral tissues:

a) alveolectomy (73020)

b) alveoloplasty (73100, 73110)

c) stomatoplasty (73123)

d) osteoplasty (73133 à 73135, 73140)

e) tuberoplasty (73150, 73151)

f) removal of hyperplasic tissue (by radiosurgery or dissection) (73171 to 73176)

g) removal of excess mucosa (by radiosurgery or dissection) (73181 to 73186)

h) alveolar ridge reconstruction with alloplastic material (73360, 73361)

i) extension of mucous folds with secondary epithelization (including vestibuloplasty) (73381 to 73384)

j) extension of mucous folds with mucous or skin graft (73401 to 73404)

- surgical excision (cyst and tumor):

  a) removal of tumor (74108, 74109)

  b) removal and curettage of intra-osseous cyst or granuloma (74408 to 74410)

- surgical incision and drainage (75100, 75101, 75110)

- removal of foreign body from the bone or soft tissue (75301, 75361)

- frenectomy (77801 to 77803)

- hemorrhage treatment (79400, 79401)

5.4.3 Additional general services :

- local anesthesia (92110, 92120)

- conscious sedation by inhalation (92311)

- professional visits (94100, 94200, 94400)

5.5 Description of major restorative services

5.5.1 Endodontics :

- caries / trauma / pain control :

  a) sedative filling/indirect capping (20111, 20121)

  b) recontouring and polishing of traumatized tooth (20131)

  c) cementation of broken tooth chip (20161)

- endodontic emergency :

  a) pulpotomy (32201, 32202, 32210)

  b) open and drain (separate emergency procedure from root canal treatment):

     i) open through natural teeth (39201, 39202)

     ii) open through metal or porcelain crown (32101)

  c) pulpectomy (separate emergency procedure from root canal treatment) (39901 to 39904)

d) relieving traumatic occlusion (39970)

e) reimplantation of avulsed tooth (39981)

f) repositioning of traumatically displaced tooth (39985)

– preparation of tooth for treatment (39100, 39110, 39120)

– root canal therapy :

a) root canal treatment :

i) 1 canal (33100 to 33102, 33110 to 33112)

ii) 2 canals (33200 to 33202, 33210 to 33212)

iii) 3 canals (33300 to 33302, 33310 to 33312)

iv) 4 canals (33400 to 33402, 33410 to 33412)

v) additional canal (33475)

b) apexification:

i) 1 canal (33521, 33531, 33541)

ii) 2 canals (33522, 33532, 33542)

iii) 3 canals (33523, 33533, 33543)

– periapical endodontic surgery :

a) apicoectomy (as a separate procedure from the root canal) (34101 to 34104)

b) apicoectomy and root canal performed in conjunction with endodontic treatment, with or without retrofilling (34111, 34112, 34114, 34115)

c) apicoectomy and retrofilling (as a separate procedure from root canal) (34201 to 34203, 34212, 34215)

d) root amputation (34401, 34402)

e) intentional reimplantation (34451 to 34453)

f) hemisection (39230)

– bleaching of endodontically treated tooth, carried out in office by the dentist: up to an overall maximum of 10 sessions per calendar year, per insured (39410)

– bleaching of vital teeth, carried out in office by the dentist: up to a maximum of one session per calendar year, per insured, for all teeth (97101, 97102)

5.5.2 Periodontics :

– management or treatment of acute infections, inflammations or other conditions (41200)

– desensitization: up to an overall maximum of 10 applications per year, per insured, for all teeth (41300)

– periodontal surgery :

a) gingival curettage and root planing (42000, 42001)

b) gingivoplasty and/or gingivectomy (42003, 42010)

c) fibrotomy (42330, 42331)

d) flap approach with osteoplasty and/or ostoectomy (42100)

e) grafts:

i) soft tissue (42200, 42300, 42560, 42561)

ii) osseous tissue (42611, 42700, 42711)

iii) gingival graft using allograft or xenograft material (42570, 42575)

f) interproximal Wedge (mesial ou distal) (42400)

g) exploratory surgery, flap approach (42441)

h) flap approach, with osteoplasty and/or ostoectomy for crown lengthening (42451)

i) postoperative visit for dressing change (42720)

– adjunctive periodontal procedures :

a) temporary splints or ligations (43200, 43211, 43212, 43260)

b) cast metal splint, acid etch bonded (43290, 43295)

c) occlusal equilibration (43300, 43310)

d) periodontal appliances (to control bruxism) (43611, 43612, 43622, 43631)

e) intraoral appliance for temporomandibular joint (occlusal guard) (43711, 43712, 43732, 43741)

f) periodontal irrigation, subgingival (49211)

g) intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents (49221, 49229)

5.5.3 Denture adjustments:

- minor adjustments, provided that adjustments are made more than 6 months after the initial insertion of the denture (54250, 54251)

- remount and equilibration of complete or partial dentures (54300 to 54302)

5.5.4 Complete or partial denture repairs:

- complete denture repairs without impression (55101 to 55104)

- complete denture repairs with impression (55201 to 55204)

- structural additions to the partial denture (55520, 55530)

- replacement of teeth in prosthesis (56602)

- vertical dimension recuperation by addition of acrylic to existing prosthesis (56631)

5.5.5 Rebasing and relining:

- reline complete or partial dentures (56200, 56201, 56210, 56211, 56220 to 56222, 56230 to 56232)

- rebasage (jump) (56260 to 56263, 56280, 56290)

- therapeutic tissue conditioning (56270 to 56273)

5.5.6 Restriction regarding article 5.5.5

These dental services are eligible for reimbursement if performed more than 6 months after insertion of the denture and at least 36 consecutive months have elapsed since the last relining or rebasing, whichever applies.

However, these services are not eligible for reimbursement if performed on a transitional denture.

5.6 Exclusions and reduction of coverage

The following dental procedures are excluded from coverage and are not eligible for reimbursement by the Insurer:

5.6.1 Dental care that is free of charge or that the insured is not required to pay, as well as those that the insured would not be required to pay if he or she had invoked the provisions of any public, private, individual or group plan for which the insured may be eligible for coverage or those the insured would not be required to pay if he or she was not covered under this contract.

5.6.2 Dental care for which the insured is entitled to reimbursement under the *Act respecting industrial accidents and occupational diseases*, the Quebec *Automobile Insurance Act*, or any other federal or foreign law with similar provisions, as well as and any dental treatments payable under any health insurance benefit in which the insured participates.

5.6.3 Dental treatments and supplies which, in accordance with the accepted standards of the dental profession, are not required from a dental viewpoint or do not meet the accepted standards of the dental profession.

5.6.4 Dental treatments administered primarily for aesthetic purposes, including the transformation, extraction or replacement of healthy teeth in order to modify their appearance.

5.6.5 Dental treatments required due to voluntary self-inflicted injury, whether or not the insured is of sound mind, or due to war or active participation in an insurrection, whether real or apprehended.

5.6.6 Fees charged by the dentist for missed appointments, filling out claim forms required by the Insurer, additional information required by the Insurer as well as travel time, transportation expenses and counselling provided by any means of telecommunication.

5.6.7 Fees charged by the dentist for treatment plans, be it for extra time spent for explanation due to the complexity of the treatment, or when the insured requires extra time for explanation, or when the diagnostic material comes from another source, as well as any related fees charged for consultation with the insured or another dentist.

5.6.8 Fees charged for diet assessments, recommendations for initial instruction or re-instruction of oral hygiene, plaque control programs or any type of mouth guard.

5.6.9 Dental treatments related to implants.

5.6.10 Expenses incurred while insurance under this benefit is not in force.

5.6.11 Expenses incurred by an insured under a treatment plan established prior to the effective date of the Dental Care Insurance benefit are not eligible under this contract.

5.7 Benefit claims

The Insurer shall be liable for the reimbursement of claims under this benefit only if such claims are submitted within the 12 months following the date on which eligible expenses were incurred. Expenses are considered to be incurred on the date services or supplies are provided.

This deadline is mandatory. However, if the participant demonstrates that it was impossible to submit the claim within this deadline and that such claim was submitted as soon as the participant was able to do so, the claim will then be eligible under this benefit.

5.8 Coordination of benefits

The total amount of benefits payable for a given person under other insurance contracts or government plans shall never exceed the amount of the actual eligible expenses incurred.

If an insured under this contract is also insured under another plan, any initial reimbursement prior to applying any coordination of benefits shall be made under the plan in which the insured is not a dependent. Thereafter, any expenses not reimbursed shall fall under the plan under which the insured is considered to be a dependent.

In the case of dependent children, any initial reimbursement prior to applying any coordination of benefits shall be made under the plan of the insured spouse whose birthday occurs earliest in the calendar year. Thereafter, any expenses not reimbursed shall fall under the other spouse's plan.

5.9 Information

The Insurer may require any information, including details, files and case histories regarding the diagnosis, treatment or services provided to each insured, either before or after the effective date of insurance for the insured. The insured hereby agrees, as a condition of the Insurer's liability under this benefit, to disclose or have disclosed all required information, and authorizes any person providing or having provided such services to disclose such information directly to the Insurer. All information is considered strictly confidential by the Insurer.

5.10 Waiver of liability

The payment of benefits under this contract shall release the Insurer from all liability for any act or omission of persons providing any of the services referred to in this contract.

5.11 Waiver of premiums

Insurance for participants, and their dependents, if any, who become disabled before the effective date of retirement is maintained in force without payment of premiums for as long as disability lasts, provided the contract remains in force and that disabled participants have not reached age 65.

However, waiver of premiums applies only once the participant becomes eligible for Long Term Disability Insurance benefits, that is to say after the 104-week elimination period which is extended, if applicable, by any unused credits in the participant's sick leave bank.

5.12 Termination of insurance

5.12.1 Subject to the provisions of article 5.11 "Waiver of premiums", a participant's insurance terminates on the earliest of the following dates:

5.12.1.1 The termination date of the contract or of the benefit.

5.12.1.2 The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant to a college whose insurance contract comes under the Committee is not considered a termination of employment.

For non-permanent employees, insurance remains in force until the first day of the following session, without exceeding a 2-month period from the termination date of the contract.

5.12.1.3 The due date of any unpaid premium.

5.12.1.4 The effective date of retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65.

5.12.2 Subject to the provisions of article 5.11 "Waiver of premiums", a dependent's insurance terminates on the earliest of the following dates:

5.12.2.1 The date of termination of the insured participant who was covering the dependent.

5.12.2.2 The date on which the person ceases to meet the definition 1.13 of section 1.

5.12.2.3 The date on which the participant changes a Family, Single-Parent or Couple coverage to an Individual coverage.

SECTION 6 - **SHORT TERM DISABILITY INSURANCE**

Upon receipt and approval by the Insurer of proof establishing that a participant insured under this contract became disabled, as defined under article 1.14, and following expiry of the elimination period indicated in article 6.2, the Insurer will pay monthly benefits to the participant according to the provisions of articles 6.3, 6.5 and 6.8.

6.1 **Benefit period**

The first benefit payment is made as of the 31st day following expiry of the elimination period indicated in article 6.2 and subsequent payments are made each month thereafter for as long as the participant remains disabled, up to a maximum period of 23 months. However, if the disability ends at the beginning or during vacation, benefits will be paid until the end of the vacation unless a specific date is indicated.

Monthly benefit payments end no later than the last week of the month in which the participant reaches age 65. However, if this insurance is registered with the Employment Insurance premium reduction program, the maximum benefit period cannot be shorter than the benefit period payable under the *Employment Insurance Act*.

6.2 **Elimination period**

The elimination period is the 30-day period that begins at the onset of disability and during which no disability benefits are payable.

However, specific provisions apply to any individuals or classes of individuals approved by the Policyholder and listed in Schedules II, IV and V attached to this contract.

6.3 **Benefit amount**

The initial amount of the monthly disability benefits payable is equal to 80% of the participant's net monthly salary, as defined in article 1.30, the net salary being the salary established upon expiry of sick leaves. However, benefits are limited to $5,000 per month.

The amount of disability benefits, for weeks or days following the last complete month of disability, is broken down, if applicable:

- into 12/52 for a complete week of disability;
- into 1/5 of the amount applicable for a complete week divided by the number of working days during a normal working week.

6.4 Change in the benefit amount

If the participant's salary is modified, the change in the benefit amount becomes effective on the latest of the date the change in salary comes into force or the date an agreement to this effect is reached between the Policyholder and the Insurer, provided the participant is effectively at his or her regular employment or failing that, when the participant resumes his or her regular employment.

6.5 Cost-of-living adjustment

The monthly benefits are indexed on January 1 of each year for as long as the participant is disabled, in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 3% for the purposes of this benefit.

6.6 Waiver of premiums

Premiums are waived as of the first payment of disability benefits.

6.7 Scope of coverage

Coverage is in force 24 hours a day, 12 months a year.

6.8 Integration

If the participant is entitled to other income during the disability period, the monthly benefits are reduced by:

6.8.1 The initial amount of any basic disability benefits under the Quebec Pension Plan, the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act* and any other public plan, regardless of future increases in basic benefits resulting from cost-of-living adjustments.

6.8.2 Parental benefits payable under any government plan. Benefits include maternity, paternity, adoption, parental leave or family leave benefits.

6.8.3 Any benefits payable under any salary continuance or sick leave policy.

6.8.4 50% of the gross amount of the retirement pension paid under a pension plan of the public or parapublic sector for a disabled participant who retired after June 30, 1996.

6.8.5 50% of the gross amount of the retirement pension that is actually paid to the participant under the Quebec Pension Plan.

6.9 Pre-existing conditions

Benefit claims related to causes that existed before the effective date of this contract shall not be excluded solely for this reason.

6.10 Rehabilitation

6.10.1 Participants enrolled in a rehabilitation program receive monthly rehabilitation benefits from the Insurer, as described in article 6.10.2. Benefits end when one of the following events occur:

a) interruption of the rehabilitation program;

b) withdrawal of the rehabilitation program by the Insurer;

c) expiry of a 12-month period following the beginning of the gradual return in the participant's occupation.

6.10.2 Subject to article 6.10.1, monthly rehabilitation benefits are equal to the amount of the participant's disability benefits that would be payable in the absence of a rehabilitation program, reduced by 50% of the remuneration for work carried out under the rehabilitation program.

6.10.3 If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program exceeds 100% of the basic net monthly salary the participant would receive if he or she was effectively at work, monthly rehabilitation benefits are reduced by the excess amount.

6.11 Extension of coverage

If a participant is disabled on the date of termination of the contract or this benefit, the participant is entitled to the disability benefits he or she would have been eligible for had the contract or coverage remained in force.

6.12 Exclusions and reduction of coverage

No benefits are payable under this coverage for a disability that results, directly or indirectly, from one of the following causes:

6.12.1 War, whether declared or not, or active participation in an insurrection.

6.12.2 Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.

6.12.3 Active participation in a criminal act.

6.12.4 Alcoholism or drug addiction, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care for the purposes of rehabilitation.

6.12.5 Any condition occurring while the insured is on active duty with army, navy or air forces.

6.13 Proof of disability

Within 30 days following the date of the accident or the onset of disability, the participant must send written proof of disability and of the accident or illness causing disability to the Insurer's Head Office.

If the participant demonstrates that he or she was unable to submit proofs within the applicable deadline and that they were provided as soon as it was possible to do so, the benefit claim will be admissible under this benefit.

However, if the participant fails to submit such documents to the Insurer within a 6-month period, the participant forfeits the right to disability benefits, for the disability in question, retroactively to the date on which the Insurer initially made the request.

Thereafter, proof of continuing disability must be submitted each time the Insurer so requests. If the participant fails to provide proof of disability or to undergo a medical examination within 31 days of the Insurer's written request, the participant forfeits the right, subject to the 2nd paragraph of this article, to disability benefits, for the disability in question, for the period extending from the end of this 31-day period up to the date on which the Insurer receives the additional proof required or the participant undergoes the required medical examination.

If the participant's and the Insurer's physicians do not agree on the participant's disability, the participant has 60 days, excluding any vacation period, to notify the Insurer of his or her intention of obtaining a medical assessment from a third physician. In such a case, the participant's and the Insurer's physicians must then agree on the choice of the third physician whose decision will be final. Fees for the assessment are at the Insurer's expense. In such cases, as well as in cases where the assessment of a third physician is required as specified in the relevant provisions of the collective agreement in force (5.5.26 of the 2000-2002 FNEEQ-CSN's collective agreement), the participant continues to receive disability benefits between the date on which the Insurer receives the opinion of the participant's physician or employer, as the case may be, and the date of the decision, without exceeding 6 months, if no decision has been rendered at the end of that period. If the decision is in favour of the Insurer, the participant will not have to reimburse the benefits paid during this period.

6.14 Termination of insurance

Subject to the provisions of article 6.11 "Extension of coverage", a participant's insurance terminates on the earliest of the following dates:

6.14.1 The date on which this benefit or contract is terminated.

6.14.2 The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract comes under the Policyholder is not considered a termination of employment.

Non-permanent employees within the meaning of the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding a 2-month period after the termination date of the contract, unless they end participation in which case the insurance terminates on the termination date of the contract.

6.14.3 The effective date of retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65.

6.14.4 The day before the due date of any unpaid premium, subject to the provisions of article 6.6 "Waiver of premiums".

6.14.5 The expiry date of the 5-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

SECTION 7 - **LONG TERM DISABILITY INSURANCE**

Upon receipt and approval by the Insurer of proof establishing that a participant insured under this contract became disabled, as defined under article 1.14, and following expiry of the elimination period indicated in article 7.2, the Insurer will pay monthly benefits to the participant according to the provisions of articles 7.3, 7.5 and 7.8.

7.1 **Benefit period**

The first benefit payment is made as of the 31st day following expiry of the elimination period indicated in article 7.2 and subsequent payments are made each month thereafter, for as long as the participant remains disabled. However, if disability ends at the beginning or during vacation, benefits will be paid until the end of the vacation unless a specific date is indicated.

Payment of benefits ends no later than the last week of the month during which the participant reaches age 65.

7.2 **Elimination period**

The elimination period is a 104-week period following the onset of the disability, extended by any unused credits in the participant's sick leave bank.

7.3 **Benefit amount**

7.3.1 Participants who became disabled before July 1, 1996

The initial amount of monthly disability benefits payable is equal to 70% of the first $2,500 of the participant's monthly salary and 50% of any excess, the salary being the one the participant would have received at the expiry of the elimination period, as provided for in the collective agreement, had he or she not become disabled. However, benefits are limited to $5,000 per month.

7.3.2 Participants who became disabled after June 30, 1996

The initial amount of monthly disability benefits payable is equal to 80% of the participant's net monthly salary, the net salary, as defined under article 1.30, being the salary the participant would have received at the expiry of the elimination period, as provided for in the collective agreement, had he or she not become disabled. However, benefits are limited to $5,000 per month.

Amount of disability benefits for the days following the last complete month of disability is broken down into 1/30 of the monthly amount payable.

7.4 Change in the benefit amount

If the salary of a participant who is not receiving benefits under Long Term Disability Insurance is modified, change in the benefit amount becomes effective on the latest of the date the change in salary comes into force or the date an agreement to this effect is reached between the Policyholder and the Insurer.

However, in the case of a temporary assignment, the amount of disability benefits is based on the salary the participant would have received in the absence of such assignment.

7.5 Cost-of-living adjustment

The monthly benefits are indexed on January 1 of each year for as long as the participant is disabled, in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 6% for participants whose disability began on or after January 1, 1981 and to 4% for participants whose disability began before January 1, 1981.

7.6 Waiver of premiums

Waiver of premiums applies after the expiry of a 30-day period following the onset of disability.

However, specific provisions apply to senior lecturers of the University Laval, which provisions are listed in Schedule IV attached to this contract.

7.7 Scope of coverage

Coverage is in force 24 hours a day, 12 months a year.

7.8 Integration

If the participant is entitled to other income during the disability period, the monthly benefits are reduced by:

7.8.1 The initial amount of any basic disability benefits payable under the Quebec Pension Plan that are paid or would have been paid if an application had been submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application was submitted and declined. A negative response from the Quebec Pension Plan shall in no way deprive the participant from his or her entitlement to benefits.

The participant must submit an application for disability benefits to the appropriate authority if the Insurer so requires, and failure to do so will result in a reduction of the benefit as described in the previous paragraph.

Future increases to basic disability benefits resulting from cost-of-living adjustment will not be taken into account.

7.8.2 Any benefits payable under any salary continuance or sick leave policy.

7.8.3 50% of the gross amount of the retirement pension paid under a pension plan of the public or parapublic sector for a disabled participant who retired after June 30, 1996.

The Insurer may ask the disabled participant to submit a retirement pension application to the appropriate authority if the disabled participant meets the 3 following criteria:

a) To be eligible for a retirement pension without actuarial reduction;

b) To have completed the waiver period for the pension plan in case of disability;

c) To have received confirmation that the Insurer will no longer challenge the participant's disability.

If the disabled participant refuses to submit such application or following the expiry of a 6-month period, the pension benefits used to reduce disability benefits will be estimated as follows:

a) based on participation status in the pension plan, which must be provided by the participant; or

b) 70% of the participant's actual salary at on the onset of disability.

The estimated pension benefits can be corrected retroactively, for a maximum period of 6 months, if the disabled participant decides to submit an application for pension benefits or to provide the Insurer with his or her participation status in the pension plan.

7.8.4 The initial amount of any basic disability benefits under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, the *Employment Insurance Act* and any other public plan, regardless of the future increases in basic benefits resulting from cost-of-living adjustment.

7.8.5 50% of the gross amount of the retirement pension paid to the participant under the Quebec Pension Plan.

7.8.6 If the disabled participant is entitled to other income during a disability period that began on or after January 1, 2008, benefits are reduced by 50% of the gross amount received for any gainful activity carried out by a disabled participant after the onset of disability. To determine the gross amount for the purposes of integration, disabled participants must provide the Insurer with a copy of their income tax return and subsequent notices of assessment.

7.9 Pre-existing conditions

Benefit claims related to causes that existed before the effective date of this contract shall not be excluded solely for this reason.

7.10 Rehabilitation

7.10.1 Participants enrolled in a rehabilitation program receive monthly rehabilitation benefits from the Insurer, as described in article 7.10.3. Benefits end when one of the following events occur:

a) expiry of a 24-month period following the beginning of the rehabilitation program;

b) interruption of the rehabilitation program;

c) withdrawal of the rehabilitation program by the Insurer.

7.10.2 Subject to the Insurer's approval, the participant who began gradual return to work can benefit from the waiver of premiums if such gradual return to work began during the elimination period, as defined in article 7.2.

7.10.3 Subject to the provisions of article 7.10.1, monthly rehabilitation benefits are equal to the amount of the participant's disability benefits that would be payable in the absence of a rehabilitation program, reduced by 50% of the remuneration for work carried out under the rehabilitation program.

7.10.4 If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program exceeds 100% of the basic net monthly salary the participant would receive if he or she was effectively at work, monthly rehabilitation benefits are reduced by any excess.

7.10.5 Furthermore, the rehabilitation program can include a gradual return to work in the participant's employment. This program must be approved by the Insurer and is limited to a maximum period of 12 months.

7.11 Extension of coverage

If a participant is disabled on the date of termination of the contract, the participant is entitled to the disability benefits he or she would have been eligible for had the contract remained in force.

7.12 Exclusions and reduction of coverage

No benefits shall be payable under this coverage for a disability that results, directly or indirectly, from one of the following causes:

7.12.1 Performing any of the duties of a crew member of a commercial aircraft, unless the participant is an employee of a flying school whose union is affiliated with the FNEEQ-CSN, as stated in the collective agreement or the participant's personal employment contract.

7.12.2 War, whether declared or not, or active participation in an insurrection.

7.12.3 Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.

7.12.4 Active participation in a criminal act.

7.12.5 Alcoholism, drug addiction or compulsive gambling, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care for the purposes of rehabilitation.

7.12.6 Any condition occurring while the insured is on active duty with army, navy or air forces.

7.13 Proof of disability

Participants from the public sector must send, to the Insurer's Head Office, written proofs of the accident or illness they suffered and of their disability after 18 months following the date of the accident or the onset of disability, but without exceeding 21 months of that date. When evidence of persistence of disability has been submitted by participants of the private or university sector under the Short Term Disability Insurance benefit, such evidence is deemed satisfactory under the Long Term Disability Insurance.

If the participant demonstrates that he or she was unable to submit proofs within the applicable deadline and that they were provided as soon as it was possible to do so, the benefit claim will be admissible under this benefit.

However, if the participant fails to submit such documents to the Insurer within a 6-month period, the participant forfeits the right to disability benefits, for the disability in question, retroactively to the date on which the Insurer initially made the request.

Thereafter, proof of continuing disability must be submitted each time the Insurer so requests. If the participant fails to provide proof of disability or to undergo a medical examination within 31 days of the Insurer's written request, the participant forfeits the right, subject to the 2nd paragraph of this article, to disability benefits, for the disability in question, for the period extending from the end of this 31-day period up to the date on which the Insurer receives the additional proof required or the participant undergoes the required medical examination. Furthermore, if the Insurer does not receive such proof or the results of the requested medical examination within a 6-month period, the participant completely forfeits the right to benefits for the disability in question.

If the participant's and the Insurer's physicians do not agree on the participant's disability, the participant has 60 days, excluding any vacation period, to notify the Insurer of his or her intention of obtaining a medical assessment from a third physician. In such a case, the participant's and the Insurer's physicians must then agree on the choice of the third physician whose decision will be final. Fees for the assessment are at the Insurer's expense. In such cases, as well as in cases where the assessment of a third physician is required as specified in the relevant provisions of the collective agreement in force (5.5.26 of the 2000-2002 FNEEQ-CSN's collective agreement), the participant continues to receive disability benefits between the date on which the Insurer receives the opinion of the participant's physician or employer, as the case may be, and the date of the decision, without exceeding 6 months, if no decision has been rendered at the end of that period. If the decision is in favour of the Insurer, the participant will not have to reimburse the benefits paid during this period.

Furthermore, the employer must inform the Insurer, upon request, of any disability that lasted for more than 6 months for the disabled participants of the public sector.

7.14 **Medical arbitration**

This process is a consensual process through which the Insurer and the Policyholder aim to settle, among themselves, any dispute related to the acknowledgement of a participant's disability in order to specifically avoid court proceedings to settle such disputes

The participant can contest any of the Insurer's decisions related to the absence or termination of disability. In such a case, a medical arbitration process will begin, based on the following provisions:

7.14.1 The Insurer informs the FNEEQ-CSN and the employer of its decision as well as of the participant's contesting.

7.14.2 The Insurer, the FNEEQ-CSN and the participant's attending physician must collaborate to agree on the choice of a medical adjudicator and on the assigned mandate to be assigned to the adjudicator. The Insurer proposes a selection of 3 medical examiners, while favouring physicians practicing in clinics. Failing an agreement to select an examiner, the attending physician can suggest other names.

7.14.3 The Insurer and the FNEEQ-CSN conjointly send the mandate to the medical adjudicator, with a copy of this article. A copy of the mandate is also sent to the participant at the same time.

7.14.4 The Insurer sends to the attending physician, through confidential mail, a copy of any reports, files or assessments the Insurer intends to submit to the medical adjudicator.

7.14.5 The medical adjudicator meets with the participant and examines him or her, if deemed pertinent, all communication being made in the language officially chosen by the participant.

7.14.6 The participant must, if need be, go the to appointment scheduled by the medical adjudicator to avoid losing his or her right to benefits, unless the participant has a valid reason which he or she must prove.

7.14.7 The participant can bring any document deemed useful for his or her case to the medical adjudicator.

7.14.8 The medical adjudicator must render a decision within 60 days of the date of the assessment.

7.14.9 The medical adjudicator's decision must be rendered in the language officially chosen by the participant. The decision must include a list of all medical documents that were submitted.

7.14.10 The medical adjudicator must send copy of the decision to both principals and the participant, unless the adjudicator believes that the invoice of such decision is medically contraindicated, in which case the participant's copy will be sent to the attending physician.

7.14.11 Copies sent to both principals will only include the following:

a) the list of medical documents submitted;

b) duration of the assessment;

c) indication of the participant's collaboration or not;

d) diagnosis;

e) prognosis, if any;

f) medico-administrative recommendations;

g) answers to other questions included in the mandate do not explicitely include medical history, family history or any other information about a person other than the participant.

7.14.12 The medical adjudicator's decision is final and irrevocable, enforceable and binds the principals and the participant and therefore exclude any courts proceedings unless the medical adjudicator raises an issue not related to his or her specialty. In such a case, a new medical arbitration will be requested with a medical adjudicator from the relevant specialty.

7.14.13 Without prejudice to the Insurer's rights, disability benefits are paid throughout medical arbitration, up to a maximum period of 6 months.

7.14.14 Expenses and fees of the medical adjudicator are not at the participant's expense.

7.14.15 If the medical adjudicator's decision entails the end of benefits and such decision is rendered between June 15 and August 15, benefits will be paid until August 15.

7.15 Termination of insurance

Subject to the provisions of article 7.11 "Extension of coverage", a participant's insurance terminates on the earliest of the following dates:

7.15.1 The date on which this benefit or contract is terminated.

7.15.2 The date on which a participant ceases to be employed, except in case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract comes under the Policyholder is not considered a termination of employment.

Non-permanent employees within the meaning of the collective agreement are considered to have terminated employment on the first day of the session following the indicated in their contract, without exceeding a 2-month period after the termination date of the contract, unless they end participation in which case the insurance terminates on the termination date of the contract.

7.15.3 The effective date of retirement. However, a disabled participant who applies for pension benefits before the age of 65 continues to benefit from the waiver of premiums until age 65.

7.15.4 The day before the due date of any unpaid premium, subject to the provisions of article 7.6 "Waiver of premiums".

7.15.5 The date the Insurer receives a written notice from the participant, or the termination date indicated in such notice, whichever is later, requesting termination of insurance, according to the terms and conditions applicable to the refusal right.

7.15.6 The expiry of the 5-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

SECTION 8 - **PREMIUM PAYMENT – GRACE PERIOD – PREMIUM RATES**

8.1 Change in government policy

Should the passing or amendment of any law, regulation or other item by the federal or provincial governments influence the Insurer's rates, the Insurer reserves the right to adjust premium rates, upon an agreement with the Policyholder, for any affected insurance benefits and provisions of the retention at the time such law, regulation, item or amendment becomes effective.

8.2 Payment of premiums

The initial premium due under this contract is payable at the beginning of the invoicing period during which the contract becomes effective. Subsequent premiums are payable at the beginning of every invoicing period.

Premiums payable under this contract are forwarded by the employer to the Insurer at the beginning of every invoicing period. The premium amount is equal to the sum of premiums due per participant at the beginning of the invoicing period in question.

The premium is based on the premium rate applicable for the participant on the first day of the pay period.

No premium is payable for an invoicing period if the participant is not covered on the first day of that period. In the same way, the full premium is payable for the invoicing period during which the participant ceased to be covered.

8.3 Grace period

The Insurer grants the Policyholder a 60-day grace period following the date on which any premium becomes due except for the first one. In the event that premiums are still unpaid after expiry of the grace period, interest will be added to the amount of premiums due. Interest is equal to the annual interest rate corresponding to the arithmetic mean of the average yield of Government of Canada 3- to 5-year bonds (V121756 series) at the end of each month of the contract year, rounded to the multiple of ¼ of 1% under or coinciding with this average.

8.4 Premium rates

Premium rates indicated in the premium tables can be modified by the Insurer on each renewal date of the contract, but no modification can be made unless a 150-day prior written notice has been sent to the Policyholder.

8.5 Premium tables

Premium rates are per 14-day period:

8.5.1 Basic Life Insurance benefit

a) $0.0841 per $1,000 for the Participant's Basic Life Insurance

b) $0.62 per family for the Dependent's Basic Life Insurance

c) $2.30 for the Participant's Critical Illness Insurance ($0.13 per $1,000)

8.5.2 Participant's and Spouse's Optional Life Insurance

Rates are per $1,000 of insurance and are based on the insured's age, gender and smoking habits.

Age	Rate per $1,000 of insurance			
	Men		Women	
	Non-smoker	Smoker	Non-smoker	Smoker
Under age 25	$0.021	$0.030	$0.012	$0.015
25 to 29	$0.021	$0.030	$0.012	$0.015
30 to 34	$0.021	$0.032	$0.012	$0.015
35 to 39	$0.028	$0.036	$0.015	$0.018
40 to 44	$0.041	$0.061	$0.021	$0.031
45 to 49	$0.068	$0.099	$0.031	$0.047
50 to 54	$0.104	$0.156	$0.059	$0.070
55 to 59	$0.166	$0.257	$0.089	$0.140
60 to 64	$0.280	$0.405	$0.138	$0.207
65 to 69	$0.386	$0.631	$0.216	$0.325

8.5.3 Health Insurance benefit

Coverage status	Basic coverage (Module A)	Standard coverage (Module B)	Extended coverage (Module C)
Participants under age 65			
Individual	$36.76	$47.62	$54.92
Single-parent	$62.46	$80.91	$93.31
Couple	$73.49	$95.22	$109.78
Family	$99.33	$128.67	$148.39
Participants age 65 and over registered with the RAMQ			
Individual	$13.50	$17.47	$20.16
Single-parent	$35.85	$46.42	$53.52
Couple	$26.96	$34.91	$40.26
Family	$49.44	$64.00	$73.80
Additional premium for participants age 65 and over not registered with the RAMQ			
Individual	$89.79	$89.79	$89.79
Single-parent	$89.79	$89.79	$89.79
Couple	$179.60	$179.60	$179.60
Family	$179.60	$179.60	$179.60

8.5.4 Dental Care Insurance benefit

Coverage status	Basic coverage (Option 1)	Extended coverage (Option 2)
Individual	$10.41	$13.88
Single-parent	$19.53	$26.02
Couple	$20.82	$27.75
Family	$29.94	$39.91

8.5.5 Short Term Disability Insurance benefit

Name of the establishment	Rate per $1,000 of salary
Lasalle College	$0.745
Université Laval	$0.345
Other colleges and universities	$0.579

8.5.6 Long Term Disability Insurance benefit

$0.409 per $1,000 of salary

SECTION 9 - **CANCELLATION OF THIS CONTRACT OR ONE OF ITS BENEFITS**

9.1 Should the Policyholder fail to pay premiums prior to expiry of the grace period, as indicated in section 8, the Insurer can notify the Policyholder to that effect and if such premiums are not paid within the 5 days following the date the notice is received, the contract is automatically cancelled as of the due date of the unpaid premiums.

9.2 The Policyholder or the Insurer may cancel this contract at any renewal date upon prior written notice to the other party of at least 30 days for the Policyholder and 90 days for the Insurer. In the absence of such notice by the Policyholder or the Insurer, this contract is automatically renewed.

9.3 The Insurer reserves the right to cancel the Life Insurance benefit at any time upon prior written notice of at least 90 days if the percentage of eligible employees who are then insured under this benefit goes under 50% after the effective date of this contract.

9.4 The Insurer reserves the right to cancel the Long Term Disability Insurance benefit at any time upon prior written notice of at least 90 days if the percentage of eligible employees who are then insured under this benefit goes under 50% after the effective date of this contract.

9.5 Any union who joins the FNEEQ-CSN and applies for the plans available under this contract, according to the applicable provisions, must maintain participation for a minimum period of 36 months. After this period, the union may terminate participation within 31 days preceding the date of renewal of this contract.

SECTION 10 - **MODIFICATIONS TO THE CONTRACT**

The Policyholder may make changes to the contract, at any time and upon agreement with the Insurer, with regard to categories of eligible individuals, the scope of coverage and the sharing of costs between categories of insureds. Any such modifications then apply to all insureds, whether they are active, disabled or retired.

SECTION 11 - **MISCELLANEOUS PROVISIONS**

11.1 Any notice given by the Insurer to the Policyholder is deemed sufficient if the Insurer mails it (by registered mail for notices indicated in articles 8.1 and 9.1 to 9.4) to the Policyholder's address as recorded in the Insurer's files. Any notice given by the Policyholder is deemed sufficient if the Policyholder mails it (by registered mail for notices indicated in article 9.2) to the Insurer's Head Office in Quebec City, Quebec.

11.2 No legal action against the Insurer regarding a claim for benefits under this contract can be taken outside of the deadlines provided for in the *Act respecting insurance*.

11.3 The Insurer must provide insurance certificates and the employer agrees to hand them over to the participants covered under this contract. Furthermore, upon specific request and in exchange of reasonable fees other than those listed in the retention formula, the Insurer will provide any information or report deemed necessary by the Policyholder in the best possible delays.

11.4 As a preliminary condition for the payment of benefits, the Insurer may require to be subrogated to all the insured's rights to compensation due to the insured by the wrongdoer (accident or illness), up to the amount due to the insured by the Insurer under this contract.

11.5 Any errors or omissions affecting the amount of the premium are corrected as soon as they are discovered and the required premium adjustments are made.

However, for any errors or omissions affecting the validity of insurance or the amount of insurance in force, true facts are used to determine whether insurance is in force and the amount of insurance in force in accordance with the terms and conditions of this contract.

No error on the part of the Policyholder or the Insurer in the keeping of insurance records, nor any delay in the compilation of such records, shall invalidate insurance in force in accordance with the sections of this contract nor extend insurance terminated in accordance with the sections of this contract.

11.6 All payments of premiums under this contract shall be made at the Insurer's Head Office in the legal tender of Canada. All payments of benefits under this benefit are made in the legal tender of Canada.

11.7 The rights of insureds under this contract may not be assigned or attached and no assignment by an insured either of an entitlement to benefits or an entitlement to payment of a benefit under this contract shall be binding on the Insurer.

11.8 Entitlement to benefits shall automatically cease for any insured who attempts to fraudulently obtain, or who assists any person in fraudulently obtaining or attempting to obtain any benefit under this contract. The Insurer will them be automatically released from any liability with regard to expenses otherwise eligible that are sustained after the termination date of such entitlement.

11.9 For the duration of this contract, the Policyholder shall be responsible for providing any information that the Insurer may require in the application of the contract.

11.10 The Policyholder shall allow the Insurer to examine its payroll records and other employee files relevant to the eligibility and enrolment of employees and eligible dependents under this contract.

11.11 Should a reduction in coverage under the government plans entail the increase of the scope of coverage under this contract, provisions of the contract continue to apply as if coverage under the government plans had not been reduced until an agreement intervenes between the contract parties to modify the premium rates accordingly.

SECTION 12 - **SCOPE OF THE CONTRACT**

This contract is complete in itself and entirely represents both parties' intentions. It is presumed to include the essential elements of the specifications, the proposal and any written agreements intervened between the parties. These documents are not part of the contract and can only be used to clarify the scope of the contract in case of ambiguity. In case of discrepancy, the contract shall prevail.

Furthermore, this contract should be considered as a consolidated version and, occasionally, a reformulated version of endorsements, written agreements and previous versions of the 1008 or 1010 contracts. This contract does confer any rights retroactively and the contract provisions applicable to any covered event remain the same as those in force on the date on which such event occurs.

Furthermore, December 31, 2014 shall not be considered the termination date of the contract, for all legal purposes, but a date of renewal. However, February 28, 1999, must be considered as the termination date of contract 1010 for the purposes of calculation of experience credits.

SCHEDULE I - TEACHERS INSTRUCTORS IN CEGEPS

1. This schedule applies to teachers who are instructors, whose union chose to apply for this contract and whose participation in the plan was decided by majority vote at their general meeting. The union must inform in writing the Policyholders of this contract. Insurance becomes effective on the 1st day of the month following the date the written notice is received, if this notice is received before the 15th of the month. Otherwise, insurance becomes effective on the 1st day of the 2nd month following such date.

2. Teachers who are instructors must have completed 450 teaching hours for 3 consecutive years to be eligible for insurance. To maintain eligibility, the participant must complete 450 teaching hours every year. If the participant has less than 450 hours for a given year, the participant is no longer eligible for insurance for the next year. The instructor becomes eligible for insurance again for the year following that during which he or she completes the required 450 hours.

3. Participation in Life Insurance and Dependent's Life Insurance is optional.

4. Participation in Health Insurance is mandatory for all employees, and their dependents, if any, who meet the eligibility conditions.

5. Participation in Short Term Disability and Long Term Disability insurance is mandatory for all employees who meet the eligibility conditions.

6. Participation in Optional Life Insurance is optional for participants and their spouses.

7. Premiums and amounts of insurance are based on the salary scale applicable for full-time teachers.

8. Provisions for the payment of premiums must be determined between the union and the employer. Premiums are then forwarded by the employer to the Insurer the usual way.

9. Calculation of hours takes into account all hours that would have been worked had it not been for the absences provided for in the collective agreement.

SCHEDULE II - TEACHERS AND INSTRUCTORS OF LASALLE COLLEGE

1. This schedule applies to teachers and instructors of Lasalle College who are joining this contract.

2. For teachers, eligibility and participation provisions of the contract apply.

3. Instructors are eligible for all benefits of this contract if they have a contract of employment providing for a minimum teaching load of 15 hours per week.

   Insurance for instructors who become eligible during the winter session extends from February 1 to August 31 while for instructors who become eligible during the fall session, insurance extends from September 1 to January 31.

4. Instructors are considered as permanent employees, within the means of the contract, 2 years after the date they were hired and eligibility and participation provisions of article 2 – Conditions of insurance will then apply.

5. For the purposes of this schedule, the expression "Wage or salary" is defined as follows, the definition of this expression found in the contract not being applicable:

   "Wage or salary": The wage or salary used is equal to the lesser of the following two amounts:

   a) The hourly rate in force at the beginning of the session multiplied by the number of teaching hours per week (up to a maximum of 24 hours), the result being multiplied by 42 weeks

   b) $55,000

   Bonuses, overtime payment, fees, accommodation and meal allowances, isolation pay or any lump-sum payments are excluded from calculation of the wage or salary.

6. The elimination period of the Short Term Disability Insurance is 10 days for individuals covered under this schedule. Furthermore, a specific rating apply for these individuals.

SCHEDULE III - TUTORS OF THE TÉLÉ-UNIVERSITÉ - CSN

1. This schedule applies to tutors of the Télé-université component of the Université du Québec in Montreal who are joining this contract.

2. The expression "salaried employee" used in the following articles 3 to 10 designates the tutors covered under this schedule.

3. Salaried employees are eligible for all benefits of this contract, in accordance with the provisions of the following articles. In the absence of specific provisions indicated in this schedule, terms and conditions of the 1008-1010 contract will apply for the benefits salaried employees are eligible for.

4. For the purposes of this schedule, the reference year used to determine eligibility and to calculate the annual salary and insurable salary extends from September 1 to August 31 preceding January 1 of each year.

5. For the purposes of this schedule, the annual salary is that defined in the 1008-1010 contract and is determined on January 1 of each year, based on the salary actually earned during the reference year for tutoring, union leaves and participation in activities listed in articles 21.08 and 21.09 of the collective agreement.

6. Salaried employees must have earned an annual salary equal to 45% of the maximum pensionable earnings (MPE) during a reference year to be eligible for the benefits indicated in this schedule for the first time. The MPE used for calculation is that applicable on January 1 included in the reference year. After becoming eligible for the first time, salaried employees must maintain an annual salary equal to 40% of the MPE during the reference years following the initial date of eligibility. Otherwise, insurance terminates and salaried employees become eligible for insurance again when the annual salary is equal to at least 45% of the MPE applicable for the reference year in question.

7. Eligibility of salaried employees is determined by the employer once a year, on January 1 of each year.

8. Application for Long Term Disability Insurance can be made without evidence of insurability within 30 days following the start date of each of the first 3 eligibility periods. Eligibility periods begin on January 1 of each year and salaried employees must submit their application forms before January 31 of each year to be eligible for Long Term Disability Insurance without evidence of insurability.

   Salaried employees can also apply at any time during the first 3 eligibility periods following the date they were hired, upon presentation of evidence of insurability deemed satisfactory by the Insurer. If the Insurer rejects the insurance application after analysis of the evidence of insurability, the salaried employee will not be entitled to submit a new application for insurance before the expiry of a 3-year period of eligibility for insurance.

   Participation in this benefit becomes mandatory at the expiry of this 3-year period and the salaried employee must apply for it, without evidence of insurability.

9. For the purposes of disability insurance benefits, calculation of benefits payable is based on the insurable salary which is established on January 1 preceding the date of onset of disability.

10. In case of temporary absences from work specified in the collective agreement, salaried employees can maintain participation in benefits they had before the date the absence began provided they continue to pay applicable premiums, including any employer's share.

    For salaried employees who are partially or completely absent from work because of a maternity leave, a family leave, a paternity leave or disability during a reference year, the salary used for the calculation of the annual salary is that earned during the reference year preceding the date the leave began.

    For any other type of leave, the annual salary is calculated based on the provision of article 5 of this schedule.

SCHEDULE IV - SENIOR LECTURERS OF UNIVERSITÉ LAVAL

1. This schedule applies to senior lecturers of Université Laval who are joining this contract.

2. Senior lecturers are only eligible for Health Insurance (Module B by default), Short Term Disability Insurance and Long Term Disability Insurance.

3. Participation in Health Insurance and Short Term Disability Insurance is mandatory as of the date the senior lecturer becomes eligible.

4. Participation in Long Term Disability Insurance is optional during the first 3 years. Senior lecturers can apply for this benefit when applying for Short Term Disability Insurance or at any time during the 3 years following this date. Upon expiry of the 3-year period, senior lecturers who are still not covered under the Long Term Disability Insurance benefit will have to apply for it, if they are still eligible for insurance.

5. Elimination period for the Short Term Disability Insurance benefit is 180 days for individuals covered under this schedule. Furthermore, a specific rating applies to these individuals.

6. Article 1.15 “**Disability period**” as set out in the contract is replaced by the following:

   1.17 "Disability period":

   During the first 180 days of disability:

   Any uninterrupted period of disability, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of less than 30 days of work, unless disability, during a given period, results from an illness or accident that is entirely independent from the illness or accident that caused the disability for the previous period, and that disability only begins upon the participant’s return to work.

Afterwards:

Any uninterrupted period of disability, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of less than 180 days of work, unless disability, during a given period, results from an illness or accident that is entirely independent from the illness or accident that caused the disability for the previous period, and that disability only begins upon the participant's return to work.

7. Waiver of premiums for the Long Term Disability Insurance benefit begins upon expiry of the 26-week period of Short Term Disability Insurance benefits.

8. All insurance benefits indicated in this schedule terminate on the date of the senior lecturer's retirement.

9. All other provisions of the contract are applicable, except if there an indication otherwise in this schedule.

CONTRACT 001008-001010

SCHEDULE V - INDIVIDUALS OR CLASSES OF INDIVIDUALS ACCEPTED BY THE POLICYHOLDER FOR THE PURPOSES OF INSURANCE

- Employees working for unions affiliated with the FNEEQ-CSN whose members are covered under this contract. For the purposes of this contract, these employees are considered as employees of the private sector.

- Employees covered by a bargaining certificate issued to a private college union affiliated with the FNEEQ-CSN.

- Managers of private establishments who were participants before January 1, 2006, namely in Collège Mont-Royal, in Collège de Lévis and in the Centre d'intégration scolaire. Payment of premiums by the participant or benefit claims reimbursed by the Insurer to the participant are proof of coverage.

  Participants who become managers in their establishments after January 1, 2006 can maintain their participation provided they keep their right to return to their bargaining unit, as specified in the applicable collective agreement.