La Capitale
Insurance and
Financial Services

Contract 004500

FÉDÉRATION DES
MÉDECINS RÉSIDENTS
DU QUÉBEC

FRMQ Insurance Committee

Amended on July 1, 2016

GROUP INSURANCE PLAN

insured by

La Capitale
Insurance and
Financial Services

Contract 004500

FÉDÉRATION DES
MÉDECINS RÉSIDENTS
DU QUÉBEC

FRMQ Insurance Committee

Amended on July 1, 2016

IMPORTANT

This document contains general provisions relating to the insurance contract.

This document does not mention all the clauses concerning definitions, eligibility, participation, end of insurance and other miscellaneous provisions. Nonetheless, you may find out more about policy contents by consulting the contract available from *Fédération des médecins résidents du Québec*.

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SCHEDULE OF INSURANCE

This table provides a brief description of your Group Insurance Plan. For a full description of each benefit, please refer to the corresponding pages in the booklet.

HEALTH INSURANCE The maximums indicated are per insured, unless indicated otherwise.			
	BASIC PLAN	**INTERMEDIATE PLAN**	**SUPERIOR PLAN**
1. Hospitalization and Travel Insurance			
Hospitalization in Canada (short-term and long-term care)	Not covered	100% Semi-private room	100% Private room, including convalescent home
Travel Insurance and Assistance	100% Lifetime maximum refund of $1,000,000	100% Lifetime maximum refund of $1,000,000	100% Lifetime maximum refund of $5,000,000
Trip Cancellation Insurance	100% Maximum refund of $5,000 per trip	100% Maximum refund of $5,000 per trip	100% Maximum refund of $5,000 per trip
2. Prescription drug expenses			
Medication	68%, up to the maximum annual contribution under the BPDIP RAMQ list Direct automated payment service	75% of the first $500 of eligible expenses, 90% of the next $500 and 100% of any excess, per certificate, per calendar year Regular list Direct automated payment service	75% of the first $500 of eligible expenses, 90% of the next $500 and 100% of any excess, per certificate, per calendar year Regular list Direct automated payment service
Preventive vaccines	Not covered	Not covered	100% Maximum refund of $500 per calendar year
Sclerosing injections (product only)	Not covered	Not covered	100% Maximum refund of $50 per treatment and 10 treatments per calendar year

HEALTH INSURANCE (cont.) The maximums indicated are per insured, unless indicated otherwise.			
	BASIC PLAN	**INTERMEDIATE PLAN**	**SUPERIOR PLAN**
3. Healthcare professionals			
Acupuncturist	Not covered	Not covered	100% Maximum refund of $30 per treatment and $600 per calendar year
Audiologist	Not covered	100% Maximum refund of $45 per treatment and $450 per calendar year	100% Maximum refund of $55 per treatment and $550 per calendar year
Chiropractor	Not covered	100% Maximum refund of $20 per treatment and $400 per calendar year	100% Maximum refund of $30 per treatment and $600 per calendar year
Chiropractor X-rays	Not covered	100% Maximum refund of $40 per calendar year	100% Maximum refund of $60 per calendar year
Dietitian	Not covered	Not covered	100% Maximum refund of $30 per treatment and $600 per calendar year
Kinesitherapist, massage therapist and orthotherapist	Not covered	Not covered	100% Maximum refund of $30 per treatment and $300 per calendar year, for all of these professionals combined
Occupational therapist	Not covered	100% Maximum refund of $35 per treatment and 20 treatments per calendar year	100% Maximum refund of $45 per treatment and 20 treatments per calendar year
Osteopath	Not covered	100% Maximum refund of $20 per treatment and $400 per calendar year	100% Maximum refund of $30 per treatment and $600 per calendar year

HEALTH INSURANCE (cont.) The maximums indicated are per insured, unless indicated otherwise.			
	BASIC PLAN	**INTERMEDIATE PLAN**	**SUPERIOR PLAN**
3. Healthcare professionals (cont.)			
Physiotherapist and physical rehabilitation therapist	Not covered	100 % Maximum refund of $25 per treatment and 20 treatments per calendar year, for all of these professionals combined	100% Maximum refund of $45 per treatment and 20 treatments per calendar year, for all of these professionals combined
Podiatrist	Not covered	100% Maximum refund of $20 per treatment and $400 per calendar year	100% Maximum refund of $30 per treatment and $600 per calendar year
Psychologist	Not covered	80%, including the professional fees for psychotherapist Maximum refund of $2,000 per calendar year	80%, including the professional fees of a psychoanalyst, psychotherapist or social worker Maximum refund of $2,000 per calendar year, for all of these professionals combined
Speech therapist	Not covered	100% Maximum refund of $45 per treatment and $450 per calendar year	100% Maximum refund of $55 per treatment and $550 per calendar year
4. Other eligible expenses			
Accidental damage to natural teeth	Not covered	100%	100%
Ambulance	Not covered	100%	100%
Artificial limb or eye	Not covered	100% Loss resulting from an accident	100% Loss resulting from an accident or illness
Closed treatment or outpatient detoxification program	Not covered	100% Maximum refund of $75 per day and lifetime maximum refund of $3,000	100% Maximum refund of $75 per day and lifetime maximum refund of $3,000
Cosmetic surgery following an accident	Not covered	Not covered	100% Maximum refund of $5,000 per accident

HEALTH INSURANCE (cont.) The maximums indicated are per insured, unless indicated otherwise.			
	BASIC PLAN	**INTERMEDIATE PLAN**	**SUPERIOR PLAN**
4. Other eligible expenses (cont.)			
External breast prosthesis	Not covered	100%	100%
Glucometer, dextrometer or other appliance of similar nature	Not covered	100% Maximum refund of $250 per period of five consecutive years, for insulin-dependent insureds only[1]	100% Maximum refund of $250 per period of five consecutive years[1]
Intra-uterine device	Not covered	100% Maximum refund of $75 per calendar year	100% Maximum refund of $200 per calendar year
Joint or intraocular prosthesis	Not covered	100% of expenses exceeding those covered by the RAMQ if the surgery is performed in a public establishment	100% of expenses exceeding those covered by the RAMQ if the surgery is performed in a public establishment 100 % of expenses incurred, not including professional fees, if the surgery is performed in a private establishment
Nursing care	Not covered	100% Maximum refund of $150 per day and $3,000 per calendar year	100% Maximum refund of $10,000 per calendar year
Orthopedic appliances	Not covered	100%	100%
Orthopedic shoes and podiatric orthotics	Not covered	100%	100%
Oxygen and devices used to administer it, blood and plasma	Not covered	100%	100%

HEALTH INSURANCE (cont.) The maximums indicated are per insured, unless indicated otherwise.			
	BASIC PLAN	**INTERMEDIATE PLAN**	**SUPERIOR PLAN**
4. Other eligible expenses (cont.)			
Support stockings	Not covered	100% Six pairs per period of 12 consecutive months[1]	100% Six pairs per period of 12 consecutive months[1]
Therapeutic devices	Not covered	100%	100%
Transportation and accommodation in Quebec for care not available in the region of residence	Not covered	Not covered	100% Maximum refund of $75 per day for accommodation and $1,500 per calendar year for accommodation and transportation
Vision care (eye exam, eyeglasses, contact lenses and laser surgery)	Not covered	Not covered	100% Maximum refund of $350 per period of 24 consecutive months[1]
Wheelchair or hospital bed	Not covered	100%	100%
Wig (capillary prosthesis)	Not covered	100%	100%
X-rays, computed tomography, magnetic resonance imaging, laboratory tests and electrocardiograms	Not covered	Not covered	100% Maximum refund of $1,500 per calendar year

1- **When a maximum applies to a period of time other than a calendar year, the start of that period corresponds to the initial purchase date of the product or supply.**

Example : If an insured purchases a pair of glasses on April 4, 2014, the period of 24 consecutive months begins on that date and ends on April 3, 2016. The subsequent period of 24 months will begin on the next date that glasses are purchased following the end of the previous period.

LIFE INSURANCE	
Participant	1 x annual earnings
Dependents:	
Spouse	$5,000
Dependent child (as of 24 hours of age)	$2,500

SHORT-TERM DISABILITY INSURANCE

See page 27 of this booklet for details

LONG-TERM DISABILITY INSURANCE	
Elimination period	105 weeks
Maximum benefit period	Up to age 65
Benefit amount	100% of the net benefits payable on the 105th week of disability
Indexation	Based on Retraite Québec rate

HEALTH INSURANCE

1. Eligibility of expenses

Eligible expenses, i.e. reasonable expenses that are generally considered to be justified by the seriousness of the case, incurred by an insured as a result of an accident, illness, pregnancy or surgery relating to family planning or from organ or bone marrow donation.

The services and supplies must be medically required and necessary for the treatment of the insured.

Only the expenses payable in excess of amounts payable under the public health and hospitalization insurance plans in the insured's province of residence are eligible, whether or not the insured is enrolled in these plans.

In order for the expenses to be eligible, the healthcare professionals consulted must be duly licensed to practice in their field and be a member in good standing of a recognized professional association authorizing them to go about their activities and use their title. If there is no such association, they must be a member of a professional association recognized by the Insurer.

Insureds may not claim for more than one treatment or consultation per day from the same healthcare professional, regardless of the number of specialities the professional practices.

The eligible expenses are subject to the exclusions and reduction set out in point 5 of the section on Health Insurance.

Basic plan

2. Basic Plan

2.1 Travel Insurance

Travel and Trip Cancellation Insurance

Travel and Trip Cancellation Insurance are an integral part of the Basic Health Insurance plan.

A full description of these coverages may be found on pages 45 and 53 of this booklet.

2.2 Prescription drug expenses

The following expenses are refunded at 68%, up to the maximum annual contribution under the Basic Prescription Drug Insurance Plan.

The Insurer refunds pharmaceutical services and medications provided by coverage under the Basic Prescription Drug Insurance Plan, as established under *An Act respecting Prescription drug insurance* (RSQ, c A-29.01). Nonetheless, these services and medications are not covered in the case of a participant age 65 or over and his or her dependents or in the case of a dependent age 65 or over, unless the participant has chosen to insure the said medication under this coverage.

Intermediate plan

3. Intermediate Plan

3.1 Hospitalization and Travel Insurance

Hospitalization in Canada (short-term and long-term care)

The Insurer refunds all hospitalization expenses incurred in Canada and in excess of amounts payable by any government insurance plan. These expenses are refunded at 100%, up to the cost of a semi-private room.

The Insurer also refunds expenses incurred in a residential and long-term care centre, within the meaning of *An Act Respecting Health Services and Social Services,* or in a hospital centre to receive long-term care.

Travel and Trip Cancellation Insurance

Travel and Trip Cancellation Insurance are an integral part of the Intermediate Health Insurance plan.

A full description of these coverages may be found on pages 45 and 53 of this booklet.

3.2 Prescription drug expenses

The following expenses are refunded at 75% of the first $500 of eligible expenses, 90% of the next $500 and 100% of any excess, per certificate, per calendar year.

The Insurer refunds pharmaceutical services and medications provided by coverage under the Basic Prescription Drug Insurance Plan, as established under *An Act respecting Prescription drug insurance* (RSQ, c A-29.01). Nonetheless, these services and medications are not covered in the case of a participant age 65 or over and his or her dependents or in the case of a dependent age 65 or over, unless the participant has chosen to insure the said medication under this coverage.

Subject to the exclusions below, the Insurer refunds expenses incurred for medications other than those mentioned in the previous paragraph and included in the list of medications of the *Association québécoise des pharmaciens propriétaires* (AQPP), which are sold by a licensed pharmacist or physician and can only be obtained on prescription by a physician or dentist, as well as prescribed medications specifically used to treat one of the following conditions:

- cardiac disorders
- pulmonary disorders
- diabetes
- arthritis
- Parkinson’s disease
- epilepsy
- cystic fibrosis
- glaucoma

3.3 Healthcare professionals

The following expenses are refunded at 100%, unless otherwise indicated.

a) Professional fees of an **audiologist**, up to a maximum refund of $45 per treatment and $450 per calendar year, per insured.

b) Professional fees of a **chiropractor**, up to a maximum refund of $20 per treatment and $400 per calendar year, per insured.

c) Professional fees of an **occupational therapist**, up to a maximum refund of $35 per treatment and 20 treatments per calendar year, per insured.

d) Professional fees of an **osteopath**, up to a maximum refund of $20 per treatment and $400 per calendar year, per insured.

e) Professional fees for the services of a **physiotherapist** and a **physical rehabilitation therapist**, rendered outside a hospital centre, up to a maximum refund of $25 per treatment and 20 treatments per calendar year, per insured, for all of these professionals combined.

f) Professional fees of a **podiatrist**, up to a maximum refund of $20 per treatment and $400 per calendar year, per insured.

g) Professional fees of a **psychologist** or a **psychotherapist** up to a maximum refund of $2,000 per calendar year, per insured. The psyshotherapist must be a member of the *Ordre des psychologues du Québec*. **These expenses are refunded at 80%.**

h) Professional fees of a **speech therapist**, up to a maximum refund of $45 per treatment and $450 per calendar year, per insured.

i) Any **x-rays performed by a chiropractor**, up to a maximum refund of $40 per calendar year, per insured.

3.4 Other eligible expenses

The following expenses are refunded at 100%.

a) Professional fees of a **dentist** for treatment of a fractured jaw or damage to healthy, natural and vital teeth caused by an accident occurring while insurance is in force. 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 begin within 12 months following the date of the accident.

b) Expenses for **transportation by ambulance** to the nearest hospital centre able to provide the care required, including emergency air transportation.

c) Expenses for the purchase of an **artificial limb** or **eye**, provided that the loss occurred as a result of an accident during the insurance period.

d) Expenses for **closed treatment** or **outpatient detoxification program** for the detoxification or rehabilitation of the insured in an establishment specializing in the treatment of alcoholism, drug addiction or compulsive gambling, up to a daily maximum refund of $75 and a lifetime maximum of $3,000 per insured.

e) Expenses for the rental or purchase, depending on the circumstances, of **dressings, prosthetic appliances**, with the exception of those covered under other clauses of this plan, **crutches, splints, plaster casts, trusses, orthopedic corsets** and **other orthopedic equipment.**

f) Expenses for the purchase of an **external breast prosthesis** following a mastectomy. The expenses covered are in excess of those covered by the RAMQ.

g) Expenses incurred for the purchase of an appliance for controlling diabetes (**glucometer, dextrometer or any other appliance of a similar nature**) as well as the travel case for transporting it, up to a maximum refund of $250 per period of five consecutive years, per insured. In order for the expenses to be eligible, insureds must submit a complete report from their attending physician stating that they are insulin-dependent and that their condition requires the use of such an appliance.

h) Expenses for the purchase of an **intra-uterine device**, up to a maximum refund of $75 per calendar year, per insured.

i) Expenses for the purchase of a **joint** or **intraocular prosthesis** in excess of those covered by the RAMQ if the surgery is performed in a public establishment.

j) Professional fees of a **nurse** or **nursing assistant** for ongoing medical care provided in the participant's home, excluding any person who usually resides in the participant's home or is a member of the participant's family, up to a maximum refund of $150 per day and $3,000 per calendar year, per insured.

k) The initial or replacement cost of **orthopedic shoes** that are custom-made for the insured and expenses for the purchase of **podiatric orthotics**. These shoes and orthotics must be sold by a specialized laboratory or establishment licensed under all applicable legislation in the insured's province of residence.

l) Expenses for **oxygen** or **rental of equipment for its administration, blood** and **plasma** (except for expenses incurred for the preservation or freezing of blood and plasma).

m) Expenses for the purchase of **support stockings** for strong or average compression (13 mm Hg or more), up to a maximum of six pairs per period of 12 consecutive months, per insured.

n) Expenses for the rental or purchase, depending on the circumstances, of **therapeutic devices**, on medical recommendation and when made necessary by the insured's physical condition.

o) Expenses for the rental or purchase, when the Insurer estimates that this means is more economical, of a basic **wheelchair** or **hospital bed**, on medical recommendation and when made necessary by the insured's physical condition.

p) Expenses for the purchase of a **capillary prosthesis (wig)** following chemotherapy or radiation therapy treatments.

4. Superior Plan

4.1 Hospitalization and Travel Insurance

Hospitalization in Canada (short-term and long-term care)

The Insurer refunds all hospitalization expenses incurred in Canada and in excess of amounts payable by any government insurance plan. These expenses are refunded at 100%, up to the cost of a private room and include stays at a convalescent home.

The Insurer also refunds expenses incurred in a convalescent home, a residential and long-term care centre, within the meaning of *An Act Respecting Health Services and Social Services*, or in a hospital centre to receive long-term care.

Travel and Trip Cancellation Insurance

Travel and Trip Cancellation Insurance are an integral part of the Superior Health Insurance plan.

A full description of these coverages may be found on pages 45 and 53 of this booklet.

Health Insurance

4.2 Prescription drug expenses

a) **The following expenses are refunded at 75% of the first $500 of eligible medication, 90% of the next $500 and 100% of any excess, per certificate, per calendar year.**

The Insurer refunds pharmaceutical services and medications provided by coverage under the Basic Prescription Drug Insurance Plan, as established under *An Act respecting Prescription drug insurance* (RSQ, c A-29.01). Nonetheless, these services and medications are not covered in the case of a participant age 65 or over and his or her dependents or in the case of a dependent age 65 or over, unless the participant has chosen to insure the said medication under this coverage.

Subject to the exclusions below, the Insurer refunds expenses incurred for medications other than those mentioned in the previous paragraph and included in the list of medications of the *Association québécoise des pharmaciens propriétaires* (AQPP), which are sold by a licensed pharmacist or physician and can only be obtained on prescription by a physician or dentist. as well as prescribed medications specifically used to treat one of the following conditions:

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

b) Expenses for the product used in **sclerosing injections** that are medically necessary and administered by a physician are refunded at 100%, up to a maximum refund of $50 per treatment and 10 treatments per calendar year, per insured.

c) Expenses for **vaccines**, including preventive vaccines, which are available only on prescription and are administered by a physician or nurse are refunded at 100%, up to a maximum refund of $500 per calendar year, per insured.

4.3 Healthcare professionals

The following expenses are refunded at 100%, unless otherwise indicated.

a) Professional fees of an **acupuncturist**, up to a maximum refund of $30 per treatment and $600 per calendar year, per insured.

b) Professional fees of an **audiologist**, up to a maximum refund of $55 per treatment and $550 per calendar year, per insured.

c) Professional fees of a **chiropractor**, up to a maximum refund of $30 per treatment and $600 per calendar year, per insured.

d) Professional fees of a **dietitian**, up to a maximum refund of $30 per treatment and $600 per calendar year, per insured.

e) Professional fees of a **kinesitherapist**, a **massage therapist** and an **orthotherapist**, up to a maximum refund of $30 per treatment and $300 per calendar year, per insured, for all of these professionals combined.

f) Professional fees of an **occupational therapist**, up to a maximum refund of $45 per treatment and 20 treatments per calendar year, per insured.

g) Professional fees of an **osteopath**, up to a maximum refund of $30 per treatment and $600 per calendar year, per insured.

h) Professional fees for the services of a **physiotherapist** and a **physical rehabilitation therapist**, rendered outside a hospital centre, up to a maximum refund of $45 per treatment and 20 treatments per calendar year, per insured, for all of these professionals combined.

i) Professional fees of a **podiatrist**, up to a maximum refund of $30 per treatment and $600 per calendar year, per insured.

j) Professional fees of a **psychologist**, a **psychoanalyst**, a **psychotherapist** or a **social worker**, up to a maximum refund of $2,000 per calendar year, per insured, for all of these professionals combined. The psyshotherapist must be a member of the *Ordre des psychologues du Québec*. **These expenses are refunded at 80%.**

k) Professional fees of a **speech therapist**, up to a maximum refund of $55 per treatment and $550 per calendar year, per insured.

l) Any **x-rays performed by a chiropractor**, up to a maximum refund of $60 per calendar year, per insured.

4.4 Other eligible expenses

The following expenses are refunded at 100%.

a) Professional fees of a **dentist** for treatment of a fractured jaw or damage to healthy, natural and vital teeth caused by an accident occurring while insurance is in force. 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 begin within 12 months following the date of the accident.

b) Expenses for **transportation by ambulance** to the nearest hospital centre able to provide the care required, including emergency air transportation.

c) Expenses for the purchase of an **artificial limb** or **eye** provided that the loss occurred as a result of an accident or illness during the insurance period.

d) Expenses for **closed treatment** or **outpatient detoxification program** for the detoxification or rehabilitation of the insured in an establishment specializing in the treatment of alcoholism, drug addiction or compulsive gambling, up to a daily maximum refund of $75 and a lifetime maximum of $3,000 per insured.

e) 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 24 months following the date of the accident, up to a maximum refund of $5,000 per accident, per insured.

f) Expenses for the rental or purchase, depending on the circumstances, of **dressings, prosthetic appliances**, with the exception of those covered under other clauses of this plan, **crutches, splints, plaster casts, trusses, orthopedic corsets and other orthopedic equipment.**

g) Expenses for the purchase of an **external breast prosthesis** following a mastectomy. The expenses covered are in excess of those covered by the RAMQ.

h) Expenses incurred for the purchase of an appliance for controlling diabetes (**glucometer, dextrometer or any other appliance of a similar nature**) as well as the travel case for transporting it, up to a maximum refund of $250 per period of five consecutive years, per insured.

i) Expenses for the purchase of an **intra-uterine device**, up to a maximum refund of $200 per calendar year, per insured.

j) Expenses for the purchase of a **joint** or **intraocular prosthesis** in excess of those covered by the RAMQ if the surgery is performed in a public establishment, or the total cost of the prosthesis if the surgery is performed in a private establishment. Any expenses other than those associated with the cost of the prosthesis, such as professional fees, are however excluded from this paragraph.

k) Professional fees of a **nurse** or **nursing assistant** for ongoing medical care provided in the participant's home, excluding any person who usually resides in the participant's home or is a member of the participant's family, up to a maximum refund of $10,000 per calendar year, per insured.

l) The initial or replacement cost of **orthopedic shoes** that are custom-made for the insured and expenses for the purchase of **podiatric orthotics**. These shoes and orthotics must be sold by a specialized laboratory or establishment licensed under all applicable legislation in the insured's province of residence.

m) Expenses for **oxygen** or **rental of equipment for its administration, blood and plasma** (except for expenses incurred for the preservation or freezing of blood and plasma).

n) Expenses for the purchase of **support stockings** for strong or average compression (13 mm Hg or more), up to a maximum of six pairs per period of 12 consecutive months, per insured.

o) Expenses for the rental or purchase, depending on the circumstances, of **therapeutic devices**, on medical recommendation and when made necessary by the insured's physical condition.

p) **Transportation and accommodation for care not available in the province of residence**

The following expenses are eligible, up to a maximum refund of $75 per day for accommodation and $1,500 per calendar year, per insured, for accommodation and transportation incurred by insureds who must travel outside their area of residence to consult a medical specialist or receive treatment not available in their area of residence, provided that the treatments are recommended by a physician and the expenses are incurred in Quebec:

- Expenses for travel of 200 kilometres or more (one way) from the insured's place of residence with the most affordable public carrier (bus, plane, boat or train) or by automobile. However, for travel by automobile, the eligible expenses are equal to those that would have been incurred had the trip been made with the most affordable public carrier.

– Accommodation expenses incurred in a public establishment, provided that the consultation or the treatment requires an overnight stay. Eligible expenses are refunded upon presentation of receipts or paid invoices.

– Expenses incurred by or for a person accompanying the insured, if justified by the medical situation, are also eligible.

– For participants with Individual coverage, eligible expenses are those incurred by and for participants. For participants with Family coverage, eligible expenses must be incurred by and for the participant or one of that person's dependents.

The Insurer refunds only expenses in excess of those payable under any government program.

q) Expenses for an **eye exam** or for the purchase of **eyeglasses** or **contact lenses** on the recommendation of a physician or optometrist, as well as expenses for **laser eye surgery** performed by a ophthalmologist who is a member of the *Collège des médecins du Québec*, in order to correct myopia, hypermetropia, astigmatism or presbyopia, up to a maximum refund of $350 per period of 24 consecutive months, per insured, for all of these expenses.

r) Expenses for the rental or purchase, when the Insurer estimates that this means is more economical, of a basic **wheelchair** or **hospital bed**, on medical recommendation and when made necessary by the insured's physical condition.

s) Expenses for the purchase of a **capillary prosthesis (wig)** following chemotherapy or radiation therapy treatments.

t) Expenses for **X-rays, computed tomography, magnetic resonance imaging, electrocardiograms** and **laboratory tests** for purposes of prevention or diagnosis performed outside a hospital centre, up to a maximum refund of $1,500 per calendar year, per insured, for all of these expenses combined.

5. Exclusions and reduction of Health Insurance coverage

5.1 Exclusions specific to medication

Expenses incurred for the following products are not eligible:

a) Medicines coded “Z” in the AQPP’s list of medications

b) Products considered to be food substitutes, cosmetic substances, soaps, skin colour oils, epidermal emollients, shampoos and other substances for scalp treatment

c) Dietary substances or foods, products for obesity and weight control

d) Homeopathic medicines

e) Medications administered primarily for preventive purposes

f) Products for treating baldness, wrinkles or any other treatment administrated primarily for aesthetic purposes

g) Smoking cessation products not covered under the Basic Prescription Drug Insurance Plan (BPDIP)

h) Medication or substances used for the treatment of infertility or impotence not covered under the BPDIP

i) Any substance used for the purpose of insemination, contraceptive and prophylactic jellies and foams

j) Medication provided during a period of hospitalization.

In addition, the Insurer may refuse to refund medication 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 refund to a reasonable maximum.

Lastly, in the event of approval by Health Canada of new medication that may substantially affect the cost of the coverage, the Insurer reserves the right to exclude such medication if it does not appear on the list of medications of the *Régie de l’assurance maladie du Québec* or to change the premium starting on the approval date with the consent of the Policyholder.

5.2 General exclusions and reduction

Subject to the provisions of *An Act respecting Prescription drug insurance*, the products and services described below are excluded from coverage under this benefit, unless they are specifically covered under the plan selected by the insured:

a) Aesthetic surgery care

b) Care, services and supplies for which the insured would not be required to pay in the absence of this plan

c) Eye examination, eyeglasses or contact lenses

d) Hearing aids

e) Hearing tests

f) Preventive vaccines

g) Sclerosing injections or injections provided as part of a weight reduction program

h) A periodic medical examination, or a medical examination for employment purposes, for being admitted to an academic institution, for insurance purposes or for travelling for health purposes

i) Care and services administered by a member of the insured's family or by someone who resides with the insured

j) Any expenses related to insemination

k) Care, services or supplies of an experimental nature

l) Any user fee, deductible or coinsurance required by any public plan for products and services eligible hereunder

m) Expenses payable under any public or private individual or group plan.

Furthermore, the exclusion extends to expenses incurred under the following circumstances:

a) Any condition occurring while the insured is on active duty with the armed forces

b) War, whether declared or undeclared, or active participation of the insured in an insurrection, whether real or apprehended

c) Participation of the insured in a criminal act or an act deemed to be criminal.

These exclusions also apply to the Travel Insurance coverage in addition to exclusions in the Travel Insurance description.

For the Trip Cancellation Insurance coverage, only the exclusions and reduction appearing in the coverage description are applicable.

6. Conversion privilege

Insureds who are no longer eligible for coverage under this benefit may apply, without evidence of insurability, for an individual health insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within 60 days following the date of termination of insurance. Evidence of insurability will be required for applications submitted after this deadline.

For insureds who exercise their conversion privilege within the specified deadline, their individual health insurance policy will be effective as of the date of termination of their group insurance.

If evidence of insurabililty is required, insurance will become effective as of the date the Insurer accepts such evidence.

LIFE INSURANCE

1. Participant's Life Insurance

The amount of insurance payable upon the participant's death is equal to 1 time the annual earnings payable on the date of death or on the date waiver of premiums began, if this date is earlier.

2. Dependents' Life Insurance

The amount payable upon the death of a participant's insured dependent is as follows:

- if the dependent is a spouse: $5,000
- if the dependent is a child: $2,500 from 24 hours after birth.

3. Conversion privilege applicable to Participant's Basic Life Insurance and to Dependents' Life Insurance

Termination of membership in the group

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

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

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 termination date of their membership in the group of insureds. 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 class of insureds does not give entitlement to the conversion privilege.

Expiry of the contract

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

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

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

Coverage available upon conversion

Participants who exercise their conversion privilege according to the aforementioned 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 the *Regulation under the Act respecting insurance*.

The premiums applicable to the Individual Life Insurance products when exercising the conversion privilege are determined in compliance with the *Regulation under the Act respecting insurance*.

DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE

The Agreement entered into by the FMRQ and the MSSS provides for the payment by the employer of Disability Insurance benefits in the case where a resident becomes disabled. These benefits are payable starting on the sixth working day of disability and are equal to 80% of the earnings. The payment of these benefits terminates after 104 weeks. For further details, please refer to the collective agreement.

LONG-TERM DISABILITY INSURANCE

1. Waiting period

The waiting period means the period during which no benefits are payable. It lasts 105 weeks.

2. Benefit period

The first benefit payment is payable beginning on the 31st day following the expiry of the waiting period, and the subsequent payments are made each month thereafter.

Furthermore, entitlement to benefits ceases on the earliest of the following dates:

- the date on which the participant reaches age 65
- the date on which the participant ceases to be totally disabled
- the date on which the participant fails to furnish evidence of continuing disability that is satisfactory to the Insurer
- the date on which the participant refuses to submit to a medical examination as requested by the Insurer
- the date of the participant's death.

3. Benefit amount

The benefit amount is equal to 100% of the net benefits payable on the 105th week of disability under the Disability Insurance plan of the collective agreement computed on a monthly basis. Net benefits are equal to gross benefits as provided in the collective agreement (80% of the basic earnings), minus federal and provincial taxes and Quebec Pension Plan, Employment Insurance and Quebec Parental Insurance Plan contributions. For the resident who is doing a fellowship, the benefit amount is equal to 80% of the net earnings.

The benefits paid by the Insurer are reduced by the sum of the following net amounts:

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

  A disabled participant who is entitled to a disability pension from Retraite Québec and who applies for his or her retirement pension from this organization is deemed to receive the disability pension that he or she would have received if he or she had applied or he or she would have continued to receive if he or she had not applied for his or her retirement pension.
- Benefits under *Act Respecting Industrial Accidents and Occupational Diseases* or the Quebec *Automobile Insurance Act* which are effectively paid or would be paid to the participant if an application had been made and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.
- Benefits related to the disability under any other social legislation or employer's retirement plan that are effectively paid or would be paid to the participant if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

In all instances of a reduction in the amount of benefits mentioned above, the participant must file an application for disability benefits with the appropriate authority if the Insurer so requires, and any failure by the participant to do so will entail the reduction of the amount of benefits as previously described.

No increase in any amount mentioned in the preceding paragraphs and originating from a cost-of-living adjustment reduces the amount of the benefit payable under this coverage.

The amount of benefits in the event of disability is divided, if applicable, at a rate of 1/30 of the monthly benefits for a calendar day during this month.

In addition, the total of net disability insurance benefits described above and the initial net income from other sources cannot exceed 100% of the net earnings that the participant would have earned on the 106th week of disability if he or she had been at work.

The following income is considered to be income from other sources:

a) disability income under:
   - *An Act Respecting Industrial Accidents and Occupational Diseases* or any other similar legislation
   - the Quebec *Automobile Insurance Act* or any other similar legislation
   - the *Crime Victims Compensation Act*, the Quebec Pension Plan or Canada Pension Plan (initial amount of benefits only)
   - any other social legislation, any other public group insurance plan, including any supplemental benefits plan to which the employer contributes or to which any previous employer has contributed

b) any earnings derived from gainful employment, with the exception of amounts received for a rehabilitation program.

In addition, for purposes of calculating income from other sources, a disabled participant who is entitled to a disability benefit from Retraite Québec and who files for his or her retirement pension from this organization is deemed to receive the disability benefit that he or she would have received if he or she had so requested or that he or she would have continued to receive if he or she had not filed for the retirement pension.

4. Cost-of-living adjustment

The benefits are indexed on January 1 of each year in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan.

5. Rehabilitation

Rehabilitation is a process through which the Insurer provides disabled insureds with medical or paramedical care and the required assistance to recover and resume their residency.

Rehabilitation is offered on a voluntary basis and the process begins with an evaluation to assess needs, identify elements which could enable the participant to resume residency or not and offer personalized assistance.

The main objective of the process is to allow, if possible, a lasting return to residency and all interventions are based on the achievement of this objective. If functional limitations permanently prevent the participant from resuming residency, the Insurer will intervene rapidly in order to help the participant to reinstate the labor market in a gainful activity for which he or she is reasonably qualified by education, training or experience. However, the rehabilitation program ends at the expiry of a 36-month period following the date of beginning of long term disability insurance benefits.

A participant who takes part in a rehabilitation program continues to receive disability insurance benefits which are equal to the monthly benefits the participant was receiving before the beginning of the program, but reduced by 50% of the net income earned for any work performed during this program.

If the participant's income from rehabilitation benefits and the net remuneration for the work accomplished during the rehabilitation program exceeds 100% of the net basic monthly earnings paid by the employeur at the beginning of the elimination period, the monthly rehabilitation benefits are reduced by the excess amount.

6. Exclusions

No benefit is payable under the present coverage for any total disability that results from:

a) War, whether declared or undeclared, or active participation of the insured in an insurrection, whether real or apprehended

b) Self harm or injury, whether or not the participant is of sound mind, except for a period of disability resulting from attempted suicide

c) Participation in a criminal act or an act deemed to be criminal

d) Any condition occurring while the insured is on active duty with the armed forces

e) Alcoholism, drug addiction or compulsive gambling, except if it is a period of disability during which the participant receives treatments or uninterrupted medical care as a part of a detoxification treatment or his or her rehabilitation in an establishment specialized for such purposes

f) Any period of disability during which the participant is not under the care of a physician, unless the physician demonstrates, to the Insurer's satisfaction, that the participant's medical condition is stable

g) Any period of disability during which the participant is not receiving the appropriate and adequate care that is required for the injury or illness resulting in the total disability and recommended by the attending physician.

GENERAL INFORMATION

1. Definitions

Accident

A sudden, unforeseen and unpredictable event that is solely due to an external cause of a violent and unintentional nature which, directly and independently of any other cause, results in bodily injury that is confirmed by a physician.

Business partner

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

Close relative

The spouse, child, father, mother, father-in-law, mother-in-law, stepfather, stepmother, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild of the insured.

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.

Dependent child

The expression "dependent child" designates one of the following persons:

i) a person under age 18 over whom the participant or his or her spouse exercises parental authority

ii) a person, without a spouse, age 25 or less, who attends on a full-time basis as a duly registered student, a recognized educational institution, and over whom the participant or his or her spouse would exercise parental authority if the dependent child were a minor

iii) a person of full age, without a spouse, who lives with the participant and over whom the participant or his or her spouse would exercise parental authority if the dependent child were a minor, and who is impaired by a total disability or a functional deficiency, as defined by applicable legislation, which occurred prior to age 18.

The concept of parental authority for a person other than a child belonging to the participant or to his or her spouse must be confirmed by a court judgment or by a valid will of the father or mother or by a statement on their part to such effect transmitted to the public curator.

Disability period

During the first 36 months of disability, a total disability period means any continuous period of total disability or a series of successive periods of disability separated by less than 15 days of effective full-time work or availability for full-time work, unless the participant establishes to the satisfaction of the employer or that of its representative that a subsequent period is attributable to an illness or accident completely unrelated to the reason for the previous total disability.

After the first 36 months of disability, a total disability period means any continuous period of total disability or a series of successive periods of disability separated by less than six months of effective full-time work or availability for full-time work. Any disability resulting from an illness or accident completely unrelated to the reason for the previous total disability is considered to be a new disability period.

Earnings

Resident: The salary scale as well as call duty, teaching and chief resident and assistant chief resident premiums, excluding overtime pay and any lump sums.

Resident doing a medicine fellowship: Earnings considered during the fellowhip is that received during the last year of residency, without any cost-of-living adjustment during the entire fellowship.

Host at destination

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

Illness

An organic or functional alteration considered in its evolution and as an entity which must be defined by a physician, including any complication resulting from pregnancy.

Net earnings

Resident: The earnings less contributions to Retraite Québec, Employment Insurance and Quebec Parental Insurance Plan and federal and provincial taxes according to the tax exemption claim submitted to the employer.

Resident doing a medicine fellowship: The earnings less contributions to Retraite Québec, Employment Insurance and Quebec Parental Insurance Plan and federal and provincial taxes according to the tax exemptions to which the participant is entitled.

Resident

A resident as defined in the agreement between the Minister of Health and Social Services and the *Fédération des médecins résidents du Québec*. A resident who begins a fellowship in the Province of Quebec, within the 3-month period following the end of his or her residency, is also considered to be a resident for the purposes of this contract.

Spouse

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

i) is married or joined by a civil union 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) has been living as husband and wife with a participant and had already lived as husband and wife with a participant for a full period of at least one year.

The status of spouse is lost on the occurrence of one of the following events, as the case may be:

- dissolution by a judgment of divorce between the participant and the spouse in the case of a marriage
- *de facto* separation for at least 90 days in the case of a *de facto* union
- dissolution of the union by a notarized act or by a court decision in the case of a civil union.

If the participant has a spouse corresponding to the definition in i) and another spouse corresponding to the definition in ii) or iii), the Insurer will recognize as the spouse the person whom the participant has designated as his or her spouse by written notice. The spouse must remain the same person for all the coverages under the contract.

Total disability

A state of incapacity that results either from an illness, an accident or a complication resulting from pregnancy, tubal ligation, vasectomy or similar cases relating to family planning, from donation of an organ or bone marrow requiring medical attention which, **during the first 60 months**, causes the participant to be totally unable to carry out the ordinary tasks of his or her employment.

Following this 60-month period, although not necessarily requiring continuous medical care, this state of disability prevents the participant from engaging in any gainful activity generating at least 80% of his or her pre-disability earnings and for which he or she is reasonably qualified by education, training or experience. Total disability is determined regardless of the existence or availability of employment.

Any disability resulting from an illness or a self-inflicted injury, alcoholism or drug addiction, active participation in a riot, insurrection or criminal act, or service in the armed forces is not recognized as a disability, except in the case of alcoholism or drug addiction if the participant is receiving treatment or medical care, or from attempted suicide.

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.

Travel expenses paid in advance

Any amount paid by the insured for him or herself for the purchase of a package tour, a ticket from a public carrier or for the rental of a motorized vehicle from an accredited agency. They also include any amount paid by the insured relating to reservations for land arrangements ordinarily included in a package tour, whether or not the reservations are made by the insured or by a travel agency, as well as any amount paid by the insured relating to registration fees for an activity of a commercial nature.

Trip

A trip for tourism or recreational purposes, an occasional business trip or an activity of a commercial nature, entailing the insured’s absence from the province of residence.

For the purposes of Trip Cancellation insurance, a trip represents a tourism or leisure trip or a trip for the purposes of business, or a commercial activity that includes a stay of at least one night at destination, either in or outside the insured's province of residence.

2. Eligibility

Residents are eligible for insurance after one (1) month of continuous service. This one-month period does not apply in the following cases:

- If the resident returns to an employer within 30 calendar days following the date the resident quit the residency program
- If the resident changes employer during the residency, provided there are less than 30 days between the date the resident leaves his or her former employer and begins working for the new employer.

Any dependent of a participant is eligible for insurance either on the same date as the participant if he or she is already a dependent, or on the date on which he or she becomes a dependent if later.

A resident who begins a medicine fellowship in the Province of Quebec within the 3 months following the end of his or her residency remains eligible for insurance under this contract. The participant's insurance is maintained in force, without interruption, after the end of the residency and terminates, at the latest, at the end of the fellowship.

3. Participation, enrolment and exemption

3.1 Participation

Participation of residents eligible for insurance is mandatory for all benefits, subject to the exemption entitlement for Health Insurance coverage.

Similarly, participation of dependents is mandatory for Health Insurance coverage, subject to the exemption entitlement, and for Dependents' Life Insurance coverage. Nonetheless, enrolment in Dependents' Life Insurance coverage is only possible if the resident holds Family Health Insurance coverage or if he or she has taken advantage of the exemption entitlement for Health Insurance coverage.

Residents must choose one of the following three Health Insurance plans:

- Basic plan
- Intermediate plan
- Superior plan

The Health Insurance Plan that a resident selects will also apply to his or her insured dependents.

The Health Insurance Plan that a resident selects at the time of enrolment remains in effect throughout the residency period.

The participant can only change his or her health insurance plan in the following situations:

- When one of the events listed under Section 5 occurs, according to the provisions of that section.
- When the participant reaches the R3 level. The participant must then send a request for change to the Insurer before the end date of the modification campaign held in June of each year, and the new plan becomes effective as of July 1st of the same year. Any request for change submitted after the end date of the campaign will be rejected. If the participant is disabled at the time he or she reaches the R3 level, the participant will be entitled to change the health insurance plan within the 31 days following the date of his or her effective return to work. No request for change will be accepted after this 31-day period.

Provisions applicable to insureds age 65 or over

A participant without any dependent children and whose spouse is age 65 or over may convert his or her Family coverage into Individual coverage. Any participant who exercises this option cannot subsequently modify his or her Individual coverage.

Furthermore, any participant age 65 or over, or any participant with a dependent age 65 or over, may choose to insure medication that is eligible under the RAMQ's Basic Prescription Drug Insurance Plan. Any participant wishing to obtain such coverage must fill out an application form for him or herself and any dependents within 60 days following the earliest of the following dates: the date on which the participant reaches age 65 or the date on which the oldest dependent to insure reaches age 65.

In such a case, the participant must pay the additional premium determined by the Insurer according to the number of insureds age 65 or over in the family. The dependent or participant, as the case may be, who reaches age 65 after the aforementioned date, must also insure the said medication under this contract.

No application form will be accepted after the expiry of the 60-day period.

3.2 Enrolment

A resident must fill out an application form for him or herself and, if applicable, his or her dependents and submit it to the Insurer within 60 days following the date on which he or she becomes eligible.

If the form is not received during this period, the resident will be automatically registered for coverage under the Intermediate Health Insurance plan, with no change possible, including Basic Life and Long-Term Disability Insurance. The Individual or Family coverage status for Health Insurance will be determined on the basis of the resident's civil status. If Family Health Insurance coverage is granted, Dependents' Life Insurance coverage will also be granted.

3.3 Exemption entitlement for Health Insurance coverage

Any eligible resident may waive or terminate Health Insurance coverage for him or herself and dependents, if any, by providing the Insurer with proof that they are covered under another Group Health Insurance plan containing similar benefits.

However, as soon as they cease to be covered under the other group plan, they must enrol in Health Insurance under this plan and demonstrate to the Insurer's satisfaction that they are no longer able to remain insured under the other plan. Residents must make their Health Insurance plan selection within 60 days of termination of coverage under the plan which enabled the exemption. If they fail to do so within this time frame, they will be automatically registered for coverage under the Intermediate Health Insurance plan.

Health Insurance coverage for a resident and his or her dependents, if applicable, comes into force on the date of termination of insurance under the plan which enabled the exemption.

4. Effective date of the insurance

a) Resident

Health Insurance

The resident's insurance becomes effective on the earliest of the following dates:

- The effective date of this contract
- The date on which the resident becomes eligible
- The date of the request for change if the request is submitted to the Insurer within the 31 days following the date a disabled participant effectively returns to work or within the 60 days following the date on which one of the events listed under Section 5 occurs.

Life Insurance and Long-Term Disability Insurance

A resident's insurance becomes effective on the date on which he or she becomes eligible, provided that the resident is actively at work on that date.

If the resident is not actively at work on that date, the insurance coverage will commence on the date of his or her return to work.

b) Dependents

Insurance for dependents becomes effective on the latest of the following dates, but never before that of the resident:

- The date on which they become eligible
- The termination date of the exemption under this Health Insurance plan

5. Change of Health Insurance plan or coverage status

Participants may change their Health Insurance plan by submitting a change request to the Insurer during the 60-day period following one of the life events listed below:

- Birth or adoption of a first child
- Marriage, civil union or cohabitation for a minimum period of 12 months
- Separation for at least 90 consecutive days, divorce or annulment of a civil union
- Death of a spouse or dependent child.

If the request is submitted within the 60-day period, the new Health Insurance plan comes into force on the date of the event. If the request is submitted after the expiry of that period, no plan change may be permitted.

Participation in the new plan that has been selected must be maintained until the end of the residency period, with no other change possible unless another life event occurs.

Participants may change their coverage status at the time of one of the events listed previously. If the request is submitted within 60 days of the event, the new coverage status is granted as of the date of the event.

If the request is submitted after this time frame, the new coverage status will apply as of the date the request for a change of coverage status is received.

6. Continuity of insurance in the event of work interruption

In the case of temporary absence without pay that lasts beyond the employer's effective pay period or in the case of paid parental leave provided under the agreement, participation in the Health Insurance coverage may be kept in force with premium payments. Participation in other coverages is suspended and is automatically reinstated upon a return to active work with pay. Nonetheless, the participant may keep all his or her other coverages in force by personally paying the total required premium, except where *An Act Respecting Labour Standards* obliges the employer to pay its contribution.

If disability occurs during one of these periods and the participant has kept his or her Disability Insurance coverage in force, the waiting period begins on the date specified for the return to work, or on the date on which the resident is entitled to the disability benefit provided under the agreement.

Upon returning to work, whether or not the resident has suspended participation, he or she is automatically entitled to the coverages held prior to his or her leave of absence, without evidence of insurability and upon notification by the employer to the Insurer.

Participation is kept in force in other cases of temporary leave of absence with pay.

A participant who has been dismissed and who has challenged the dismissal by a grievance or petition for arbitration within the meaning of the *Labour Code* must keep his or her Health Insurance coverage in force by personally, through the offices of the employer, paying the total required premium provided under the contract until a decision has been handed down. He or she may also keep in force the other coverages in which he or she participates, except for Long-Term Disability Insurance, by personally paying through the offices of the employer the total required premium provided under the contract until a decision has been handed down. In the event that the dismissed participant is exonerated but has not kept coverage in force, he or she is deemed to have never ceased participating in the insurance and must pay the overdue premiums retroactively, including Long-Term Disability Insurance premiums.

Furthermore, if a disability occurs between the date of dismissal and the date of the decision when the participant was exonerated, the waiting period for the Long-Term Disability Insurance begins on the date of the decision.

7. Waiver of premiums in the event of total disability

a) Health Insurance and Dependents' Life Insurance

In the event of total disability, the participant's and dependents' insurance remains in force while premiums are waived from the sixth working day for the duration of said disability, without exceeding a period of three years. After said three-year period, the insurance terminates. In the case of total disability resulting from an industrial accident or an occupational disease recognized as such by the CNESST, the participant continues to be insured without having to pay premiums for as long as his or her total disability is recognized by the CNESST.

However, the employer is only exempted from paying its share of the premium after a two-year period following the beginning of the disability. In all cases, exemption from premium payments cannot extend beyond age 71.

b) Long-Term Disability Insurance

In the event of total disability, the participant's insurance remains in force while premiums are waived from the sixth working day for the duration of said disability, but not extending beyond the date on which he or she reaches age 65.

c) Participant's Life Insurance

In the event of total disability, the participant's insurance remains in force while premiums are waived from the sixth working day for the duration of the disability, but not beyond the date on which the participant reaches age 65 if he or she had not yet reached age 62 when the disability began. If the participant was age 62 or over when the disability began, the insurance will remain in force without payment of premiums for a maximum disability period of three years or the attainment of age 71, if earlier.

8. Termination of insurance

a) Resident

Subject to the waiver of premiums in the event of disability, a resident's insurance ends on the earliest of the following dates:

- The date on which the contract terminates
- The date on which the resident ceases to meet the eligibility conditions, subject to the Life Insurance conversion privilege
- The date on which the resident leaves his or her employment, subject to the Life Insurance conversion privilege
- The date of the resident's 65th birthday, for Long-Term Disability Insurance. However, payment of premiums ceases on the date of the resident's 63rd birthday.
- The date on which the resident takes advantage of the exemption entitlement for Health Insurance coverage.

b) Dependents

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

- The date on which the resident's insurance contract terminates, subject to the Life Insurance conversion privilege
- The date as of which the dependent no longer meets the requirements of the definition
- The date on which the participant takes advantage of the Health Insurance exemption entitlement for his or her dependents under this contract
- The date on which the participant changes a Family coverage for an Individuaul coverage.

9. Beneficiary

Subject to provisions under law, any participant may at any time designate a beneficiary or change the beneficiary already designated by making a written notice and filing it at the head office of the Insurer. The Insurer is not liable for the legal validity of any change of beneficiary.

10. Claims

Health Insurance:

Medication expenses – Automated payment service: When purchasing medication covered under this plan, participants are not required to complete a claim form for themselves or their dependents. Insureds simply present their service card to the pharmacist and pay the uninsured portion of the prescription drug expenses incurred.

Hospitalization expenses: For hospitalization expenses, insureds present their service card to the hospital which, in turn, files the claim directly with La Capitale. It is necessary to mention the group number, the employer number and the insured's social insurance number.

Other expenses: Participants must complete and sign a claim form and submit it to the Insurer with the original receipts or paid invoices.

Claims must be submitted within 12 months following the date expenses were incurred.

Life Insurance: The beneficiary or the person responsible for submitting the claim must contact the Insurer to obtain the forms required for payment of the insured amount.

Long-Term Disability Insurance: The claim form must be submitted to the Insurer, duly completed by the participant, the employer and the attending physician, within 30 days prior to the start of the Long-Term Disability Insurance benefit period to avoid any delays.

TRAVEL INSURANCE

The Insurer will refund ordinary and reasonable expenses and services described in the Travel Insurance section, if incurred following an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the government health insurance plan of his or her province of residence.

In order to qualify as being temporarily outside one's province of residence, the stay must not extend beyond the maximum coverage period under the government health insurance plan of the insured's province of residence. The stay may however be extended beyond this period if the extension is due to an illness or accident that occurs during the said period and a return to the province of residence is impossible due to justifiable medical reasons.

Benefits are granted over and above and not as a replacement for benefits provided under government programs.

A lifetime maximum refund of $1,000,000 applies to insureds covered under the Basic or Intermediate Health Insurance plan. A lifetime maximum refund of $5,000,000 applies to insureds covered under the Superior plan.

EXCLUSION AND REDUCTION OF COVERAGE

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

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

- Deterioration
- Relapse
- Diagnosis of terminal phase or
- Chronicity likely to lead to deterioration or complications during the planned trip outside the province of residence.

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

1. Eligible expenses

1.1 Hospitalization, medical and paramedical expenses

a) Hospitalization expenses for a semi-private or private room in excess of that which is refunded or refundable under the government health insurance plan of the insured's province of residence.

b) Out-of-pocket expenses (telephone, television, parking, etc.) owing to hospitalization upon presentation of vouchers up to a maximum of $100 per hospitalization.

c) Physician's professional fees for medical, surgical or anesthesia care other than fees for dental care; expenses incurred are payable solely for the part of expenses over and above benefits provided under the government health insurance plan of the insured's province of residence.

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

e) Nurses' fees for a licensed nurse for private nursing care dispensed exclusively at the hospital, when medically required and prescribed by the attending physician up to a maximum refund of $3,000. The nurse must not be a member of the insured's family, nor be a travel companion.

f) The rental of therapeutic equipment and the purchase of trusses, corsets, crutches, splints, plaster casts, or other orthopedic equipment when prescribed by the attending physician.

g) Professional fees of a dental surgeon for accidental injury to natural teeth due to an accident occurring outside the insured's province of residence up to a maximum refund of $1,000 per accident; insured expenses must be incurred within 12 months following the accident.

1.2 Transportation expenses

a) Transportation expenses by air or surface ambulance for taking the insured to the nearest adequate medical centre. This service also includes transferring between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing his or her condition.

b) Repatriation expenses for the insured to his or her place of residence by an adequate public carrier in order for him or her to receive appropriate care in such place as soon as his or her condition of health so allows and insofar as the means of transport initially planned for the return cannot be used. If his or her condition of health so requires, the Assistor will send a medical escort on site to accompany the insured during the return trip. The repatriation must be approved and planned by the Assistor.

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

d) When the insured's state of health does not allow medical repatriation and hospitalization outside the province must extend beyond seven days, the Assistor organizes and pays round-trip transportation expenses for a close relative of the insured's family residing in his or her province of residence in order to allow the said relative to be at the insured's bedside. The maximum refund is $1,500. These expenses are not eligible for refund if the insured was already accompanied by a close relative age 18 or over, or the necessity of a visit is not confirmed by the attending physician, or the visit is not previously approved and planned by the Assistor.

e) The Assistor makes necessary arrangements for the return of children under age 18 accompanying the insured to their residence if following the insured's accident or illness, the latter or another accompanying adult is unable to perform this task.

f) Whenever an insured is unable to drive his or her vehicle following illness or an accident occurring during the trip and no other passenger is able to drive the said vehicle, the Assistor pays the expenses incurred by a commercial agency for the return of the insured's personal vehicle or of a rental vehicle to his or her residence or to the nearest appropriate rental agency, subject to a maximum refund of $1,000.

g) In the event that the insured dies, the Assistor organizes and pays expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing no close relative age 18 or over has accompanied the insured on the trip. The maximum refund is $1,500.

h) in the event that the insured dies, the Assistor pays for the cost of the preparation and return of the remains (excluding the cost of the casket) to the place of burial in the province of residence, subject to a maximum refund of $5,000 or the cost of cremation or burial on site, subject to a maximum refund of $3,000.

1.3 Living expenses

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

2. Travel assistance service

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

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

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

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

d) The Assistor takes charge of transmitting urgent messages when the insured is personally incapable of doing so.

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

f) Upon presentation of vouchers, the Assistor refunds the insured for telephone call expenses and other communication expenses incurred by the insured in order to gain access to such services in case of difficulty abroad.

g) The Assistor provides any information required in the event of major problems during the insured's trip following the loss of his or her passport, visa, credit card or other essential document.

h) The Assistor provides an insured in distress abroad with access to a multilingual telephone interpretation service.

i) In the event of legal proceedings or following a traffic accident, a highway code offence or any other civil offence, the Assistor provides assistance by referring the names of lawyers. This service is only applicable in Canada and the United States.

3. Obligations of the insured

a) The insured has the obligation to notify the Assistor as soon as possible of the occurrence of the incident, accident or illness.

b) As soon as he or she is able to do so, the insured must obtain the prior approval of the Assistor before taking any initiative or incurring any expenses. If the insured fails in this obligation, the Assistor will be relieved of its obligations to the insured.

c) When an insured has profited from transportation for medical purposes under the terms of travel assistance coverage, the Assistor reserves the right to claim from the insured the ticket he or she holds and has not used due to services rendered by the Assistor.

d) For the purposes of the present coverage and for any moneys advanced or refunded by the Assistor, the insured assigns and subrogates the Assistor in all of his or her rights and recourses to any refund from which he or she benefits or claims to benefit under any public or private plan of insured services similar to those for which the advances or expenses have been incurred by the Assistor. The insureds agree to sign any document and execute any deed required by the Assistor in order to give full and complete effect to the present assignment and subrogation and especially mandate the Assistor for this purpose as attorney and representative for submitting any claim and collecting any refund.

4. Exclusions and reduction of Travel Insurance coverage

No amount is paid, no refund is made nor any assistance is given to the insured by the Insurer or the Assistor in the following cases:

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

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

c) If there was failure in contacting the Assistor as soon as possible in the event of a medical consultation or hospitalization following a sudden accident or illness.

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

e) When the expenses incurred outside the insured's province of residence could have been incurred in his or her province of residence, without endangering the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from a sudden accident or illness. The mere fact that the care given in the province of residence may be of lesser quality than that which may be received outside such province does not, within the meaning of this exclusion, constitute a danger for the insured's life or health.

f) When hospitalization expenses are incurred in hospitals for the chronically ill, or in a department for the chronically ill in a public hospital, or for patients who are in extended care homes or thermal spas.

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

h) For an accident occurring during the insured's participation in a sport for consideration, in any kind of speed contest, in flying a glider or deltaplane, mountain climbing, parachuting whether or not in free fall, bungee jumping or any other dangerous activity.

i) Following the voluntary abusive absorption of medication, drugs or alcohol and the ensuing conditions.

j) When the loss occurs in a country that is at war, whether declared or undeclared, is known to be experiencing political instability or during a riot, uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving an Act of God making any intervention by the Assistor physically impossible.

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

TRIP CANCELLATION INSURANCE

The Insurer pays, according to the terms and conditions set out hereunder, 100% of the expenses incurred by the insured following the cancellation or interruption of a trip insofar as the expenses incurred are related to travel expenses paid in advance by the insured while this coverage is in force, and the insured was not aware at the time of finalizing the travel arrangements of any event that might reasonably entail the cancellation or interruption of the planned trip. Insured expenses are limited to $5,000 per insured per trip.

1. Causes of cancellation or interruption

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

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

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

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

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

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

f) Quarantine of the insured or travel companion, except if quarantine ends seven days or more before the scheduled date of departure.

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

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

i) Transfer of the insured or travel companion, 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.

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

k) Missed departure due to a delay in the means of transportation used to reach the point of departure, provided that the means of transportation used provides for scheduled arrival at the point of departure at least 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.

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

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

n) The exclusion or dismissal of the participant as a medical resident or the permanent involuntary loss of employment of the participant's spouse, provided the person in question has occupied a permanent position with the same employer for at least one year.

2. Covered expenses

The following expenses are covered providing that they are effectively paid by the insured and are limited to $5,000 per insured per trip.

a) In the event of cancellation prior to departure:

- The non-refundable portion of the expenses paid in advance
- The supplemental expenses incurred by the insured who decides to travel alone in the event that his or her travel companion must cancel his or her trip for one of the reasons provided hereunder, up to the amount of the penalty for cancellation applicable to the insured at the time when his or her travel companion must make the cancellation
- The non-refundable portion of the travel expenses paid in advance, up to 70% of the said expenses, if the departure of the insured is delayed owing to atmospheric conditions and he or she decides not to make the trip.

b) If a departure is missed, at the beginning or during the trip, for one of the reasons provided hereunder, the supplemental cost required by a regularly scheduled public carrier for an economy class ticket by the most direct route to the planned destination.

c) If the return is advanced or delayed:

- If the supplemental cost of a regular ticket in economy class by the most direct route for the return to the point of departure by the initially planned carrier, or if the latter cannot be used, the expenses required in economy class by a regularly scheduled public carrier for the most economical means by the most direct route for the return to the planned point of departure; these expenses must be agreed to in advance by the Insurer.

  Nonetheless, if the insured's return is delayed for more than seven days following an illness or accident sustained by the insured or his or her travel companion, incurred expenses are covered insofar as the person involved has been admitted to a hospital centre as an inpatient for more than 48 hours within the said seven-day period.
- The unused and non-refundable portion of the land part of travel expenses paid in advance.

3. Exclusions to Trip Cancellation Insurance coverage

This coverage does not extend to losses occasioned by the following causes or to losses to which these causes have contributed:

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

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

c) War, whether declared or undeclared, or active participation of the insured in an insurrection, whether real or apprehended.

d) The active participation of the insured or his or her travel companion in a criminal act or one deemed to be so.

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

f) An injury that the insured or his or her travel companion has intentionally inflicted upon him or herself, suicide or attempted suicide, whether or not the person is of sound mind.

g) The voluntary and abusive consumption of medication, drugs or alcohol and the ensuing conditions.

h) The participation in a sport for consideration, in any form of competition involving motor vehicles or any contest involving speed, gliding or hang-gliding, mountain climbing, parachute jumping whether or not in free fall, bungee jumping or any other dangerous activity.

i) A medical condition for which the insured or his or her travel companion has been hospitalized, or has received or has been prescribed medical treatment or for which he or she has consulted a physician within 90 days preceding the date on which the travel expenses were incurred, except if it is proven, to the satisfaction of the Insurer, that the condition of the person in question had stabilized when the expenses were incurred. A change regarding medication, dosage or its use is considered to be a medical treatment.

j) When the loss is related to any known condition of the insured or his or her travel companion and is subject to periods of sudden aggravation which cannot be controlled by medication or otherwise.

4. Deadline for requesting cancellation

In the event that a cause for cancellation occurs prior to the departure, the trip must be cancelled within a maximum period of 48 hours, or on the first ensuing working day if it falls on a holiday, and the Insurer must be notified at the same time. The Insurer's liability is limited to the cancellation expenses stipulated in the travel contract 48 hours after the date of the cause of cancellation, or on the first ensuing working day if it falls on a holiday.

5. Coordination

Benefits payable hereunder are reduced by any amount payable under another group or individual insurance contract. Expenses incurred, for which the insured is not required to pay in the absence of this coverage, are also excluded.

6. Claims under Trip Cancellation Insurance

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

a) Unused travel tickets.

b) Official receipts for additional transportation expenses.

c) Receipts for ground travel arrangements and other expenses paid. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation. Written proof that the insured has requested a reimbursement of travel expenses must be forwarded to the Insurer, along with the reply received as to the outcome of such request.

d) Official documents certifying the reason for cancellation. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practicing where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip.

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

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

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

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

NOTICE TO PARTICIPANTS COMPLETING THEIR RESIDENCY ON JUNE 30

Please note that on June 30 of each year, the FMRQ provides us with a list of persons about to complete their residency.

From that date onwards, we must deactivate the automated payment service card of those whose name appears on the list. If your name is on the list, then your coverage will end at midnight on June 30.

In accordance with *An Act respecting Prescription drug insurance*, it is mandatory that you be insured, as of July 1, with any organization or federation offering a group insurance plan for which you become eligible. However, should there be a gap between your coverage with the FMRQ (end of residency) and the effective date of your new insurance plan (following receipt of your license to practice), you must inform the FMRQ in order to extend your coverage until the expected effective date of your new insurance. On receipt of approval from the FMRQ, La Capitale will bill you directly for this extension period.

However, if, for any reason whatsoever, your residency period should continue beyond June 30, you must inform the FMRQ upon receipt of your training card.

If you begin a fellowship in medicine in Quebec within three months following the end of your residency, you remain eligible for coverage under this group insurance plan. However, certain specific provisions apply in order to take your new situation into account.

Regardless of whether you wish to apply for extended coverage, continue your residency beyond the expected date or register for a fellowship, you must call the FMRQ at 514 282-0256 or 1 800 465-0215.

PREMIUM RATES EFFECTIVE AS OF JULY 1, 2016

The premium rates below will apply from July 1, 2016 to June 30, 2017.

HEALTH INSURANCE				
	PER 7-DAY PERIOD		PER 14-DAY PERIOD	
	Individual coverage	Family coverage	Individual coverage	Family coverage
BASIC PLAN				
Total premium	$14.78	$29.26	$29.55	$58.52
Employer's contribution	$1.19	$2.99	$2.39	$5.97
Employee's contribution	$13.59	$26.27	$27.16	$52.55
INTERMEDIATE PLAN				
Total premium	$22.93	$45.47	$45.86	$90.94
Employer's contribution	$1.19	$2.99	$2.39	$5.97
Employee's contribution	$21.74	$42.48	$43.47	$84.97
SUPERIOR PLAN				
Total premium	$30.00	$59.44	$59.99	$118.88
Employer's contribution	$1.19	$2.99	$2.39	$5.97
Employee's contribution	$28.81	$56.45	$57.60	$112.91

LIFE INSURANCE		
	PER 7-DAY PERIOD	PER 14-DAY PERIOD
Dependents' Life Insurance	$0.13 per family	$0.26 per family
Participant's Life Insurance	0.059% of paid salary[1]	

SALARY INSURANCE	
Long-Term Salary Insurance	0.643% of paid salary[1]

1- The paid salary includes the call duty and teaching premiums.

Note: The 9% provincial tax must be included in the costs indicated in this document.

Contact La Capitale Insurance and Financial Services Inc.

Quebec City	Montreal
625 Saint-Amable St	Suite 820
PO Box 1500	425 de Maisonneuve Blvd W
Quebec QC G1K 8X9	Montreal QC H3A 3G5
418 644-4200	514 873-6506

Toll free: **1 800 463-4856**

If you would like to meet with an agent, please make an appointment during office hours, Monday to Friday, between 8:30 a.m. and 5:00 p.m., before coming to our offices in person.

TRAVEL INSURANCE

You can contact the Assistor at the following numbers:

In Canada and the United States: 1 800 363-9050

Elsewhere in the world (collect call): 514 985-2281

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

THIS DOCUMENT IS PROVIDED FOR INFORMATION PURPOSES ONLY AND IN NO WAY MODIFIES THE TERMS AND CONDITIONS OF THE CONTRACT.

Reminder / Notes

Group No.: 004500

Employer No.:

Identification No.:

Person contacted:

Telephone No.:

Fax No.:

Email:

Notes

A people-driven company
whose activities are centred
around group insurance.

Advisers who are available and
motivated to build a productive
partnership with our customers.

A wide range of group insurance
products and services.

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