GROUP INSURANCE PLAN

administered by

La Capitale

REGROUPEMENT des organismes nationaux de Loisir et de Sport du Québec

CENTRE québécois de services aux associations

Contract 001962
Employees

Plan modified on
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In collaboration with

SGC
L'ACTUARIAT EN SANTÉ

IMPORTANT

This booklet contains general information about your group insurance contract.

This document does not include all contractual clauses regarding definitions, eligibility, enrolment, termination of insurance and other specifications. You may access this information by consulting the contract available from your employer or group policyholder.

This document is printed on paper made from 100% post-consumer recycled material. A simple gesture that goes a long way to help protect our environment and the resources around us.

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This summary table provides a brief description of the coverage included in your group insurance plan. A full description of all the benefits is provided in the following pages.

Individuals eligible for insurance	
All employees with permanent employee status or who were hired with a view to obtaining a permanent position or who have an employment contract for one (1) year or more and are actively working full-time.	
GENERAL INFORMATION	
Maximum age for dependent children	Up to age 21, if not a full-time student Up to age 26, if a full-time student
Total disability – Own occupation	Long-term disability insurance elimination period + following 24 months
Disability period or recurrence	Any uninterrupted period of total disability or a series of successive periods of total disability due to the same cause or to connected causes separated by a period of full-time work of less than: – 15 days during the elimination period for long-term disability insurance. – 6 months thereafter.
Eligibility	After 3 months of active, continuous service
Minimum number of hours worked	20 hours per week
Conversion privilege **– Health insurance** **– Dental care insurance**	 60 days No
Maintaining insurance during a temporary interruption of work **– Maternity, paternity, parental or adoption leave** **– Authorized unpaid absence or temporary layoff**	 12 months 12 months

BENEFIT	COVERAGE
PARTICIPANT'S BASIC LIFE INSURANCE	
Coverage – Employee with Individual coverage status for health insurance:	1 times annual salary, the result being rounded to the next highest $1,000
– Employee with a coverage status other than Individual for health insurance:	2 times annual salary, the result being rounded to the next highest $1,000
Reduction of benefit	50% at age 65
Non-evidence maximum	$770,000
Maximum with evidence of insurability	$1,100,000
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Participant's 71st birthday or date of retirement, if earlier
DEPENDENTS' BASIC LIFE INSURANCE	
Coverage	$10,000 – spouse / $5,000 – dependent child (24 hours of age or older)
Waiver of premiums	Same as basic life
Extension of coverage for dependents of a deceased participant	24 months immediately following the death of the participant
Termination of insurance	Same as basic life

PARTICIPANT'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	
Coverage – Employee with Individual coverage status for health insurance:	1 times annual salary, the result being rounded to the next highest $1,000
– Employee with a coverage status other than Individual for health insurance:	2 times annual salary, the result being rounded to the next highest $1,000
Reduction of benefit	50% at age 65
Non-evidence maximum	$770,000
Maximum with evidence of insurability	$1,100,000
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Participant's 71st birthday or date of retirement, if earlier
PARTICIPANT'S OPTIONAL LIFE INSURANCE	
Coverage	1 to 25 units of $10,000
Non-evidence maximum	Evidence of insurability is always required
Maximum with evidence of insurability	$250,000
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Participant's 65th birthday or date of retirement, if earlier
SPOUSE'S OPTIONAL LIFE INSURANCE	
Coverage	1 to 25 units of $10,000
Non-evidence maximum	Evidence of insurability is always required
Maximum with evidence of insurability	$250,000
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Spouse's 65th birthday or date of participant's retirement, if earlier
Early benefit payment in the event of terminal illness (for participant's basic and optional life insurance)	25%, maximum of $50,000

HEALTH INSURANCE – BASIC AND COMPLETE PLANS			
1. Expenses exempt from deductibles and reimbursed at 100%			
	OPTION A	OPTION B	OPTION C
Minimum participation period	24 months	24 months	48 months
Hospitalization	Semi-private room	Semi-private room	Semi-private room
Accommodation expenses in a residential and long-term care centre	Semi-private room Maximum 180 days per calendar year, per insured	Semi-private room Maximum 180 days per calendar year, per insured	Semi-private room Maximum 180 days per calendar year, per insured
Rehabilitation centre and convalescent home	Maximum 180 days per disability, per insured	Maximum 180 days per disability, per insured	Maximum 180 days per disability, per insured
Travel insurance and assistance	Length of trip: 6 months $1,000,000 lifetime maximum The maximum trip length for retirees is 60 days.	Length of trip: 6 months $1,000,000 lifetime maximum The maximum trip length for retirees is 60 days.	Length of trip: 6 months $1,000,000 lifetime maximum The maximum trip length for retirees is 60 days.
Trip cancellation insurance	Maximum of $5,000 per insured, per trip	Maximum of $5,000 per insured, per trip	Maximum of $5,000 per insured, per trip

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
2. Prescription drugs			
	OPTION A	OPTION B	OPTION C
Electronic claims payment	Direct	Direct	Direct
Annual deductible	Applicable to prescription drugs and other eligible expenses	Applicable to prescription drugs and other eligible expenses	Applicable to prescription drugs and other eligible expenses
– Individual coverage **– Family coverage** **– Single-Parent coverage**	$125 $250 $200	$100 $200 $150	$75 $150 $100
Prescription drugs	70% up to the annual maximum reimbursement specified in the BPDIP and 100% of the excess per certificate	75% up to the annual maximum reimbursement specified in the BPDIP and 100% of the excess per certificate	80% up to the annual maximum reimbursement specified in the BPDIP and 100% of the excess per certificate
Clause	Standard	Standard	Standard
RAMQ deductible and coinsurance for insureds age 65 and older	Yes	Yes	Yes
Substitution	Mandatory generic	Mandatory generic	Mandatory generic
Provisions applicable to those age 65 and older	Extra premium Yes – based on age of insured	Extra premium Yes – based on age of insured	Extra premium Yes – based on age of insured

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
3. Other eligible expenses – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
Coinsurance	70%	75%	80%
Ambulance	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Hearing aid	N/A	$750 per 60 consecutive months, per insured	$1,250 per 36 consecutive months, per insured
Support stockings	4 pairs per calendar year, per insured	4 pairs per calendar year, per insured	4 pairs per calendar year, per insured
Private clinic for treatment of alcoholism or drug addiction	$80 per day and $2,500 lifetime maximum per insured	$80 per day and $2,500 lifetime maximum per insured	$80 per day and $2,500 lifetime maximum per insured
Dental treatment following accident	Treatment must be provided within 12 months following the date of the accident.	Treatment must be provided within 12 months following the date of the accident.	Treatment must be provided within 12 months following the date of the accident.
Corrective elements, orthopaedic shoes, orthoses and corrective footwear	$250 per calendar year, per insured	$450 per calendar year, per insured	$750 per calendar year, per insured
Wheelchair, hospital bed or therapeutic devices	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Glucometer or dextrometer for insulin-dependent insureds	$500 per 36 consecutive months, per insured	$500 per 36 consecutive months, per insured	$500 per 36 consecutive months, per insured
Nursing care	$15,000 per calendar year, per insured	$15,000 per calendar year, per insured	$15,000 per calendar year, per insured

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
3. Other eligible expenses (Cont.) – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
Sclerosing injections	$25 per injection, 20 injections per calendar year, per insured	$25 per injection, 20 injections per calendar year, per insured	$25 per injection, 20 injections per calendar year, per insured
Glasses or contact lenses following cataract surgery	N/A	N/A	Maximum lifetime reimbursement of $200
Artificial limb or eye, supports, corsets, trusses, casts, crutches or other orthopaedic equipment	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Transcutaneous electrical nerve stimulation (TENS)	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Breathing assistance device and oxygen, blood, blood plasma and transfusion	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Insulin pump	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Capillary prosthesis (wig) following chemotherapy	$500 lifetime, per insured	$500 lifetime, per insured	$500 lifetime, per insured
External breast prosthesis following a mastectomy	In excess of the benefits paid under the government plan	In excess of the benefits paid under the government plan	In excess of the benefits paid under the government plan

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
3. Other eligible expenses (Cont.) – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
X-rays, laboratory analyses, magnetic resonance imaging and computed tomography	$1,000 per calendar year, per insured	$1,250 per calendar year, per insured	$2,000 per calendar year, per insured
Home care and assistance	$500 per calendar year, per insured	$500 per calendar year, per insured	$500 per calendar year, per insured
Vision care insurance	N/A	N/A	$250 per 36 consecutive months
Intrauterine device (IUD)	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
Special treatments not available in the province of residence	$50,000 lifetime maximum per insured	$50,000 lifetime maximum per insured	$50,000 lifetime maximum per insured
Vaccinations	Reasonable and customary expenses	Reasonable and customary expenses	Reasonable and customary expenses
4. Healthcare professionals – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
Applicable coinsurance	70%	75%	80%
Acupuncturist	$70 per treatment and 10 treatments per calendar year, per insured	$70 per treatment and 10 treatments per calendar year, per insured	$70 per treatment and 10 treatments per calendar year, per insured
Audiologist **Speech-language therapist**	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
4. Healthcare professionals (Cont.) – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
Chiropractor **Osteopath** **Physiotherapist** **Physical rehabilitation therapist** **Sports therapist**	$700 per calendar year, per insured, for all of these healthcare professionals	$800 per calendar year, per insured, for all of these healthcare professionals	$900 per calendar year, per insured, for all of these healthcare professionals
Dietitian* **Kinesiologist*** *** On physician's referral**	$65 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$65 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$65 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals
Occupational therapist	$75 per treatment and 10 treatments per calendar year, per insured	$75 per treatment and 10 treatments per calendar year, per insured	$75 per treatment and 10 treatments per calendar year, per insured
Kinesitherapist* **Massage therapist*** **Orthotherapist*** ***On physician's referral**	$70 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$70 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$70 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals
Naturopath	$65 per treatment and 10 treatments per calendar year, per insured	$65 per treatment and 10 treatments per calendar year, per insured	$65 per treatment and 10 treatments per calendar year, per insured
Podiatrist **Chiropodist**	$75 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$75 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$75 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals

HEALTH INSURANCE (Cont.) – BASIC AND COMPLETE PLANS			
4. Healthcare professionals (Cont.) – The maximums indicated below are maximum eligible amounts			
	OPTION A	OPTION B	OPTION C
Outpatient psychoanalyst **Psychiatrist** **Psychotherapist** **Psychologist** **Social worker**	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals	$85 per treatment and 10 treatments per calendar year, per insured, for all of these healthcare professionals
Chiropractor X-rays	1 per calendar year, per insured	1 per calendar year, per insured	1 per calendar year, per insured
Waiver of premiums	No	No	No
Extension of coverage for dependents of a deceased participant	24 months immediately following the participant's death	24 months immediately following the participant's death	24 months immediately following the participant's death
Termination of insurance	At the participant's retirement	At the participant's retirement	At the participant's retirement

DENTAL CARE INSURANCE – Complete Plan only			
	OPTION A	OPTION B	OPTION C
Electronic claims payment	Included	Included	Included
Annual deductible	Applies to modules A, B and C	Applies to modules A, B, C and D	Applies to modules A, B, C and D
– Individual coverage	$75	$75	$50
– Family coverage	$150	$150	$100
– Single-Parent coverage	$100	$100	$75
Late application – Maximum reimbursed	$250 per insured during first 12 months of insurance	$250 per insured during first 12 months of insurance	$250 per insured during first 12 months of insurance
Reimbursement	Based on fee guide for current year	Based on fee guide for current year	Based on fee guide for current year
Module A: Preventive services	70%	80%	90%
– Frequency of preventive services	1 per period of 12 consecutive months	1 per period of 12 consecutive months	1 per period of 12 consecutive months
Module B: Basic restorative services	70%	75%	85%
Module C: Major restorative services	50%	50%	60%

DENTAL CARE INSURANCE (Cont.) – Complete Plan only			
	OPTION A	OPTION B	OPTION C
Module D: Complex restorative services	N/A	50%	60%
Maximum reimbursement per calendar year	$1,000 per insured for modules A to C	$1,000 per insured for modules A to D	$2,000 per insured for modules A to D
Module E: Orthodontics	N/A	50%	50%
Maximum lifetime reimbursement for dependent children only	N/A	$1,000 per insured for module E	$2,000 per insured for module E
Laboratory fees	67%	67%	67%
Waiver of premiums	No	No	No
Extension of coverage for dependents of a deceased participant	24 months immediately following the participant's death	24 months immediately following the participant's death	24 months immediately following the participant's death
Termination of insurance	At the participant's retirement	At the participant's retirement	At the participant's retirement

SHORT-TERM DISABILITY INSURANCE – Complete Plan only	
Elimination period	
– Accident	7 consecutive days
– Hospitalization	7 consecutive days
– Illness	7 consecutive days
– Day surgery	No
Maximum benefit period	15 weeks
Benefit amount as a percentage of weekly salary	75%
Non-evidence maximum	$2,300
Maximum with evidence of insurability	$2,800
Income from all sources	100% of gross salary
Fiscal status	Taxable
Plan integrated with Employment Insurance (EI)	No
Plan integrated with EI and Supplemental Unemployment Benefit (SUB)	No
Benefit splitting	1/7
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Participant's 70th birthday or date of retirement, if earlier

LONG-TERM DISABILITY INSURANCE – Basic and Complete Plans	
Elimination period	16 weeks
Maximum benefit period	The last day of the week during which the participant reaches age 65
Benefit amount as a percentage of monthly salary	75%
Non-evidence maximum	$11,000
Maximum with evidence of insurability	$16,500
Fiscal status	Taxable
Income from all sources	80% of gross salary
Indexation	Yes, based on QPP, maximum 3%
Waiver of premiums	Long-term disability insurance elimination period
Termination of insurance	Participant's 65th birthday or date of retirement, if earlier

LIFE INSURANCE

1. Participant's basic life insurance

Upon the death of a participant, the Insurer pays the beneficiary a benefit equal to the amount indicated in the *Schedule of Insurance*, subject to the maximums and reductions indicated in the schedule.

2. Accidental death and dismemberment insurance

If a participant suffers an accident while this coverage is in force and sustains any of the losses listed in the schedule below within 365 days following the date of such accident, the Insurer will pay a benefit equal to the percentage specified below of the amount indicated in the *Schedule of Insurance*.

LOSS	PERCENTAGE
– Paraplegia, quadriplegia or hemiplegia	200%
– Loss of life	100%
– Loss of vision in both eyes	100%
– Loss of both hands or both feet	100%
– Loss of one hand or one foot and the sight in one eye	100%
– Loss of one hand and one foot	100%
– Loss of speech and of hearing in both ears	100%
– Loss of use of both hands or of both feet	100%
– Loss of use of one hand and of one foot	100%
– Loss of one leg or one arm	75%
– Loss of use of one arm or of one leg	75%
– Loss of one hand or one foot or the sight in one eye	67%
– Loss of use of one hand or of one foot	67%
– Loss of speech or hearing	50%
– Loss of hearing in one ear	50%
– Loss of the thumb and index finger of the same hand	33%
– Loss of four fingers of the same hand	33%
– Loss of all toes of one foot	25%

Rehabilitation of participant

If the participant suffers a loss, other than loss of life, while this coverage is in force and benefits are payable under the coverage, the Insurer pays all reasonable and necessary training expenses incurred, up to a maximum of $10,000.

To be eligible, the loss must require the participant to undergo special training in order to work in an occupation other than the one held before the accident. In addition, the expenses must be approved in advance by the Insurer and incurred within three (3) years following the date of the accident.

Living, transportation and clothing expenses are not reimbursed.

Professional training of spouse

In the event of a death covered by this benefit, the spouse may be eligible for benefits for a professional training program in order to work in an occupation that he or she would not have been able to otherwise. Benefits are payable up to a maximum of $10,000. The spouse must submit a written request to the Insurer to cover the expenses incurred for a professional training program that has been previously approved by the Insurer and recognized by the appropriate government authorities.

Expenses must be incurred within three (3) years following the date of the participant's death and deemed necessary and reasonable by the Insurer.

Return of deceased

In the event of a death covered by this benefit occurring more than 100 km from the participant's usual residence, additional benefits are payable for expenses incurred to prepare and return the remains, up to a maximum of $10,000.

The Insurer must receive a written request and deem the expenses necessary and reasonable.

Tuition fees for children

In the event of the accidental death of a participant for which benefits are payable under this coverage, the insured's dependent children may be eligible for additional benefits for tuition fees, up to a maximum of $5,000 per child. The request must be made in writing to the Insurer.

Eligible expenses include annual tuition fees and books enabling the dependent children to pursue a full-time education in a post-secondary institution. In order for benefits to be payable, the child must be enrolled as a full-time student in a post-secondary institution at the time of the participant's death or within 365 days following the date of the participant's death.

Proof of the dependent child's full-time enrolment must be submitted to the Insurer at the beginning of each school year.

Exclusions, limitations and reduction of coverage

This coverage does not apply, and no benefit is payable to the participant, if the loss sustained occurs in the following cases:

- While carrying out any of the duties of an airplane crew or any duty whatsoever related to a flight.
- War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
- Due to attempted suicide or suicide of the participant, or voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.
- Any condition occurring while the participant is on active duty with the armed forces of any country.
- Due to an illness which appears at the time of an accident but which is not due to such accident.
- Following medical or dental treatment, a surgical operation or anaesthesia.

3. Dependents' life insurance

The amount payable upon the death of an insured dependent is equal to the amount indicated in the *Schedule of Insurance*.

4. Participant's and spouse's optional life insurance

Participant

The amount of insurance payable on the death of a participant who exercised this option is determined based on the amount selected. The amount that a participant may purchase is indicated in the *Schedule of Insurance*.

Spouse

The amount of insurance payable on the death of the spouse of a participant who exercised this option is determined based on the amount selected. The amount that a participant may purchase for his or her spouse is indicated in the *Schedule of Insurance*.

Participants may not exercise this option if their spouse is not insured under the dependents' life insurance benefit. This option is also unavailable for participants who are totally disabled. In such a case, participants may exercise this option upon returning to active employment.

In no case may the total amount payable under basic and optional life insurance exceed $1,100,000.

Evidence of insurability

This coverage is subject to evidence of insurability deemed satisfactory by the Insurer, which must be provided by the proposed insured at the time of application or in order to obtain an additional amount of optional life insurance. Any misstatement or omission by an insured may result in this benefit's being voided for such insured.

EXCLUSIONS, RESTRICTIONS AND REDUCTION OF COVERAGE

The optional life insurance benefit does not apply if the insured dies from suicide or the effects of any attempted suicide during the first two (2) years following the effective date of this benefit, its reinstatement or any increase in the amount of insurance, whether or not the insured is of sound mind at the time of suicide or attempted suicide. In such case, insurance under this benefit, or the increase in insurance, as the case may be, is null and void and the liability of the Insurer is limited to a refund of the premiums collected.

5. Accelerated benefit payment in the event of terminal illness

A disabled participant whose life expectancy is no more than 12 months and who is benefiting from the "Waiver of premiums in the event of total disability" may obtain an accelerated benefit payment by submitting an application in writing to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent, if designated irrevocable.

The amount paid under this section is limited to the percentage (indicated in the *Schedule of Insurance*) of the participant's life insurance amount (basic and optional), up to the maximum indicated in the schedule.

The amount of life insurance used to calculate the accelerated benefit excludes any amount or fraction of an amount expiring in accordance with the provisions of the contract during the 24 months following the date of the application that cannot be replaced with another life insurance benefit.

At the participant's death, the insured amount payable by the Insurer is reduced by the amount paid as an accelerated benefit plus interest. The interest rate used to calculate the final payment for a given year corresponds to the return on five- to 10-year Government of Canada bonds as posted in the monthly review of the Bank of Canada (V121757 series) as at the preceding December 31, rounded up by ¼ of 1%.

The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid. Furthermore, all other benefits cease upon termination of the contract, even for participants who have been granted a waiver of premiums.

HEALTH INSURANCE

Please refer to the SCHEDULE OF INSURANCE on page 5 for information about coinsurance and applicable maximums.

Eligible expenses are those reasonably incurred and justified by the seriousness of the case as well as by current medical practice and the customary and reasonable charges in force in the area, as described below.

DEDUCTIBLE CARRYOVER

If a deductible has been paid in whole or in part for covered expenses incurred during the last three (3) months of a calendar year, the amount of the covered expenses incurred during the last three (3) months to pay the deductible are carried over and applied to the deductible for the following year.

HOSPITALIZATION EXPENSES

Hospitalization expenses incurred in Canada in excess of amounts payable under any government hospitalization and health insurance plan, up to the cost indicated in the *Schedule of Insurance*, without any limit as to the number of days, provided that the hospitalization begins while insurance is in force.

ACCOMMODATION EXPENSES IN A RESIDENTIAL AND LONG-TERM CARE CENTRE

The expenses incurred for a stay in a residential and long-term care centre as defined by the *Act respecting health services and social services* or in a hospital centre if the insured is receiving long-term care in excess of the expenses payable under any public health insurance plan, up to the cost indicated in the *Schedule of Insurance*, provided that the hospitalization begins while insurance is in force. However, expenses for help with activities of daily living are excluded.

REHABILITATION CENTRE OR CONVALESCENT HOME

Expenses for occupying a room, including meals, for at least 12 consecutive hours in a rehabilitation centre or convalescent home, as defined by the *Act respecting health services and social services*, in excess of the expenses payable under a public health insurance plan, up to the cost indicated in the *Schedule of Insurance*, provided that the insured is admitted to the centre within 14 days following hospitalization and that the hospitalization begins while insurance is in force.

TRAVEL INSURANCE AND ASSISTANCE

(See description of benefit at end of booklet)

TRIP CANCELLATION INSURANCE

(See description of benefit at end of booklet)

PRESCRIPTION DRUGS

The Insurer provides reimbursement for pharmaceutical services and prescription drugs covered under the RAMQ's BPDIP, as established under the *Act respecting prescription drug insurance* (R.S.Q., c. A-29.01). However, for an insured age 65 or older, and any insured dependents, only the portion not reimbursed under the public plan (prescription drugs, deductible and coinsurance) is eligible for reimbursement, unless the insured opts out of the public plan. In this case, the participant must pay an additional premium as determined by the Insurer.

Subject to the following exclusions, the Insurer reimburses prescription drug expenses other than those mentioned in the preceding paragraph that are included in the Compendium of Pharmaceuticals and Specialities, bear a Drug Identification Number (DIN), are dispensed by a licensed pharmacist or duly authorized physician and may only be obtained on prescription from a physician, dentist or legally authorized healthcare professional. Also eligible for reimbursement are drugs obtained on prescription with directions for use specifically related to treatment of the following pathological conditions: heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma.

MANDATORY GENERIC SUBSTITUTION

Only expenses for the least expensive generic drug equivalent to the drug prescribed are eligible, even if the healthcare professional has indicated "No substitution" on the prescription.

To obtain reimbursement of expenses incurred for a brand name drug or equivalent product, an insured must obtain the appropriate form from the Insurer and have the healthcare professional complete it, specifying the medical contraindications preventing the insured from purchasing the least expensive equivalent product. The insured must then submit the form to the Insurer for analysis. Prescription drug refills for drugs that have been accepted by the Insurer will then be approved through the Insurer's electronic transmission system. The physician will not be required to complete another medical form.

EXCLUSIONS – PRESCRIPTION DRUG EXPENSES

- Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment.
- Dietetic substances or foods, anti-obesity and weight control products.
- Homeopathic medicines.
- Drugs administered primarily for preventive purposes, except preventive vaccines. For the purposes of this exclusion, a drug used to stabilize or regulate a pathological condition diagnosed by a physician is not considered to be used for preventive purposes.
- Products used to treat hair loss or wrinkles or any other treatment administered primarily for aesthetic purposes.
- Smoking cessation products not covered under the BPDIP.
- Drugs or substances used for the treatment of infertility or impotence not covered under the BPDIP.
- Any substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams.
- Drugs provided during a period of hospitalization.
- Any treatments or drugs of an experimental nature.

Furthermore, the Insurer may deny reimbursement of any drugs prescribed for a condition other than those listed in the manufacturer's directions for use or not prescribed in accordance with current medical practice. The Insurer may, among other things, require a medical diagnosis and limit reimbursement to a reasonable maximum.

In the event that Health Canada approves a new drug that may substantially affect the cost of coverage under this benefit, the Insurer reserves the right to exclude such drug from coverage if it does not appear on the RAMQ drug formulary, or modify the applicable premium as of the drug's date of approval.

OTHER ELIGIBLE EXPENSES

The following services and supplies are eligible for reimbursement, provided they are medically required, prescribed by a physician and necessary for the treatment of the insured.

- Expenses for transportation by **ambulance** to the nearest hospital centre able to provide the care required, including emergency air transportation.
- Expenses for the purchase of a **hearing aid**.
- Expenses for the purchase of **support stockings.**

- Expenses incurred for a stay in a recognized **private clinic**, specialized in rehabilitation treatment of alcoholism or drug addiction excluding tobacco use.
- Professional fees of a **dentist** for treatment of a fractured jaw or damage to healthy, natural and vital teeth caused by an accident occurring while insurance is in force. However, 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. Treatment must be provided within 12 months following the date of the accident.
- Expenses for the purchase of **corrective elements** added to ordinary shoes, **orthopaedic shoes** or **corrective footwear** made by a specialized orthopaedic laboratory or an establishment licensed under all applicable legislation in the insured's province of residence, as well as the initial or replacement cost of an **orthosis** or **orthopaedic shoes** that are custom made for the insured by a specialized orthopaedic laboratory and adjustments to orthopaedic shoes.
- Expenses for the rental, or purchase of a basic model if this option is deemed more economical by the Insurer, of a **wheelchair**, **hospital bed** or **other therapeutic device**.
- Expenses for the purchase of an appliance used to manage diabetes (**glucometer**, **dextrometer** or any other appliance of a similar nature) as well as the travel case for transporting it, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent.
- Professional fees for medical care provided in the participant's home by a **registered nurse** or **nursing assistant** who is a member in good standing of a professional order recognized by appropriate legislative authorities, excluding any person who usually resides in the participant's home or is a close relative.
- Expenses for the substance used in **sclerosing injections** that are medically required and administered by a physician.
- Expenses for the rental or purchase, depending on circumstances, of an **artificial limb** or **eye**, **supports**, **corsets**, **trusses**, **casts**, **crutches** or **other orthopaedic equipment**.
- Expenses for the purchase of a **transcutaneous electrical nerve stimulation (TENS)** unit.
- Expenses for a **breathing assistance device**, **oxygen**, **blood**, **blood plasma** and a **transfusion**, except expenses for the preservation or freezing of blood or plasma.
- Expenses for the purchase of an **insulin pump** used to manage diabetes, provided that the use of such an apparatus is required by the medical condition of the insured.
- Expenses for the purchase of a **capillary prosthesis (wig)** required following chemotherapy treatments.
- Expenses for the purchase of an **external breast prosthesis** following a mastectomy.

- Expenses for **X-rays**, **laboratory analyses**, **magnetic resonance imaging** and **computed tomography** for purposes of prevention or diagnosis performed outside a hospital centre.
- Expenses for the **home care and assistance** described below, when recommended by a physician and deemed necessary following hospitalization or day surgery, are eligible for reimbursement provided the expenses are incurred within 30 days following the hospitalization or discharge from the day surgery unit and the services cannot be provided by a person who resides with the insured.

  a) Fees for home assistance services, invoiced by a specialized organization, for purposes of washing, feeding, dressing and looking after the insured's basic hygienic needs.

  b) Basic expenses for general home maintenance services (meal preparation, housekeeping, laundry and dishwashing, lawn mowing and snow removal) performed by someone other than a close relative of the insured.

  c) Expenses for childcare services provided for minor children by a person other than a close relative of the insured.

  d) Public transportation expenses incurred to attend medical appointments at a physician's office or hospital, including expenses for accompaniment, if necessary, by someone other than a close relative of the insured.

  e) Expenses incurred for a stay in a convalescent hospital specialized in post-hospitalization care.

  To obtain the services described under items a) and e), please contact our customer service at the numbers listed at the end of the booklet. Furthermore, following hospitalization or one-day surgery, we offer information regarding the various services available in the region where the insured resides (local community health centres, drugstores, laboratories, hospitals, etc.).

- Expenses for **vision care**, subject to the exclusions provided hereunder, if a participant personally or for an insured dependent incurs fees for an eye examination carried out by an ophthalmologist or optometrist for insureds age 18 to 64. Expenses incurred for the purchase of glasses or contact lenses on recommendation of a physician or optometrist due to a change in visual acuity, as well as expenses related to laser eye surgery performed by an ophthalmologist who is a member of the *Collège des médecins du Québec*, in order to correct myopia, hypermetropia, astigmatism or presbyopia, are also covered.

  Additional expenses of $250 per insured, per period of 24 consecutive months, are also eligible for contact lenses, provided that visual acuity is sufficiently corrected to reach 20/40, a level that would have been unobtainable with regular glasses.

- Expenses for the purchase of an **intrauterine device (IUD)**.

– In the event that an insured under age 65 must receive **special treatments not available in the province of residence**, the Insurer reimburses medical and hospital expenses in accordance with the following conditions:

  a) The treatments must be recommended by a physician and approved by RAMQ and the Insurer. Treatments of an experimental nature are excluded. "Treatment" is defined as a series of acts performed by one and the same physician within a period of 24 consecutive months.

  b) The treatments must not be offered in the province of residence, i.e. the insured's claim is not related to a temporary lack of availability of such treatments.

  c) Treatments provided outside Canada are eligible only if such treatments are not available anywhere in Canada.

– Expenses for **vaccines**, including preventive vaccines, must be available only on prescription and be administered by a physician or nurse.

HEALTH PROFESSIONALS

The following services and supplies are eligible for reimbursement, provided they are medically required and necessary for the treatment of the insured.

All of the healthcare professionals referred to in this document must be members in good standing of a professional order recognized by a legislative authority or of a professional association recognized by the Insurer.

Only one treatment per day per insured is eligible for reimbursement, for each of the healthcare professionals specified below.

– Professional fees of an **acupuncturist**.

– Professional fees of an **audiologist**.

– Professional fees of a **chiropodist**.

– Professional fees of a **chiropractor** including **X-rays taken by a chiropractor**.

– Professional fees of a **dietitian**.

– Professional fees of a **kinesiologist**.

– Professional fees of a **kinesitherapist**.

– Professional fees of a **massage therapist**.

– Professional fees of a **naturopath**.

– Professional fees of an **occupational therapist**.

– Professional fees of an **orthotherapist**.

– Professional fees of an **osteopath**.

- Professional fees of a **physical rehabilitation therapist**.
- Professional fees of a **physiotherapist**.
- Professional fees of a **podiatrist**.
- Professional fees of a **psychiatrist**, **psychoanalyst in an outpatient clinic**, **psychologist**, **psychotherapist** and **social worker**. Expenses incurred for marital therapy involving both spouses are also eligible. The services of a psychiatrist are those rendered as psychoanalytic treatments, insofar as the professional is a member of the Canadian Psychoanalytic Society.
- Professional fees of a **speech-language therapist**.
- Professional fees of a **sports therapist**.

Exclusions, limitations and reduction of coverage

Subject to the provisions of the applicable laws in the participant's province of residence, any expenses incurred for the products and services below are excluded from coverage, and no reimbursement is made by the Insurer for any expenses incurred due to any of these events. Moreover, the following exclusions apply, unless the coverage is provided in the *Schedule of Insurance*:

- Dentures, eyeglasses, contact lenses or laser eye surgery.
- Injections provided as part of a weight reduction program
- Surgery, treatments or prostheses provided for aesthetic purposes, except following an accident.
- Care or treatment provided primarily for aesthetic purposes, protective glasses or sunglasses and care or treatment provided free of charge.
- Any product or service that is not medically required.
- Eye or hearing examinations, unless fees are specifically covered by the option chosen by the participant.
- Voluntary self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.
- Treatment or services provided by a close relative of the insured or by a person who resides with the insured.
- Periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or health trips.
- The insured's participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

- War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
- Any condition occurring while the insured is on active duty with the armed forces of any country.
- Any expenses related to insemination.
- Any expenses related to infertility treatment not covered by the BPDIP.
- Any treatment, services or products of an experimental nature.
- Any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this benefit.

The above-mentioned exclusions also apply to the travel insurance benefit.

Also excluded are any expenses payable under any other individual or group plan and expenses for which the insured is entitled to an indemnity under the Quebec *Act Respecting Industrial Accidents and Occupational Diseases*, *Automobile Insurance Act*, *Hospital Insurance Act*, *Health Insurance Act* or any other similar federal or foreign law.

Also excluded are any expenses for care, services or supplies that the insured is not required to pay, that the insured would not be required to pay if he or she had invoked the provisions of a government insurance plan, or that the insured would not have had to pay in the absence of this coverage.

DENTAL CARE INSURANCE (Complete Plan only)

Please refer to the *SCHEDULE OF INSURANCE* on page 5 for information about coinsurance and applicable maximums.

Eligible expenses are expenses that are reasonably incurred, recommended by a dentist and justified by current dental practice for the treatment described below, up to the amount of the fees specified in the Fee Guide and Description of Dental Treatment Services approved by the provincial dental association of the insured's province of residence, in effect when the expenses are incurred.

When a dental fee guide is not published for a given year, "dental fee guide" means the adjusted fee guide established by the Insurer.

For the first year of insurance, the deductible is prorated to the number of months between the effective date and the end of the calendar year, unless the Insurer and the Policyholder have agreed otherwise.

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.

When the insured's application form is sent to the Insurer after the expiry of a 90-day period following the date the insured became eligible, reimbursement of all dental care is limited to the amount indicated in the *Schedule of Insurance*.

DEDUCTIBLE CARRYOVER

If a deductible has been paid in whole or in part for covered expenses incurred during the last three (3) months of a calendar year, the amount of the covered expenses incurred during the last three (3) months to pay the deductible are carried over and applied to the deductible for the following year.

1. Eligible expenses

MODULE A – PREVENTIVE SERVICES

DIAGNOSIS AND PREVENTION

- Examination and diagnosis
  - Oral examination
  - Basic examination
  - Recall oral examination: up to one treatment per period indicated in the *Schedule of Insurance*
  - One examination per period of 6 consecutive months.
  - Specific oral examination
  - Treatment plan
  - Minor emergency treatment
  - Consultation
  - Visit to home, institution or workplace
- Laboratory analyses and examinations
  - Tissue biopsy
  - Vitality tests
- Radiographs
  - Complete series: One examination per period of 24 consecutive months
  - Periapical films
  - Occlusal films
  - Bitewing films: One examination per period of 12 consecutive months
  - Extraoral films
  - Sialography
  - Radiopaque dyes to detect lesions
  - Panoramic film: One examination per period of 24 consecutive months
  - Interpretation of radiographs from another source
  - Tomography
- Preventive services
  - Dental polishing: One examination per period indicated in the *Schedule of Insurance*
  - Fluoride treatment for dependents age 16 and under: One treatment per period indicated in the *Schedule of Insurance*
  - Pit and fissure sealants for dependents age 19 and under
  - Interproximal discing
  - Recontouring of teeth for functional reasons
- Other services
  - Space maintainers
  - Drug injections
  - Laboratory fees

MODULE B – BASIC RESTORATIVE SERVICES

MINOR RESTORATIVE SERVICES

- Restorative services
  - Emergency treatments
  - Amalgam
  - Acrylic or composite
  - Transitional restoration of fractured anterior
  - Prefabricated restorations
  - Bonded bicuspids
  - Bonded, composite molars
- Periodontics
  - Non-surgical procedures
  - Occlusional adjustment/equilibration, up to a maximum of 8 time units per year
  - Scaling and root planing, up to a maximum of 16 time units per year
- Rebasing and relining of dentures

These dental services are eligible for reimbursement if performed more than six (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.

- Surgical procedures
  - Uncomplicated extraction
  - Surgical extraction/repositioning
  - Surgical excision
  - Surgical incision
  - Fracture
  - Laceration
  - Frenectomy
  - Miscellaneous surgical procedures
- Anaesthesia for oral surgery
  - General anaesthesia
  - Local anaesthesia
  - Deep sedation
  - Conscious sedation
- Laboratory fees

MODULE C – MAJOR RESTORATIVE SERVICES

PERIODONTICS

- Periodontics
  - Surgical procedures
  - Post-surgical treatment
  - General services
  - Post-treatment evaluation
- Major surgical procedures
  - Alveoplasty
  - Enucleation of cysts
  - Dislocations
- Radiographs
  - X-rays of temporomandibular joint
- Anaesthesia for oral surgery
  - Deep sedation
  - Conscious sedation
- Laboratory fees

ENDODONTICS

- Endodontics
  - Pulpotomy
  - Root canal treatment
  - Periapical treatment
  - Other orthodontic services
  - Emergency treatments
- Anaesthesia for oral surgery
  - Deep sedation
  - Conscious sedation
- Laboratory fees

MODULE D – COMPLEX RESTORATIVE SERVICES (OPTIONS B AND C)

PROSTHODONTICS

- Complete and partial dentures
  - Complete dentures
  - Partial dentures
  - Repairs

- Remake and adjustments
  - Denture adjustments
  - Remake, partial dentures
- Examinations
  - Oral examination
  - Diagnostic casts
- Laboratory fees

BRIDGES

- Hemisection
- Fixed bridges
  - Pontics
  - Splints
  - Other prosthetic services
- Repairs and adjustments
  - Porcelain repair
  - Bridge repair
- Examinations
  - Oral examination
  - Diagnostic casts
- Laboratory fees

The replacement of a denture, bridge, crown, inlay or onlay is an eligible expense if it is required to replace a prosthesis that is at least five (5) years old, subject to an eligible maximum equivalent to the value and quality of the initial prosthesis.

The addition of teeth to a partial denture or bridge is an eligible expense if the addition is required to replace one or more teeth removed while the participant or dependent is covered under this policy.

CROWNS

- Crowns, inlays and onlays
  - Metal inlays
  - Composite inlays
  - Porcelain or ceramic inlays
  - Crowns
  - Other treatments

- Repairs and adjustments
  - Porcelain repair
  - Recementation of a crown
- Examinations
  - Oral examination
  - Diagnostic casts
- Laboratory fees

RESTRICTIONS CONCERNING REMOVABLE AND FIXED PROSTHODONTICS AND FIXED BRIDGES

- Any purchase of a prosthesis or fixed bridge is only eligible for reimbursement if the extraction that makes the purchase necessary takes place while the insured is covered under this benefit.
- Any replacement of a prosthesis or fixed bridge or the addition of teeth to a removable prosthesis or a fixed bridge is only eligible for reimbursement if satisfactory proof is provided that:

  a) The replacement or addition of teeth is necessary following the removal of teeth after the initial insertion of the prosthesis or fixed bridge or

  b) The prosthesis or fixed bridge cannot be repaired and, if the prosthesis or fixed bridge was inserted while this dental care insurance coverage was in force, that at least five (5) years have elapsed prior to the replacement.
- Any replacement of a prosthesis or fixed bridge is eligible for reimbursement up to the maximum reimbursement amount provided for an equivalent model to the prosthesis or fixed bridge that the person had prior to the first replacement for which expenses were reimbursed.
- When fixed prostheses are used as retainers for a fixed bridge, the fixed prostheses are eligible for reimbursement under the same conditions as fixed bridges.
- Implant-supported prostheses are eligible for payment according to the amount for a standard equivalent denture, in accordance with the provisions of this contract. However, implants and surgery related to implants are not eligible.

MODULE E – ORTHODONTICS (OPTIONS B AND C) (FOR DEPENDENT CHILDREN ONLY)

- Follow-up and adjustments
  - Oral examination
  - Skull and facial bone examination
  - Cephalometric radiographs
  - Radiograph, hand and wrist
  - Diagnostic casts

  - Surgical procedures
  - Follow-up and adjustments
  - Repairs and alterations
  - Appliances for tooth guidance or minor tooth movement
  - Retention appliances
- Evaluation of oral habits
  - Appliances
  - Adjustment, repairs and maintenance
- General services
- Anaesthesia for oral surgery
  - Deep sedation
  - Conscious sedation
- Laboratory fees

2. Exclusions, limitations and reduction of coverage

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

- Dental care that is free of charge or expenses for dental care that the insured is not required to pay, or 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 under which the insured is covered or those the insured would not be required to pay if not covered under this benefit.
- Dental treatments 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 Canadian or foreign law with similar provisions; and any dental treatments payable under any health insurance benefit in which the insured participates.
- Dental treatments and supplies which, in accordance with the accepted standards of the dental profession, are not required from a dental viewpoint, or which do not meet the accepted standards of the dental profession.
- Dental treatments administered primarily for aesthetic purposes, including the transformation, extraction or replacement of healthy teeth in order to modify their appearance.
- Dental treatments required due to voluntary self-inflicted injury, whether or not the insured is of sound mind or due to war, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.

- Fees charged for missed appointments, filling out claim forms required by the Insurer, or for additional information required by the Insurer; also for travel time, transportation expenses and counselling provided by any means of telecommunication.
- Fees charged 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.
- Fees charged in relation to diet assessments, recommendations for initial instruction or oral hygiene re-instruction, plaque control programs or any type of mouth guard.
- Dental implants and surgery related to implants.
- Dental treatments provided by a close relative of the insured or by a person who resides with the insured.
- Expenses incurred while insurance under this benefit was not in force.
- Replacement of appliances that are lost, misplaced or stolen.
- Procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- Experimental treatments.
- Dental services required due to congenital malformation or acquired defects.
- Expenses resulting from the participation in a criminal offence.

SHORT-TERM DISABILITY INSURANCE (Complete plan only)

Upon receipt and approval by the Insurer of proof establishing that a participant has become disabled as defined under the contract, and following expiry of the elimination period, the Insurer pays weekly benefits to the participant, the amount of which is determined below.

1. Elimination period

The elimination period indicated in the *Schedule of Insurance* is a period that begins at the start of total disability, during which no disability benefit is payable.

2. Benefit period and amount

The first benefit payment is made as of the seventh day following expiry of the elimination period defined above and subsequent payments are made each week thereafter, for the maximum period indicated in the *Schedule of Insurance*.

The benefit amount corresponds to the percentage of the participant's weekly salary at the onset of disability indicated in the *Schedule of Insurance*. This benefit is subject to the maximums indicated in the schedule and reduced by the sum of the following amounts:

a) Any disability income benefits the participant is entitled to receive under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP), before any apportionment or deduction of any sort, or which the participant would be entitled to receive if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

   A disabled participant who is entitled to disability income benefits under the QPP and who has applied for retirement income from the QPP is presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that the participant would continue to receive if an application for retirement income benefits had not been submitted.

b) All benefits, indemnities and income received by the participant from the employer, or from a retirement plan of the employer.

c) Any disability income benefits the participant is receiving, or which the participant would be entitled to receive if an application were submitted and approved, under the *Act respecting industrial accidents and occupational diseases* or the Quebec *Automobile Insurance Act*, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

d) Employment Insurance benefits in case of accident or illness (if the employer has a SUB program).

In all cases involving a reduction of the benefit amount as stated in sections a) and c), it is the participant's responsibility to submit an application for disability benefits to the relevant authorities when required by the Insurer, and if the participant fails to do so, the benefit will be reduced as described in these sections.

No increase in any amount referred to in sections a) to d) that is due to a cost-of-living adjustment reduces the benefit amount payable under this insurance coverage.

The total of the disability insurance benefits specified above and income from other sources may not exceed the percentage of the participant's salary at the onset of disability indicated in the *Schedule of Insurance*. The following income is considered to be income from other sources:

- Disability benefits payable under:
  - > The *Act respecting industrial accidents and occupational diseases* or any similar legislation.
  - > The provisions of the Quebec *Automobile Insurance Act* or any legislation with similar provisions, when such legislation does not take into account benefits payable under the *Employment Insurance Act* when calculating disability benefits.
  - > The Quebec Pension Plan and the Canada Pension Plan (initial benefit amount only).
  - > Any other social legislation excluding Employment Insurance benefits.
  - > Any other public or private group insurance plan, including any supplemental income plan to which the employer contributes.
- Employment Insurance benefits in case of accident or illness (if the employer has a SUB program).
- Any other remuneration received from the employer (with the exception of amounts received for a rehabilitation program).

For the purposes of calculating income from other sources, a disabled participant who is entitled to disability income benefits under the QPP and who has applied for retirement income from the QPP is presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that he or she would continue to receive if an application for retirement income benefits had not been submitted.

3. Exclusions, limitations and reduction of coverage

No benefit is payable in the following cases:

a) If the participant's total disability occurs due to any of the following causes:

- War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
- Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.
- Absence from work in order to undergo plastic surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.
- Any condition occurring while the participant is on active duty with the armed forces of any country.
- Alcoholism or drug addiction, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care as a part of a detoxification treatment or rehabilitation in an establishment, agency or institution specialized for such purposes.

b) For a period of total disability corresponding to one of the following periods:

- A period of maternity leave taken in compliance with a provincial or federal statute or maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.
- A period during which the participant is receiving maternity benefits provided for under the *Employment Insurance Act* or the Quebec *Parental Insurance Act*.

c) Benefits are not payable for any period during which the participant engages in any gainful occupation, except within a rehabilitation program.

d) No benefit is payable after the participant's date of retirement.

e) No benefit is payable for any period during which the participant refuses to take part in a rehabilitation program or perform rehabilitative work considered appropriate by the Insurer.

4. Gradual return to work

Under the rehabilitation program, a participant who receives disability insurance benefits may, after submitting a medical certificate from his or her attending physician regarding a gradual return to work and with the Insurer's approval, carry out all the duties associated with the position held before the start of the disability period or those of a comparable position.

The rehabilitation program may not result in an extension of the benefits period, whether the participant is receiving full or partial benefits, beyond the period stipulated in the *Schedule of Insurance*.

Under the rehabilitation program, the participant receives a salary for the time worked, as well as disability insurance benefits which are prorated for the time not worked, provided the position corresponds to the rehabilitation program and the disability persists.

The participant is considered to be in a state of total disability during this period.

5. Pregnancy-related Supplemental Unemployment Benefits or Quebec Parental Insurance Plan benefits

When a participant who is otherwise eligible for benefits is subject to exclusion b) in relation to maternity leave mentioned above and is receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, La Capitale will pay a supplement calculated to cover the difference between the amount of pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits payable and the amount to which the participant would have been entitled if exclusion b) in relation to maternity leave was not applicable.

LONG-TERM DISABILITY INSURANCE

Upon receipt and approval by the Insurer of proof establishing that a participant insured under this contract has become disabled, as defined under the contract, and following expiry of the elimination period as determined in the *Schedule of Insurance*, the Insurer pays the monthly benefits to the participant, as defined below.

1. Elimination period

The elimination period is the period that begins when the participant becomes disabled and ends on the last day for which short-term disability insurance benefits are payable.

If short-term disability insurance coverage has not been selected, the elimination period indicated in the *Schedule of Insurance* is the period that begins at the start of the total disability, during which no disability benefit is payable.

2. Benefit period and amount

The first benefit payment is made as of the 31st day following expiry of the above-mentioned elimination period and subsequent payments are made each month thereafter.

The benefit amount corresponds to the percentage of the participant's monthly salary at the onset of disability indicated in the *Schedule of Insurance*. This benefit is subject to the maximums indicated in the *Schedule of Insurance* and reduced by the sum of the following amounts:

a) Any disability income benefits the participant is entitled to receive under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP), before any apportionment of any sort, or which the participant would be entitled to receive if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

   A disabled participant who is entitled to disability income benefits under the QPP and who has applied for retirement income from the QPP is presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that the participant would continue to receive if an application for retirement income benefits had not been submitted.

b) Any disability income benefits the participant is receiving, or which the participant would be entitled to receive if an application were submitted and approved, under the *Act respecting industrial accidents and occupational diseases* or the Quebec *Automobile Insurance Act*, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

c) All benefits, indemnities and income received by the participant from the employer, including notice and severance payments, or from a retirement plan of the employer or any previous employer, with the exception of any amounts that the participant was receiving from a retirement plan before the start of the disability.

In all cases involving a reduction of the benefit amount as stated in sections a) and b), it is the participant's responsibility to submit an application for disability benefits to the relevant authorities when required by the Insurer, and if the participant fails to do so, the benefit will be reduced as described in these sections.

No increase in any amount referred to in sections a) to c) that is due to a cost-of-living adjustment reduces the benefit amount payable under this insurance coverage.

For any incomplete months, the amount of disability benefits is adjusted by dividing it by 30 and multiplying it by the number of days in the month the participant is disabled.

For the week of benefits coinciding with the participant's return-to-work day, the benefit payable is prorated to the number of working hours effectively lost.

The total of the disability insurance benefits specified above and income from other sources may not exceed the percentage of the participant's salary at the onset of disability indicated in the *Schedule of Insurance*. The following income is considered to be income from other sources:

- Disability benefits payable under:
  - > The *Act respecting industrial accidents and occupational diseases* or any similar legislation.
  - > The Quebec *Automobile Insurance Act* or any similar legislation.
  - > The *Crime Victims Compensation Act*, the Quebec Pension Plan or Canada Pension Plan (initial benefit amount only).
  - > Any other social legislation and any other public or private group insurance plan, including any supplemental income plan to which the employer contributes or to which any previous employer has contributed.
- Any other remuneration received from the employer or any previous employer (with the exception of amounts received for a rehabilitation program).

For the purposes of calculating income from other sources, a disabled participant who is entitled to disability income benefits under the QPP and who has applied for retirement income from the QPP is presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that he or she would continue to receive if an application for retirement income benefits had not been submitted.

3. Indexation

During the period of disability and for as long as the participant is disabled, the benefit amount is indexed on January 1 each year in accordance with the conditions indicated in the *Schedule of Insurance*.

4. Rehabilitation

Any participant who participates in a rehabilitation program sponsored by the Insurer is entitled to monthly benefits equal to the amount of the participant's monthly benefit prior to registration in the rehabilitation program, reduced by an amount of 50% of the remuneration for work carried out under the rehabilitation program. If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program exceeds 100% of the gross basic monthly salary received from the participant's employer at the beginning of the elimination period, monthly rehabilitation benefits are reduced by the excess amount. The benefits end after the expiry of a 24-month period following the beginning of the program, an interruption of the program, or the withdrawal of the Insurer's approval of the rehabilitation program.

5. Exclusions, limitations and reduction of coverage

No benefit is payable in the following cases:

a) If the participant's total disability occurs due to any of the following causes:

- War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
- Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

- Any condition occurring while the participant is on active duty with the armed forces of any country.
- Alcoholism or drug addiction, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care as a part of a detoxification treatment or rehabilitation in an establishment, agency or institution specialized for such purposes.
- Absence from work in order to undergo plastic surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.

b) For a period of total disability corresponding to one of the following periods:
   - A period of maternity leave taken in compliance with a provincial or federal statute or maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.
   - A period during which the participant is receiving maternity benefits provided for under the *Employment Insurance Act* or the Quebec *Parental Insurance Act*.

c) For any disability period during which the participant is not under the care of a physician. In the event of a disability due to a mental illness, the disabled participant must be under the care of a specialist in psychiatry

d) No benefit is payable for any period during which the participant engages in any gainful occupation, except within a rehabilitation program.

e) No benefit is payable if the participant is dismissed for reasons not related to disability and the disability does not prevent the participant from engaging in any gainful activity for which he or she is reasonably suited due to education, training or experience.

f) No benefit is payable after the participant's date of retirement.

g) No benefit is payable for any period during which the participant refuses to take part in a rehabilitation program or perform rehabilitative work

h) For contractual employees, no benefit is payable after the planned end date of employment.

6. Pregnancy-related Supplemental Unemployment Benefits or Quebec Parental Insurance Plan benefits

When a participant who is otherwise eligible for benefits is subject to exclusion b) in relation to maternity leave mentioned above and is receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, La Capitale will pay a supplement calculated to cover the difference between the amount of pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits payable and the amount to which the participant would have been entitled if exclusion b) in relation to maternity leave was not applicable.

7. Pre-existing conditions

If the participant's disability results from a pre-existing condition, the participant is not entitled to disability insurance benefits or waiver of premiums under this coverage.

A pre-existing condition is defined as an accident suffered or an illness that began before the effective date of the participant's disability insurance and for which, during the three-month period immediately preceding this date:

- The participant consulted a healthcare professional or
- The participant received treatments or medical care or
- The participant was prescribed drugs that can only be obtained on prescription by a healthcare professional legally authorized to do so.

This provision applies to any participant who is a new employee of the Policyholder and who was not covered under a disability insurance benefit that ended within the 30 days immediately preceding the date of the first day of work for his or her new employer.

However, this provision no longer applies when the participant has been effectively and continuously at work, according to his or her regular schedule, for a 12-month period following the effective date of the participant's insurance under this disability benefit.

GENERAL INFORMATION

1. Definitions

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. Any bodily injury sustained following an attempted suicide is not considered to be an accident.

ACTIVE EMPLOYEE

An employee who performs his or her work as provided for in the contract of employment binding that person to the employer.

AGE

The age of an insured, at his or her last birthday, at the time of calculation, or at the time an event provided for under the contract occurs.

ASSISTOR

CanAssistance or any other assistance company designated by the Insurer.

BASIC PRESCRIPTION DRUG INSURANCE PLAN (BPDIP)

The Basic Prescription Drug Insurance Plan administered by the *Régie de l'assurance maladie du Québec*.

BUSINESS PARTNER

A person with whom the insured is associated for business purposes as part of a company comprised of four shareholders or fewer, or a profit-making corporation comprised of four partners or fewer.

CLOSE RELATIVE

The insured's spouse, child, father, mother, father-in-law, mother-in-law, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

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.

DEDUCTIBLE

The portion of eligible expenses for which the insured is not entitled to any reimbursement from the Insurer.

DENTIST

A person who is a member of the *Ordre des dentistes du Québec* or a professional association recognized by the legislative authority having jurisdiction in the place where dental services are provided.

DEPENDENT CHILD

The term "dependent child" means an unmarried child of the participant or the participant's spouse over whom they exercise parental authority, or would do so if the child were a minor, and for whom they provide financial support . The child must also:

i) Not be over the age indicated in the *Schedule of Insurance* if not a full-time student or

ii) Not be over the age indicated in the *Schedule of Insurance* if enrolled as a full-time student at a recognized educational institution. In such case, the participant must provide the Insurer with proof of the dependent child's enrolment at the beginning of each school year or

iii) Have reached the age of majority and be totally disabled or have a functional impairment that is recognized by the appropriate authorities in the participant's province of residence. The disability or the impairment must have occurred while the child met one of the above criteria and have persisted since that date. In addition, the dependent child must reside with the participant or the latter's spouse, who would exercise parental authority over the child or who would be the child's legal guardian if a minor. Evidence of the disability or impairment may be required by the Insurer at any time.

The concept of parental authority over a person other than a child of the participant or participant's spouse 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 public curator or public trustee.

DISABILITY PERIOD

Any uninterrupted period of total disability, or a series of successive periods of total disability due to the same cause or to connected causes separated by a period of full-time work of less than 15 days during the first 17 weeks of total disability or of less than six (6) months thereafter.

ELIMINATION PERIOD

A period that begins at the start of total disability, during which no disability benefit is payable. In the event of a hospitalization as the result of an illness, the elimination period is the same as for an accident.

EMPLOYEE

A person who resides in Canada and works for the employer on an active full-time basis, as indicated in the *Schedule of Insurance*.

EMPLOYER

The Policyholder of this contract or any employer whose employees or a category of whose employees are represented by the Policyholder of this contract.

HOSPITAL CENTRE

A hospital centre within the meaning of the *Act respecting health services and social services*, excluding self-financed private health facilities within the meaning of said Act. In the event of hospitalization outside Quebec, this definition also applies to any institution recognized and accredited as a hospital centre by the appropriate authorities under which the institution operates, except for care homes, homes for the aged or chronically or mentally ill, hospital centres for long-term care, nursing homes, convalescent homes, establishments that provide treatment for abuse of alcohol or drugs, sanatoriums, reception centres, thermal spas, dispensaries or other establishments or parts of establishments that aim to provide custodial care.

HOSPITALIZATION

The act of occupying a room in a hospital centre as an admitted inpatient, excluding any period during which the insured is only receiving services that could be dispensed by a residential and long-term care centre or rehabilitation centre, whether or not a place is available in such a centre.

HOST AT DESTINATION

The person at whose principal residence the insured is planning to stay by prior agreement.

ILLNESS

An organic or functional alteration considered in its evolution and as a definable entity that is diagnosed by a physician, including any complication resulting from pregnancy.

INSURED

A participant or one of a participant's insured dependents under this contract.

NET SALARY

Salary after deduction of Quebec Pension Plan contributions, Employment and Social Development Canada contributions, Quebec Parental Insurance Plan contributions and applicable provincial and federal government income taxes, in accordance with the declarations of exemption made to the employer.

NON-SMOKER

An insured who during the last 12 months has not used tobacco in any form. In the case of any misrepresentation by the insured, the insurance under this benefit is null and void and the liability of the Insurer is limited to refunding the premiums collected. A person who changes his or her smoking patterns must provide the Insurer with a written attestation to this effect. The insured must have ceased smoking for 12 months before the change may be put into effect.

PARTICIPANT

An eligible employee who is insured under this contract.

PARTICIPANT'S RETIREMENT DATE

The date on which an employee's retirement begins in accordance with the participant's retirement plan, in accordance with the collective agreement in force with the employer, or in accordance with the employer's current practice.

Participants who become disabled before age 65 will be considered to be retired as soon as they reach age 65. For a participant who becomes disabled at age 65 or older, the date of retirement is the day following expiry of the long-term disability insurance elimination period.

PHYSICIAN

A person who is a member of the *Ordre des médecins du Québec* and is authorized to provide medical services according to the *Medical Act* or any other law in effect in the place where services are provided.

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.

PREVIOUS CONTRACT

The group insurance contract(s) in force immediately prior to the effective date of this contract covering the employees and retirees of the employer and their dependents, if applicable.

REHABILITATION CENTRE

A rehabilitation centre or convalescent home designated as such that is legally authorized to provide care and treatment to individuals who are hospitalized, and which is required to ensure nursing and medical care can be provided at all times. Care homes, homes for the aged or chronically or mentally ill, rest homes or establishments that provide treatment for abuse of alcohol or drugs are not included.

REHABILITATION PROGRAM

A program approved in writing by the Insurer for a participant that consists of:

- A gainful activity on a full-time or part-time basis or
- A professional training course or employment provided for rehabilitation purposes.

REMISSION PERIOD

A period during which a participant who was disabled is no longer disabled.

RESIDENTIAL AND LONG-TERM CARE CENTRE

A residential and long-term care centre legally authorized to provide care and treatment to individuals who are hospitalized, and which must provide nursing and medical care on a 24-hour basis. Hospitals for short-term care legally designated as such, as well as convalescent homes, rehabilitation centres, care homes, homes for the aged or chronically ill, rest homes, sanatoriums and establishments that provide treatment for abuse of alcohol or drugs are excluded.

SALARY

The participant's gross regular pay, excluding amounts received from the employer that are not part of the participant's regular pay, such as bonuses, overtime pay, fees, accommodation and meal allowances, isolation pay, lump-sum payments and any other amounts payable from time to time.

SINGLE-PARENT

The expression "Single-Parent" refers to the coverage status held by participants with no spouse who insure their dependent children.

SPOUSE

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

i) Is married or civilly united to the participant or

ii) Has been cohabiting in a conjugal relationship with the participant 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 cohabiting in a conjugal relationship with the participant and had previously cohabited with the participant for an entire period of at least one (1) year.

Note that 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.

If the participant has one spouse who meets the definition in i) and another spouse who meets the definition in ii) or iii), the Insurer recognizes the person designated as the spouse in a written notice from the participant. The spouse must remain the same person for all insurance benefits under this contract.

TOTAL DISABILITY

During the period indicated in the *Schedule of Insurance*: A state of incapacity resulting from an illness or an accident which prevents the participant from carrying out the essential duties of his or her regular employment and requires continuous medical care.

Thereafter: A state of incapacity resulting from an illness or an accident which prevents the participant from carrying out any gainful employment for which he or she is reasonably qualified by education, training or experience.

Total disability is determined regardless of the existence or availability of such employment.

Participants who must hold a government permit or licence to perform the duties of their regular employment are not considered totally disabled solely because such permit or licence has been revoked or has not been renewed.

Total disability beginning more than 31 days following an accident is deemed to be resulting from illness.

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.

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 a registered charity, 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. No other type of trip is covered under this benefit, unless the Policyholder and the Insurer have agreed otherwise. Furthermore, the trip must entail the insured's absence from his or her 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.

2. Eligibility

Employees are eligible after having completed the eligibility waiting period stipulated in the *Schedule of Insurance*, provided that the employee is actively at work full-time on that date, on a permanent or contractual basis for at least one (1) year, for the minimum hours per week stipulated in the *Schedule of Insurance* and that no evidence of insurability is required.

3. Enrolment

ENROLMENT OF EMPLOYEES

Participation in all benefits is mandatory for any employee who satisfies the eligibility conditions. Participation must be confirmed in writing to the Insurer within a period of 90 days following the date on which the employee satisfies the eligibility conditions.

Any employee who submits an application for insurance after this deadline will be subject to evidence of insurability deemed satisfactory by the Insurer for all benefits, with the exception of:

- Health insurance if participation in this benefit is required by applicable legislation in the insured's province of residence and
- Dental care insurance.

PROVISIONS APPLICABLE TO INSUREDS AGE 65 OR OLDER

If the public prescription drug insurance plan of the insured's province of residence provides for the reimbursement of drugs for any insured aged 65 or over, this public plan then acts as the first payor for reimbursement of eligible drugs.

If the public plan offers to any insured aged 65 or older the option to remain covered for drugs under the present health insurance, participants may submit their request to this effect to the Insurer within 31 days following the date the participant or the spouse reaches age 65, according to the provisions of the *Schedule of Insurance* and pay any extra premium established by the Insurer. Furthermore, the insured must cancel his or her registration with the public prescription drug insurance plan.

Finally, an individual who agrees to become insured under the public prescription drug insurance plan may not subsequently choose to become insured under the present benefit for drugs eligible under this public plan.

EXTRA PREMIUM BASED ON AGE OF INSURED

The extra premium becomes payable when the participant or the latter's spouse reaches age 65, whichever is earlier. If the spouse reaches age 65 before the participant and chooses to become insured under the public prescription drug insurance plan, the participant may select an Individual or Single-Parent coverage status, if available, for health insurance. This change in coverage status is then irrevocable.

PARTICIPATION OF DEPENDENTS

Participants whose health insurance coverage status is other than Individual must enrol their dependents in health insurance and dependents' life insurance. Participants with one or more dependents must select a coverage status that corresponds to their family situation, based on the options available. They may also opt to obtain coverage for their dependents under other benefits.

Participants who do not have a spouse, as defined above, may select Single-Parent coverage if that status is available.

In all cases, participants must submit an application to the Insurer within 31 days following the date on which the dependent becomes eligible. This 31-day period also applies to any request for a change in coverage status submitted by a participant following one of the following events: the participant's marriage or civil union, birth or adoption of a first child or end of insurance of an exempted dependent.

If the enrolment or change request form is completed after the 31-day period, participants must present evidence of insurability, deemed satisfactory by the Insurer, for all of their dependents, for all benefits, with the exception of:

- Health insurance if participation in this benefit is required by applicable legislation in the insured's province of residence and
- Dental care insurance.

In addition, the Insurer reserves the right to refuse to insure a family member following examination of the evidence of insurability.

4. Participation in health insurance and dental care insurance plans

Participation in the above plans is mandatory for all eligible individuals, unless taking advantage of the exemption right.

Participants must choose one (1) of the following three (3):

Option A

This plan has a minimum participation requirement of 24 months.

Option B

This plan has a minimum participation requirement of 24 months.

Option C

This plan has a minimum participation requirement of 48 months.

The employer must offer its employees one (1) of the following two (2) options:

BASIC PLAN

This plan allows employees to choose between health insurance options A, B or C. The basic option does not include dental care insurance and short-term disability insurance. For all options, the minimum waiting periods apply.

COMPLETE PLAN

This plan has a minimum participation requirement of 48 months.

5. Change of option

Participants may change their option, either increasing or decreasing their coverage, as of April 1 following the expiry of the 24-month participation period for option A or B or the 48-month participation period for option C.

The participant can also change option following the end of total exemption, which is exemption from both health and dental care insurance benefits, before completing the minimum participation requirement applicable to the option under which the participant was covered or would have been covered before the beginning of exemption.

In case of partial exemption, which is exemption from either health insurance or dental care insurance, the participant cannot change option before completing the minimum participation requirement applicable to the option under which the participant was covered or would have been covered before the beginning of exemption.

A new organization joining the Regroupement may offer its employees the change of option privilege only as of April 1 of the odd year following the end of the minimum participation requirement applicable to the option initially chosen.

The employer may replace the basic plan by the complete insurance plan on the first day of April of any odd year following the end of a 24-month period after the date on which the plan comes into force. In this case, participants do not have to complete the minimum waiting period for the option in which they were enrolled before the date of the change.

The employer may also replace the complete plan by the basic insurance plan on the first day of April of any odd year following the end of a 48-month period after the date on which the complete plan comes into force. In this case, participants do not have to complete the minimum waiting period for the option in which they were enrolled before the date of the change.

6. Exemption right

HEALTH INSURANCE AND DENTAL CARE INSURANCE BENEFITS

Employees may, however, waive or terminate coverage benefit by providing written notice to the employer along with proof of coverage under another group insurance plan containing similar benefits.

Employees who have waived or terminated coverage under dental care insurance may obtain such coverage once again without having to present evidence of insurability by demonstrating to the Insurer's satisfaction that:

i) They were previously insured under this contract as a dependent or under any other group insurance contract offering similar benefits

ii) They are no longer able to remain insured under the other plan and

iii) They have submitted an application within 31 days following termination of their insurance.

7. Maintaining insurance during a temporary interruption of work

MATERNITY, PATERNITY, PARENTAL OR ADOPTION LEAVE

Participants who cease to be actively at work full time due to maternity, paternity, parental or adoption leave remain insured, with payment of premiums, under the health insurance benefit.

Such participants may also remain insured under all other benefits, provided they submit a request in writing to the Insurer within 31 days following the start date of the leave and continue to pay the required premiums, excluding the employer's share, which remains payable by the employer. However, insurance coverage may not be maintained in force later than the maximum period indicated in the *Schedule of Insurance*. In certain situations, governing legislation may take precedence over this clause, requiring the employer to pay its share of the premium and providing for an extension of the maximum period.

If disability insurance coverage is maintained in force, the elimination period, for a disability that begins during a period in which the participant is not receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, begins on the day the participant returns to active full-time work, and payment of disability benefits, if applicable, only begins upon expiration of the elimination period.

If the Policyholder does not maintain coverage in force, it is reinstated on the date the participant returns to active full-time work.

AUTHORIZED UNPAID ABSENCE OR TEMPORARY LAYOFF

Participants who cease to be actively at work full time due to an authorized unpaid leave of absence or a temporary layoff remain insured, with payment of premiums, under the health insurance benefit.

Such participants may also remain insured under all other benefits, provided they submit a request in writing to the Insurer within 31 days following the start of the leave and continue to pay the required premiums, including the employer's share, except in cases where the *Act respecting labour standards* requires the employer to pay its share of the premium. However, insurance coverage may not be maintained in force later than the maximum period indicated in the *Schedule of Insurance*.

If disability insurance coverage is maintained in force, the elimination period for a disability that begins during the above-mentioned period begins as of the planned date of return to work, and payment of disability benefits, if applicable, only begins upon expiry of the elimination period. In the event that disability insurance coverage is not maintained in force, such coverage is reinstated once the participant returns to active full-time work.

Temporary layoff is defined as a leave of absence of a fixed length, during which the participant is still considered an employee by the employer.

DISMISSAL OR DISPUTED SUSPENSION

When a participant is dismissed or suspended and disputes the dismissal or suspension by means of a grievance or resorting to arbitration under the *Labour Code* or any similar legislation, including the *Act respecting labour standards*, the participant is considered to have remained insured without interruption during the period in question if the decision rendered in arbitration or by the competent court reinstates the participant's rights and obligations as an employee. Any unpaid premiums are payable within 31 days following the date of the final decision rendered by the arbitrator or court.

STRIKE OR LOCKOUT

In the event of a strike or a lockout, health insurance coverage is maintained in force, with payment of premiums, for a minimum period of 30 days. Thereafter, health insurance coverage may be maintained in force by paying the required premiums. Coverage under all other benefits may be maintained in force by paying the required premiums, provided health insurance coverage is maintained in force. However, coverage may only be maintained beyond the 30-day period if there is an agreement between the Policyholder and the Insurer.

In the event that coverage is not maintained in force by the Policyholder, such coverage is automatically reinstated once the participant returns to work.

8. Conversion privilege

Conversion privilege applicable to participant's life insurance, dependents' life insurance and participant's and spouse's optional life insurance.

TERMINATION OF MEMBERSHIP IN THE GROUP

Participants whose membership in the group of insureds terminates before age 65 and who hold an amount of life insurance of at least $10,000 are entitled to convert their life insurance in whole or in part or, if applicable, the life insurance for their dependents, to an individual life insurance policy without having to provide evidence of insurability for themselves or their dependents.

The amount of insurance on the participant's life that may be converted must be at least $10,000 and may not exceed the amount of all the life insurance coverage that the participant held under the contract on the conversion date or $400,000, whichever is lower.

In addition, each dependent who has at least $5,000 of life insurance coverage under this contract may convert a minimum of $5,000, without exceeding the amount of insurance on his or her life on the conversion date or $400,000.

To exercise this conversion option, participants must apply in writing to the Insurer within 31 days following the date on which their membership in the group of insureds terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, without however exceeding the above-mentioned 31-day period. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

EXPIRY OF THE CONTRACT

Participants who have been insured for a minimum of five (5) years and who have at least $10,000 of life insurance coverage are entitled to convert their life insurance coverage, in whole or in part, to an individual life insurance policy within 31 days following the expiry of this contract if it is not replaced or the replacement contract provides for a lesser amount of insurance.

The amount of insurance that may be converted must be at least $10,000 or 25% of the amount of the participant's life insurance on the expiry of the contract, whichever amount is greater.

To exercise this conversion option, participants are not required to provide evidence of insurability but must apply in writing to the Insurer within 31 days following the expiry date of this contract. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

COVERAGE AVAILABLE UPON CONVERSION

Participants who exercise their conversion privilege according to the above-mentioned provisions may obtain an individual whole life or term life insurance policy, without accessory coverage, of the type issued at that time by the Insurer in such circumstances and in accordance with applicable insurance regulations and governing legislation.

The premiums applicable to the individual life insurance products when exercising the conversion privilege are determined in compliance with applicable insurance regulations and governing legislation.

PARTICIPANT'S HEALTH INSURANCE

Insureds who are no longer eligible for coverage under this benefit 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 the period indicated in the *Schedule of Insurance* following the termination date. Evidence of insurability is required for applications submitted after this period. 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.

9. Extension of coverage for dependents of a deceased participant

Following the death of a participant, life, health and dental care insurance coverage for the participant's dependents will be extended without payment of premiums until the earliest of the following dates:

- The last day of a period indicated in the *Schedule of Insurance*.
- The date on which the dependents' life insurance would have ended if the participant had been alive.
- The date on which this benefit or contract is terminated.

However, the additional premium for prescription drug expenses for dependents who reach age 65 during this period is assumed by the insured.

10. Waiver of premiums in the event of total disability

The waiver of premiums applies to coverage when this clause is included in the *Schedule of Insurance*.

PARTICIPANTS' BASIC LIFE INSURANCE, DEPENDENTS' LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AND OPTIONAL LIFE INSURANCE

If before reaching age 65, a participant becomes totally disabled while this coverage is in force, the Insurer will waive payment of any premiums payable with regard to the participant that fall due after the expiry of the long-term disability insurance elimination period, for as long as the total disability lasts. The waiver of premiums ends on the earliest of the following dates: the date on which total disability ends, the date of the participant's 65th birthday or the date of the participant's retirement.

SHORT-TERM DISABILITY INSURANCE

If before reaching age 65, a participant becomes totally disabled while this coverage is in force, the Insurer will waive payment of any premiums payable with regard to the participant that fall due after the expiry of the long-term disability insurance elimination period, for as long as the total disability lasts. The waiver of premiums ends on the earliest of the following dates: the date on which total disability ends, the date of the participant's 65th birthday, the date of the participant's retirement or the date on which this benefit or contract terminates.

LONG-TERM DISABILITY INSURANCE

If before reaching age 65, a participant becomes totally disabled while this coverage is in force, the Insurer will waive payment of any premiums payable with regard to the participant that fall due after the expiry of the long-term disability insurance elimination period, for as long as total disability lasts. The waiver of premiums ends on the earliest of the following dates: the date on which total disability ends, the date of the participant's 65th birthday or the date of the participant's retirement.

11. Beneficiary

Participants may designate a beneficiary or change an existing beneficiary designation by means of a written statement filed at the Head Office of the Insurer. The Insurer is not liable for the validity of any change of beneficiary. 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 has not designated a beneficiary in writing, the amount of insurance becomes a part of the participant's estate.

12. Termination of insurance

Insurance for any participant terminates on the earliest of the following dates:

Life insurance

- The date on which this contract or benefit terminates, subject to the provisions of the "Waiver of premiums in the event of total disability" section above.
- The date on which the participant's employment terminates for a reason other than retirement, subject to the provisions of the "Waiver of premiums in the event of total disability" and the "Conversion privilege" sections.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" and the "Conversion privilege" sections.
- The date on which the Insurer receives written notice from a participant to terminate his or her coverage under the optional life insurance benefit.
- The date of termination indicated in the *Schedule of Insurance* for the benefit in question.
- For a participant who becomes disabled before age 65: the date of the participant's 65th birthday.
- For a participant who becomes disabled at age 65 or older and has not returned to active full-time work: the date corresponding to the expiry of the long-term disability insurance elimination period.

Health insurance

– The date on which this benefit or contract terminates.

– The date on which the participant's employment terminates for a reason other than retirement, subject to the provisions of the "Conversion privilege" section.

– In the event of non-payment of premium, 30 days following the date on which written notice of termination is sent by the Insurer to the participant's last known address.

– The date of termination indicated in the *Schedule of Insurance*.

– In the event of disability, the date of the termination of employment, as set out in the collective agreement or working conditions applicable to the participant's group.

Dental care insurance

– The date on which this benefit or contract terminates.

- The date on which the participant's employment terminates for a reason other than retirement.

- The due date of any unpaid premium.

– The date of termination indicated in the *Schedule of Insurance*.

– In the event of disability, the date of the termination of employment, as set out in the collective agreement or working conditions applicable to the participant's group.

Short-term disability insurance

– The date on which the contract or benefit terminates, subject to the *Regulation respecting the application of the Act respecting insurance*.

– The date on which the participant's employment terminates subject to the provisions of the "Waiver of premiums in the event of total disability" section.

– The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section.

– The date of termination indicated in the *Schedule of Insurance.*

Long-term disability insurance

– The date on which the contract or benefit terminates, subject to the *Regulation respecting the application of the Act respecting insurance*.

– The date on which the participant's employment terminates subject to the provisions of the "Waiver of premiums in the event of total disability" section.

– The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section.

– The date of termination indicated in the *Schedule of Insurance*.

Insurance for dependents terminates on the earliest of the following dates:

Life insurance

- The date on which the participant's insurance terminates, subject to the provisions of the "Waiver of premiums in the event of total disability," the "Conversion privilege" and the "Extension of coverage for dependents of a deceased participant" sections.
- The date on which the person ceases to be considered a dependent.
- The due date of any unpaid premium for a dependent, subject to the provisions of the "Waiver of premiums in the event of total disability," the "Conversion privilege" and the "Extension of coverage for dependents of a deceased participant" sections.
- The date on which the Insurer receives written notice from a participant to terminate coverage for the spouse under the optional life insurance benefit.
- The date of termination indicated in the *Schedule of Insurance*.

Health insurance

- The date on which the participant's insurance terminates, subject to the provisions of the "Extension of coverage for dependents of a deceased participant" section.
- The date on which the person ceases to be considered a dependent.
- The date on which the participant changes from Family or Single-Parent coverage status to Individual coverage status.

Dental care insurance

- The date on which the participant's insurance terminates, subject to the provisions of the "Extension of coverage for dependents of a deceased participant" section.
- The date on which the person ceases to be considered a dependent.
- The date on which the participant changes from Family or Single-Parent coverage status to Individual coverage status.

CLAIMS

All claim forms are available from your employer's group plan administrator or the group policyholder. You can also download forms from our website at www.lacapitale.com.

Health insurance
Prescription drugs – direct electronic claims payment

When making prescription drug purchases, insureds present their service card to the pharmacist. La Capitale will automatically issue payment for the insured portion of prescription drug expenses. There is no need to fill out a claim form, and insureds only have to pay the uninsured portion of prescription drug expenses (including any applicable deductible).

Other expenses

Insureds must submit a duly completed, signed and dated claim form to La Capitale. It is important to follow the directions on the form and enclose original receipts and paid invoices for the expenses incurred. Insureds should keep copies for their own records as the originals will not be returned. In the event of hospitalization, insureds show their service card at the time of admission, and the hospital centre will then bill the Insurer directly for any expenses payable under the contract. All claims must be submitted to the Insurer no later than 12 months following the date expenses are incurred.

Dental care insurance – electronic claims payment

Insureds present their service card in the dentist's office. The system validates the card and confirms whether the dental treatment is covered as well as the percentage of reimbursement applicable. There is no need to fill out a claim form since the insured portion of treatment expenses is claimed directly by the dentist from the Insurer. Insureds pay only the uninsured portion of dental expenses (including any applicable deductible). If the dentist does not offer this service, insureds must pay the treatment expenses in full and submit a claim to the Insurer.

Direct deposit of health and dental care benefits

It is easy to take advantage of this handy service. Just fill out the Direct Deposit application form and send it to the Insurer. With Direct Deposit, when a claim is approved, benefits are deposited directly in the insured's account. The Insurer then sends a statement to the insured confirming the date the claim was processed and the amount that was paid.

Life insurance

The beneficiary must contact the Insurer to obtain all required claim forms and submit a claim for the insured amount.

Disability insurance

Benefits are payable to the participant after expiry of the elimination period. The claim form must be completed by the participant, the employer and the attending physician, then forwarded to La Capitale as soon as possible.

TRAVEL INSURANCE

IMPORTANT

If you plan to travel outside the province, we recommend that you notify the Claims Department at La Capitale Civil Service Insurer. That way, our agents can provide you with any additional information you may need to know about how your travel insurance coverage works.

La Capitale will reimburse the customary and reasonable expenses described in the travel insurance section, if incurred following an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the government hospitalization and health insurance plans of the province of residence.

For the insured to be considered as temporarily outside the province of residence, the trip must not exceed the period indicated in the *Schedule of Insurance*. The trip may however be extended beyond this period if the extension is due to an illness or accident that occurs during the said period and a return to the province of residence is impossible due to justifiable medical reasons.

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

To be covered under this benefit, insureds 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 or recurrence
- diagnosis of terminal phase
- chronicity likely to lead to deterioration or complications during the planned trip outside the province of residence

Insureds 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.

ELIGIBLE EXPENSES

1) HOSPITALIZATION, MEDICAL AND PARAMEDICAL EXPENSES:

   a) Expenses for hospitalization in a semi-private room (two beds) or private room (one bed), in excess of the amounts reimbursed or eligible for reimbursement under the government hospitalization and health insurance plans 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 amount 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 hospitalization and health insurance plans 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. 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 healthy, natural and vital 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.

2) EXPENSES FOR TRANSPORTATION:

   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 seven (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, provided 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, up to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

3) LIVING EXPENSES:

a) 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 eight (8) days.

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 hospitalization and health insurance plans 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 information 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, 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.

OBLIGATIONS OF THE INSURED

1) **NOTICE:** Insureds must notify the Assistor of any incident, accident or illness as soon as possible, but no later than five (5) days following the date of the event.

2) **RESTRICTION:** As soon as they are able to do so, and no later than five (5) days following the date of the event, 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.

3) **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.

4) **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. The insureds 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.

EXCLUSIONS AND REDUCTION OF TRAVEL INSURANCE COVERAGE

In addition to the exclusions and reductions of coverage which apply to the health insurance benefit, 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; required care means the treatment needed to stabilize the insured's medical condition.

c) If the insured fails to contact the Assistor as soon as possible 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 eight (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.

i) If the insured has consumed toxic quantities of alcohol, drugs or medication.

j) For repatriation or travel assistance services, when the loss occurs in a country that is at war, whether declared or undeclared, is known to be experiencing political instability or for which the Government of Canada has issued a warning that Canadians should not travel in that country, during a riot, 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.

COORDINATION OF BENEFITS

This insurance is a second payor plan. The Insurer reimburses the eligible expenses, subject to the exclusions and reductions of this contract, in excess of the benefits paid under any public or private individual or group plan. It is understood that the benefit coordination rules of the different plans are carried out in accordance with guidelines set by the Canadian Life and Health Insurance Association.

LA CAPITALE MAY, AT ANY TIME AND AT ITS SOLE DISCRETION, CHANGE THE ASSISTOR FOR THE PURPOSES OF THIS BENEFIT.

TRIP CANCELLATION INSURANCE

In accordance with the conditions below, the Insurer will reimburse 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 that, 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*.

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) 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 (1) year.

g) Quarantine of the insured or travel companion, provided that quarantine ends more than seven (7) days prior to the scheduled date of departure.

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

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

j) 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.

k) 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.

l) 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 three (3) hours prior to the time of departure, or at least two (2) hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by atmospheric conditions, mechanical problems (except for a private automobile), a traffic accident or an emergency road closure, each of the latter two causes requiring confirmation by a police report.

m) Atmospheric 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.

n) 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.

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 atmospheric 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 return is delayed by more than seven (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 hospital as an inpatient for more than 48 hours within the seven-day period.

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

3. Exclusions applicable to trip cancellation insurance

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

a) Any trip 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.

b) Any trip taken to visit a person who is ill or has suffered an accident, whereby the cancellation or interruption of the trip is due to a change in the medical condition or the death of such person.

c) Any trip to a country that is at war, whether declared or undeclared, known to be experiencing political instability or for which the Government of Canada has issued a warning that Canadians should not travel in that country, insofar as the expenses are related to the conflictual situation in the country and were incurred after the warning was issued, or by reason of active participation in a real or apprehended insurrection.

d) Active participation of the insured or travel companion in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft:

   – while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or

   – while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

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

f) Suicide or attempted suicide by the insured or travel companion, or voluntary self-inflicted injury or self-mutilation, whether or not the person is of sound mind.

g) Consumption of toxic quantities of alcohol, drugs or medication by the insured.

h) 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.

i) 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.

j) 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.

k) Any trips for purposes of hunting or fishing.

4. Notice of cancellation

In the event that a cause for cancellation occurs prior to departure, the trip must be cancelled within a maximum period of 48 hours, or if this period ends on a statutory holiday, by the next working day, and notice must be provided to the Insurer at the same time. The Insurer's liability is limited to the cancellation costs stipulated in the travel contract that are applicable 48 hours following the date of the cause for cancellation, or if a statutory holiday, on the next working day.

5. Coordination of benefits

Any benefits payable hereunder will be reduced by any amounts payable under another individual or group insurance plan. Also excluded from coverage are any expenses incurred that an insured would not have had to pay if not covered under this benefit.

6. Trip cancellation insurance claims

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

a) Unused travel tickets.

b) Official receipts for additional transportation expenses.

c) 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.

d) 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.

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

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

g) Written proof issued by the official organizer of a commercial activity confirming that the event was cancelled and the specific reasons why.

h) Any other report required by the Insurer in support of the insured's claim.

ANSWERS TO YOUR QUESTIONS

When and how can you contact La Capitale?

Call 1 800 463-4856 or 418 644-4200 Monday to Friday, from 8:30 a.m. to 5:00 p.m.

Be sure to have your service card handy when you call. It shows your contract number and identification number and having this information to hand helps us to provide you with the most efficient service possible.

> Moving?

Please contact us and tell us your new address as soon as possible. This is the best way to avoid any mailing delays.

> Do you have dependent children over age 21?

Remember that every semester, you must provide us with confirmation of full-time student status by completing and returning the section at the bottom of your claim form.

> Need a claim form?

Most claim forms are available to download from our website at www.lacapitale.com. You can also obtain forms from your employer's group plan administrator or the group Policyholder.

> Want to facilitate processing of your claim?

In all correspondence, please indicate your name, contract number, employer number as well as the identification number shown on your service card.

> Claiming expenses for services provided by healthcare professionals?

For healthcare professionals such as physiotherapists, psychologists or otherwise, if you are using a claim form, the professional must stamp or seal the form. The professional's signature and licence number must also be provided, along with the dates of treatments and the name of the patient.

La Capitale accepts personalized and computerized receipts from healthcare professionals, provided they contain the information specified above.

> Have any questions about your reimbursement cheque?

If you've received a lower reimbursement than you expected, remember that at the beginning of the year, you may have a deductible to cover or coinsurance to pay. You can see the breakdown of your reimbursement on your cheque stub or deposit confirmation.

Please be reminded that uncashed cheques expire after six (6) months.

La Capitale

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Toll free: 1 800 463-4856

lacapitale.com

TRAVEL INSURANCE

You can contact the Assistor at the following numbers:

In Canada and the United States: 1 800 363-9050
Elsewhere in the world (collect call): 514 985-2281

The Policyholder may at any time, upon agreement with La Capitale, make modifications to the insurance benefits with regard to the individuals eligible for insurance, the scope of coverage and the sharing of costs between classes of insureds. Any such modifications may then apply to all insureds, whether they are active, disabled or retired.

This document is provided for information purposes only and in no way modifies the terms and conditions of the contract.

Notes

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