Group insurance contract 009995

Administrative version on January 1, 2021

La Capitale
Insurance and
Financial Services

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GROUP INSURANCE PLAN

CONTRACT **009995**

ENTERED INTO BY

LA CAPITALE CIVIL SERVICE INSURER INC.

(the Insurer)

AND

THE FÉDÉRATION AUTONOME DE L'ENSEIGNEMENT

(the Policyholder)

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

The clauses and conditions contained in the following pages and in the financial agreement are an integral part of this contract, as if they appeared above the signatures.

Any modification to this contract or to the financial agreement must be accepted by the Insurer and the Policyholder and signed by the authorized representatives of both parties.

Effective date: This contract comes into force on January 1, 2018.

This contract is an updated version of the contract that went into force on September 13, 2006, the version updated on January 1, 2009 and the agreements and endorsements subsequently issued. It does not confer any new rights retroactively, and the contract provisions applicable to any event giving entitlement to benefits remain those that were effective on the date of the event.

Contract year: The period between the contract effective date and the renewal date that immediately follows, as well as any 12-month period between two renewal dates.

Renewal date: January 1, 2019 and January 1 of each subsequent year.

Effective time: All insurance comes into effect, is amended or terminates at 12:01 a.m. at the head office of the Insurer on the date when one of the events covered by the contract occurs.

Certain sections that do not apply to all insureds were withdrawn from this administrative version of the contract.

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009995 – Fédération autonome de l'enseignement

SECTION 1 – DEFINITIONS

For the interpretation of this contract, unless otherwise stipulated, the following terms mean:

1.1 **Accident**: Any bodily injury confirmed by a physician and directly resulting from a sudden and unforeseeable action of an external cause, and independently of any other cause. Any bodily injury sustained following an attempted suicide is not considered to be an accident.

1.2 **Commercial activity**: An assembly, conference, convention, exhibition, show or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legislation, regulations and policies of the region where it will be held. The commercial activity must be the only reason for the planned trip.

1.3 **Age**: The age of the person in question on the last birthday when calculated or on the day that an event covered by the contract occurs.

1.4 **Assistor**: CanAssistance or any other assistance services company designated by the Insurer.

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

1.6 **Insurer**: La Capitale Civil Service Insurer Inc.

1.7 **Hospital centre**: A hospital centre within the meaning of the *Act respecting health services and social services* (CQLR, c. S-4.2), excluding self-financed private health facilities within the meaning of this Act. In the case of a hospitalization outside Quebec, this definition applies to any institution recognized and accredited as a hospital centre by the appropriate competent authorities, with the exception of rest homes, thermal spas and other similar institutions.

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

1.9 **Previous contract**: The group insurance contract(s), in force immediately prior to the effective date of this contract, covering the employer's employees, retirees and their dependents.

1.10 **Collective agreement**: The collective agreement within the meaning of the *Labour Code* (CQLR c. C-27) that also designates the national agreement. By extension, this also means any regulation in lieu thereof.

1.11 **Retirement date**: The date on which an employee retires in accordance with his or her pension plan, the labour agreement in force with the employer or the employer's usual practice.

1.12 **Elimination period**: A period commencing at the beginning of a period of total disability, during which disability benefits are not payable.

1.13 **Dentist**: Any person who is a member of the *Ordre des dentistes du Québec* or another professional association recognized by legislative authority in the jurisdiction where the dentist practises.

1.14 **Employer**: The *Fédération autonome de l'enseignement* (FAE), its affiliated unions or those covered under a service agreement, a school service centre, a general and vocational college or any other institution accepted by the Policyholder whose personnel or a portion of whose personnel are covered by a collective labour agreement signed with a union that is affiliated with the FAE or has a service agreement with the latter.

1.15 **National agreement**: All stipulations negotiated and approved on the national level in accordance with the *Act respecting the process of negotiation of the collective agreements in the public and parapublic sectors* (CQLR c. R-8.2). By extension, this also means any regulation in lieu thereof.

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

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

1.18 **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.

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

1.20 **Total disability**:

1.20.1 **Plan A**

A state of incapacity, resulting from an illness or accident, which requires continuous medical care and which, during the first 48 months, prevents the participant from carrying out the regular duties of his or her employment or any comparable employment offered by the employer and, after 48 months, although not necessarily requiring continuous medical care, prevents the participant from carrying out any gainful occupation 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 or occupation.

1.20.2 **Plan B**

A state of incapacity, resulting from an illness or accident, which requires medical care and prevents the participant from carrying out the regular duties of his or her employment or any comparable employment with similar remuneration offered by the employer.

1.21 **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, a surgical procedure directly related to family planning or an absence due to an organ or bone marrow donation.

1.22 **Physician**: A person who is a member of the *Ordre des Médecins* and is authorized to provide medical services in accordance with the *Medical Act* (CQLR c. M-9) or any other legislation with similar provisions in the place where the services are provided.

1.23 **Non-smoker**: A person who meets the conditions established by the Insurer for this status at the time he or she signs the Status Statement form.

1.24 **Period of disability**: Any continuous period of disability, or a series of successive periods separated by fewer than 35 days[(1)] of active full-time work or availability for full-time work, unless the participant provides satisfactory proof that a subsequent period is caused by an illness or accident that is completely unrelated to the cause of the previous disability.

(1) Replace “35 days” by “8 days” if the continuous period of disability preceding the return to work is three calendar months or less, excluding the period between the end of the work year and the beginning of the subsequent work year and the annual vacation periods for adult education teachers and those doing professional training.

1.25 **Dependent**: The spouse or dependent child of a participant as defined below.

1.25.1 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 year, or for less than one 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 year.

Note that the status of spouse is forfeited by the occurrence of any of the following events:

- 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 a spouse meeting the definition in i) and another spouse meeting the definition in ii) or iii), the Insurer recognizes as the spouse the person designated by the participant as his or her spouse by written notice to the Insurer. The spouse must remain the same person for all the benefits under the contract.

1.25.2 Dependent child: The term “dependent child” designates any of the following individuals:

i) A person under age 18 for whom the participant or spouse exercises parental authority.

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

Furthermore, a dependent child on sabbatical leave from school may maintain the status of dependent child, provided the participant meets the following requirements:

- A request must be submitted in writing and approved by the Insurer before the start of the leave.
- The request must indicate the start date of the sabbatical leave.

Sabbatical leave is only approved once per lifetime for each dependent child.

The sabbatical leave may not exceed 12 months, subject to eligibility for *Régie de l'assurance maladie du Québec* coverage, and must end at the beginning of a school year or semester (September or January).

iii) A person who has reached the age of majority, who has no spouse and is living at the participant's home, for whom the participant or spouse would exercise parental authority if a minor, and who is afflicted with a total disability or functional impairment, as defined in applicable legislation, that occurred while the person met any of the conditions indicated above, and has remained totally and continuously disabled since that date.

The concept of parental authority for a person other than a child of the participant or the participant's spouse must be confirmed by a court judgment or by a valid will of the father or mother or by a statement made by them to such effect transmitted to the public curator.

1.26 **Participant**: An employee who is eligible for insurance and is insured under this contract.

1.27 **Insured**: A participant or one of a participant's dependents who is insured under this contract.

1.28 **Employee**: Any person covered under a national agreement or collective labour agreement signed by the Policyholder or by one of the unions affiliated with the Policyholder or that has a service agreement with the latter, and who is eligible for the insurance plan according to the eligibility criteria set out in the national or collective agreement.

1.29 **Employee actively at work**: Refers to employees who are performing their regular duties according to their contract of employment.

1.30 **Retiree**: A person who retired while considered an employee under this contract or a previous contract.

1.31 **Policyholder**: The *Fédération autonome de l'enseignement* (FAE).

1.32 **Evidence of insurability**: Evidence deemed satisfactory by the Insurer for determining if a participant or his or her dependents are eligible for insurance given their state of health and lifestyle habits.

1.33 **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, grandchild, half-brother, half-sister, step-father, step-mother, step-brother or step-sister.

1.34 **Rehabilitation program**: A program for the participant that is approved in writing by the Insurer and consists of either:

a) A gainful activity carried out by the disabled participant on a full- or part-time basis;

b) An occupational training course or work for rehabilitation purposes.

1.35 **Basic Prescription Drug Insurance Plan**: The Basic Prescription Drug Insurance Plan administered by the *Régie d'assurance maladie du Québec*.

1.36 **Annual salary**: Remuneration in legal tender calculated on an annual basis, in accordance with the applicable collective agreement, including regional disparity premiums and any retroactive pay, but excluding bonuses, overtime pay and severance pay. For teachers, this remuneration is based on the annual salary used to calculate benefits under the disability insurance plan provided under the national agreement.

For part-time employees, the salary is prorated according to the time worked in relation to the regular week of a full-time employee. However, for part-time teachers, the salary is prorated according to their teaching load in relation to the full-time individual teaching load.

In all cases, the annual salary used for premium contribution purposes is the salary defined in the above paragraphs while the annual salary used for establishing benefits is the salary defined in the above paragraphs, subject to a minimum of $14,400.

1.37 **Weekly salary**: 1/52 of the annual salary. However, for employees who receive their annual salary over a period of less than 12 months, the weekly salary is obtained by dividing the annual salary by the number of pay periods scheduled for paying their salary.

1.38 **Family coverage status**: The coverage status of participants who insure their spouse and dependent children or just their spouse.

1.39 **Individual coverage status**: The coverage status of participants who only insure themselves and not a spouse or dependent children.

1.40 **Single-Parent coverage status**: The coverage status of participants who do not have a spouse as defined in the contract and who insure their dependent children.

1.41 **Trip**: Under Trip Cancellation Insurance, a trip means a trip made for tourism or recreational purposes, a business trip or a commercial activity, entailing the insured's absence from home for a period of at least two consecutive nights and requiring travel of at least 400 kilometres (round trip) from the insured's place of residence. A cruise with a planned duration of at least two consecutive nights operated under the responsibility of an accredited firm is also considered to be a trip.

SECTION 2 – CONDITIONS OF INSURANCE

2.1 Eligibility

2.1.1 An employee is eligible for insurance beginning:

2.1.1.1 The effective date of this contract in the case of an employee insured under a previous contract, in accordance with the transfer provisions.

2.1.1.2 The employment date or the effective date of this contract, if later, for any employees who were not insured under a previous contract.

2.1.2 Part-time employees of the FAE or an affiliated union are eligible for the Short-Term Disability Insurance plan.

2.1.3 Employees are eligible for the Dental Care Insurance plan if they work for the employer and are a member of a union that opted for this plan at the employer's workplace.

2.1.4 A retiree who returns to work is eligible for insurance as of the employment date, in accordance with the terms set out in section 2.1.1.2.

2.1.5 Dependents of a participant are eligible for insurance either on the same date as the participant if such person is already a dependent, or on the date when such person becomes a dependent.

2.2 Participation in the Life Insurance plan

2.2.1 Participation in the Life Insurance Plan is mandatory for all employees at a basic amount of $10,000 and optional for any amount in excess. An application must be submitted in writing to the Insurer. However, the participant may exercise the right to opt out at the time of the initial application or within 90 days following the effective date of the participant's insurance by sending the appropriate form to the Insurer. If the participant exercises the right to opt out within 90 days following the effective date of his or her insurance, all premiums paid since that date are reimbursed.

Participation in the Dependents' Life Insurance plan is optional and is not subject to participation in the Participant's Life Insurance Plan.

2.2.2 When enrolling, employees must select Participant's Life Insurance, or exercise their right to opt out, and select one of the following benefits:

a) Dependents' Basic Life Insurance;

b) Spouse's Optional Life Insurance, subject to the spouse's participation in Dependents' Basic Life Insurance.

2.2.3 Change in coverage

2.2.3.1 Increase in coverage

The participant may increase coverage in the following ways:

a) Enrol in Participant’s Life Insurance, if he or she had previously exercised the right to opt out.

b) Increase the amount of life insurance.

c) Enrol in Dependents’ Basic Life Insurance.

d) Enrol in Spouse's Optional Life Insurance.

e) Increase the amount of Spouse’s Optional Life Insurance.

2.2.3.2 Decrease in coverage

The participant may decrease coverage in the following ways:

a) Terminate Participant's Life Insurance coverage by exercising the right to opt out within 90 days after the effective date of the insurance.

b) Reduce the amount of life insurance.

c) Terminate Dependents’ Basic Life Insurance.

d) Terminate Spouse’s Optional Life Insurance.

e) Reduce the amount of Spouse’s Optional Life Insurance.

2.3 **Participation in the Health Insurance plan**

2.3.1 Participation in one of the Health Insurance plans is mandatory for all employees and any dependents who are eligible for insurance. The application must be submitted in writing to the Insurer within 30 days following the date the employee becomes eligible.

Employees who submit their application after this time frame are assigned Individual coverage status under Health Insurance Plan 1 by default. Employees applying for Single-Parent or Family coverage status or an exemption from coverage are granted the requested coverage status under Health Insurance Plan 1 starting on the first day of the pay period following the date on which the Insurer receives the request.

The other Health Insurance plans are subject to evidence of insurability deemed satisfactory by the Insurer.

2.3.2 Employees must enrol in one of the following Health Insurance plans:

a) Health Insurance Plan 1;

b) Health Insurance Plan 2; the minimum participation requirement for this plan is 12 months, for participants and their dependents;

c) Health Insurance Plan 3; the minimum participation requirement for this plan is 24 months, for participants and their dependents.

2.3.3 No changes are made to coverage for participants upon reaching age 65. Participants remain covered for all benefits provided under their Health Insurance plan, including prescription drug insurance coverage, with no change in premiums.

However, according to RAMQ regulations, all individuals who reach age 65 are automatically registered for coverage under the public Basic Prescription Drug Insurance Plan and must contact the RAMQ to opt out to avoid paying the related premiums. Individuals who prefer to obtain prescription drug coverage with the RAMQ may be exempted from participating in the group insurance plan and choose to participate in the Insurer's individual plan for coverage of other health insurance benefits.

2.3.4 Participants with one or more dependents must request Family or Single-Parent coverage status, if the latter is available.

2.3.5 Exemption entitlement

Subject to prior written notice to the employer, individuals who are eligible for insurance may waive or terminate coverage under the Health Insurance plan by providing satisfactory proof to the Insurer of coverage under another group insurance plan or benefits plan with similar coverage. A request for exemption must be received by the employer within 30 days following the beginning of the insurance allowing for an exemption.

For individuals who are eligible for insurance and who submit their exemption request within this time frame, the exemption will apply retroactively to the effective date of the plan allowing for the exemption.

However, for individuals who are eligible for insurance but who submit their exemption request after this time frame, the exemption will take effect on the first day of the pay period following the date the Insurer receives the request.

Individuals participating in Health Insurance Plan 2 or 3 may be exempted from coverage even if the minimum participation period of 12 or 24 months has not been completed.

Participants who are exempt from coverage under the Health Insurance plan must continue to participate in the Long-Term Disability Insurance plan and must also enrol in the Additional Life Insurance plan, subject to the right to opt out provided for in section 2.2.1.

2.3.6 Termination of exemption

Individuals who are exempt from the Health Insurance plan and whose coverage under another group insurance plan ends may obtain or resume coverage under this Health Insurance plan subject to the following:

a) The request to terminate the exemption is received by the Insurer within 30 days following termination of insurance under the plan allowing for the exemption:

   Participants may select one of the three Health Insurance plans with the coverage status of their choice, i.e. Individual, Family or Single-Parent. Coverage comes into force on the date of termination of insurance under the plan allowing for the exemption.

b) The request to terminate the exemption is received by the Insurer more than 30 days following termination of insurance under the plan allowing for the exemption:

   Participants are assigned Health Insurance Plan 1 by default, which will take effect on the first day of the pay period following receipt by the Insurer of the request for the desired coverage status, i.e. Individual, Family or Single-Parent.

   If participants wish to enrol in Health Insurance Plans 2 or 3, they must provide, at their own expense, evidence of insurability deemed satisfactory by the Insurer. Coverage under these plans comes into force on the first day of the pay period following the date on which the Insurer approves the evidence of insurability.

2.3.7 Change of Health Insurance plan

Any change in coverage status or Health Insurance plan must be made according to the terms set out in section 2.7.1.2 b).

2.3.7.1 Increase in coverage status or Health Insurance plan

The participant may increase coverage in the following ways:

a) By changing from Individual to Single-Parent or Family coverage status;

b) By changing from Single-Parent to Family coverage status;

c) By changing from Health Insurance Plan 1 to Health Insurance Plan 2 or 3;

d) By changing from Health Insurance Plan 2 to Health Insurance Plan 3.

2.3.7.2 Decrease in coverage status or Health Insurance plan

The participant may decrease coverage in the following ways:

a) By changing from Family to Single-Parent or Individual coverage status;

b) By changing from Single-Parent to Individual coverage status;

c) By changing from Health Insurance Plan 3 to Health Insurance Plan 2 or 1;

d) By changing from Health Insurance Plan 2 to Health Insurance Plan 1.

However, participants must satisfy the minimum participation requirements of 12 months for Health Plan 2, or 24 months for Health Plan 3, before any decrease in Health Insurance plans may be granted.

2.4 Participation in the Dental Care Insurance plan

2.4.1 Participation in the Dental Care Insurance plan is mandatory for all eligible employees who work for the same employer and are members of the same union, provided the union has opted for this plan at the employer's workplace. The application must be submitted in writing to the Insurer within 30 days following the date the employee becomes eligible.

Employees who submit their application after this time frame are assigned Individual coverage status under the Dental Care Insurance plan. If this employee has requested Single-Parent or Family coverage status, the coverage status requested will be granted as of the first day of the pay period following approval of evidence of insurability by the Insurer. In the case of an exemption, the coverage status will be granted as of the first day of the pay period following the date the Insurer receives the request.

Insuring dependents is optional.

2.4.2 Exemption entitlement

Subject to prior written notice to the employer, individuals who are eligible for insurance may waive or terminate coverage under the Dental Care Insurance plan by declaring that they are insured under another group insurance plan or benefits plan with similar coverage. Individuals who are eligible for insurance who

waive or cease to participate in the Dental Care Insurance plan may obtain or resume coverage under this plan, without having to submit evidence of insurability, if they submit their request within 30 days following the end of their insurance and establish 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; and

ii) It is no longer possible to maintain this insurance.

2.4.3 Participants who wish to insure their dependents must complete an enrolment application. If this application is completed more than 30 days following the date on which the dependents become eligible, evidence of insurability for the dependents that is deemed satisfactory by the Insurer must be provided, at the participant's expense.

In addition, the Insurer may grant Family or Single-Parent coverage status that excludes a member of the family after examining the evidence of insurability.

2.4.4 The minimum participation requirement for the Dental Care Insurance plan is 36 months.

2.4.5 Change of Dental Care Insurance plan

Any change in coverage status must be made according to the terms set out in section 2.7.1.3 b).

2.4.5.1 Increase in coverage status

The participant may increase coverage in the following ways:

a) By changing from Individual to Single-Parent or Family coverage status;

b) By changing from Single-Parent to Family coverage status.

2.4.5.2 Decrease in coverage status

The participant may decrease coverage in the following ways:

a) By changing from Family to Single-Parent or Individual coverage status;

b) By changing from Single-Parent to Individual coverage status.

2.5 Participation in the Short-Term Disability Insurance plan

2.5.1 Participation in the Short-Term Disability Insurance plan is mandatory for employees who are eligible, provided that the union to which the employee belongs has opted for this plan.

The application must be submitted in writing to the Insurer within 30 days following the date on which the person becomes eligible. Employees who submit their application after this time frame must present evidence of insurability deemed satisfactory by the Insurer.

2.6 Participation in the Long-Term Disability Insurance plan

2.6.1 Participation in the Long-Term Disability Insurance plan is mandatory for all eligible employees, subject to the exemption entitlement.

The application must be submitted in writing to the Insurer within 30 days following the date on which the person becomes eligible. Employees who submit their application after this time frame must present evidence of insurability deemed satisfactory by the Insurer.

2.6.2 The Long-Term Disability Insurance plan in force is either Plan A or Plan B, as selected by the union to which the employee belongs, and the definition of total disability that applies is the one specified in section 1.20, in accordance with the plan selected by the union.

The union’s selection is irrevocable until the January 1 following a period of 36 months after the date the choice was made.

2.6.3 Waiver or exemption entitlement

Employees may waive or terminate their participation in the Long-Term Disability Insurance plan, provided they meet one of the following conditions:

- They participate exclusively in the Teachers’ Pension Plan (TPP), the Civil Service Superannuation Plan (CSSP) or the Pension Plan of Certain Teachers (PPCT).

- They participate in the Government and Public Employees Retirement Plan (RREGOP) and have accumulated 33 or more years of service.

- They are age 53 or over.

- They are a member of a professional order and are covered under an equivalent long-term disability insurance plan provided by the order.

- They have signed a retirement agreement (without the option of returning), provided there are two years or less between the date of waiver and the date of retirement.

Employees wishing to take advantage of the waiver or exemption entitlement must notify the Insurer in writing. They may not obtain coverage under the Long-Term Disability Insurance plan at a later date, regardless of whether evidence of insurability is submitted.

The waiver or exemption becomes effective on the first day of the pay period following the date on which the Insurer receives the request.

2.7 Effective date of insurance

2.7.1 Effective date of insurance for employees

2.7.1.1 Life Insurance plan

a) Initial application

Employees are initially insured under this plan according to the following:

Applications received less than 30 days after the eligibility date

Insured amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability, and coverage comes into force as of the eligibility date.

Insured amounts over $50,000 are subject to approval of evidence of insurability by the Insurer. Coverage comes into force on the first day of the pay period following the date on which the evidence of insurability is approved.

Applications received more than 30 days but less than 180 days after the eligibility date

Insured amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability, and coverage comes into force as of the first day of the pay period following the date on which the Insurer receives the application.

Insured amounts over $50,000 are subject to approval of evidence of insurability by the Insurer. Coverage comes into force on the first day of the pay period following the date on which the evidence of insurability is approved.

Applications received more than 180 days after the eligibility date

All life insurance amounts are subject to approval of evidence of insurability by the Insurer, unless the participant demonstrates to the Insurer's satisfaction that there were valid reasons preventing him or her from submitting the request within the specified time frame. Coverage comes into force on the first day of the pay period following the date on which the Insurer approves any required evidence of insurability.

However, for a newly hired employee signing an employment contract after the date on which he or she becomes eligible for insurance under this plan, the time frames referred to above are calculated as of the date the contract of employment is signed.

In all cases, insurance for an employee who is disabled on the effective date of the contract begins on his or her return-to-work date, if he or she is eligible. If not, the insurance begins on the date he or she becomes eligible.

b) Change request

Employees may request a change after one of the following events occurs:

- Marriage;

- Cohabitation for at least one year or less than one year if a child has been born of the union or if legal adoption procedures have been initiated;

- Birth or adoption of a child;

- Death of the spouse;

- Regular employment status is obtained.

Insurance then comes into force according to the following:

Requests for change received less than 30 days after any of the events specified above

Insured amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability, and coverage comes into force as of the date of the event.

Insured amounts over $50,000 are subject to approval of evidence of insurability by the Insurer. Coverage comes into force on the first day of the pay period following the date on which the evidence of insurability is approved.

Requests for change received more than 30 days but less than 180 days after any of the events specified above

Insured amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability, and coverage comes into force as of the first day of the pay period following the date on which the Insurer receives the application.

Insured amounts over $50,000 are subject to approval of evidence of insurability by the Insurer. Coverage comes into force on the first day of the pay period following the date on which the evidence of insurability is approved.

Requests for change received more than 180 days after any of the events specified above

All life insurance amounts are subject to approval of evidence of insurability by the Insurer, unless the participant demonstrates to the Insurer's satisfaction that there were valid reasons preventing him or her from submitting the request within the specified time frame. Coverage comes into force on the first day of the pay period following the date on which the evidence of insurability is approved.

2.7.1.2 Health Insurance plan

a) Initial application

Employees are insured under the selected plan on the effective date of the contract or on the date they become eligible, if that date is later. However, if evidence of insurability is required for Health Insurance Plans 2 or 3, the insurance comes into effect on the first day of the pay period following the date the evidence of insurability is approved.

b) Change request

Employees may request a change after one of the following events occurs:

- Marriage;
- Cohabitation for at least one year or less than one year if a child has been born of the union or if legal adoption procedures have been initiated;

- Birth or adoption of a child;

- Death of the spouse;

- Regular employment status is obtained;

- Termination of insurance coverage for a spouse or dependent child that results in a change to the coverage status.

Requests for an increase in insurance must be submitted to the Insurer within 30 days after the date of the event that supports the request, and insurance will be effective as of the date of the event.

If the request is submitted more than 30 days after the event or if such an event does not occur, insurance is effective as of the first day of the pay period following receipt of the request or approval of evidence by the Insurer, when required.

All coverage reduction requests take effect on the first day of the pay period following the date on which the Insurer receives the request.

2.7.1.3 **Dental Care Insurance plan**

a) Initial application

Employees are insured under the Dental Care Insurance plan on the effective date of the contract or on the date they become eligible, if that date is later.

b) Change request

Employees may request a change after one of the following events occurs:

- Marriage;

- Cohabitation for at least one year or less than one year if a child has been born of the union or if legal adoption procedures have been initiated;

- Birth or adoption of a child;

- Death of the spouse;

- Regular employment status is obtained;

- Termination of insurance coverage for a spouse or dependent child that results in a change to the coverage status.

Requests for a change of coverage status must be submitted to the Insurer within 30 days after the event that supports the request, and the new coverage status will be effective as of the date of the event. If the change request is submitted more than 30 days after the event, the new status is effective as of the first day of the pay period following receipt of the request or approval of evidence by the Insurer, when required.

All coverage status reduction requests take effect on the first day of the pay period following the date on which the Insurer receives the request.

2.7.1.4 **Short-Term Disability Insurance plan**

Employees are insured under the Short-Term Disability Insurance plan on the effective date of the contract or on the date they become eligible, if that date is later.

However, insurance for an employee who is disabled on the effective date of the contract begins on his or her return-to-work date, if he or she is eligible. If not, the insurance begins on the date he or she becomes eligible.

2.7.1.5 **Long-Term Disability Insurance plan**

Employees are insured under the Long Term Disability Insurance plan on the effective date of the contract or on the date they become eligible, if that date is later.

However, insurance for an employee who is disabled on the effective date of the contract begins on his or her return-to-work date, if he or she is eligible. If not, the insurance begins on the date he or she becomes eligible.

2.7.2 Dependents

Under all plans for which they are eligible, insurance for dependents begins on the latest of the following dates:

- The date they become eligible;
- The date the employee completes the enrolment application or change request for his or her dependents;
- The date of acceptance by the Insurer of evidence of insurability, if applicable.

Under no circumstances can insurance for dependents become effective before the employee's insurance.

2.8 Transfer provisions

2.8.1 For participants insured alone or with dependents under a previous contract, the Insurer guarantees continuity between this contract and the previous contract in compliance with any applicable act or regulation respecting insurance, to ensure that participants do not sustain any harm due to a change in contract, regardless of whether they are actively at work.

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

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

2.8.2 The Insurer settles all payable benefits as of the effective date of this contract, whether under the provisions of this contract or a previous contract, except in the case of benefits under a previous contract where the previous insurer agrees to pay directly. The Insurer is automatically subrogated to participants' rights with regard to the previous insurer for all benefits that it pays and to which participants are entitled, for themselves or for their dependents, under the previous contract.

2.8.3 For an employee who is disabled on the effective date of the contract who is exempt from paying premiums under the previous contract, coverage under the Life and Disability Insurance plans begins on the date of his or her return to work.

The effective date of insurance for an employee who is disabled who is not yet exempt from paying premiums under the Life and Disability Insurance plans is established in accordance with the provisions applicable in the event of a change of insurers.

2.9 Renewal of employment contracts (school service centers only)

When an individual signs a new employment contract for a position eligible for group insurance coverage, the effective date of this new contract determines the start date of insurance and payment of premiums.

2.9.1 New employment contract that comes into force during the first three pay periods of the school year

Insurance is retroactive to the start date of the school year, and premiums are deducted as of that same date. Individuals then participate in the plans in which they participated at the end of the previous school year. They are not considered to be new employees for the purposes of eligibility for the group insurance plan. Individuals who were not participating in the Life Insurance plan at the end of the previous school year and who now wish to do so must submit evidence of insurability to the Insurer. Insurance comes into force on the first day of the pay period following the date on which the Insurer approves the evidence of insurability.

2.9.2 New employment contract that comes into force after the first three pay periods of the school year, but within the 60-day period for maintaining coverage

Individuals who do not return to employment in a position eligible for group insurance coverage within the first three pay periods of the school year must choose, for a 60-day period, one of the following two options described in 2.10.5 The collection of premiums upon an individual's return to work will depend on the choice made.

a) Individuals maintaining all plans previously held

Collection of premiums will begin only at the end of the 60-day period.

b) Individuals maintaining coverage under Health Insurance Plan 1 only

Collection of premiums for all plans held at the end of the previous school year will begin on the individual's return to work, and the Insurer will reimburse the premiums already paid for Health Insurance Plan 1, i.e. the premium paid for the period from the return-to-work date until the end of the 60-day period. They are not considered to be new employees for the purposes of eligibility for the group insurance plan. Individuals who were not participating in the Life Insurance plan at the end of the previous school year and who now wish to do so must submit evidence of insurability to the Insurer. Insurance comes into force on the first day of the pay period following the date on which the Insurer approves the evidence of insurability.

2.9.3 New employment contract that comes into force after the 60-day period for maintaining coverage

Individuals are considered to be new employees for the purposes of eligibility for the group insurance plan. Plans held at the end of the previous year are not automatically granted. Individuals may, once again, select the Health Insurance plan of their choice (Health 1, 2 or 3) and choose whether or not to participate in the Life Insurance plan. The terms of this contract regarding new employees apply.

However, individuals who maintained their participation in the Life Insurance plan during the 60-day period and whose new employment contract comes into force within 31 days following the end of the 60-day period will not have to provide evidence of insurability to maintain any amount of life insurance exceeding $50,000.

2.10 Maintaining insurance during a temporary interruption of work

2.10.1 Leave without pay

Participants who cease to be actively at work full time due to an authorized unpaid leave of absence must choose one of the following two options:

2.10.1.1 Maintain participation in Health Insurance Plan 1 only. In this case, the participant's other plans are reinstated once he or she returns to active work.

2.10.1.2 Maintain participation in all plans held. In this case, the participant must submit a written request to the Insurer within 30 days following the start of the leave and pay the total premium, including the employer's share unless the *Act respecting labour standards* (CQLR c. N-1.1) requires the employer to pay ~~its pay~~ its share of the premium.

In the event the Disability Insurance plans are maintained in force, the elimination period for a disability that occurs during this period begins on the scheduled return-to-work date, and payment of disability benefits does not begin until the end of the elimination period.

2.10.2 Partial leave without pay or phased retirement

In the event of partial leave without pay or phased retirement, participants must maintain participation in all plans held.

a) For the Long-Term Disability Insurance plan:

The premium payable is determined based on the full salary the participant would receive if not benefiting from reduced duties. If a disability occurs during this period, the amount of benefits payable is determined based on the salary the participant would be receiving at the end of the 104th week of total disability, if not benefiting from reduced duties.

b) For the Short-Term Disability Insurance plan

The premium payable is determined based on the salary actually received by the participant. If a disability occurs during this period, the benefit amount is determined based on the salary actually received by the participant. However, the premium and the payable benefit amount will be determined based on the full salary as of the termination date of the partial leave without pay or the phased retirement agreement.

2.10.3 Deferred salary leave

In the event of a deferred salary leave, participants must maintain participation in all plans held.

The premium payable is determined based on the full salary the participant would receive if not benefiting from deferred salary leave. If a disability occurs during this period, the amount of benefits payable is determined based on the salary the participant would be receiving at the end of the 104th week of total disability if not benefiting from deferred salary leave.

2.10.4 Preventive withdrawal from work or maternity leave

In the event of a preventive withdrawal from work or maternity leave with pay, participants must maintain participation in all plans held.

The premium payable is determined based on the salary applicable immediately prior to the preventive withdrawal from work or maternity leave.

Any disability that begins during a preventive withdrawal from work or maternity leave is considered to have started on the date of the participant's normal expected return to work or the end date of the preventive withdrawal from work.

2.10.5 Layoff or termination of contract

In the event of layoff or termination of contract, participants must choose one of the following two options:

2.10.5.1 Maintain participation in Health Insurance Plan 1 only, by paying the related premium. In this case, the participant's other coverage is reinstated once he or she returns to active work.

2.10.5.2 Maintain participation in all plans held by paying the total premium. In this case, the participant must submit a written request to the Insurer within 30 days following the start date of one of these events. However, the plans cannot be maintained in force for a period exceeding 60 days from the layoff or contract termination date. If the participant does not return to work after this 60-day period, his or her participation in the coverage terminates.

For any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, the 30-day period for submitting the written request referred to in this section begins on the August 31 immediately following the layoff or termination of employment contract.

In the event the Disability Insurance plans are maintained in force, the elimination period for a disability that occurs during this period begins on the scheduled return-to-work date, and payment of disability benefits does not begin until the end of the elimination period.

Employees whose employment contracts are renewed or who are offered a new contract within 60 days following the layoff or contract termination date are not considered to be new employees for the purposes of eligibility for the group insurance plan. Subject to section 2.9, the applicable plans on the layoff or contract termination date are reinstated as of the rehire date, and the premiums applicable to these plans are payable as of the pay period coinciding with or immediately following the rehire date.

For any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, all deadlines set out in the preceding paragraphs are calculated as of September 1.

Participants whose employment terminates and who maintain their coverage under the Life Insurance plan during the 60-day period may maintain this coverage for an additional period of up to two years. They must submit a written request within 30 days following the end of the 60-day period and continue to pay the required premiums.

If the participant maintains participation in Health Insurance Plan 1 only, any total disability occurring after the layoff or employment contract termination date will not be recognized.

2.10.6 Dismissal, non-rehiring, discharge or suspension

In the event of suspension, dismissal, non-rehiring or discharge contested by grievance, participants must choose one of the following two options:

2.10.6.1 Maintain participation in all plans held. However, in the event of dismissal, non-rehiring or discharge contested by grievance, coverage under the Disability Insurance plans cannot be maintained.

2.10.6.2 Maintain participation in Health Insurance Plan 1 only.

Participants who cannot continue paying the total premium through the employer can send it directly to the Insurer. To do this, participants must submit a written request to the Insurer within 90 days following the dismissal, discharge or suspension date.

Coverage terminates at the end of any grievance procedure or legal action taken by the parties involved.

2.10.7 Strike or lockout

In the event of a strike or lockout, coverage is maintained in force, provided that premiums continue to be paid further to an agreement with the Insurer.

The elimination period for a disability that begins during a strike or a lockout begins on the date the participant would normally have returned to work.

In the case of any period of total disability that begins before the start of such interruption of work while the participant was covered under this contract, benefits under the Disability Insurance plans continue to be payable according to the provisions of this plan during such an interruption of work.

2.11 Proof of disability

When a participant becomes disabled as defined herein, he or she must forward to the head office of the Insurer, a notice within 30 days of the beginning of the disability. He or she must also provide written proof of the illness or accident he or she sustained, and of his or her disability within 90 days of the beginning of the disability.

The mentioned deadlines are mandatory. However, if no more than 36 months have elapsed since the deadline for submission of written evidence, and the participant proves to the Insurer's satisfaction that it was impossible to submit the evidence earlier, the participant does not forfeit entitlement to the coverage stipulated herein.

Thereafter, proof of continuing disability must be submitted each time the Insurer so requests.

In the event of a dispute between the participant and the Insurer, the participant must provide supplementary proof, at the Insurer's expense. If the participant fails to provide such proof or refuses to undergo a medical examination within 31 days of a written request, the participant forfeits their entitlement to any privileges under this contract with regard to the pertinent disability from the end of the 31-day period to the date the Insurer receives the supplementary proof or the results of the requested medical examination.

Under no circumstance may the period for submitting proof of disability exceed 36 months after the termination date of the contract.

SECTION 3 – LIFE INSURANCE

3.1 Participant's Life Insurance plan

3.1.1 Insured amount

In the event of the participant's death while this plan is in force, the Insurer pays the beneficiary the following insured amount, in accordance with the participant's selection:

Available insured amounts		
$10,000	$100,000	$200,000
$25,000	$125,000	$225,000
$50,000	$150,000	$250,000
$75,000	$175,000	

The first $25,000 of coverage is considered to be Basic Life Insurance, while amounts in excess of $25,000 are considered to be Optional Life Insurance.

Subject to section 2.7.1.1, the amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability. Amounts over $50,000 are always subject to approval of evidence of insurability by the Insurer.

Participants who are totally disabled may not enrol in Life Insurance or Optional Life Insurance. Such participants may submit their application when they return to active work.

Amounts in excess of $25,000 are reduced by 50% on the date of the participant's 65th birthday.

3.1.2 Exclusions and reduction of the plan

For amounts in excess of $25,000 applied for more than 30 days after the eligibility date, this plan does not apply if the participant dies as a result of suicide or from the effects of any attempted suicide, whether or not the insured is of sound mind at the time, during the first 12 months following the effective date of the plan, its reinstatement or any increase in the insured amount. The plan or the increase, as applicable, is then null and void, and the Insurer's liability is limited to refunding the premiums collected.

For a newly hired employee signing a contract after the date on which he or she becomes eligible for insurance, the 30-day period applies as of the date the employment contract is signed.

3.2 Dependents' Life Insurance

3.2.1 Dependents' Basic Life Insurance plan

Provided this plan is in force, the amount payable on the death of a participant's insured dependent is the following:

3.2.1.1 Spouse: $10,000

3.2.1.2 Dependent child $5,000 (age 24 hours or older). In the case of Single-Parent coverage status, the insured amount payable for a dependent child is increased by an amount of $10,000 divided by the number of dependent children in the family.

These amounts are available without evidence of insurability.

3.2.2 Spouse's Optional Life Insurance:

3.2.2.1 Participants may also obtain 1 to 10 units of Optional Life Insurance for their spouse, each unit being equal to $10,000.

The amount of Spouse's Optional Life Insurance is reduced by 50% on the date of the participant's 65th birthday.

3.2.2.2 Participants may not submit an application for Spouse's Optional Life Insurance if their spouse is not insured under the Dependents' Basic Life Insurance plan. This coverage is also unavailable for participants who are totally disabled. Such participants may submit their application when they return to active work.

3.2.2.3 Coverage under this benefit is subject to approval by the Insurer of the required evidence of insurability, which must be provided by the person concerned at the time of enrolment and each time a new unit of Optional Life Insurance is added. Any misrepresentation or non-disclosure on the part of the person concerned at the time of enrolment may nullify this benefit for that person.

3.2.2.4 Exclusions and reduction of the plan (ICI)

This plan does not apply if the insured dies as a result of suicide or from the effects of any attempted suicide, whether or not the insured is of sound mind at the time, during the first 12 months following the effective date of the plan, its reinstatement or any increase in the insured amount. The plan or the increase, as applicable, is then null and void, and the Insurer’s liability is limited to refunding the premiums collected.

3.3 **Beneficiary**

Participants may designate one or more beneficiaries or change existing beneficiary designations 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, subject to any applicable legislation.

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 part of the participant’s estate.

3.4 **Payment of insurance**

The payable amount of insurance is the amount of insurance in force at the time of the death of the participant or insured dependent. In the event of the death of a participant's spouse or a dependent child, the insured amount is payable to the participant.

The claimant must provide the evidence required by the Insurer for attesting to the insured’s death and establishing the cause of death, the accuracy of the date of birth stated by the participant and the claimant’s rights. The payment is only made if the plan is in force on the date of death.

3.5 **Waiver of premiums in the event of total disability**

If, before retirement, a participant sustains a total disability, in accordance with the definition of disability applicable to the Long-Term Disability Insurance plan selected by the union to which the participant belongs, while this plan is in force, the Insurer will waive payment of any premiums payable by the participant that fall due after the expiry of a 52-week period, for as long as the total disability persists.

Waiver of premiums terminates on the earliest of the following dates:

a) The date on which the total disability ends;

b) The date of the participant's 65th birthday.

Any totally disabled participant who takes early retirement leave with pay remains eligible for the Life Insurance plan but is not entitled to a waiver of premiums during the period of early retirement leave.

3.6 Accelerated benefit payment in the event of illness in the terminal phase

Any participant or spouse whose life expectancy is no more than 12 months and who is benefiting from the "Waiver of premiums in the event of total disability" provision may obtain an accelerated payment of a portion of the insured amount by submitting a written request to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent, if the latter is designated as irrevocable.

The amount payable under this provision is limited to 50% of the total amount of the participant's or spouse's Basic and Optional Life Insurance, without exceeding $50,000.

The amounts of Life Insurance used to calculate the accelerated benefit exclude 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 death of the participant or the spouse, 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 5- to 10-year Government of Canada bonds, as posted in the monthly review of the Bank of Canada (V80691330 series) as at the preceding December 31, rounded up by ¼ of 1%.

The Insurer assumes no responsibility for the tax treatment of any accelerated benefit paid. Furthermore, the conditions set out in this section cease to apply upon termination of the contract, even for participants who have been granted a waiver of premiums.

3.7 Termination of insurance

3.7.1 The Life Insurance plan for insureds terminates on the earliest of the following dates:

3.7.1.1 The date on which this plan or this contract terminates, subject to section 3.5 "Waiver of premiums in the event of total disability".

3.7.1.2 The date on which the participant ceases to be an eligible employee for a reason other than retirement, subject to sections 3.5 “Waiver of premiums in the event of total disability” and 3.8 “Conversion privilege applicable to the Participant's and the Dependents’ Life Insurance plans”. However, for any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, coverage ends at midnight (24:00) on August 31 of the same year.

3.7.1.3 The date on which the provisions of the waiver of premiums end, even if the participant is still disabled.

3.7.1.4 The date on which the union to which the participant belongs ceases to participate in this plan.

3.7.1.5 The date corresponding to the end of the last period for which premiums were paid for employees who benefited from the provisions of section 2.10 and who stopped paying premiums before the end of the work interruption.

3.7.1.6 The due date of any unpaid premium, subject to sections 3.5 “Waiver of premiums in the event of total disability” and 3.8 “Conversion privilege applicable to the Participant's and the Dependents’ Life Insurance plans”. However, when payment of premiums is late for all participants of the same category, for the same employer, the Insurer agrees to send six month’s written notice to the Policyholder before applying this provision.

3.7.1.7 The date on which the Insurer receives written notice from a participant to terminate participation in this plan or the date of termination indicated in such notice, whichever is later.

3.7.1.8 The participant’s retirement date. However, for any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, coverage ends at midnight (24:00) on August 31 of the same year.

3.7.1.9 The date on which a dependent ceases to be considered a dependent.

3.7.1.10 The date on which the Insurer receives written notice from a participant to terminate insurance for his or her dependents or the date of termination indicated in such notice, whichever is later.

3.7.1.11 The effective date of the participant’s Basic Life Insurance if he or she exercises the right to opt out within 90 days following the effective date.

3.8 Conversion privilege applicable to the Participant's and the Dependents' Life Insurance plans

3.8.1 Termination of membership in the group

Participants whose membership in the group of insured persons 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 lesser amount of all the life insurance coverage that the participant held under the contract on the conversion date or $400,000.

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 insured persons 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.

3.8.2 Expiry of the contract

Participants who have been insured for a minimum of five 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.

3.8.3 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 any applicable act or regulation respecting insurance.

SECTION 4 – HEALTH INSURANCE

The eligible expenses described below 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.

When a participant or any dependents incur expenses covered by the selected Health Insurance plan, the Insurer reimburses the expenses in accordance with the conditions mentioned below. The **Schedule of Insurance** described in section 4.1 indicates the expenses included under Health 1, 2 or 3 and the following sections describe the covered expenses.

4.1 Schedule of Insurance

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Deductible	Yes	No	No	N/A
Prescription drugs Coinsurance *Direct Automated Payment card*	80% This coinsurance applies up to the maximum annual contribution determined by the BPDIP and increases to 100% for any expenses in excess * Tier indexed annually to that of the RAMQ	80% This coinsurance applies up to the maximum annual contribution determined by the BPDIP and increases to 100% for any expenses in excess * Tier indexed annually to that of the RAMQ	80% This coinsurance applies up to the maximum annual contribution determined by the BPDIP and increases to 100% for any expenses in excess * Tier indexed annually to that of the RAMQ	Yes
Generic substitution	Included	Included	Included	
Travel Insurance	100% $5,000,000 / insured / trip	100% $5,000,000 / insured / trip	100% $5,000,000 / insured / trip	N/A
Trip cancellation insurance	100% $5,000 /	100% $5,000 /	100% $5,000 /	N/A

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
	insured / trip	insured / trip	insured / trip	
Ambulance	80%	80%	80%	No
Transportation by air of a non-ambulatory patient	80%	80%	80%	Yes
Hospitalization expenses in Canada	100% Semi-private room	100% Semi-private room	100% Semi-private room	No
Residential and long-term care centre	100% Semi-private room Maximum 180 days / calendar year / insured	100% Semi-private room Maximum 180 days / calendar year / insured	100% Semi-private room Maximum 180 days / calendar year / insured	No
Rehabilitation centre	100% Semi-private room Maximum 180 days / calendar year / insured	100% Semi-private room Maximum 180 days / calendar year / insured	100% Semi-private room Maximum 180 days / calendar year / insured	No
Accidental dismemberment	N/A	Yes $25,000 or $50,000 according to the loss	Yes $25,000 or $50,000 according to the loss	N/A
Dental treatment following accident	N/A	80%	80%	No
Wheelchair or hospital bed	N/A	80%	80%	Yes
Respirator and oxygen	N/A	80%	80%	Yes
Therapeutic devices	N/A	80%	80%	Yes

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Artificial limbs and external prostheses	N/A	80%	80%	No
Hair prostheses (wigs)	N/A	80% Maximum lifetime reimbursement of $300 / insured	80% Maximum lifetime reimbursement of $300 / insured	Yes
Breast prosthesis	N/A	80% In excess of amount paid by RAMQ	80% In excess of amount paid by RAMQ	Yes
Orthopedic appliances	N/A	80%	80%	Yes
Foot orthoses	N/A	80%	80%	Yes
Orthopedic shoes	N/A	80%	80%	Yes
Speech therapist, occupational therapist or audiologist	N/A	80%	80%	No
Support stockings	N/A	80% 3 pairs / insured / calendar year	80% 3 pairs / insured / calendar year	Yes
Blood glucose monitor	N/A	80% Maximum reimbursement of $240 / 36 consecutive months / insured	80% Maximum reimbursement of $400 / 36 consecutive months / insured	Yes
Transcutaneous electrical nerve stimulator	N/A	80% Maximum reimbursement of $800 / 60 consecutive months / insured	80% Maximum reimbursement of $800 / 60 consecutive months / insured	Yes

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Cosmetic surgery following an accident	N/A	N/A	80% Maximum reimbursement of $5,000 / insured / accident	Yes
Hearing aid	N/A	80% Maximum reimbursement of $560 / insured / 48 months, including fees of a hearing aid specialist	80% Maximum reimbursement of $800 / insured / 48 months, including fees of a hearing aid specialist	No
Ultrasound examination	N/A	80% Maximum reimbursement of $300 / calendar year / insured	80% Maximum reimbursement of $300 / calendar year / insured	Yes
X-rays and laboratory analyses	N/A	80%	80%	Yes
Electro-cardiograms, ultrasounds other than echographies, radium and X-ray tests	N/A	80%	80%	Yes
Magnetic resonance imaging	N/A	80% Maximum reimbursement of $500 / insured / calendar year	80% Maximum reimbursement of $600 / insured / calendar year	Yes
Post-surgical bras	N/A	N/A	80% 2 bras / calendar year / insured	No

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Eye exams	N/A	80% Maximum reimbursement of $35 / 24 months / insured	80% Maximum reimbursement of $50 / 24 months / insured	No
Psychologist, psychoanalyst, psychiatrist, psychotherapist, psychoeducator, social worker and career counsellor	N/A	80% Maximum reimbursement of $64 / treatment, maximum 10 treatments / calendar year / insured, for all of these professionals	80% Maximum reimbursement of $64 / treatment, maximum 25 treatments / calendar year / insured, for all of these professionals	No
Acupuncturist	N/A	80% Maximum reimbursement of $32 / treatment, maximum 15 treatments / calendar year / insured	80% Maximum reimbursement of $44 / treatment, maximum 15 treatments / calendar year / insured	No
Chiropractor	N/A	80% Maximum reimbursement of $28 / treatment, maximum 20 treatments / calendar year / insured X-rays: Maximum reimbursement of $40	80% Maximum reimbursement of $36 / treatment, maximum 20 treatments / calendar year / insured X-rays: Maximum reimbursement of $40	No

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Podiatrist and chiropodist	N/A	80% Maximum reimbursement of $32 / treatment, maximum 15 treatments / calendar year / insured, for both of these professionals	80% Maximum reimbursement of $44 / treatment, maximum 15 treatments / calendar year / insured, for both of these professionals	No
Physiotherapist, physical rehabilitation therapist and sports therapist	N/A	80% Maximum reimbursement of $40 / treatment, maximum 15 treatments / calendar year / insured, for all of these professionals	80% Maximum reimbursement of $52 / treatment, maximum 15 treatments / calendar year / insured, for all of these professionals	No
Homeopath (including homeopathic medicines)	N/A	N/A	80% Maximum reimbursement of $36 / treatment, Maximum reimbursement of $720 / calendar year / insured	No

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Osteopath	N/A	N/A	80% Maximum reimbursement of $56 / treatment, maximum 15 treatments / calendar year / insured	No
Naturopath	N/A	N/A	80% Maximum reimbursement of $36 / treatment, maximum 20 treatments / calendar year / insured	No
Massage therapist, kinesitherapist and orthotherapist	N/A	N/A	80% Maximum reimbursement of $44 / treatment, maximum 15 treatments / calendar year / insured, for all of these professionals	No
Dietitian	N/A	N/A	80% Maximum reimbursement of $44 / treatment, maximum 15 treatments / calendar year / insured	No
Nursing care	80% Maximum reimbursement of $5,000 / insured / calendar year	80% Maximum reimbursement of $5,000 / insured / calendar year	80% Maximum reimbursement of $10,000 / insured / calendar year	Yes

INSURANCE PLAN				
BENEFITS	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**	**Medical prescription**
Homecare and domestic services	N/A	N/A	80% Maximum reimbursement of $400 / insured / calendar year	Yes
Detoxification	N/A	N/A	80% Eligible expenses of $80 / day Maximum of 30 days / insured / calendar year	Yes
Transportation and accommodation expenses in Quebec	N/A	N/A	80% Maximum reimbursement of $1,000 / insured / calendar year	Yes

4.2 Description of benefits

The eligible expenses under the Health Insurance plan selected by the participant 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.

The cost of services and supplies described below is reimbursed according to the coinsurance percentage set out in the Schedule of Insurance. If the Health Insurance plan selected by the participant is Health Insurance Plan 1, an annual deductible of $50 is applicable for participants who hold Individual coverage status, $75 for participants who hold Single-Parent coverage status and $100 for participants who hold Family coverage status. This annual deductible is applicable to all expenses covered by the Health Insurance plan with the exception of expenses set out in sections 4.2.1, 4.2.2, 4.2.3, 4.2.34 and 4.2.35.

4.2.1 Hospitalization expenses in Canada

Hospitalization expenses incurred in Canada in excess of the expenses payable under any government insurance plan, up to the cost of a semi-private room, without any limit as to the number of days, provided that the hospitalization begins while insurance is in force.

4.2.2 **Travel insurance**

The customary and reasonable expenses and the services described below are eligible for reimbursement if incurred following a death or an emergency situation resulting from an accident or an illness, occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the health and hospitalization insurance plan of the province of residence in Canada for the duration of his or her stay outside the province of residence.

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

The maximum reimbursement per insured is $5,000,000 per trip.

IMPORTANT

Insureds having a known illness must ensure before departure that their health condition is good and stable, 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 trip outside the province of residence.

In other words, for an individual to be covered for a known illness or condition, the illness or condition must be under control prior to the date of departure.

In any of the following cases:

- Symptoms worsen;
- A relapse occurs;
- The illness or condition is unstable;
- The illness or condition is in the terminal phase;
- The illness or condition is chronic and shows signs that deterioration or complications may occur during the trip;

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

4.2.2.1 Eligible expenses

a) Expenses for hospitalization in a hospital centre providing active treatment where the patient is receiving curative treatment. Expenses incurred are payable only if they are eligible under the government hospitalization insurance plan of the insured’s province of residence and only for the portion of expenses in excess of the benefits payable under that plan.

b) Professional fees of a physician for medical, surgical or anesthetic care, other than fees for dental care. Expenses incurred are payable only if they are eligible under the government health insurance plan

of the insured's province of residence and only for the portion of expenses in excess of the benefits payable under that plan.

c) Transportation by a licensed ambulance service to the hospital centre nearest to where the event requiring ambulance transportation occurred.

d) Drugs available only on medical prescription.

e) Professional fees of a registered nurse for private nursing care received exclusively in a hospital centre, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $5,000. The nurse must not be related to the insured nor be a travel companion.

f) Professional fees of a chiropractor, podiatrist or physiotherapist.

g) Rental of a wheelchair, hospital bed or respirator.

h) Expenses for laboratory analyses and x-rays.

i) Purchase of trusses, corsets, crutches, splints, casts and other orthopedic devices.

j) Professional fees of a dental surgeon for treatment of accidental injury to natural teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident. To be covered, expenses must be incurred within 12 months following the accident and treatment may be obtained once the insured has returned to the province of residence.

k) Repatriation expenses for the insured to return to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Transportation and repatriation expenses must be preapproved by the Insurer or the Assistor and benefits are limited to the cost of the most economical transport option, as determined by the Insurer, taking the insured's health condition into account.

l) The cost of economy class round-trip air fare for a medical escort when required by the air carrier and preapproved by the Insurer or the Assistor. The medical escort must not be a relative of the insured nor a travel companion.

m) The cost of returning the insured's personal vehicle home or a rental vehicle to the nearest appropriate vehicle rental agency, by a commercial agency, if the insured is incapable of doing so personally due to an illness or injury, subject to a maximum reimbursement of $1,000. The insured must provide a medical certificate issued by the attending physician attesting to his or her incapacity to use the vehicle in question.

n) If the insured dies while outside the province of residence, expenses incurred to prepare and return the deceased insured's remains to the province of residence by the most direct route, not including the cost of the coffin, up to a maximum of $5,000. Expenses must be preapproved by the Insurer or the Assistor.

o) The cost of accommodation and meals in a commercial establishment incurred by the insured, when obliged to postpone the return home due to hospitalization of the insured, a close relative or a travel companion for a minimum of 24 hours, up to a maximum of $200 per day, subject to a limit of $2,500 per trip outside the province of residence, for all persons covered under this benefit.

p) The cost of accommodation and meals in a commercial establishment and round-trip transportation expenses in economy class by the most direct route by plane, bus or train of a single close relative to travel to the hospital centre where the insured is hospitalized for at least seven days or to identify the insured's body for transporting the remains. The concept of close relative also includes a friend in the event the insured does not have a close relative in the context previously specified.

   These expenses must be preapproved by the Insurer or the Assistor and the insured must provide a document issued by the attending physician or local authorities certifying the necessity of the visit. The expenses eligible for reimbursement per trip outside the province of residence for all insureds are as follows:

   - For transportation: $2,500

   - For accommodation and meals: $200 per day, up to a maximum of $1,600

4.2.2.2 Travel assistance services

The Assistor provides worldwide travel assistance 24 hours a day, 365 days a year, to any insured who so requests, excluding countries at war or known to be politically unstable, making any intervention by the Assistor materially impossible.

The travel assistance services that are available in the event of an emergency situation following an accident or an illness are the following:

a) Directing the insured to an appropriate clinic or hospital centre.

b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for services up front.

c) Ensuring the proper follow-up of the insured's medical file.

d) Coordinating the return and transport of the insured as soon as medically possible.

e) Providing emergency support, coordinating claims and, when necessary, providing an emergency advance of funds.

f) If necessary, arranging the transportation of a close relative to the patient's bedside or to identify the deceased's body or to coordinate the repatriation of the deceased.

g) If necessary, arranging for the return of the spouse and dependent children to their home (return expenses not included).

h) If necessary, arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident.

i) If necessary, contacting the insured's family and employer.

j) Acting as an interpreter for emergency calls.

k) Recommending a lawyer in the case of a serious accident (legal fees not included).

Neither the Insurer nor the Assistor can be held responsible for the availability or quality of the medical or hospital care provided nor the possibility of obtaining such care.

The services described may not be available in all countries. They are subject to change by the Insurer or the Assistor at any time without notice.

4.2.2.3 Assignment outside the province of residence

Expenses provided for in sections 4.2.2.1 and 4.2.2.2, which are not eligible for reimbursement due to the sole fact of being incurred for non-urgent treatment or pregnancy-related care, are covered under this benefit if the expenses are incurred while the participant is on assignment outside the province of residence for the purposes of his or her employment for a period of 30 consecutive days or more. To be

eligible, expenses must be incurred in the nearest area to the participant's assignment where the required treatment or services are available.

4.2.2.4 Limitations

If an insured must be hospitalized due to an accident or sudden illness, the insured must notify the Insurer or the Assistor as soon as possible. If the insured fails to contact the Insurer or the Assistor, claims may be denied or benefits substantially reduced.

The Insurer and the Assistor reserve the right to repatriate the insured to the province of residence as soon as the insured's medical condition permits. If the insured refuses to be repatriated, the Insurer is not liable for any expenses incurred thereafter.

In the case of a medical condition that requires extended medical services, treatments or surgery, if medical evidence shows that after diagnosis of or emergency treatment of this condition that the insured could have returned to the province of residence but opted to obtain the services, treatments or surgery outside the province of residence, the Insurer will not assume the cost of such services, treatments or surgery, or any other related costs.

4.2.2.5 Exclusions and reduction of Travel Insurance

i) In addition to the exclusions and reduction indicated in section 4.3, the Insurer and the Assistor will issue no reimbursement or provide any assistance to the insured in the following cases:

   a) Expenses incurred after the insured's return to the province of residence.

   b) Expenses payable under any social legislation or social assistance plan.

   c) 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 was taken on the recommendation of a physician.

   d) Hospital or medical expenses which are not covered under the public health or hospitalization insurance plan of the insured's province of residence.

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 lesser quality than that available outside the province does not constitute a danger for the insured's life or health.

f) Any expenses incurred by the insured, after the date the risk level of a Canadian government travel advisory is modified recommending that travellers avoid:

- Any trip to a location where the insured is or will be travelling; or

- Any trip on a cruise ship, whether the insured is on board or not.

If the risk level of an advisory is modified while the insured is visiting the location in question or during the insured's cruise, the insured must take all the necessary measures to comply with the advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible.

ii) In addition, this benefit does not cover losses due to the following causes or to which such causes have contributed:

a) The insured's active participation in a riot or insurrection or perpetration or attempted perpetration of a criminal act by the insured.

b) Intentional self-inflicted injury, suicide or attempted suicide, whether or not the insured is of sound mind. In the event of suicide, only the costs incurred to prepare and return the remains are covered.

c) Abusive consumption of medication, drugs or alcohol and the ensuing consequences.

d) Participation in a sport for remuneration, any kind of motor vehicle competition or any kind of speed contest, flying a glider or deltaplane, mountain climbing, parachuting whether or not in free fall, bungee jumping or any other dangerous activity.

e) Pregnancy, or, if occurring within the two months preceding the normal expected date of delivery: miscarriage, childbirth or related complications.

f) War or acts of war, whether declared or not, in Canada or abroad, provided the government of Canada has issued a warning that Canadians should not travel in that country. This exclusion does not apply to an insured already present in a foreign country at the time war breaks out or an act of war occurs, provided the insured takes the necessary measures to leave the country as soon as possible once the government of Canada issues a recommendation to do so.

4.2.2.6 Claims

It is agreed and understood that no hospital or medical expenses will be reimbursed under this benefit until the relevant government authorities have completed their assessment of the insured's claim and any payable benefits have been paid.

All other expenses covered under this benefit may be claimed directly from the Insurer upon presentation of supporting documents deemed satisfactory (invoices, receipts, prescriptions, etc.)

4.2.2.7 Coordination of benefits

This insurance is deemed to be "second payor" insurance. The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of the benefits paid under any other public or private, individual or group plan. It is understood that the rules for the coordination of benefits are applied in accordance with the guidelines issued by the Canadian Life and Health Insurance Association.

4.2.3 **Trip cancellation insurance**

The Insurer pays 100% of the expenses incurred by the insured following the cancellation or interruption of a trip according to the terms of this provision, insofar as the expenses incurred are related to travel expenses paid in advance by the insured while this benefit was in force and, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip. The covered expenses are limited to $5,000 per insured, per trip.

4.2.3.1 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 or the travel companion, or a close relative of either, or a business partner of the insured from performing his or her usual activities, and 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 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 insured's 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. However, a subpoena is not considered cause for cancellation or interruption of a trip when the insured is a police officer and has been subpoenaed as part of his or her duties.

f) The insured's or the spouse's involuntary loss of employment, provided that the person in question was employed by the same employer for more than one year.

g) Quarantine of the insured or travel companion, unless quarantine ends seven days or more 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, the travel companion or the host at destination uninhabitable, provided the residence remains uninhabitable seven days prior to the scheduled date of departure, or the damage occurs during the time of the trip.

j) Transfer of the insured or the travel companion, for 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) Upgraded risk level of a Canadian government travel advisory recommending that travellers avoid:

   i) Any trip or any non-essential trip to a location where the insured is or will be travelling; or

   ii) Any trip on a cruise ship, whether the insured is on board or not.

   Trip cancellation expenses are eligible if the following conditions are met:

   - The risk level of an advisory was modified after travel expenses were incurred.
   - The modified risk level of the advisory is still in effect on the departure date of the insured's trip.

   Trip interruption expenses are eligible if the following conditions are met:

   - The risk level of an advisory was modified after the departure date of the insured's trip.
   - The modified risk level of the advisory is still in effect during the scheduled period of the insured's trip.
   - The insured took the necessary measures to comply with this advisory within 14 days following the date the risk level was modified.

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 least three hours prior to the time of departure, or at least two 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 delaying departure of the public carrier used by the insured, at the scheduled point of departure, by at least 30% (minimum 48 hours) of the planned duration of the trip, or preventing the insured from making a scheduled connection with another carrier, provided the scheduled connection 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.

o) Death, illness or accident suffered by a person for whom the insured is the legal guardian.

p) Suicide or attempted suicide of a member of the insured's family, or the family of the insured's travel companion.

q) Death of a person for whom the insured is the testamentary liquidator.

r) Death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. Reimbursement is limited to transportation expenses and a maximum of three days' accommodation.

4.2.3.2 Eligible expenses

The following expenses are covered provided that they were assumed by the insured and are limited to $5,000 per insured per trip.

Only the portion of prepaid travel expenses that has not been the subject of any form of credit, compensation or indemnity (with or without restriction as to use) offered by the travel service provider or any organization is eligible.

Moreover, any prepaid travel expenses paid to a travel service provider must be unused, unusable, non-refundable and non-transferable.

a) In the event of cancellation prior to departure:

   i) The non-refundable portion of prepaid travel expenses.

   ii) Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the reasons specified under this benefit and the insured decides to travel alone; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.

   iii) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's 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 for one of the reasons covered under this benefit, the additional cost charged by a scheduled public carrier for an economy class ticket, via the most direct route, to the initially planned trip destination.

c) If the return is earlier or later than planned

i) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially planned means of transportation cannot be used, the expenses covered will be equal to 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 preapproved by the Insurer.

Restriction

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

If travel expenses were not paid in advance, the expenses incurred by the insured are covered provided that before the scheduled date of departure, the insured was not aware of any event that could reasonably lead to the interruption of the planned trip.

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

4.2.3.3 Round-trip transportation

The cost of transportation by the most economical means, following approval by the Insurer or the Assistor, for the insured to return to the province of residence and then back to the trip destination, provided the return is due to one of the following reasons:

a) Death or hospitalization of a member of the insured's family, a person for whom the insured is the legal guardian or a person for whom the insured is the testamentary liquidator.

b) Damage rendering the principal residence of the insured uninhabitable or causing significant damage to the insured's business establishment.

4.2.3.4 Exclusions from Trip Cancellation Insurance coverage

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 or be at the bedside of a person who is ill or has suffered an accident, and whose medical condition or subsequent death leads to cancellation, early return or late return.

c) Any expenses incurred by the insured, after the date the risk level of a Canadian government travel advisory is modified recommending that travellers avoid:

- Any trip or any non-essential trip to a location where the insured is or will be travelling; or
- Any trip on a cruise ship, whether the insured is on board or not.

If the risk level of an advisory is modified while the insured is visiting the location in question or during the insured's cruise, the insured must take all the necessary measures to comply with the advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible.

d) For fees related to eligible causes for trip cancellation, benefits are not payable if the insured made travel arrangements while a Canadian government travel advisory was in effect, recommending that travellers avoid trips to a location where the insured will be travelling or on a cruise ship, and the risk level of the advisory remains in effect when the cause for cancellation provided for under this contract occurs.

Furthermore, benefits are not payable for any fees related to causes for trip interruption if the insured leaves on a trip while a Canadian government travel advisory is in effect, recommending that travellers avoid trips to a location where the insured will be travelling or on a cruise ship, and the risk level of the advisory remains in effect when the cause for interruption provided for under this contract occurs. However, if the risk level of an advisory is modified to a recommendation to avoid all trips to the location that the insured is visiting or during the insured's cruise, the insured must take all the necessary measures to comply with this advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible, regardless of the cause.

e) Active participation of the insured in a riot or insurrection or perpetration or attempted perpetration of a criminal act by the insured or the insured's travel companion.

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

g) Abusive consumption of medication, drugs or alcohol and the ensuing consequences.

h) Participation in contact sports, gliding, mountaineering, parachuting, skydiving, whether or not in free fall, or any other similar activity; participation in races or speed trials of any nature whatsoever; as well as participation in any professional sporting or underwater activities.

i) Pregnancy, or, if occurring within the two months preceding the normal expected date of delivery: miscarriage, childbirth or related complications.

4.2.3.5 Notice of cancellation

In the event that cancellation occurs prior to departure, the trip must be cancelled within a maximum period of 48 hours of the date of knowledge of the cause resulting in the cancellation, or if this period ends on a statutory holiday, by the next business 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.

However, this deadline for requesting cancellation does not apply if it is demonstrated to the Insurer's satisfaction that the insured and spouse were totally and completely incapable of acting; the trip must be cancelled as soon as one of these persons is able to do so.

If the risk level of a Canadian government travel advisory is modified, the insured must contact the Assistor within 72 hours before the date of payment of the deposit required for the prepaid travel expenses or 72 hours before the departure date of the insured’s trip, depending on the case.

4.2.3.6 Coordination

This insurance is deemed to be “second payor” insurance. The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of the benefits paid under any other public or private, individual or group plan. It is understood that the rules for the coordination of benefits are applied in accordance with the guidelines issued by the Canadian Life and Health Insurance Association.

4.2.4 **Accidental dismemberment**

4.2.4.1 Insured amount

In the event that the participant, or one of the participant's dependents, if applicable, sustains an accidental loss of a limb while this insurance coverage is in force, provided the loss occurs within 365 days following the accident, the participant will receive the amount specified in the table below.

Loss	Insured amount
– Loss of both hands or both feet or vision in both eyes	$50,000
– Loss of one hand and one foot	$50,000
– Loss of one hand and vision in one eye	$50,000
– Loss of one foot and vision in one eye	$50,000
– Loss of one hand or one foot	$25,000
– Loss of vision in one eye	$25,000

The loss of a hand or a foot means the total and irrecoverable loss of the use of a hand or a foot, or amputation at or above the wrist or the ankle joint.

The loss of vision in an eye means the total and irrecoverable loss of vision in this eye that cannot be corrected by surgery.

The accidental dismemberment benefit is granted on a 24-hour basis, whether or not the participant is at work.

Before granting the insured amount, the Insurer is entitled to have the insured examined.

At no time may the total indemnities payable for all losses sustained by the insured under the Accidental Dismemberment Insurance benefit exceed $50,000.

4.2.4.2 Exclusions and reduction of Accidental Dismemberment coverage

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

a) While the insured is carrying out any of the duties of an airplane crew or any duty whatsoever related to a flight.

b) War, whether declared or not, or active participation of the insured in an insurrection, whether real or apprehended.

c) Due to attempted suicide or suicide of the insured, or voluntary self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.

d) Participation of the insured 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.

e) Any condition occurring while the insured is on active duty with the armed forces of any country.

f) Due to an illness which occurs at the time of an accident but which is not due to such accident.

g) Following medical or dental treatment, a surgical operation or anaesthesia.

h) While driving a motor vehicle, boat or aircraft while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

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

4.2.5 **Prescription drugs**

a) **Definitions**

The following definitions apply to this provision:

- **Prior authorization drug list:** This list, which the Insurer has established and may review at any time, applies to prescription drugs for which insureds must obtain authorization before they can be eligible for reimbursement under this contract.
- **Generic drugs**: Copies of brand name drugs whose market exclusivity is no longer protected by a patent.
- **Brand name drugs:** Original marketed version of a patented drug for which there exists at least one generic version.
- **Single source drugs**: Brand name drugs whose market exclusivity is temporarily patent protected and for which there are no generic drugs available.

b) **Eligible expenses**

- The Insurer reimburses pharmaceutical services and prescription drugs that are covered under the RAMQ's Basic Prescription Drug Insurance Plan (BPDIP), as established under the *Act respecting prescription drug insurance* (CQLR, c. A-29.01).
- Subject to the exclusions below, reimbursement is also provided with regard to prescription drugs bearing a valid Drug Identification Number (DIN) issued by Health Canada. Such prescription drugs must be dispensed by a pharmacist or a duly authorized physician. They must only be obtained on prescription from a physician, dentist or healthcare professional legally authorized to do so. They must be administered in accordance with the manufacturer's directions for use or, if no such directions exist, in accordance with instructions issued by the appropriate government authorities. Also eligible for reimbursement are drugs obtained on prescription with directions for use specifically related to treatment of the following pathological conditions: cardiac disorders, pulmonary disorders, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma.
- The drug must be approved and recognized by the Insurer for its effectiveness and therapeutic value. Drugs on the prior authorization drug list must meet the criteria determined by the Insurer. To this end, the Request for Assessment – Prior Authorization Drug form must be completed by a healthcare professional, at the insured's expense. The form is available from the Insurer or the plan administrator.

The following expenses are also eligible for reimbursement:

- Expenses for the **substance used in sclerosing injections** that are medically required and administered by a physician, up to an eligible maximum of $35 per session
- Expenses for the purchase of an **intrauterine contraceptive device** (IUD).

For the purposes of this prescription drug insurance, it is understood that the Insurer considers any product that meets the above conditions as a prescription drug.

c) **Generic substitution for brand name drugs**

Only expenses for the least expensive drug equivalent to the drug prescribed are eligible, even if the healthcare professional has indicated on the prescription that no substitutions are to be made.

In the event of medical contra-indications associated with the use of the generic drug, insureds wishing to obtain reimbursement of a brand name drug must have the Request for Brand Name Drug Coverage form completed by a healthcare professional at their own expense. This form may be

obtained from the Insurer. Insureds must then submit this form to the Insurer for analysis.

d) **Exclusions**

- Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment.
- Dietary substances or foods intended as a meal supplement or replacement.
- However, dietary supplements prescribed for the treatment of a metabolic disorder that is clearly diagnosed are covered, provided they are used in compliance with the conditions and therapeutic indications determined by the BPDIP's applicable regulation. The only evidence accepted by the Insurer is a complete medical report detailing all conditions justifying the prescription of the substance or food that would not be covered otherwise.
- Drugs administered primarily for preventive purposes; 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 Basic Prescription Drug Insurance Plan.
- Drugs or substances used for the treatment of infertility, erectile dysfunction or any other sexual dysfunction.
- 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 drug formulary of the *Régie de l'assurance maladie du Québec*, or modify the applicable premium as of the drug's date of approval, subject to the consent of the Policyholder.

4.2.6 Speech therapist, occupational therapist and audiologist

Professional fees of speech therapists, occupational therapists and audiologists if they are members in good standing of a professional order recognized by legislative authority. Only one treatment per day, per insured, is eligible for reimbursement.

4.2.7 Nursing care

Professional fees for medical care provided in the insured's home by a registered nurse or nursing assistant who is a member in good standing of a professional order recognized by legislative authorities, excluding any person who resides in the insured's home or is a close relative.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 1: Up to a maximum reimbursement of $5,000 per calendar year, per insured;

- Health Insurance Plan 2: Up to a maximum reimbursement of $5,000 per calendar year, per insured;

- Health Insurance Plan 3: Up to a maximum reimbursement of $10,000 per calendar year, per insured.

4.2.8 Wheelchair or hospital bed

Expenses for the rental, or purchase of a basic model if this option is deemed more economical by the Insurer, of a non-motorized wheelchair or a hospital bed similar to those used in a hospital centre and that is only needed on a temporary basis.

4.2.9 Orthopedic devices

Expenses for the rental or purchase, depending on the circumstances, of corsets, trusses, casts, crutches, splints and other orthopedic devices.

4.2.10 Respirator and oxygen

Expenses for the rental, or purchase if this option is deemed more economical, of a respirator and oxygen.

4.2.11 Therapeutic devices

Expenses for the rental, or purchase if this option is deemed more economical, of therapeutic devices. This benefit also covers expenses for adjustment, replacement and repair.

The following equipment or supplies are also considered to be therapeutic devices:

a) Aerosoltherapy devices, namely devices required for treating, among other conditions, acute emphysema, chronic bronchitis and chronic asthma (e.g. nebulizer or compressor);

b) Fracture consolidation stimulators (e.g. bone stimulator);

c) Respiratory monitors in cases of respiratory arrhythmia (e.g. apnea monitor);

d) Intermittent positive pressure respirators (e.g. volumetric ventilator);

e) Insulin pumps;

f) Burn treatment garments;

g) Purchase of diapers for incontinence, probes, catheters and other similar hygienic items required following a total and irrecoverable loss of bladder or intestinal function.

This benefit does not cover measuring devices such as stethoscopes, thermometers, etc.; nor does it cover domestic devices such as whirlpool baths, air purifiers, humidifiers and air conditioners or other devices of a similar nature.

4.2.12 Artificial limbs and external prostheses

Expenses for the purchase of an artificial limb or eye, or other external prostheses.

4.2.13 Hair prosthesis (wig)

Expenses for the purchase of a hair prosthesis (wig) required following chemotherapy treatments, up to a maximum lifetime reimbursement of $300 per insured.

4.2.14 Foot orthoses

Expenses for the purchase of foot orthoses (arch supports, corrective lifts) made by a specialized orthopedic laboratory licensed by the legal authorities. These expenses are limited to the amounts specified in the price list of the *Association nationale des orthésistes du pied*.

4.2.15 Orthopedic shoes

The initial or replacement cost of orthopedic shoes that are custom made for the insured by a specialized orthopedic laboratory licensed under applicable provincial legislation. Modifications or additions to prefabricated shoes, open,

flared or straight shoes, as well as shoes required for Denis Browne splints, are also covered.

4.2.16 Support stockings

Expenses for the purchase of support stockings, up to a maximum of three pairs per calendar year, per insured.

4.2.17 Blood glucose monitor

Expenses for the purchase, adjustment, replacement or repair of a device used for measuring blood glucose levels (blood glucose monitor, dextrometer or any other similar device) as well as the travel case. The insured must submit a complete report from the attending physician stating that the insured is insulin-dependent.

These expenses are eligible in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $240 per 36 consecutive months per insured;
- Health Insurance Plan 3: Up to a maximum reimbursement of $400 per 36 consecutive months, per insured.

4.2.18 Transcutaneous electrical nerve stimulation (TENS)

Expenses for the purchase, adjustment, replacement or repair of a transcutaneous electrical nerve stimulator, up to a maximum reimbursement of $800 per 60 consecutive months, per insured.

4.2.19 Hearing aids

Expenses for the purchase, adjustment, replacement or repair of a hearing aid and professional fees of a hearing aid specialist.

These expenses are eligible in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $560 per 48 consecutive months, per insured;
- Health Insurance Plan 3: Up to a maximum reimbursement of $800 per 48 consecutive months, per insured.

4.2.20 **Dental treatment following accident**

Professional fees of a dentist or denturist 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 24 months following the date of the accident.

4.2.21 **Ambulance**

Expenses for round-trip transportation by ambulance to the nearest hospital centre able to provide the care required, including emergency air or train transportation. Oxygen therapy treatment during or directly before transportation is included.

4.2.22 **Transportation by air of a non-ambulatory patient**

a) Expenses for air transportation of a non-ambulatory patient occupying the equivalent of two single seats when part of the journey requires the use of this means of transportation;

b) Expenses for transportation by airplane to the nearest hospital centre where the required medical or surgical care is available, for immediate hospitalization as an inpatient, as prescribed by a physician;

c) Transportation expenses to return home immediately following a period of hospitalization.

4.2.23 **Physiotherapist, physical rehabilitation therapist and sports therapist**

Professional fees of a physiotherapist, physical rehabilitation therapist or sports therapist, if they are members in good standing of a professional order recognized by legislative authority or a professional association recognized by the Insurer. Only one treatment per day, per insured, is eligible for reimbursement.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $40 per treatment and a maximum of 15 treatments per calendar year, per insured. **These maximums apply for all of these professionals**;
- Health Insurance Plan 3: Up to a maximum reimbursement of $52 per treatment and a maximum of 15 treatments per calendar year, per insured. **These maximums apply for all of these professionals**.

4.2.24 Psychologist, psychoanalyst, psychiatrist, psychotherapist, psychoeducator, social worker and career counsellor

Professional fees of a psychologist, psychoanalyst, psychiatrist, psychotherapist, psychoeducator, social worker or career counsellor, if they are members in good standing of a professional order recognized by legislative authority or a professional association recognized by the Insurer, for one treatment per day. The only eligible services of psychiatrists are those rendered as psychoanalytic treatments, insofar as these professionals are members of the Canadian Psychoanalytic Society. Only one treatment per day, per insured, is eligible for reimbursement.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $64 per treatment and a maximum of 10 treatments per calendar year, per insured. **These maximums apply for all of these professionals.**
- Health Insurance Plan 3: Up to a maximum reimbursement of $64 per treatment and a maximum of 25 treatments per calendar year, per insured. **These maximums apply for all of these professionals.**

4.2.25 Homeopath

Professional fees of a homeopath, if a member of a professional association recognized by the Insurer, up to a maximum reimbursement of $36 per treatment and a maximum reimbursement of $720 per calendar year, per insured, including expenses for homeopathic medicines obtained on prescription from a homeopath or a physician. Only one treatment per day, per insured, is eligible for reimbursement.

4.2.26 Transportation and accommodation expenses in Quebec

Expenses for transportation and accommodation incurred in Quebec to obtain the services of a medical specialist not available in the insured's area of residence. The following expenses are eligible for reimbursement up to a maximum reimbursement of $1,000 per calendar year, per insured:

- Expenses for travel by automobile or with a public carrier (bus, airplane, boat, train) and expenses for accommodation incurred in a commercial establishment, provided the consultation or treatment requires an overnight stay.

However, the following conditions apply:

- Eligible expenses must be incurred, by medical prescription, for a consultation with a medical specialist not available in the insured's area of

residence. Also eligible are expenses incurred for treatment not available in the insured's area of residence that is provided by a specialist.

- The trip must be at least 200 km (one way) from the insured's residence to the location where the consultation will take place, and such location must be the nearest one to the insured's residence.

- When travelling by automobile, eligible expenses are equal to those that would have been incurred had the trip been made by bus.

- Eligible expenses are reimbursed on submission of receipts or paid invoices, except if the means of transport used is an automobile.

- Eligible expenses include expenses incurred by an insured as well as the person accompanying the insured, if applicable.

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

4.2.27 **Acupuncturist**

Professional fees of an acupuncturist, if a member in good standing of a professional order recognized by legislative authority. Only one treatment per day, per insured, is eligible for reimbursement.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $32 per treatment and a maximum of 15 treatments per calendar year, per insured.
- Health Insurance Plan 3: Up to a maximum reimbursement of $44 per treatment and a maximum of 15 treatments per calendar year, per insured.

4.2.28 **Chiropractor**

Professional fees of a chiropractor, if a member in good standing of a professional order recognized by legislative authority. Only one treatment per day, per insured, is eligible for reimbursement. X-rays are eligible for reimbursement and subject to a maximum reimbursement of $40 per calendar year, per insured.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $28 per treatment and a maximum of 20 treatments per calendar year, per insured;
- Health Insurance Plan 3: Up to a maximum reimbursement of $36 per treatment and a maximum of 20 treatments per calendar year, per insured.

4.2.29 **Podiatrist and chiropodist**

Professional fees of a podiatrist and chiropodist if they are members in good standing of a professional order recognized by legislative authority. Only one treatment per day, per insured, is eligible for reimbursement.

These fees are eligible for reimbursement in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $32 per treatment and a maximum of 15 treatments per calendar year, per insured. **These maximums apply for all of these professionals.**
- Health Insurance Plan 3: Up to a maximum reimbursement of $44 per treatment and a maximum of 15 treatments per calendar year, per insured. **These maximums apply for all of these professionals.**

4.2.30 **Osteopath**

Professional fees of an osteopath, if a member in good standing of a professional association recognized by the Insurer. A single treatment per day, per insured, is eligible for reimbursement up to a maximum reimbursement of $56 per treatment and a maximum of 15 treatments per calendar year, per insured.

4.2.31 **Massage therapist, kinesitherapist and orthotherapist**

Professional fees of a massage therapist, kinesitherapist or orthotherapist if they are members in good standing of a professional association recognized by the Insurer, up to a maximum reimbursement of $44 per treatment and a maximum of 15 treatments per calendar year, per insured. **These maximums apply for all of these professionals.** Only one treatment per day, per insured, is eligible for reimbursement.

4.2.32 **Dietitian**

Professional fees of a dietitian, if a member in good standing of a professional order recognized by legislative authority, up to a maximum reimbursement of $44 per treatment and a maximum of 15 treatments per calendar year, per insured. Only one treatment per day, per insured, is eligible for reimbursement.

4.2.33 **Detoxification**

Expenses incurred for a stay in a recognized private clinic specialized in rehabilitation treatment of alcoholism or drug addiction excluding tobacco use, up to a maximum eligible amount of $80 per day and a maximum of 30 days per calendar year, per insured. Expenses for a stay in a clinic specialized in rehabilitation treatment for gambling addiction are also eligible for reimbursement.

4.2.34 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 government insurance plan, up to the cost of a semi-private room, provided the stay begins while insurance is in force. These expenses are limited to 180 days per calendar year, per insured. However, expenses for assistance with activities of daily living are excluded.

4.2.35 Rehabilitation centre

Expenses for occupying a room, including meals, for at least 12 consecutive hours in a rehabilitation centre as defined by the *Act respecting health services and social services* in excess of the expenses payable under any government insurance plan, up to the cost of a semi-private room, provided that the insured is admitted to the centre within 14 days following hospitalization and that hospitalization begins while insurance is in force. However, these expenses are limited to a maximum period of 180 days per calendar year, per insured.

4.2.36 X-rays and laboratory analyses

Expenses for blood, plasma and transfusion, except expenses for the preservation or freezing of blood or plasma, as well as expenses for x-rays and laboratory analyses for purposes of prevention or diagnosis performed outside a hospital centre.

4.2.37 Electrocardiograms, ultrasounds, radium and x-ray tests

Expenses for electrocardiograms, ultrasound examinations, other than echographies, radium and X-ray tests for purposes of diagnosis performed outside a hospital centre.

4.2.38 Magnetic resonance imaging (MRI)

Expenses for magnetic resonance (MRI) tests performed outside a hospital centre for purposes of diagnosis.

These expenses are eligible in accordance with the insurance plan selected by the participant:

- Health Insurance Plan 2: Up to a maximum reimbursement of $500 per calendar year, per insured;
- Health Insurance Plan 3: Up to a maximum reimbursement of $600 per calendar year, per insured.

4.2.39 **External breast prosthesis**

Expenses for the purchase of an external breast prosthesis following a mastectomy, in excess of the amount paid by the *Régie de l'assurance maladie du Québec*.

4.2.40 **Cosmetic surgery following an accident**

Expenses for cosmetic surgery required to repair disfigurement resulting from an accident that occurs while this insurance is in force, provided that services are rendered within 12 months following the date of the accident, up to a maximum reimbursement of $5,000 per accident, per insured.

4.2.41 **Ultrasound examination**

Expenses for echographies (other than fetal), performed outside a hospital centre, up to a maximum reimbursement of $300 per calendar year, per insured.

4.2.42 **Home care and assistance**

Expenses for the services described below, when recommended by a physician and deemed necessary following hospitalization or day surgery, are eligible for reimbursement of up to $400 per insured, per calendar year for all of these expenses, provided they are incurred within 30 days following the insured's hospitalization or discharge from a 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) Expenses incurred for a stay in a convalescent home specialized in post-hospitalization care.

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

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

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

4.2.43 **Naturopath**

Professional fees of a naturopath, if a member in good standing of a professional association recognized by the Insurer, up to a maximum reimbursement of $36 per treatment and a maximum of 20 treatments per calendar year, per insured. Only one treatment per day, per insured, is eligible for reimbursement.

4.2.44 **Post-surgical bras**

Expenses for the purchase of post-surgical bras following a radical mastectomy.

4.2.45 **Eye examination**

Fees incurred for an eye examination performed by an ophthalmologist or an optometrist.

4.3 Exclusions and reduction of the plan

Subject to the provisions of the *Act respecting prescription drug insurance* (CQLR, c. A-29.01), any expenses incurred in the following cases are excluded from this plan and are not eligible for reimbursement by the Insurer:

4.3.1 Preventive vaccines.

4.3.2 Dentures, eyeglasses, contact lenses and their adjustment or laser surgery, except if required following an accident.

4.3.3 Hearing aids and their adjustment except if required following an accident. This exclusion applies to Health Insurance Plan 1 only.

4.3.4 Injections provided as part of a weight reduction program.

4.3.5 Surgery, treatments or prostheses provided for aesthetic purposes, except following an accident.

4.3.6 Care provided primarily for aesthetic purposes, protective glasses or sunglasses and care provided free of charge.

4.3.7 Any product or service that is not medically required.

4.3.8 Hair prostheses (wigs), except following chemotherapy treatments. This exclusion applies to Health Insurance Plan 1 only.

4.3.9 Eye or hearing examinations.

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

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

4.3.12 Periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or health trips.

4.3.13 Any condition occurring while the insured is on active duty with the armed forces of any country.

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

4.3.15 Any condition occurring due to the insured's participation in a criminal act or an act deemed to be criminal.

4.3.16 Any expenses related to insemination.

4.3.17 Any expenses related to infertility treatment.

4.3.18 Any treatment, services or products of an experimental nature.

4.3.19 Any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this benefit, with the exception of the deductible and coinsurance required by the RAMQ.

For the Travel Insurance benefit, the exclusions and reductions stipulated in section 4.2.2.5 apply in addition to those stipulated in this section.

For the Trip Cancellation Insurance benefit, only the exclusions and reductions stipulated in section 4.2.3.4 apply.

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 *Act respecting industrial accidents and occupational diseases* (CQLR, c. A-3.001), the *Automobile Insurance Act* (CQLR, c. A-25), the *Hospital Insurance Act* (CQLR, c. A-28), the *Health Insurance Act* (CQLR, c. A-29) and any other federal or foreign law with similar provisions.

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

4.4 **Claims**

The Insurer is required to pay under this plan if there has been a claim submitted within 12 months following the date on which the eligible expenses were incurred. Expenses are considered as being incurred on the date the services were rendered or the supplies were provided.

The above-mentioned deadline is mandatory. If, however, the participant can demonstrate to the Insurer's satisfaction that it was impossible to act prior to the expiry of this period, and that the claim was submitted as soon as the inability to act was resolved, then the insured may take advantage of this insurance benefit.

4.5 **Coordination of benefits**

The total amount of benefits paid under this plan, other insurance plans and government plans to the same person may not exceed the amount of expenses actually incurred.

If the person insured under this contract is also insured under another plan, the initial reimbursement prior to coordination is made under the plan under which the insured is not a dependent. Thereafter, any expenses that are not reimbursed are payable by the plan under which the insured is considered to be a dependent.

In the case of dependent children, the initial reimbursement prior to coordination is made under the plan in which the spouse whose birthday comes first during the calendar year participates. Thereafter, any expenses that are not reimbursed are the responsibility of the other spouse's plan.

4.6 **Information**

The Insurer may require any information, details and files concerning the diagnosis, the treatment or services for each insured either before or after the effective date of his or her insurance, and the insured agrees, as a condition of the Insurer's liability under this insurance plan, to disclose or have disclosed to it all information, details and files and authorizes any hospital centre or person rendering or having rendered these services to provide the foregoing directly to the Insurer. All such information is considered as strictly confidential by the Insurer.

4.7 **Waiver of liability**

The payment of benefits under this contract discharges the Insurer from any liability for an act or omission by any hospital centre or any person rendering any of the services mentioned in this contract.

4.8 Waiver of premiums in the event of total disability

If, before retirement, a participant sustains a total disability while this plan is in force, the Insurer waives any premiums payable by the participant that fall due after the expiry of a 52-week period.

Waiver of premiums terminates on the earliest of the following dates:

a) For participants who became disabled before January 1, 2014:
   i) The date of the participant's 61st birthday if the waiver of premiums has been effective for at least 36 months due to the same total disability.
   ii) The date of the participant's 65th birthday or the last day remuneration is received from the employer.

b) For participants who became disabled on or after January 1, 2014:
   i) The expiry of a 104-week period for the same total disability. Participants who have maintained their seniority with the employer must resume regular premium payments. Participants who no longer have an employment relationship with the employer then become eligible for the individual health insurance plan offered by the Insurer and must submit an application within 90 days of this date.
   ii) The date of the participant's 65th birthday or the last day remuneration is received from the employer.

c) The date on which total disability ends.

d) The termination date of the contract or the plan.

Any totally disabled participant who takes early retirement leave with pay remains eligible for the Health Insurance plan but is not entitled to a waiver of premiums during the period of early retirement leave.

4.9 Conversion privilege

Any participant whose insurance under this plan ends because he or she ceases to be eligible may obtain an individual health insurance policy of the type issued at that time by the Insurer in such circumstances. To do so, the participant must submit a written request to the Insurer within 90 days following the date he or she ceases to be eligible.

Any dependent whose insurance under this plan ends because he or she ceases to be a dependent according to the definition in the contract or because the participant ceases to be eligible or dies is also entitled to exercise the conversion privilege under the same conditions as the participant.

The conversion privilege is not available if insurance under this plan terminates due to termination of the contract.

4.10 **Method of payment**

Participants making prescription drug purchases may use the automated payment card for the direct automated payment service.

4.11 **Termination of insurance**

4.11.1 The Health Insurance plan for participants terminates on the earliest of the following dates:

4.11.1.1 The date on which this contract terminates.

4.11.1.2 The date corresponding to the end of the last period for which premiums were paid for employees who benefited from the provisions of section 2.10 and who stopped paying premiums before the end of the work interruption.

4.11.1.3 In the event of non-payment of premiums, subject to the provisions of section 4.8 “Waiver of premiums in the event of total disability”, 30 days after notice to this effect was sent by the Insurer to the participant’s last address. However, when payment of premiums is late for all participants of the same category, for the same employer, the Insurer agrees to send six month’s written notice to the Policyholder before applying this provision.

4.11.1.4 The date on which the participant ceases to be an eligible employee for a reason other than retirement, subject to the provisions of section 4.8 “Waiver of premiums in the event of total disability”. However, for any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, coverage ends at midnight (24:00) on August 31 of the same year.

4.11.1.5 The date on which the union to which the participant belongs ceases to participate in this plan.

4.11.1.6 The participant’s retirement date. However, for any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, coverage ends at midnight (24:00) on August 31 of the same year.

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

4.11.2.1 The date on which the participant’s insurance terminates.

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

4.11.2.3 The first day of the pay period following the date on which a request is received from the participant to change the coverage status from Family or Single-Parent coverage to Individual coverage, in accordance with the provisions of section 2.3.7.2.

SECTION 5 – DENTAL CARE INSURANCE

This section is not available since the content does not apply to all insureds.

SECTION 6 – SHORT-TERM DISABILITY INSURANCE

This section is not available since the content does not apply to all insureds.

SECTION 7 – LONG-TERM DISABILITY INSURANCE

Each union may select Plan A or Plan B, as set out in section 1.20 of this contract. This choice is irrevocable until the January 1 following the end of a 36-month period after the date of the selection, unless there is an amendment to this effect to the collective agreement.

When the Insurer receives and approves the evidence establishing that a participant is disabled as defined in this contract, in accordance with the plan selected by the union and after expiry of the elimination period defined in section 7.2, the Insurer pays this participant monthly benefits, the amount of which is determined as follows:

7.1 **Benefit period**

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

Entitlement to benefits ends on the earliest of the following:

- The last day of the week during which the participant reaches age 65;
- The date on which total disability ends;
- Failure to provide proof of continuing disability deemed satisfactory by the Insurer;
- Refusal to submit to a medical examination as required by the Insurer;
- The participant’s death.

7.2 **Elimination period**

Monthly benefits are payable after expiry of the elimination period, which ends on the latest of the following dates:

- The end of the 104th week of total disability for the same period of total disability;
- The end of disability benefit payments provided under the collective agreement or under an equivalent disability insurance plan;
- For participants who receive their annual salary over a period of less than 12 months and for whom the monthly benefits become payable during the period when the payment of their salary is usually suspended by their employer, the monthly benefit becomes payable on the September 1 that follows the end of disability benefits provided under the collective agreement or under an equivalent disability insurance plan.

7.3 Benefit amount

The benefit amount is equal to 75% of net annual salary, which is the gross salary less income taxes and contributions to the QPP, the QPIP and Employment Insurance. Benefits are non-taxable.

To calculate the benefit amount payable under the Long-Term Disability Insurance plan, the salary used is the gross salary applicable at the end of the 104th week of disability under the disability insurance plan provided under the collective agreement. If the salary applicable at the end of the 104th week of disability is lower than the salary that was applicable at the start of the same period of disability, the salary at the start of disability will be used for calculating benefits. If the salary is higher than $0 and lower than $1,200 per month, the latter amount ($1,200) is used as the gross salary for calculating the benefit amount payable under the Long-Term Disability Insurance plan.

The benefit amount in the event of disability is divided, if applicable, by 1/30 of the monthly benefits for each day of total disability during the month.

For the week of benefits which coincides with the return-to-work day, the payable benefit will be in proportion to the number of work hours effectively lost.

7.4 Reduction of benefits

The benefit amount described in section 7.3 is reduced by the total of the following amounts:

7.4.1 Any remuneration received from the employer, excluding payable holidays and sick leaves.

7.4.2 80% of the amount of any retirement pension payable under the Teachers' Pension Plan (TPP) or other retirement plan for employees in the public and parapublic sectors applying to the participant.

7.4.3 100% of the initial amount of any pension benefit payable by the Quebec Pension Plan or the Canada Pension Plan.

7.4.4 When an employee who is not retired sustains a total disability and ceases to participate in his or her private pension plan while being entitled only to a deferred pension and decides to transfer the current value of such pension plan to a locked-in retirement account (LIRA), the Insurer will determine the amount of the monthly benefit payable under this plan as if such transfer had not taken place. To do so, an evaluation is carried out on the date the employee would have been entitled to the retirement pension had the current value of the retirement pension not been transferred to the LIRA. For the purposes of this section, the simulated value of the retirement pension obtained is then considered to be paid to the employee as of the date he or she would have been entitled to it, had there been no transfer to the LIRA.

7.4.5 The amount of disability benefits under the Quebec Pension Plan or Canada Pension Plan to which the participant is entitled before any apportionment or deductions of any sort, or which the participant would be entitled to receive if an application had been submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application was submitted and declined.

A disabled participant who is entitled to disability income benefits under the Quebec Pension Plan (QPP) and who has applied for a retirement pension from the QPP is deemed 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 have continued to receive if an application for a retirement pension had not been submitted.

7.4.6 The amount of disability benefits under the *Act respecting industrial accidents and occupational diseases*, the Quebec *Automobile Insurance Act* or any other social legislation that is paid or would have been paid to the participant, if an application had been submitted and approved, less any federal or provincial taxes, unless proof is submitted in due form to the Insurer demonstrating that an application was submitted and declined.

7.4.7 95% of the initial net monthly amount of any benefit payable for the disability in question under the Teachers Pension Plan (TPP), the Civil Service Superannuation Plan (CSSP) or any other private pension plan applying to the employee. The term “net amount” means the benefit amount provided under the plan in question, less any federal and provincial income taxes payable on these benefits.

7.4.8 75% of the income obtained from any gainful occupation, except income earned from work performed under a rehabilitation program approved by the Insurer. “Gainful occupation” means any professional or commercial activity for which the participant receives direct or indirect remuneration, either immediate or deferred, with deductions made for current expenses incurred in the exercise of his or her duties, in accordance with the standards established by the *Ministère du Revenu du Québec*.

Investment income is not considered to be income from a gainful occupation, unless it generates an income greater than 20% of the total disability benefit amount. In such case, only the amount in excess of 20% is considered to be income from a gainful occupation.
However, any assets held prior to the onset of disability and the ensuing investment income, including any capital gains resulting from the sale of such assets, are not taken into consideration.

Notwithstanding the first paragraph of this provision, any individual who engages in a gainful occupation without notifying the Insurer will have the amount of the monthly benefit reduced by 100%, rather than 75%, of the income obtained from such occupation, retroactive to the start date of employment.

For the benefits mentioned in sections 7.4.2, 7.4.3, 7.4.5 and 7.4.6, the participant must submit a claim with the relevant authority if required by the Insurer, failing which the benefit amount will be reduced as described in these paragraphs. However, employees are not required to apply for payment of a pension if such payment would cause an actuarial reduction to be applied to the pension or when benefiting from a waiver of contributions to their pension plan without having 35 years of contributions.

If the disabled participant has received a total or partial refund of contributions to his or her pension plan or payment of a portion of the current value of his or her pension, the integration set out in this section applies based on the pension that would have been payable if it were not for such refund or payment.

No increase in any amount mentioned in sections 7.4.2, 7.4.3, 7.4.5 and 7.4.6 that is due to a cost-of-living adjustment may reduce the benefit amount payable under this plan.

7.5 Cost-of-living adjustment

As long as the participant is disabled, the amount of monthly benefits is indexed on January 1 each year in accordance with the same conditions as those applicable under the Quebec Pension Plan. However, the annual cost-of-living adjustment is limited to 3%.

7.6 Exclusions and reduction of the plan

No benefits are payable under this plan:

7.6.1 If the participant’s total disability occurs due to any of the following causes:

- War, whether declared or not, or the participant's active involvement in an insurrection, whether real or apprehended;
- Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind;
- The participant's involvement in a criminal act or an act deemed to be criminal;
- Any condition occurring while the participant is on active duty with the armed forces of any country;
- Alcoholism, drug addiction or compulsive gambling, 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 specialized for such purposes;

- Termination of employment in order to undergo cosmetic surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.

7.6.2 For a period of total disability during which the participant is in one of the following situations:

- 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.*

7.6.3 For any disability period during which the participant is not under the care of a physician except in the case where a physician certifies to the Insurer's satisfaction that the participant's state of health is stable.

7.6.4 A period during which the participant engages in any gainful occupation. This exclusion does not apply if the participant is engaging in a gainful occupation as provided for in the provisions of this contract or under a rehabilitation program.

7.7 Rehabilitation program

When a participant performs work as part of a rehabilitation program approved by the Insurer, his or her benefits are reduced by 50% of the remuneration for the work.

7.8 Tandem support services

7.8.1. In the event of personal problems that may affect an insured's psychological health or life balance and normal performance, the Insurer will provide access to assistance and counselling services according to the following terms for the following reasons:

a) Support service for insureds having relationship or family difficulties;

b) Support service for insureds having work-related problems;

c) Support service for insureds having personal problems: loss of interest, fatigue, stress, insomnia, burnout;

d) Support service for insureds abusing alcohol, drugs and/or medication.

This service is a short-term guidance and intervention service. It can be extended for up to 12 hours per insured, per year for all of the services mentioned.

7.8.2 Termination of Tandem support services

Upon the termination of this insurance benefit following cancellation by the Policyholder or the Insurer, ongoing services under the insurance benefit may be continued for an additional period of 30 days. These services are limited to a total of two hours, unless the 12-hour maximum is reached sooner.

7.9 Waiver of premiums in the event of total disability

If, before retirement, a participant sustains a total disability, in accordance with the definition of disability applicable to the Long-Term Disability Insurance plan selected by the union to which he or she belongs, while this plan is in force, the Insurer waives any premiums payable by the participant that fall due after the expiry of a 52-week period, as long as the total disability persists:

Waiver of premiums terminates on the earliest of the following dates:

a) The date on which the total disability ends;

b) The date of the participant’s 65th birthday.

7.10 Termination of insurance

The Long-Term Disability Insurance plan terminates on the earliest of the following dates:

7.10.1 The date the contract terminates, subject to any applicable legislation.

7.10.2 The date on which the participant’s employment terminates, subject to section 7.9 “Waiver of premiums in the event of total disability”. However, for any participant whose annual premium is payable over a period of 10 months, who is insured for at least one day during the month of May or June in a given year and who ceases to be an employee in May, June, July or August of the same year, coverage ends at midnight (24:00) on August 31 of the same year.

7.10.3 The date corresponding to the end of the last period for which premiums were paid for employees who benefited from the provisions of section 2.10 and who stopped paying premiums before the end of the work interruption.

7.10.4 The due date of any unpaid premium, subject to section 7.9 “Waiver of premiums in the event of total disability”. However, when payment of premiums is late for all participants of the same category, for the same employer, the Insurer agrees to send six month’s written notice to the Policyholder before applying this provision.

7.10.5 The date on which the participant exercises the exemption entitlement, in accordance with the provisions of this contract.

7.10.6 The date on which the union to which the participant belongs ceases to participate in this plan.

7.10.7 The date of the participant’s 63rd birthday.

7.10.8 The participant’s retirement date.

SECTION 8 – PREMIUM RATES - PREMIUM PAYMENTS - GRACE PERIOD

This section is not available since the content does not apply to all insureds.

SECTION 9 – CONTRACT CANCELLATION

9.1 Unpaid premium

In the event the premium is not paid before expiry of the grace period, the Insurer reserves the right to cancel this contract, as of the due date of the unpaid premium.

9.2 Notice

The Insurer may terminate this contract on any renewal date by giving the Policyholder written notice of at least 120 days before the renewal date. The Policyholder may terminate this contract at any time by giving the Insurer written notice of at least 30 days. In the absence of such notice by the Policyholder or the Insurer, this contract is automatically renewed.

SECTION 10 – CONTRACT CHANGES

The Policyholder may at any time, upon agreement with the Insurer, make modifications to the contract with regard to the categories of individuals eligible for insurance, the scope of coverage and the sharing of costs among categories of insureds. Such changes may then be applied to all insureds, whether they are active, disabled or retired.

SECTION 11 – MISCELLANEOUS PROVISIONS

11.1 Any notice given by the Insurer to the Policyholder is deemed sufficient if sent by mail to the Policyholder's last address as recorded in the Insurer's files. Any notice given by the Policyholder is deemed sufficient if sent by mail to the Insurer's head office in Quebec City, Quebec. No insurance representative or agent of the Insurer is authorized to make any changes to this contract or to delete any of its provisions. Any change must be approved in writing by the Insurer.

11.2 Legal action may be taken against the Insurer with regard to a claim under this contract if it is instituted within 36 months after the right to take legal action arises, but not before 60 days after the proof of claim, reports, documents and information that may be required by the Insurer has been submitted.

11.3 The Insurer is subrogated to all rights of the participant against a third party liable for damage that results in an entitlement to payment of benefits under this contract, up to the limitation of the amounts paid to the participant by the Insurer.

11.4 For the purposes of administering this contract, it is assumed that all insureds are covered under the public health Insurance plan of their province of residence. As a result, benefits payable under the Health and Dental Care Insurance benefits are reduced by the amount of any benefits payable under such plans, whether or not the insured submits a claim. However, employees assigned abroad for occupational reasons, who are expressly identified as such by their employer, and their dependents are not subject to this provision.

11.5 Any errors or omissions affecting the amount of the premium are corrected as soon as they are discovered, and the required premium adjustments are made. However, for any errors or omissions affecting the validity of insurance or the amount of insurance in force, the accurate data is used to determine whether insurance is in force and establish the amount of insurance in force, in accordance with the terms and conditions of this contract.

Errors made by the Policyholder or the Insurer in keeping insurance records, or any delay in compiling such records, do not invalidate insurance that is in force in accordance with the provisions of this contract, nor extend insurance terminated in accordance with the provisions of this contract.

11.6 All payments under this contract must be made to the Insurer's head office in the legal tender of Canada.

11.7 For the duration of this contract, the Policyholder is responsible for providing any information that the Insurer may require for applying this contract.

11.8 It must allow the Insurer to examine its payroll records and other employee files that might pertain to the eligibility and enrolment of employees and eligible dependents under this contract.

11.9 Insureds' rights under this contract may not be assigned or attached. The Insurer is not bound by the assignment made by an insured of the right to benefits or right to payment of benefits under this contract.

11.10 Entitlement to benefits automatically ceases for any insured who obtains or attempts to obtain, or who assists any person in obtaining or attempting to obtain any benefit under this contract to which they are not entitled. In addition, the Insurer is immediately discharged from any liability with regard to expenses that would otherwise be eligible for reimbursement after the date the insured's entitlement to benefits has ceased.

11.11 Invalidation of any of the clauses or a part of any of the clauses of this contract does not nullify the entire contract, but only invalidates the clause or the part of the clause concerned.

11.12 The use of titles, paragraphs, sections, and subsections is for information and reference purposes only, and in no case may this be interpreted as restricting the rights of the parties when interpreting this contract, which is always interpreted as a whole and as a single entity.

11.13 Any individual holding a group insurance representative's licence, with the exception of employees of the Insurer, who contributed to finalizing this contract, is deemed to be an authorized representative of the Policyholder.

11.14 The expiry or cancellation of any coverage under this contract may not be set up against any claim based on an event that occurred while this contract was in force or on a death resulting from a disability that occurred while this contract was in force.

11.15 The expiry or cancellation of any coverage under this contract may not be set up against any claim based on:

a) Death or dismemberment due to an accident that occurred while this contract was in force;

b) Disability or illness that occurred while this contract was in force.

11.16 The expiry or cancellation of a disability insurance benefit under this contract may not be set up against any claim based on a total disability that occurred before the expiry or cancellation, and the Insurer remains bound to compensate the participant for salary loss if the total disability persists after the contract expires.

SECTION 12 – CONTRACT

This contract, the endorsements, the specifications, the Insurer's quotation, any agreements concluded in the meantime, participants' enrolment applications and any required evidence of insurability constitute the entire contract between the contracting parties. In the event of a contradiction, the terms and conditions of this contract prevail over the specifications and the call for tender documents and any other document or explanatory folder distributed to insureds.

In addition, this contract is to be considered as the consolidation and, from time to time, as a reformulation of the endorsements, written agreements and initial contract that came into force on September 13, 2006. It does not confer any new rights retroactively, and the contract provisions applicable to a loss remain those in force at the time such loss occurs.

In addition, December 31, 2017 is not considered the termination date of the contract for legal purposes but as the end of a contract year.

APPENDIX

This appendix is not available since the content does not apply to all insureds.