La Capitale
Civil Service Insurer

(Insurer)

FTQ

FTQ Intersectoral Parity Committee
(Policyholder)

GROUP INSURANCE PLAN
Contract 6000 – FTQ
Health and Social Services Sector

for wage-earners
represented by

Union des employés et employées de service
SECTION LOCALE 800

CUPE Canadian Union of Public Employees

SQEES Syndicat québécois des employées et employés de service, section locale 298 FTQ

SEPB QUÉBEC

Plan modified on January 1, 2016

THE GROUP INSURANCE PLANS FOR CONTRACT 6000 ARE OFFERED TO WAGE-EARNERS WHO ARE MEMBERS OF THE FOLLOWING FTQ-AFFILIATED UNIONS:

- **HEALTH AND SOCIAL SERVICES SECTOR**

  Canadian Union of Public Employees (CUPE)

  Syndicat québécois des employés et employées de service, Local 298 (SQEES)

  Canadian Office and Professional Employees' Union – Québec (SEPB-Québec)

- **ELEMENTARY AND SECONDARY EDUCATION SECTOR**

  Canadian Union of Public Employees (CUPE)

  Service Employees Union (UES-800)

  Canadian Office and Professional Employees' Union – Québec (SEPB-Québec)

- **COLLEGE EDUCATION SECTOR**

  Canadian Union of Public Employees (CUPE)

- **ORGANIZATIONS**

  SOCIÉTÉ QUÉBÉCOISE DES INFRASTRUCTURES (SQI)

  SOCIÉTÉ DE DÉVELOPPEMENT DES ENTREPRISES CULTURELLES (SODEC)

  MUSÉE NATIONAL DES BEAUX-ARTS DU QUÉBEC

  SOCIÉTÉ QUÉBÉCOISE D'INFORMATION JURIDIQUE (SOQUIJ)

  LA FÉDÉRATION DES COMMISSIONS SCOLAIRES DU QUÉBEC (FCSQ)

  INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC (INSPQ)
  Canadian Union of Public Employees (CUPE)

  RÉGIE DE L'ÉNERGIE
  Canadian Office and Professional Employees' Union – Québec (SEPB-Québec)

THIS BOOKLET IS FOR WAGE-EARNERS WORKING IN ESTABLISHMENTS REPRESENTED BY:

- **THE HEALTH AND SOCIAL SERVICES SECTOR**

  Ministère de la Santé et des Services sociaux (MSSS)

  Association québécoise d'établissements de santé et de services sociaux (AQESSS)

  Association des centres de réadaptation en dépendance du Québec (ACRDQ)

  Association des établissements privés conventionnés – santé et services sociaux (AEPC)

  Association des établissements de réadaptation en déficience physique du Québec (AERDPQ)

  Fédération québécoise des centres de réadaptation en déficience intellectuelle et en troubles envahissants du développement (FQCRDITED)

  Association des centres jeunesse du Québec (ACJQ)

  Health and social services agencies

YOUR GROUP INSURANCE PLAN

IMPORTANT

The Policyholder may at any time, upon agreement with the Insurer, make modifications to the contract with respect 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 booklet does not include all the contractual provisions regarding definitions, eligibility, enrolment, effective date and termination of insurance and other specifications. For more information about the content, you may consult the administrative guide available from your employer or obtain a copy of the policy by contacting the local union representative.

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

The electronic version of this booklet is available online at www.lacapitale.com, under “Individuals/Group Insurance/Information for Insureds.”

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

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INSURANCE PLANS

Schedule of Insurance

The following tables present a brief summary of the coverage provided under the plans for active and retired participants and a summary of the benefits payable under Contract 6000. For a full description of each plan, please refer to the corresponding pages in the booklet.

ACTIVE PARTICIPANTS

Complete Basic Health Insurance Plan (page 13) (Mandatory participation)	
Prescription drugs and other expenses	80% of the first $2,500 of eligible expenses and 100% of any excess
Automated payment service	Direct
▪ Coagulation self-monitoring device (CoaguChek) ▪ Hearing aid	100%, up to the maximums specified on pages 16 and 17
Trip Cancellation Insurance	100%, maximum per trip, per insured: $5,000
Travel Insurance	100%, lifetime maximum: $5,000,000
▪ Blood glucose monitor ▪ Detoxification ▪ Hospitalization in a semi-private room ▪ Intrauterine device (IUD)	100%, up to the maximums specified on pages 16 and 17

Reduced Basic Health Insurance Plan (page 19) (Mandatory participation)	
Prescription drugs	71% of the first $2,586 of eligible expenses and 100% of any excess
Automated payment service	Direct
Travel Insurance	100%, lifetime maximum: $5,000,000
Trip Cancellation Insurance	100%, maximum per trip, per insured: $5,000
Dentists' fees in the event of accidental damage to natural teeth	71% of the first $2,586 of eligible expenses and 100% of any excess

ACTIVE PARTICIPANTS

Extended Health Insurance Plan (Option I) (Page 22) (Optional participation for a minimum period of 36 months)	
Healthcare professionals	
Chiropractor	80%, up to a maximum reimbursement of $20 per treatment and $400 per calendar year
Homeopath, osteopath, naturopath, acupuncturist or dietitian	80%, up to a maximum reimbursement of $20 per treatment and $400 per calendar year, per specialist
Kinesitherapist, orthotherapist, kinotherapist and massage therapist	80%, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, for all of these specialists
Physiotherapist and physical rehabilitation therapist	80%, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, for all of these specialists
Podiatrist and foot care nurse	80%, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, for all of these specialists
Psychologist, psychiatrist, psychoanalyst, psychotherapist and social worker	50%, up to an overall maximum reimbursement of $500 per calendar year, for all of these specialists
Registered nurse or nursing assistant	80%, up to a maximum reimbursement of $200 per day and $4,000 per calendar year
Other expenses	
Ultrasound examinations (excluding fetal) and thermographic evaluations	80%, up to an overall maximum reimbursement of $400 per calendar year, for all of these expenses
X-rays	80%, up to a maximum reimbursement of $40 per calendar year

ACTIVE PARTICIPANTS

Dental Care Insurance Plan (Option II) (page 24) (Optional participation for a minimum period of 36 months)	
Diagnostic, preventive, basic restorative and major restorative services Fixed prosthodontics	80%* 50%* * Up to a maximum reimbursement of $1,000 per calendar year, for all of these expenses
Removable prosthodontics	80%, up to a maximum reimbursement of $1,000 per calendar year, 1 replacement per period of 4 consecutive years
Automated payment service	Direct

Life Insurance Plan (Option III) (Page 35) (Optional participation)	
Participant's Basic Life Insurance	Under age 65: 1 times the salary Age 65 or over: ½ the salary
Participant's Accidental Death and Dismemberment Insurance	Under age 65: 1 times the salary Age 65 or over: ½ the salary
Participant's Optional Life Insurance	1 to 5 times the salary
Spouse's Life Insurance Dependent Children's Life Insurance	$5,000 $2,500
Spouse's Optional Life Insurance	1 to 20 units of $5,000
This plan provides for an accelerated benefit payment in the event of terminal illness.	

RETIRED PARTICIPANTS

Life Insurance Plan (Option III) (page 37)
(Optional participation)

Upon retirement, participants may apply for, under the retired participant's group life insurance, the benefits they held under the active participants' life insurance plan immediately prior to retirement.

All applications must be submitted within **30 days** following the retirement date. The form may be obtained from the employer or downloaded from the Insurer's website at www.lacapitale.com, under "Individuals/Group Insurance/Information for Insureds/Intersectoral Parity Committee (Group 6000)."

RETIRED PARTICIPANTS (cont.)

LIFE INSURANCE COVERAGE TABLE	
Retiree's Life Insurance	1 to 20 units of $5,000, up to the amount held before retirement
Spouse's Life Insurance Dependent Children's Life Insurance	$5,000 $2,500
Spouse's Optional Life Insurance	1 to 20 units of $5,000, up to the amount held before retirement

This plan provides for an accelerated benefit payment in the event of terminal illness.

Individual Healthcare Insurance product – Policy 3992 (Optional participation)

Participants who are retiring and are not eligible for another group Health insurance plan that includes prescription drug insurance must register for coverage with the *Régie de l'assurance maladie du Québec* (RAMQ).

They may also apply for the individual Healthcare Insurance product – Policy 3992, which also includes Travel and Trip Cancellation insurance. Participants may choose between 3 plans: Basic, Intermediate and Enriched. An optional coverage supplement is also available for Dental Care and Vision Care insurance, as well as for the reimbursement of the deductible and coinsurance required for prescription drugs eligible under the RAMQ's Prescription Drug Insurance Plan.

All applications must be submitted within **60 days** following the retirement date or the date of termination of the plan which enabled the exemption. Beyond this period, evidence of insurability will be required.

The documents required for enrolment (leaflet and enrolment form) may be obtained from the employer or downloaded from the Insurer's website at www.lacapitale.com, under "Individuals/Group Insurance/Information for Insureds/Intersectoral Parity Committee (Group 6000)."

COMPLETE BASIC HEALTH INSURANCE PLAN

Mandatory participation

Eligible expenses are reasonable expenses that are justified by the seriousness of the case as well as by current medical practice and customary charges, and incurred by an insured following an accident, illness, pregnancy or surgical procedure related to family planning or organ or bone marrow donation.

1. The following expenses are reimbursed at 80% for participants and their dependents, if applicable, and at 100% once the total expenses exceed $2,500 in a given calendar year.

a) Expenses for **drugs prescribed** by a physician or a dentist and dispensed by a licensed pharmacist or by a duly authorized physician, subject to the following exclusions: The term "prescription drugs" refers to products included in the drug formulary of the *Régie de l'assurance maladie du Québec* (RAMQ) or in the drug formulary of the *Association québécoise des pharmaciens propriétaires* (AQPP), with the exception of drugs coded "V" or "Z."

The following products are not considered to be prescription drugs:

- Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment, except on medical recommendation deemed satisfactory by the Insurer
- Dietetic substances or foods
- Homeopathic medicines
- Any substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams
- Preventive vaccines
- Injections provided as part of a weight reduction program
- Over-the-counter laxatives and antacids, except on medical recommendation deemed satisfactory by the Insurer
- Drugs or substances used for the treatment of impotence

- Drugs administered primarily for preventive purposes
- Smoking cessation products (except those included on the RAMQ list)
- Drugs administered for aesthetic purposes, except if required due to an accident.

Notwithstanding any definition or the above-mentioned exclusions, all prescription drugs that must be covered under the group insurance contract in accordance with the *Quebec Act respecting prescription drug insurance* are considered to be eligible expenses.

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

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

b) Transportation to hospital by **ambulance** (round trip), including emergency or medically required air or rail transportation.

c) Expenses for the purchase of **artificial limbs, external prostheses, trusses, special bandages (severe burns), corsets, crutches, splints, casts, artificial eyes, support stockings** with a compression ratio of 13 mm Hg or more (maximum 4 pairs per calendar year), incurred on medical recommendation and required by the insured's physical condition. For the purposes of this plan, breast and capillary prostheses (wigs) are not considered to be external prostheses.

d) Expenses that exceed those payable by the RAMQ for the purchase of **breast prostheses** following a mastectomy, up to an eligible maximum of $500 per period of 24 consecutive months, per insured.

e) Expenses for the purchase of an initial **capillary prosthesis (wig)** required following chemotherapy or radiotherapy treatments, up to an eligible maximum of $700 per calendar year, per insured.

f) Expenses for the purchase, rental or replacement of **any product or equipment required by the insured's physical condition** made by a orthotist-prosthesist or other professional specialized in the manufacturing of such equipment or products and prescribed by a physician (e.g. compression garment for burn victim, device other than a foot orthosis, knee brace, device for asthmatics). These expenses are eligible for reimbursement once per calendar year, per insured.

g) Expenses for the rental, repair or purchase of a basic model if this option is deemed more economical, of a **wheelchair**, a **hospital bed** (excluding the mattress) or a **breathing assistance apparatus**.

h) Expenses incurred for the following services and supplies provided under medical supervision or on prescription and not otherwise eligible for reimbursement:

- **Audiology**
- **Injectable medications, with the exception of professional fees**
- **Laboratory tests**
- **Occupational therapy**
- **Oxygen therapy**
- **Speech therapy**
- **Test strips, syringes and needles for diabetics.**

i) Expenses for the substance used in **sclerosing injections, with the exception of professional fees,** if treatment is medically required, up to a maximum reimbursement of $30 per treatment and 10 treatments per calendar year, per insured.

j) Professional services of a **dentist** to repair accidental damage to natural teeth occurring after the insurance is in force and provided that the treatment takes place within 12 months following the date of the accident.

k) Expenses for the purchase of **orthopedic shoes** that are custom-designed and made for an insured from a mould to correct a foot defect, including straight, flared or open shoes, as well as shoes required for Denis Browne splints, up to a maximum of three pairs per calendar year, per insured. The cost of **additions or modifications to shoes** is also eligible. This equipment must be made by a specialized orthopedic laboratory licensed under the *Public Health Protection Act* (R.S.Q., Chapter P.35).

l) Expenses for the purchase of **foot orthoses**, up to an eligible maximum of $525, per calendar year, per insured, for an adult or a child. These orthoses must be made by a specialized orthopedic laboratory licensed under the *Public Health Protection Act* (R.S.Q., Chapter P.35).

m) Expenses for an **eye examination** carried out by an ophthalmologist or optometrist for insureds age 18 to 64, up to a maximum reimbursement of $40 per period of 24 consecutive months, per insured.

n) **Transport and accommodation for remote areas**

If, on medical prescription, an insured is required to travel outside his or her area of residence to consult or receive treatment from a medical specialist not available in the insured's area of residence, the following expenses are eligible, up to a maximum reimbursement of $1,000 per calendar year, per insured:

- Expenses for travel with a public carrier (bus, plane, boat or train) or by automobile if the situation requires round-trip travel of at least 400 kilometres from the insured's place of residence to the place where the insured is required to consult with or receive treatment from a medical specialist. However, when travelling by automobile, eligible expenses are equal to those that would have been incurred had the trip been made by bus.
- Expenses for accommodation incurred in a public establishment, up to an eligible maximum of $60 per day, provided the consultation or treatment requires an overnight stay.

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

If the participant has Individual coverage, eligible expenses must be incurred for and explicitly apply to the participant.

If the participant has Family or Single-Parent coverage, eligible expenses must be incurred for and explicitly apply to the participant or dependents.

This coverage allows for the presence of a person accompanying the insured, if justified by the situation.

The expenses reimbursed are those exceeding the amounts reimbursed by the *Régie de l'assurance maladie du Québec* (RAMQ).

2. The following expenses are reimbursed at 100%.

a) Blood glucose monitor

Expenses incurred for the purchase or repair of a blood glucose monitor, up to a maximum reimbursement of $250 per period of 60 consecutive months, per insured, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of this appliance.

b) Coagulation self-monitoring device (CoaguChek)

Expenses for the purchase or repair of a coagulation self-monitoring device, if such a device is required due to the insured's medical condition and it is obtained on medical recommendation. The expenses are limited to a maximum reimbursement of $500 per period of 60 consecutive months, per insured.

c) Detoxification

In the event of rehabilitation treatment for alcoholism or drug use, excluding addiction to the use of tobacco, eligible expenses are provided for a stay in an establishment officially recognized for such purpose, subject to a maximum reimbursement of $40 per day and $1,000 per calendar year, per insured.

d) Hearing aid

Expenses incurred for the purchase or repair of a hearing aid, up to a maximum reimbursement of $500 per period of 36 consecutive months, per insured.

e) Hospitalization in a semi-private room

Hospitalization expenses that are incurred in Canada in excess of amounts payable under any government insurance plan, up to the cost of a semi-private room for each day of hospitalization at the rates in force in the province in which the expenses are incurred, without any limit as to the number of days.

f) Intrauterine device (IUD)

Expenses for the purchase of an intrauterine device (IUD), up to a maximum reimbursement of $100 per period of 24 consecutive months, per insured.

g) Travel Insurance

A full description of each benefit is provided on Page 67 of the booklet. Maximums apply.

h) Trip Cancellation Insurance

A full description of this benefit is provided on Page 75 of the booklet. Maximums apply.

3. Exclusions

Subject to the provisions of the Quebec *Act respecting prescription drug insurance*, no benefit is payable for expenses incurred:

- For the purchase or adjustment of dental prostheses, eyeglasses or contact lenses.
- For hearing examinations.

- For periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or required for health trips.
- Due to self-mutilation, regardless of the insured's state of mind at that time.
- For plastic surgery.
- For any condition occurring while the insured is on active duty with the armed forces.
- For treatment, services or products that the insured is not required to pay.
- For expenses payable under any public or private, individual or group plan. Any such expenses are deducted from any benefits payable under this plan.
- Active participation in an insurrection, whether real or apprehended.
- Following the insured's participation in a criminal act.
- In the event of hospitalization for extended care. Expenses for a stay in a reception centre, including hospital centres providing the same type of service (accommodation) or any other establishment, are not eligible for reimbursement.
- For any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this plan.

These exclusions also apply to the Travel Insurance benefit in addition to those included in the description for that coverage.

REDUCED BASIC HEALTH INSURANCE PLAN

Mandatory participation

Eligible expenses are reasonable expenses that are justified by the seriousness of the case as well as by current medical practice and customary charges, and incurred by an insured following an accident, illness, pregnancy or surgical procedure related to family planning or organ or bone marrow donation.

1. The following expenses are reimbursed at 71% for participants and their dependents, if applicable, and at 100% once the total expenses exceed $2,586 in a given calendar year.

a) Expenses for **drugs prescribed** by a physician or a dentist and dispensed by a licensed pharmacist or by a duly authorized physician, subject to the following exclusions: The term "prescription drugs" refers to products included in the drug formulary of the *Régie de l'assurance maladie du Québec* (RAMQ) or in the drug formulary of the *Association québécoise des pharmaciens propriétaires* (AQPP), with the exception of drugs coded "V" or "Z."

The following products are not considered to be prescription drugs:

- Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment, except on medical recommendation deemed satisfactory by the Insurer
- Dietetic substances or foods
- Homeopathic medicines
- Any substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams
- Preventive vaccines
- Injections provided as part of a weight reduction program
- Over-the-counter laxatives and antacids, except on medical recommendation deemed satisfactory by the Insurer
- Drugs or substances used for the treatment of impotence

- Drugs administered primarily for preventive purposes
- Smoking cessation products (except those included on the RAMQ list)
- Drugs administered for aesthetic purposes, except if required due to an accident.

Notwithstanding any definition or the above-mentioned exclusions, all prescription drugs that must be covered under the group insurance contract in accordance with the *Quebec Act respecting prescription drug insurance* are considered to be eligible expenses.

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

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

2. The following expenses are reimbursed at 71% for participants and their dependents, if applicable, and at 100% once the total expenses exceed $2,586 in a given calendar year.

a) Professional services of a **dentist** to repair accidental damage to natural teeth occurring after the insurance is in force and provided that the treatment takes place within 12 months following the date of the accident.

3. The following expenses are reimbursed at 100%.

a) Travel Insurance

A full description of this benefit is provided on Page 67 of the booklet. Maximums apply.

b) Trip Cancellation Insurance

A full description of this benefit is provided on Page 75 of the booklet. Maximums apply.

4. Exclusions

Subject to the provisions of the Quebec *Act respecting prescription drug insurance*, no benefit is payable for expenses incurred:

- For the purchase or adjustment of dental prostheses, eyeglasses or contact lenses.
- For hearing examinations.
- For periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or required for health trips.
- Due to self-mutilation, regardless of the insured's state of mind at that time.
- For plastic surgery.
- For any condition occurring while the insured is on active duty with the armed forces.
- For treatment, services or products that the insured is not required to pay.
- For expenses payable under any public or private, individual or group plan. Any such expenses are deducted from any benefits payable under this plan.
- Active participation in an insurrection, whether real or apprehended.
- Following the insured's participation in a criminal act.
- In the event of hospitalization for extended care. Expenses for a stay in a reception centre, including hospital centres providing the same type of service (accommodation) or any other establishment, are not eligible for reimbursement.
- For any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this plan.

These exclusions also apply to the Travel Insurance benefit in addition to those included in the description for that coverage.

OPTIONAL EXTENDED HEALTH INSURANCE PLAN – Option I

Optional participation for a minimum period of 36 months

Eligible expenses are reasonable expenses that are justified by the seriousness of the case as well as by current medical practice, and incurred by an insured following an accident, illness, pregnancy or surgical procedure related to family planning or organ or bone marrow donation.

NOTE: Healthcare professionals must be members in good standing of their professional order or of a professional association, or must be recognized by the Committee and the Insurer. They must work within the legal scope of their practice.

1. The following expenses are reimbursed at 80%.

a) Professional services of a **chiropractor**, up to a maximum reimbursement of $20 per treatment and $400 per calendar year, per insured. Only one treatment per day, per insured, is eligible for reimbursement.

   The initial examination done by the chiropractor is eligible in the same capacity as a treatment, it being understood that only one of these two services is eligible for reimbursement if both are received on the same day.

b) Professional services of a **registered nurse or nursing assistant** for medical care provided in the insured's home, excluding any person who usually resides in the insured's home or is a member of the insured's family, up to a maximum reimbursement of $200 per day and $4,000 per calendar year, per insured.

c) Professional services of a **homeopath**, an **osteopath**, a **naturopath**, an **acupuncturist** or a **dietitian**, up to a maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, per specialist. Only one treatment per day, per specialist, per insured, is eligible for reimbursement.

d) Professional services of a **physiotherapist** and a **physical rehabilitation therapist**, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, for all of these specialists. Only one treatment per day, per insured, is eligible for reimbursement.

e) Professional services of a **podiatrist** and a **foot care nurse**, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, for all of these specialists. Only one treatment per day, per insured, is eligible for reimbursement.

f) Professional services of a **kinesitherapist**, an **orthotherapist**, a **kinotherapist** and a **massage therapist**, up to an overall maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, for all of these specialists. Only one treatment per day, per specialist, per insured, is eligible for reimbursement.

g) Expenses for **X-rays** required for the treatment provided by a specialist covered under Option I, up to an overall maximum reimbursement of $40 per calendar year, per insured, for all of the specialists covered under this plan.

h) Expenses for **ultrasound examinations** and **thermographic evaluations**, excluding fetal ultrasounds, up to an overall maximum reimbursement of $400 per calendar year, per insured, for all of these expenses incurred on medical prescription.

2. The following expenses are reimbursed at 50%.

Professional services of a **psychologist**, a **psychiatrist**, a **psychoanalyst**, a **psychotherapist** and a **professional social worker** are reimbursed up to an overall maximum of $500 per calendar year, per insured, for all of these specialists. Only one treatment per day, per specialist, per insured, is eligible for reimbursement. The only professional services of psychiatrists eligible for reimbursement are those rendered as psychoanalytic treatments, insofar as these professionals are members of the Canadian Psychoanalytic Society.

3. Exclusions

The exclusions provided for the Basic Health Insurance Plan also apply to the Extended Health Insurance Plan.

OPTIONAL DENTAL CARE INSURANCE PLAN – Option II

Before incurring any major treatment expenses, participants should first check with the Insurer as to the amounts that may be eligible for reimbursement. To do so, they should use the Canadian Dental Association or the *Association des chirurgiens dentistes du Québec* (ACDQ) dental claim form available in the dentist's office, or the Insurer's Dental Claim Form available through their employer or online, specifying "Treatment Plan."

Optional participation for a minimum period of 36 months

Eligible expenses are expenses for treatment reasonably provided and recommended by a dentist, up to the amount of the fees specified in the fee guide approved by the *Association des chirurgiens dentistes du Québec* (ACDQ) at the time services are rendered.

The Insurer reimburses 80% of expenses for the diagnostic, preventive, basic restorative and major restorative services and 50% of expenses for fixed prosthodontics described below, up to an overall maximum reimbursement of $1,000 per calendar year, per insured, for all of these expenses.

The Insurer reimburses 80% of expenses for removable prosthodontics. These expenses are eligible up to a maximum reimbursement of $1,000 per calendar year, per insured. *See restrictions on Page 33.*

The codes used in the description are drawn from the document entitled "2014 Fee Guide and Description of Dental Treatment Services" approved by the *Association des chirurgiens dentistes du Québec* (ACDQ). For subsequent years, these codes are replaced by their equivalents from later documents approved by the Association. All new dental procedure code numbers related to the following expenses, added while the contract is in force, are automatically recognized.

1. Eligible expenses

Description of diagnostic services

– Clinical oral examination

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

  b) Recall or periodic examination: up to one examination per period of 9 consecutive months (01200)

c) Dental examination for dependent children under age 10, if not covered under the public plan provided by the *Régie de l'assurance maladie du Québec*: up to one examination per period of 12 consecutive months (01250)

d) Emergency examination (01300)

e) Specific oral examination: up to one examination per period of 9 consecutive months (01400, 01600, 01700)

f) Complete periodontal examination: up to one examination per period of 36 consecutive months (01500)

Limitation: Only one recall, periodic, specific or complete oral examination is covered per period of 9 consecutive months. However, any examination carried out by a specialist on the recommendation of a dentist (eligible according to the ACDQ fee guide) is not subject to this limitation.

– Radiographs

a) Intraoral radiographs

i) Radiograph, periapical (02111 to 02116)

ii) Occlusal film (02131, 02132)

iii) Bitewing film (02141 to 02144)

iv) Radiograph of soft tissue (02151, 02152)

b) Extraoral radiographs

i) Extraoral film (02201, 02202)

ii) Radiograph, sinus (02304)

iii) Radiograph, sialography (02400)

iv) Radiopaque dyes (02430)

v) Radiograph, temporomandibular joint (02504)

vi) Panoramic film (02600)

vii) Cephalometric film (02701, 02702)

c) Radiograph, hand and wrist, as diagnostic aid for dental treatment (02915)

d) Tomography (02920, 02929)

Limitation: No more than one series of radiographs is eligible for reimbursement per period of 9 consecutive months, except for a series of radiographs taken during an emergency examination or an examination carried out by a specialist on the recommendation of a dentist. Furthermore, a complete series of periapical and bitewing films is eligible for reimbursement only once per period of 36 consecutive months.

- Tests and laboratory examinations
    a) Bacteriological culture to identify pathological agents (04100)
    b) Bacteriological culture to determine susceptibility to cavities (04201)
    c) Biopsy of soft tissue or hard tissue (04302, 04311, 04312)
    d) Cytology tests (04401, 04402)
- Diagnostic casts
    a) Unmounted (04501, 04502)
    b) Mounted (04510, 04520)
    c) Diagnostic wax-up (04730)
- Presentation of case/treatment plan (05101)
- Consultation (04500, 05201)

Description of preventive services

- Polishing of coronal portion of teeth (prophylaxis): up to one treatment per period of 9 consecutive months (11100, 11200, 11300)
- Periodontal scaling: up to one treatment per period of 9 consecutive months for all related dental procedures (43411 to 43414, 43417, 43419)
- Topical application of fluoride: up to one treatment per period of 9 consecutive months (12400)
- Nutritional counselling (13100)
- Oral hygiene instruction (13200, 13210)
- Plaque control program (13220)
- Finishing restorations (13300)
- Removal of subgingival filling material, requiring anesthesia, without flap, per tooth (13301)
- Pit and fissure sealants (13401, 13404)
- Mouth guard (13510)
- Tooth discing
    a) Interproximal discing of teeth (13700)
    b) Enameloplasty, per tooth (13715)

- Space maintainers
  a) Band type (15108 to 15111, 15120)
  b) Stainless steel crown type (15200, 15210)
  c) Removable appliance (15400, 15410)
  d) Acid etched bonded type (15420)

Description of basic restorative services

RESTORATION

- Primary teeth
  a) Amalgam, non-bonded anteriors or posteriors (21101 to 21105)
  b) Amalgam, bonded anteriors or posteriors (21121 to 21125)
  c) Composite, bonded anteriors (23311 to 23315)
  d) Composite, bonded posteriors (23411 to 23415)
- Permanent teeth
  a) Amalgam, non-bonded anteriors or bicuspids (21211 to 21215)
  b) Amalgam, non-bonded molars (21221 to 21225)
  c) Amalgam, bonded anteriors and bicuspids (21231 to 21235)
  d) Amalgam, bonded molars (21241 to 21245)
  e) Composite anteriors (23111 to 23115, 23118)
  f) Veneer (anteriors and bicuspids) (23121, 23122)
  g) Diastema closure, per tooth (23124)
  h) Composite, bonded bicuspids (23210 to 23215)
  i) Composite, bonded molars (23220 to 23225)
- Retentive pins (amalgam or composite) (21301 to 21304)
- Supplement for restoration of a tooth under an appliance or supporting an existing removable partial denture: per restoration (in addition to the code used for retrofilling) (21601)
- Gold foil (24101, 24102)

- Inlays/onlays
  a) Metal (25100, 25200, 25300, 25500)
  b) Porcelain, resin or ceramic (25121 to 25123, 25521)
- Retentive pins for inlays or onlays (25601 to 25604)

ORAL SURGERY

- Removal of erupted teeth (uncomplicated) (71101, 71111)
- Surgical removals
  a) Erupted teeth (complex) (72100, 72110)
  b) Impacted tooth (72210, 72220, 72230, 72240)
  c) Residual roots (72300, 72310, 72320)
  d) Removal of fragment(s) of a fractured tooth (72350)
  e) Surgical exposure of teeth (72410 to 72412)
  f) Surgical movement of teeth (72430, 72440)
  g) Enucleation of teeth (72450)
- Supplement for suturing, per visit: these expenses are only eligible if claimed together with expenses for removal of erupted teeth (uncomplicated) (71121)
- Remodelling and recontouring of oral tissues
  a) Alveolectomy (73020)
  b) Alveoloplasty (73100, 73110)
  c) Stomatoplasty (73123)
  d) Osteoplasty (73133 to 73135, 73140)
  e) Tuberoplasty (73150, 73151)
  f) Removal of hyperplasic tissue (by radiosurgery or dissection) (73171 to 73176)
  g) Removal of excess mucosa (by radiosurgery or dissection) (73181 to 73186)
  h) Alveolar ridge reconstruction with alloplastic material (73360, 73361)
  i) Extension of mucous folds with secondary epithelization (including vestibuloplasty) (73381 to 73384)
  j) Extension of mucous folds with mucous or skin graft (73401 to 73404)

- Surgical excision (cyst and tumor)
  a) Removal of tumor (74108, 74109)
  b) Removal and curettage of intra-osseous cyst or granuloma (74408 to 74410)
- Surgical incision and drainage (75100, 75101, 75110)
- Removal of foreign body from the bone or soft tissue (75301, 75361)
- Frenectomy (77801 to 77803)
- Hemorrhage, control (79400, 79401)
- Post-surgical treatment (79601, 79602)

GENERAL ADDITIONAL SERVICES

- Local anesthesia (04470, 04471)
- Conscious sedation by inhalation (92311 to 92319)
- Conscious sedation, intravenous (92331 to 92339)
- Oral or percutaneous conscious sedation (92421 to 92429)
- Professional visits (94100, 94200, 94400)

Description of major restorative services

ENDODONTICS

- Caries/trauma/pain control
  a) Sedative filling/indirect capping (20111, 20121)
  b) Recontouring and polishing of traumatized tooth (20131)
  c) Bonding/cementation (20161)
- Endodontic emergency
  a) Pulpotomy (32201, 32202, 32210)
  b) Open and drain through natural tooth (separate emergency procedure) (39201, 39202)
  c) Pulpectomy through natural tooth (separate emergency procedure) (39901 to 39904)
  d) Relieving traumatic occlusion (39970)
  e) Reimplantation of avulsed tooth (39981)
  f) Repositioning of traumatically displaced tooth (39985)

- Other endodontic services: supplement for endodontic treatment through a metal and/or porcelain crown (32101, 32102)
- Preparation of tooth for treatment (39100, 39110, 39120)
- Root canal therapy
    a) Root canal treatment and retreatment
        i) One canal (33100 to 33102, 33110 to 33112)
        ii) Two canals (33200 to 33202, 33210 to 33212)
        iii) Three canals (33300 to 33302, 33310 to 33312)
        iv) Four canals (33400 to 33402, 33410 to 33412)
        v) Additional canal (33475)
    b) Apexification
        i) One canal (33521, 33531, 33541)
        ii) Two canals (33522, 33532, 33542)
        iii) Three canals (33523, 33533, 33543)
        iv) Four canals or more (33524, 33534, 33544)
    c) Perforation repair (34511)
- Periapical endodontic surgery
    a) Apicoectomy (as a separate procedure from root canal) (34101 to 34104)
    b) Apicoectomy and root canal treatment performed jointly, with or without retrofilling (34111, 34112, 34114, 34115)
    c) Apicoectomy and root canal retreatment performed jointly, with or without retrofilling (34171, 34172, 34174, 34175)
    d) Apicoectomy and retrofilling (as a separate procedure from root canal) (34201 to 34203, 34212, 34215)
    e) Root amputation (34401, 34402)
    f) Intentional reimplantation (34451 to 34453)
    g) Hemisection (39230)
- Bleaching of tooth, in office, by a dentist: subject to an overall maximum of 10 sessions per calendar year, per insured for all teeth
    a) Non-vital (39410)
    b) Vital, in office (97101, 97102)

PERIODONTICS

- Management of acute infections and other oral lesions (41200)
- Desensitization: up to an overall maximum of 10 applications per calendar year, per insured, for all teeth (41300)
- Periodontal surgery
    a) Root planing and curettage (42000, 42001)
    b) Gingivoplasty and/or gingivectomy (42002, 42003, 42010)
    c) Fibrotomy (42330, 42331)
    d) Flap approach with osteoplasty and/or ostoectomy (42100)
    e) Grafts
        i) Soft tissue (42200, 42300, 42301, 42560, 42561, 42565)
        ii) Gingival (42570, 42575)
        iii) Osseous tissue (42611, 42700, 42711)
    f) Proximal wedge (mesial or distal) (42400)
    g) Exploratory surgery, flap approach (42441, 42451)
    h) Postoperative visit for dressing change (42720)
- Adjunctive periodontal procedures
    a) Temporary splints or ligations (43200, 43211, 43212, 43260)
    b) Cast metal splint, acid etch bonded (43290)
    c) Removal or recementation of splint, per tooth (43295)
    d) Occlusal equilibration (43300, 43310)
    e) Periodontal appliances (to control bruxism) (43611, 43612, 43622, 43631)
    f) Intraoral appliance for temporomandibular joint (occlusal guard) (43711, 43712, 43732, 43741)
    g) Periodontal irrigation, subgingival (49211)
    h) Intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents (49221, 49229)

FIXED PROSTHODONTICS

- Individual crowns
    a) Acrylic processed (27100)

b) Provisional, acrylic (transitional) (27130, 27140, 27150)

c) Porcelain, acrylic, ceramic, resin or metal (27200, 27210, 27300, 27310)

d) Complementary services (27401, 27501, 27503, 28211)

– Other restorative services

a) Crown or veneer repair (27721 à 27723)

b) Recementation and/or removal (29100, 29200)

c) Removal of inlay, onlay, non-prefabricated crown or veneer (in addition to preparation of a new restoration), first unit of time and each additional unit (29301, 29302)

Restrictions concerning crowns

Replacement of individual crowns will be refundable provided satisfactory evidence may establish that the individual crowns may not be repaired and, if this crown has been inserted while this dental care coverage was in force, that at least 4 years have gone by prior to the replacement.

Description of expenses for removable prosthodontics

REMOVABLE PROSTHODONTICS

– Complete dentures

a) Standard (51100, 51110, 51120)

b) Equilibrated (51201 to 51203)

– Immediate complete dentures (51300, 51310, 51320)

– Immediate complete dentures (transitional) (51600, 51610, 51620)

– Dentures, complete, overdenture

a) Standard (51701 to 51703)

b) Equilibrated (51711 to 51713)

– Partial dentures, acrylic base (immediate, transitional, or permanent) (52101 to 52105, 52120 to 52124, 52129, 52230 to 52232)

– Cast partial dentures, chrome-cobalt alloy with cast and/or wrought rests and clasps (52400, 52410, 52420, 52500, 52510, 52520, 53131 to 53133, 53150, 53221 to 53223)

– Complete dentures with partial dentures (opposing arch), chrome-cobalt, with or without free end base (52531, 52532, 52542, 52543)

- Removable cast partial dentures with precision attachments (52600, 52610, 52620)
- Semi-precision cast partial dentures (52601, 52611, 52630)
- Hybrid partial dentures, cast (52701, 52702)

DENTURE ADJUSTMENTS

- Minor adjustments, provided that adjustments are made more than six months after the initial insertion of the denture (54250, 54251)
- Remount and equilibration of complete or partial dentures (54300 to 54302)

COMPLETE OR PARTIAL DENTURE REPAIRS

- Complete denture repairs without impression (55101 to 55104)
- Complete denture repairs with impression (55201 to 55204)
- Structural additions to partial denture (55520, 55530)
- Replacement of teeth in prosthesis (56602)
- Vertical dimension recuperation by addition of acrylic to existing prosthesis (56631)

DENTURE CLEANING AND POLISHING (55700)

DUPLICATE OF A PROSTHESIS (56100, 56101)

REBASING AND RELINING

- Relining of complete or partial denture (56200, 56201, 56210, 56211, 56220 to 56222, 56230 to 56232)
- Rebase (jump) (56260 to 56263, 56280, 56290)
- Therapeutic tissue conditioning (56270 to 56273)

REMAKE, PARTIAL DENTURES (using existing framework) (56411 to 56413)

Restrictions concerning removable prosthodontics

- Any replacement of a prosthesis or the addition of teeth to a removable prosthesis is only eligible for reimbursement if satisfactory proof is provided that:

  a) the replacement or addition of teeth is necessary following the extraction of teeth after the initial denture insertion; or

b) at least 4 years have elapsed since the initial denture insertion.

Limitations to eligible expenses

The following dental procedures are not eligible for reimbursement by the Insurer:

- Dental care provided free of charge or for which the insured does not have to pay
- Dental care for which the insured is entitled to reimbursement under the Act respecting industrial accidents and occupational diseases, the Quebec Automobile Insurance Act, or any other Canadian or foreign law with similar provisions
- Dental treatments payable under any health insurance plan in which the insured participates

2. Exclusions

No benefits are payable for dental care expenses incurred:

- for a third party
- for cosmetic surgery, including the transformation, extraction or replacement of healthy teeth in order to modify their appearance
- for any condition occurring while the insured is on active duty with the armed forces

ACTIVE PARTICIPANT'S AND RETIREE'S OPTIONAL LIFE INSURANCE PLAN – Option III

Optional participation

1. Active participants

a) Participant's Basic Life Insurance

The amount of Basic Life Insurance payable in the event of the participant's death is equal to:

– 1 times the annual salary, rounded to the nearest multiple of $5, for participants under age 65

– ½ the annual salary, rounded to the nearest multiple of $5, for participants age 65 and over

b) Participant's Optional Life Insurance

NOTE: Participation in this benefit is conditional on participation in Basic Life Insurance.

Participants may opt for an additional amount of life insurance equal to their choice of 1 to 5 times their annual salary. This amount is rounded to the nearest multiple of $5.

This benefit is subject to evidence of insurability in accordance with the Insurer's standards in force at the time of enrolment and each time a new unit of Optional Life Insurance is added.

This benefit does not apply if the participant dies from suicide or the effects of any attempted suicide during the first year following the effective date of this benefit, its reinstatement or any increase in the benefit amount, whether or not he or she is of sound mind at the time of suicide or attempted suicide. In such case, insurance under this benefit, or the increase in insurance, as the case may be, shall be null and void, and the liability of the Insurer shall be limited to a refund of the premiums collected.

c) Participant's Accidental Death and Dismemberment Insurance

NOTE: Participation in this benefit is conditional on participation in Basic Life Insurance.

If the participant sustains any of the losses specified below within 365 days following the date of an accident, provided the participant is covered under this benefit at the time of the accident, the Insurer will pay the percentage of annual salary indicated below, without exceeding 100% of salary for all losses related to the same accident. This percentage is reduced by half when the participant reaches age 65.

TABLE OF LOSSES	PERCENTAGE OF ANNUAL SALARY
– Loss of life	100%
– Loss of both hands or both feet or loss of sight in both eyes	100%
– Loss of one hand and one foot	100%
– Loss of one hand or one foot and the sight in one eye	100%
– Loss of one hand or one foot	50%
– Loss of sight in one eye	50%
– Loss of one finger	10%

The word "loss" means, for a hand, foot or finger, total and definitive loss of use; with respect to eyesight, it means the total, definitive and irrecoverable loss of eyesight. In the event of a loss sustained by a disabled person, the percentage of annual salary remains that established at the onset of disability. For insurance purposes, a disabled person is deemed to be a retiree as of his or her 65th birthday.

This coverage does not apply if the loss sustained occurs in the following cases:

- While the participant is carrying out any of the duties of an airplane crew, except as required in the course of his or her duties as stipulated in the collective agreement or individual employment contract
- Due to war, whether declared or not, or participation in an insurrection
- Due to attempted suicide or suicide of the participant, or voluntary self harm or injury, whether or not the participant is of sound mind
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle while having a blood alcohol level in excess of the prescribed legal limit

- While the participant is on active duty with the armed forces
- Subsequent to an illness or affliction that does not result from an accident and becomes apparent at the time of an accident

d) Participant's Spouse's and Dependent Children's Life Insurance

NOTE: Participation in this benefit is conditional on participation in Participant's Basic Life Insurance.

The benefits payable in the event of death are equal to:

- $2,500 for an insured dependent child age 24 hours or older
- $5,000 for the insured spouse

e) Participant's Spouse's Optional Life Insurance

NOTE: Participation in this benefit is conditional on participation in Spouse's and Dependent Children's Life Insurance.

Participants may choose an additional amount from 1 to 20 units of $5,000 on the life of their spouse. This benefit is subject to evidence of insurability in accordance with the Insurer's standards in force at the time of enrolment and each time a new unit of Optional Life Insurance is added.

This benefit does not apply if the spouse dies from suicide or the effects of any attempted suicide during the first year following the effective date of this benefit, its reinstatement or any increase in the benefit amount, whether or not he or she is of sound mind at the time of suicide or attempted suicide. In such case, insurance under this benefit, or the increase in insurance, as the case may be, shall be null and void, and the liability of the Insurer shall be limited to a refund of the premiums collected.

2. Retired participants

a) Retiree's Life Insurance

Starting on the date of retirement, participants may continue to be insured without evidence of insurability and choose an amount of up to 20 units of $5,000, without exceeding the amount held as an active participant, provided they submit an application to the Insurer within 30 days following the date of retirement.

However, for part-time participants or participants on unpaid leave without maintaining participation, whose amount of insurance in force immediately prior to retirement was lower than $5,000, the amount is deemed to be $5,000.

Participants may subsequently reduce, but cannot increase, the amount of insurance selected. In addition, they may terminate their insurance at any time, in which case they will no longer be able to participate.

Retired participants who return to work may keep the amount of insurance held as a retiree. In such case, any new amount of life insurance for the participant or his or her dependents to which the participant becomes entitled once he or she retires again is added to the amount of insurance already held. The total of these amounts therefore forms a single amount of insurance for the purposes of applying the maximums provided under this benefit (retiree and dependents).

b) Retiree's Spouse's and Dependent Children's Life Insurance

Retired participants may keep the amount of insurance they held under the active participant's plan for their spouse and dependent children, if applicable, provided they take out Retiree's Life Insurance coverage.

Enrolment must occur at the same time for all life insurance plans available to the retiree.

The benefits payable in the event of death are equal to:

- $2,500 for an insured dependent child age 24 hours or older
- $5,000 for the insured spouse

c) Retiree's Spouse's Optional Life Insurance

Retired participants may keep some or all of the amount of optional life insurance coverage they held on the life of their spouse under the active participant's plan, i.e. between 1 and 20 units of $5,000, provided they take out Retiree's Life Insurance and Spouse's and Dependent Children's Life Insurance coverage.

Premium rates are the same as those for the amount of Retiree's Life Insurance coverage, taking the retiree's age and spouse's gender into account.

Enrolment must occur at the same time for all life insurance plans available to the retiree.

3. Accelerated benefit payment in the event of terminal illness

A person who is insured under any of the life insurance plans, whose life expectancy is no more than 12 months, may obtain an accelerated benefit payment by submitting a written request to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent. The total amounts paid out (Basic and Optional) may not exceed $50,000 or 25% of the insured's amount of life insurance. All of the provisions regarding the accelerated benefit payment can be found on Page 65 of this booklet.

GENERAL INFORMATION

1. Definitions

a) Assistor

CanAssistance Inc. or any other assistance provider designated by the Insurer.

b) Business partner

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

c) Close relative

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

d) 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. In addition, the commercial activity must be the only reason for the planned trip.

e) Committee

The Intersectoral Parity Committee – Fédération des travailleurs et travailleuses du Québec (CPI – FTQ).

f) Dependent

The participant's spouse or dependent child, as defined below.

– Spouse

  A person of the same or opposite gender who, on the date of the event giving entitlement to benefits:

  a) is legally married or civilly united to the participant; or

b) has been living in a conjugal relationship with the participant for over a year, or less than one year if that person is the mother or father of a participant's child; or

c) has been living in a conjugal relationship with the participant for at least a year.

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

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

If the participant has a spouse who corresponds to the definition under item a) above and another spouse who corresponds to the definition under items b) or c), the Insurer shall recognize as the spouse the person designated by the participant as his or her spouse by written notice to the Insurer.

– Dependent child

Refers to any of the following persons:

- A person under 18 years of age over whom the participant or spouse exercises parental authority
- A person age 25 or under who has no spouse, attends a recognized educational institution as a duly registered full-time student, and over whom the participant or spouse would exercise parental authority if a minor
- A person who has reached the age of majority, without a spouse, who is domiciled in the participant's home and is afflicted with a total disability which occurred while the person met either of the two previous definitions, and has remained totally and continuously disabled since that date, over whom the participant or spouse would exercise parental authority if he or she were a minor
- A person who has reached the age of majority, without a spouse, afflicted with a functional deficiency defined in the *Regulation respecting the Basic Prescription Drug Insurance Plan* that occurred before he or she reached age 18, who receives no benefits under a last resort assistance plan provided under the *Act respecting income security*, who is domiciled in the participant's home and over whom the participant or spouse would exercise parental authority if the person was a minor.

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

g) Disability

i) Disability of 48 months or less

Disability means a state of incapacity that results either from an illness, including an accident or a complication resulting from pregnancy, tubal ligation, vasectomy or similar cases relating to family planning or from donation of an organ or bone marrow requiring medical attention which makes the wage-earner totally incapable of carrying out the ordinary tasks of his or her employment, or any equivalent employment offered by the employer that pays similar remuneration.

ii) Disability of more than 48 months

Disability means a state of incapacity which renders the wage-earner completely incapable of performing any gainful occupation for which he or she is reasonably suited given his or her education, training and experience.

The wage-earner is not deemed to be disabled for any period of disability during which he or she is not under the care of a physician or surgeon legally authorized to practise medicine, except in stationary cases where the disability is recognized to the Insurer's satisfaction. In the event of a disability due to mental illness, the disabled wage-earner must be under the care of a psychiatric specialist, except in the event of stationary cases where the disability is recognized to the Insurer's satisfaction.

h) Disability period

For the first 36 months, a period of disability is any continuous period of disability or series of successive periods of disability separated by a period of effective full-time work or availability for full-time work, unless the wage-earner establishes to the satisfaction of his or her employer or its representative that a subsequent period is due to an illness or accident that is completely unrelated to the cause of the previous disability.

The period of effective full-time work or availability for full-time work is:

i) Less than 15 days if the period of disability is less than 78 weeks

ii) Less than 45 days if the period of disability is 78 weeks or more.

After the 36th month, a period of disability is any continuous period of disability which may be interrupted by less than 6 months of effective full-time work or availability for full-time work, if the same disability is involved.

NOTE: A period of disability resulting from a sickness or injury that has been voluntarily self-inflicted by the wage-earner, from alcoholism or substance abuse, active participation in a riot, insurrection or criminal acts or service in the armed forces is not recognized as a period of disability for the purposes herein. However, a period of disability resulting from alcoholism or substance abuse during which the wage-earner receives treatment or medical care for rehabilitation purposes is recognized as a period of disability.

i) Health and Social Services sector

The Health and Social Services sector includes all centres operated by public institutions under the meaning of the *Act respecting health and social services* (R.S.Q., c.S-4.2), private institutions contracted under the meaning of this law, and any organization that provides services to a centre or users in compliance with the act and declared by the government to be an establishment within the meaning of the *Act respecting health and social services* and represented by the following groups of employers:

- Ministère de la Santé et des Services sociaux (MSSS)
- Association québécoise d'établissements de santé et de services sociaux (AQESSS)
- Association des centres de réadaptation en dépendance du Québec (ACRDQ)
- Association des établissements privés conventionnés – santé et services sociaux (AEPC)
- Association des établissements de réadaptation en déficience physique du Québec (AERDPQ)
- Fédération québécoise des centres de réadaptation en déficience intellectuelle et en troubles envahissants du développement (FQCRDITED)
- Association des centres jeunesse du Québec (ACJQ)
- Health and social services agencies

j) Host at destination

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

k) Insured

The participant or one of his or her dependents under this contract.

l) Participant

The wage-earner or retired person insured under this contract.

m) Prepaid travel expenses

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

n) Salary

Salary to scale increased, if applicable, by seniority pay and regional differentials, including additional remuneration for continuing education, but excluding payments for overtime and any lump-sum payments.

o) 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.

p) Trip

A trip for the purposes of tourism or recreation, a trip for the purposes of humanitarian aid or cooperative work that is supervised by a registered charity, or a commercial activity. No other type of trip is covered under this benefit, unless the Policyholder and the Insurer have agreed otherwise.

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

2. Eligibility

a) Wage-earners

– All wage-earners working either full-time or 70% or more of a full-time schedule:
  - in a permanent position: after 1 month of continuous service
  - in a temporary position: after 3 months of continuous service.

– All part-time wage-earners working less than 70% of a full-time schedule: after 3 months of continuous service.

b) Dependents

All dependents of a participant are eligible for coverage as of the same date as the participant if they are already a dependent, or as of the date on which they subsequently become dependents.

c) Retirees

All wage-earners become eligible for Retiree's Life Insurance coverage as of the date of retirement if they were covered under the Active Participant's Optional Life Insurance plan.

A retired participant who is rehired on or after May 14, 2006 remains covered by the Retiree's Life Insurance plan and the Individual Health Insurance policy, if he or she had enrolled prior to retirement. This participant is not eligible for any of the group insurance plans for active participants.

3. Participation

a) Basic Health Insurance (Mandatory)

– **Enrolment**

  Enrolment is mandatory for any eligible wage-earner under the age of 65 and for his or her dependents, if any, subject to the exemption entitlement. Wage-earners must select one of the following tiers at the time of enrolment:

  - Complete
  - Reduced

Wage-earners must complete an application form within 30 days following the date they become eligible or the date on which they lose coverage under another contract under which they were insured.

This provision also applies to wage-earners who were disabled on the effective date of the new plan, i.e. January 1, 2014. If a disabled wage-earner wants to select the reduced tier, the applicable 30-day period begins on the date on which the wager-earner returns to active work. If the application is submitted after the 30-day period, the wage-earner will automatically have the complete tier.

The participant's coverage entails coverage of the participant's dependents, if he or she opts for Family coverage (spouse and dependent children) or Single-Parent coverage (dependent children only). Participants must complete an application form within 30 days following the date on which they become eligible.

Enrolment is optional for wage-earners age 65 or over. A wage-earner age 65 or over who chooses not to enrol in the plan cannot enrol at a later date.

However, a participant with no dependent children and whose spouse is age 65 or over may opt to replace Family coverage with Individual coverage. Participants who exercise this option cannot make any subsequent changes to the choice of Individual coverage status.

– **Minimum participation period**

Wage-earners who opt for the complete tier must maintain their participation for a minimum period of 36 months. This period includes any exemption period of which a wage-earner has taken advantage or any disability period.

No minimum participation period applies to the reduced tier. Wage-earners who have opted for this tier may upgrade to the complete tier at any time.

– **Coverage change request**

All wage-earners may apply for a change of coverage following any of these events:

- Marriage or civil union
- Cohabitation for at least one year, or for less than one year if a child has been born of their union or if legal adoption procedures have been initiated
- Birth or adoption of a first child
- Death of the spouse
- Termination of the spouse's or a dependent child's insurance requiring a change of coverage.

All coverage change requests must be submitted to the Insurer within 30 days of the date of the event giving rise to the request. The insurance then becomes effective on the date of the event.

If the request is submitted more than 30 days after the date of the event, the insurance becomes effective on the first day of the premium period following the date of receipt of the request.

– **Exemption entitlement**

A wage-earner may waive or terminate coverage for him or herself and dependents, if any, under this plan provided that they are insured by a group insurance plan with similar coverage. The wage earner's decision may also apply only to dependents, in which case the same provisions apply. This decision is irreversible as long as the wage-earner and dependents, if any, are eligible for the other plan. However, as soon as coverage under the other group insurance plan ends, they must participate in this plan.

Wage-earners who have exercised their exemption entitlement for the Basic Health Insurance plan may opt to take out coverage under the optional plans, for themselves and their dependents, by completing an application form within 30 days following the date on which the dependents become eligible.

– **Termination of exemption entitlement**

A wage-earner or dependents, if any, who is exempt from the Basic Health Insurance Plan may terminate the exemption. This also applies to a disabled participant. The following conditions must be met to the Insurer's satisfaction:

- Prior to the application, the wage-earner must establish that he or she was covered by a group insurance plan providing similar coverage.
- The wage-earner must establish that it has become impossible for him or her to continue to be insured by the plan or plans that provided the exemption entitlement.

Wage-earners must therefore send an application form to the Insurer within 30 days following the end of their exemption, indicating the coverage tier selected. If the application is not received within 30 days following the end of the exemption period, the wage-earner will automatically have the complete tier. The wage-earner will then have to maintain participation for the minimum period before being able to change for the reduced tier.

IMPORTANT
For participants reaching age 65

As this group insurance plan does not include any additional premium for prescription drugs, La Capitale considers that participants will remain insured under this group plan.

Participants must therefore ensure they opt out of the RAMQ's Basic Prescription Drug Insurance Plan.

This decision is reversible, as participants may enrol in the RAMQ plan at any time.

Participants age 65 who choose to maintain enrolment in the RAMQ plan may enrol in the 3992 individual Health Insurance product if they wish to maintain coverage for expenses other than those incurred for prescription drug purchases.

As enrolment in the RAMQ plan is irrevocable, these participants may no longer choose to be covered by La Capitale for prescription drugs covered by the RAMQ.

b) Optional plans

– **Extended Health Insurance (Option I)**

– **Dental Care Insurance (Option II)**

Participation in each plan is optional. No evidence of insurability is required if the wage-earner enrols within 30 days following eligibility or the date on which the participant ceases to be eligible for another group insurance plan under which he or she was insured.

If the Insurer receives the application more than 30 days after the eligibility date, the participant must provide evidence of insurability for him or herself and dependents to the Insurer's satisfaction. Insurance then becomes effective on the date on which the Insurer accepts the evidence of insurability.

The minimum participation requirement is 36 months for all participants and their dependents, if applicable, as of the effective date of their insurance. After this period, participants may cease to participate in these plans at any time by notifying their employer.

Participants with Individual coverage may choose to insure a spouse and dependent children (Family coverage) or dependent children only (Single-Parent coverage) as soon as they have dependents or their dependents are no longer eligible for another group insurance plan offering similar benefits. Insurance for dependents becomes effective at that time, provided that a new application form is completed by the wage-earner and received by the Insurer within the following 30 days.

A participant cannot have Single-Parent or Family coverage under the optional plans if that participant has Individual coverage under the Basic Health Insurance plan. A participant who has Single-Parent or Family coverage under the Basic Health Insurance Plan may, however, take out Individual coverage under the optional plans.

Following examination of the evidence of insurability, the Insurer may grant Family or Single-Parent coverage that excludes one or more members of the family from coverage.

In addition, coverage under the optional plan (Individual, Single-Parent, Family) must be the same.

Note that Single-Parent coverage is only for participants who do not have a spouse.

– **Life insurance for active participants and retirees**

I) ACTIVE PARTICIPANTS

- **Participant's Basic Life Insurance**

  Participation is optional. No evidence of insurability is required if the wage-earner enrols within 30 days following eligibility.

  After this time, evidence of insurability deemed satisfactory by the Insurer is required.

  Wage-earners may also enrol in Participant's Basic Life Insurance without having to provide evidence of insurability by completing an application form within 30 days following the adoption or birth of a first child, or the date on which the wage-earner takes a spouse in accordance with the definition of spouse under this contract.

  If the wage-earner ceases to participate in this benefit, evidence of insurability must be provided to the Insurer's satisfaction if a new application is submitted.

- **Participant's Optional Life Insurance**
- **Participant's Accidental Death and Dismemberment Insurance**
- **Participant's Spouse's and Dependent Children's Life Insurance**

  Participation in each of these benefits is optional but conditional on participation in Participant's Basic Life Insurance.

  For Participant's Accidental Death and Dismemberment Insurance and Spouse's and Dependent Children's Basic Life Insurance, when the Insurer receives the application more than 30 days after the eligibility date, the participant must provide evidence of insurability for him or herself and dependents to the Insurer's satisfaction.

  For Participant's Optional Life Insurance, all amounts of insurance require evidence of insurability.

  If the wage-earner ceases to participate in any of these benefits, evidence of insurability must be provided to the Insurer's satisfaction if a new application is submitted.

- **Participant's Spouse's Optional Life Insurance**

  Participation is optional but conditional on participation in Participant's Basic Life Insurance and Spouse's and Dependent Children's Life Insurance.

  All amounts of optional life insurance require evidence of insurability.

When a participant obtains a first position

Any eligible wage-earner who does not hold a position and has not enrolled in the optional plans may do so without evidence of insurability by completing an application form within 30 days following the date on which he or she obtains a first position.

II) RETIRED PARTICIPANTS

- **Retiree's Life Insurance**

  Participation is optional but conditional on participation in this benefit under the active participant's plan. A retired participant can choose to enrol in this benefit by submitting an application within 30 days following the retirement date. No applications will be accepted after this period. However, if the participant should die before the 30-day period is up, he or she is assumed to have taken out the coverage and maintained the amount of life insurance held immediately prior to retirement, without exceeding the maximum amount of $50,000.

- **Retiree's Spouse's and Dependent Children's Life Insurance**
- **Retiree's Spouse's Optional Life Insurance**

  Participation in each of these benefits is optional but conditional on participation in these benefits under the active participant's plan and on participation in Retiree's Life Insurance.

  For life insurance of a new dependent, a retiree must submit an application to the Insurer within 30 days following the date on which the new dependent becomes eligible. If the Insurer receives the application more than 30 days after this period, the participant must provide evidence of insurability for the new dependent to the Insurer's satisfaction.

4. Effective date of insurance

a) Wage-earner and dependents

WAGE-EARNER

– **Basic Health Insurance Plan (Mandatory)**
Complete and Reduced Tiers

  Wage-earners are covered as of the date on which they become eligible.

– **Optional Plans I – II – III**

  Wage-earners are covered as of the date on which they become eligible, provided they are at work or were at work on the last day they would usually have been at work, otherwise the day of their return to work, provided they complete an application form within 30 days following that date.

  If the application is completed after that time, the wage-earner will be covered as of the date on which the Insurer approves the evidence of insurability, provided the wage-earner is at work or was at work on the last day he or she would usually have been at work, otherwise the day of his or her return to work.

DEPENDENTS

Insurance for dependents begins on the latest of the following dates:

– The date on which they become eligible

– The date the Insurer approves any required evidence of insurability

– The date on which they cease to be eligible for another group insurance plan, provided the application is submitted within 30 days of termination of coverage under the other plan.

b) Retirees and their dependents

RETIREES

– **Optional Life Insurance plan**

  Insurance for retirees begins on the date they become eligible, provided they complete an application within 30 days following that date.

DEPENDENTS

Insurance for dependents begins on the latest of the following dates:

– The date on which they become eligible

– The date the Insurer approves any required evidence of insurability.

5. Conversion privilege

a) Complete and reduced Basic Health Insurance and Extended Health Insurance

Any participant whose coverage under the terms of the Basic Health Insurance plan ceases because that person is no longer eligible or any wage-earner age 65 or over who has opted to cease participation in the plan may, without evidence of insurability, apply for the individual Healthcare Insurance product offered by the Insurer, which also includes Travel and Trip Cancellation insurance. Participants may choose between 3 plans: Basic, Intermediate and Enriched.

Participants wishing to exercise their conversion privilege must submit an application within **60 days** following the termination date of their group insurance.

They must also register for coverage with the *Régie de l'assurance maladie du Québec* (RAMQ) in order to obtain basic coverage for prescription drug expenses.

b) Dental Care Insurance

Any participant under age 65 whose coverage ceases because he or she is no longer eligible for a reason other than retirement may apply, without evidence of insurability, in the 31 days following the date on which coverage terminates, for an individual Dental Care Insurance product offered by the Insurer.

c) Participant's Basic Life Insurance
Participant's Optional Life Insurance

Active participants who are no longer eligible for this plan for a reason other than retirement are entitled, without evidence of insurability, if they apply in writing to the Insurer within 31 days following the termination of their eligibility, to convert all or part of their coverage amount, with the exception of Accidental Death and Dismemberment coverage, to an individual whole life or term life insurance policy, without accessory coverage, offered by the Insurer.

The amount of insurance that may be converted cannot exceed the sum of all life insurance coverage held by the participant under the contract on the conversion date or $400,000, whichever is lower. However, this amount cannot be lower than $10,000.

d) Spouse's and Dependent Children's Life Insurance
Spouse's Optional Life Insurance

When an active participant's spouse or dependent child ceases to be eligible due to the termination of the active participant's coverage subsequent to his or her death, termination of employment (for a reason other than retirement) or termination of membership in the group, or due to the fact that the spouse or dependent child no longer meets the definition of dependent, provided that he or she makes a request in writing to the Insurer's head office within 31 days following termination of eligibility, he or she may, without evidence of insurability, convert the amount of insurance held to an individual whole life or term life insurance policy, without accessory coverage, offered by the Insurer.

The amount of life insurance that may be converted cannot exceed the amount of insurance held on the life of these individuals on the date of the conversion. However, this amount cannot be lower than $5,000.

6. Maintaining insurance during a temporary interruption of work

a) In the event of **temporary absence without pay of more than 30 days**, participation in all plans is suspended from the start of the temporary absence, except in the Basic Health Insurance plan, and coverage automatically resumes without evidence of insurability upon return to active work with pay. The participant must personally pay the total premium stipulated for the Basic Health Insurance Plan, except where the *Act respecting labour standards* obliges the employer to pay its contribution. However, the participant may choose to maintain participation in other plans by paying the full applicable premium personally.

In addition, for a wage-earner who is temporarily struck off the recall list for more than 30 days, the provisions of the previous paragraph apply.

During an authorized absence, if a participant maintains participation in any of the optional plans but fails to pay the required premiums, the optional plans will be cancelled until the participant's return to work. Upon returning to work, if the participant wishes to obtain coverage once again under the optional plans, he or she must provide evidence of insurability deemed satisfactory by the Insurer.

b) A participant who takes a **partial leave without pay as an extension of maternity, paternity or adoption leave** maintains participation in the plans as if he or she were not taking a leave.

c) A participant who is taking **progressive retirement**, as provided under his or her collective agreement, must maintain participation in all plans. The premium and life insurance amounts are determined based on the salary he or she would receive if he or she had not participated in this type of program.

d) A participant who is participating in a **deferred pay leave program**, as stipulated in his or her collective agreement, must maintain participation in the Basic Health Insurance Plan. This participant may also maintain participation in the other plans. The premium and life insurance amounts are determined based on the salary he or she would receive if he or she had not participated in this type of program.

e) Participation in the plans is maintained in cases of **temporary absence with pay** and for a **temporary leave without pay** of 30 days or less. Amounts of coverage are based on amounts held prior to the beginning of the leave.

f) When a participant is dismissed or suspended and disputes the **dismissal or suspension** by means of a grievance or recourse to arbitration under his or her collective agreement, he or she must maintain participation in the Basic Health Insurance Plan, with payment of premiums. He or she can also maintain participation in the other plans in which he or she participates by paying, through the employer, the total premium stipulated in the contract until a decision is rendered. If the dismissed or suspended participant wins the case and has not maintained participation in the optional plans, participation in these plans is reinstated on the date the decision is rendered and application of the provisions regarding these plans continues.

g) For a part-time wage-earner who maintains participation in the Optional Life Insurance Plan during a temporary leave without pay, the premium and benefit payable in the event of death are based on a portion of his or her salary established on a prorata basis of the time paid in relation to time paid on a full-time basis over the 12 months before the beginning of the temporary leave or parental leave for which no period of disability, maternity, paternity, adoption or unpaid leave was authorized. The period over which the average time is calculated cannot, however, precede the participant's date of hire. In this case, calculations are done using the reduced period. If disability arises during this period, the wage-earner is entitled to a waiver of premiums and, in the event of death, the benefit payable is based on the exempt insurance amount.

h) When a participant temporarily ceases to be at work due to a **strike or lockout**, participation in the Basic Health Insurance Plan is maintained, with payment of premiums, for a 30-day period. Thereafter, participation in the Basic Health Insurance Plan remains in force if the regular premiums are paid or there is an agreement between the Insurer and the union section of the Committee. Insurance under the other plans also remains in effect if regular premiums are paid or there is an agreement between the Insurer and the union section of the Committee, as long as participation in the Basic Health Insurance Plan is maintained.

i) For **unpaid leave**, life insurance amounts are based on the amounts held prior to the beginning of the leave.

7. Extension

a) Complete and reduced Basic Health Insurance Extended Health Insurance (Option I) Dental Care Insurance (Option II)

Upon the death of a participant, insurance coverage for the participant's dependents will be extended without payment of premiums until the earliest of the following dates:

- 12 months following the participant's death
- The date on which the dependents' insurance would have ended if the participant had been alive
- The date on which the contract terminates
- The date indicated in the Committee's written notice confirming the termination of union affiliation of the group of wage-earners to which the deceased participant belonged.

8. Waiver of premiums in the event of total disability

a) Start of waiver

– For participants

In the event of disability, the participant's insurance, and that of any dependents, remains in force without payment of premiums as of:

- the 8th working day for full-time wage-earners; or
- the 6th working day for full-time wage-earners working 4 days a week as part of a program to reduce working time; or
- the 9.9th calendar day for part-time wage-earners.

– For the employer

The employer is only exempt from paying its portion of the premium at the end of the payment period for salary insurance benefits stipulated in the collective agreement, i.e. after the 104th week of disability.

b) End of waiver

The waiver of premiums ends at 24:00 on the earliest of the following dates:

– The date on which the participant is no longer disabled

– The date on which the participant reaches age 65

– The date on which the participant is no longer entitled to Long-Term Disability Insurance benefits

– For **Health Insurance** (Basic and Extended) and **Dental Care** Insurance plans:

- The date that corresponds to the end of a period of **36 months** from the onset of the disability
- The date on which the contract or plan terminates, or the date on the written notice from the Committee confirming that the group of wage-earners to which the disabled person belonged is no longer affiliated with the union party
- The date on which the participant's employment is terminated

The waiver of premiums does not apply:

– to a participant who is taking a CSST-approved preventive withdrawal due to pregnancy;

– to Retiree's Life Insurance coverage, Retiree's Spouse's and Dependent Children's Life Insurance coverage, and Retiree's Spouse's Optional Life Insurance coverage.

NOTE: The participant is exempt as of the first full pay period following the date on which he or she is entitled to the waiver. When the waiver terminates, adjustments are made to the first full pay period following the date of termination of the waiver.

c) Provisions regarding employment injury

– Non-consolidated employment injury

When a participant suffers an employment injury, cannot return to work, and the injury is still not consolidated according to the attending physician, the participant is exempt from payment of premiums, subject to the provisions set out in item b) End of waiver, and coverage is maintained for a maximum of one (1) year as of the end of the income replacement indemnities paid by the CSST.

– Temporary assignment

When a participant who has suffered an employment injury is temporarily assigned to a position:

- he or she benefits from waiver of premiums for any pay period during which he or she is receiving an income replacement indemnity, subject to item b) End of waiver;
- he or she does not benefit from waiver of premiums if he or she is not receiving an income replacement indemnity.

– Employment injury with right to rehabilitation

When a participant suffers an employment injury and is entitled to rehabilitation as provided under Section 145 and the following sections of the *Act respecting industrial accidents and occupational diseases*, he or she benefits from waiver of premiums and coverage is maintained in the following cases:

- The participant is looking for employment as part of a rehabilitation program
- The participant is working in a job that is not his or her usual employment with the original employer
- The participant is working in a job with another employer

However, the waiver of premiums terminates once the participant has completed 36 months of disability.

d) Preventive withdrawal

A participant who is taking a CSST-approved preventive withdrawal due to pregnancy is not eligible for waiver of premiums.

e) Filing a grievance related to disability

A participant who files a grievance subsequent to the contesting of his or her disability or imposition of an administrative measure related to his or her disability is, during grievance proceedings, exempt from payment of premiums for all of the plans in which he or she is participating, until the earliest of the following dates:

- The date of his or her return to work
- The date of an arbitrator's decision
- The date of an agreement between the parties
- The date that corresponds to the end of a period of 36 months from the onset of the disability.

f) Gradual return to work

When a participant on disability makes a gradual return to work as provided for under the collective agreement, he or she continues to be exempt for the whole gradual return to work period. However, the waiver of premiums terminates once the participant has completed 36 months of disability.

9. Termination of insurance

Subject to the waiver of premiums in the event of disability, a participant's insurance ends at 24:00 on the earliest of the following dates:

- The date on which the contract terminates or, for each plan, their respective termination dates
- The date on which the participant ceases to meet the eligibility criteria
- The date on which the participant leaves his or her employment, subject to the conversion privilege for Participant's Life Insurance coverage and enrolment in the Retiree's Life Insurance plan
- The date on which coverage under another group insurance plan begins for a participant who has terminated coverage under the Basic Health Insurance plan because he or she has exercised his or her right of exemption, if the application is made within 30 days, otherwise the date of receipt by the Insurer

- The date on which the Insurer receives written notice from a participant who wishes to terminate his or her coverage under a plan other than the Basic Life Insurance plan or a benefit, or the termination date indicated on the notice, whichever is later, subject to the obligation to maintain coverage for 36 months for optional plans I and II
- The date indicated in the Committee's written notice confirming the termination of union affiliation of the group of wage-earners
- The date on which the disabled participant's employment is terminated
- The date that corresponds to the end of a period of 48 months from the onset of the disability, except if he or she is working for the original employer, in the case of a participant who has suffered an employment injury and is entitled to rehabilitation.

Insurance for dependents terminates at 24:00 on the earliest of the following dates:

- The date on which the participant's insurance terminates, subject to the extension provided for the basic plans and optional plans I and II
- The date on which the person ceases to be considered a dependent
- The date on which the Insurer receives written notice from a participant who wishes to be insured individually, subject to the obligation to cover dependents under the basic plan and the 36-month minimum participation requirement for optional plans I and II
- The date on which coverage under another group insurance plan begins for dependents who terminate coverage under the Basic Health Insurance plan because they have exercised their right of exemption, if the application is made within 30 days, otherwise on the date of receipt by the Insurer.

10. Dependent child age 18 to 25 inclusive

To continue to be insured, a dependent child age 18 to 25 inclusive must be a **full-time student** in a recognized educational institution.

The participant must therefore confirm to the Insurer that the dependent child who has reached age 18 is attending an educational institution on a full-time basis. The confirmation must be submitted once a year, at the beginning of the fall semester. The insurance then continues for one year, until the start of the next school year. If the annual confirmation is not submitted, the dependent child's coverage will be automatically terminated on the child's 18th birthday or on the start date of the school year for which the participant does not submit confirmation to the Insurer. Confirmation may be submitted by sending a copy of the statement of enrolment by mail, fax or mobile application, or by means of a telephone call, in which case the confirmation will be subject to verification. As well, the Insurer reserves the right to verify the child's continued attendance at the educational institution at the time of any claim submitted with regard to the child.

11. "Smoker" and "non-smoker" categories

Rates for Participant's and Spouse's Optional Life Insurance are provided for "smoker" and "non-smoker" categories. To be eligible for the "non-smoker" category, a person must not have smoked cigarettes in the past year. Any person who changes their smoking habits following the declaration of insurability **must notify the Insurer in writing within 30 days following the change**.

CLAIMS PROCEDURE

Eligible expenses are reasonable expenses that are justified by the seriousness of the case as well as by current medical practice and customary charges, and incurred by an insured.

All claims and correspondence must include the identification number of the participant, the group and the employer.

a) Hospitalization, medical and paramedical expenses following an occupational or motor vehicle accident

Medical, paramedical or hospitalization expenses arising from an occupational or motor vehicle accident are reimbursable by the CSST or SAAQ, not the Insurer.

b) Hospitalization expenses (semi-private room)

Insureds must present their group insurance service card upon admission to a hospital. The establishment will send the claim directly to the Insurer.

Certain establishments do not accept the service card. In such case, the insured must pay the expenses and forward the invoice to the Insurer with the appropriate claim form for medical and paramedical expenses.

c) Prescription drugs (direct automated payment service)

When making prescription drug purchases, insureds present their service card, which shows their identification number, to the pharmacist. La Capitale will automatically issue payment for the insured portion of prescription drug expenses. There's no need to fill out a claim form, and insureds pay only the uninsured portion of prescription drug expenses.

d) Medical and paramedical expenses

Expenses must be claimed within 12 months following the date on which they were incurred. The Insurer recommends filing claims every 3 months.

– HEALTHCARE PROFESSIONALS

  An official receipt must be presented to the Insurer when filing a claim for the services of healthcare professionals.

The back of the Claim for Prescription Drug and for Medical and Paramedical Expenses form can be used as the receipt. In this case, it must bear the professional's stamp or seal along with his or her signature, licence number and specific dates of services, along with the name of the person receiving the treatments. Electronic and personalized receipts from healthcare professionals are also accepted, provided they contain the information specified above.

– OTHER ELIGIBLE EXPENSES

All other Health Insurance claims must be filed using the "Claim for Prescription Drug and for Medical and Paramedical Claim" form. Participants must enclose original receipts and paid invoices for the expenses claimed. Participants must keep a copy of the invoices sent to the Insurer as no originals will be returned. The Insurer may contact the insured to request more information, if considered necessary for processing of the claim.

The Insurer reimburses the expenses claimed according to the terms of the contract. Electronic forms are available online at www.lacapitale.com, under "Individuals/Group insurance/Information for insureds/Download or order forms." They can also, upon request, be sent to participants by mail or mobile application.

e) Dental expenses (direct automated payment service)

Insureds present their service card in the dentist's office. The system validates the card and confirms whether the dental treatment is covered as well as the percentage of reimbursement applicable. There's no need to fill out a claim form since the insured portion of treatment expenses is claimed directly by the dentist from the Insurer.

Insureds pay only the uninsured portion of dental expenses. If the dentist does not offer this service, insureds must pay the treatment expenses in full and submit a claim to the Insurer. Note that claims may still be filed in the traditional way, using the appropriate form, which is available through the employer and online.

f) Dental expenses (treatment plan)

Before incurring any major treatment expenses, participants should first check with the Insurer as to the amounts that may be eligible for reimbursement. To do so, they should use the Canadian Dental Association or the *Association des chirurgiens dentistes du Québec* (ACDQ) dental claim form available in the dentist's office, or the Insurer's Dental Claim Form, specifying "Treatment Plan."

g) Life insurance

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

When settling a claim for a participant's death, the Insurer checks with the employer regarding the weekly salary on which the life insurance amount is based.

To calculate the amount of life insurance, the weekly salary is multiplied by 52.18.

h) Accelerated life insurance benefit payment in the event of terminal illness

A person who is insured under the life insurance plan and whose life expectancy is no more than 12 months may obtain an accelerated benefit payment by submitting a written application to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent.

The total amounts paid out may not exceed $50,000 or 25% of the insured's amount of life insurance. The amount of life insurance used to calculate the accelerated benefit excludes any amount, or fraction of an amount, expiring in accordance with the provisions of the contract during the 24 months following the date of the application and that cannot be replaced with another life insurance benefit. After the date of payment, the premium, if any, continues to be calculated on the full insurance amount as if there had been no accelerated payment. Upon the insured's death, the amount payable by the Insurer is reduced by the amount paid as an accelerated benefit, including accrued interest on this amount at the annual rate of 6%. The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid. Furthermore, this benefit ceases upon termination of the contract, even for participants who have been granted a waiver of premiums.

i) Direct deposit

If they wish, participants may receive medical and dental care reimbursements through preauthorized direct deposit. A statement will be issued confirming the amount deposited and the date on which the claim was processed. To register, participants must complete the Application for Direct Deposit of Benefits form, available through their employer or online, and enclose a cheque specimen marked "Void."

TRAVEL INSURANCE

La Capitale will reimburse the customary and reasonable expenses described below, 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 the province of residence.

Benefits are granted over and above and not in replacement of any benefits provided under government programs. The maximum lifetime reimbursement is $5,000,000 per insured.

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;
- 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

a) Hospitalization, medical and paramedical expenses

- Expenses for hospitalization in a semi-private or private room, in excess of the amounts reimbursed or eligible for reimbursement under the government health insurance plan of the insured's province of residence.
- Incidental expenses (telephone, television, parking, etc.) related to hospitalization, upon presentation of supporting documents, up to a maximum of $100 per hospitalization.
- Professional fees of a physician for medical, surgical or anesthetic care other than fees for dental care; expenses incurred are payable only for the portion of expenses in excess of the benefits payable under the government health insurance plan of the insured's province of residence.
- The cost of drugs obtained on prescription by a physician in an emergency treatment situation.
- Professional fees of a registered nurse for private nursing care dispensed exclusively in a hospital, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $3,000. The nurse must not be related to the insured nor be a travel companion.
- Rental of therapeutic devices and purchase of trusses, corsets, crutches, splints, casts and other orthopedic devices, when prescribed by the attending physician.
- Professional fees of a dentist for treatment of accidental injury to natural teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident; to be covered, expenses must be incurred within 12 months following the accident.

b) Expenses for transportation

- Expenses for transportation of the insured by air or surface ambulance to the nearest medical centre where adequate medical care is available. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing the patient's condition.
- Repatriation expenses for the insured to return to the place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as the insured's health condition so allows and insofar as the means of transport initially planned for the return cannot be used.

If required by the insured's health condition, the Assistor will send a medical escort on site to accompany the insured on the return trip. Repatriation must be approved and planned by the Assistor.

- 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.
- When the insured's health condition does not allow medical repatriation and hospitalization outside the province must extend beyond seven (7) days, the Assistor will organize and pay round-trip transportation expenses to enable a close relative of the insured, residing in the insured's province of residence, to be at the bedside of the insured. The maximum reimbursement is $1,500. However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative age 18 or over, if the necessity of a visit is not confirmed by the attending physician, or if the visit is not approved in advance and planned by the Assistor.
- The Assistor will make necessary arrangements to return home any children under age 18 accompanying the insured if, following the insured's accident or illness, the insured or another accompanying adult is unable to do so personally.
- If the insured is unable to drive the automobile used for a trip following an illness or accident that occurs during the trip and no other passenger is able to drive the vehicle, the Assistor will pay the expenses incurred by a commercial agency to return the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency, subject to a maximum reimbursement of $1,000.
- In the event of the insured's death, when necessary, the Assistor will organize and pay expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing that no close relative age 18 or over is accompanying the insured on the trip. The maximum reimbursement is $1,500.
- In the event of the insured's death, the Assistor will pay for the cost of preparing and returning the remains of the insured (excluding the cost of the coffin or casket) to the place of burial in the province of residence, subject to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

c) Living expenses

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

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

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

– 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.

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

– The Assistor will ensure, insofar as possible, the dispatch of any drugs that are indispensable for the ongoing treatment of the insured in the event that it is impossible to obtain such drugs or equivalent drugs on site.

– In all cases, drugs must be paid for by the insured and then, if eligible, reimbursed by the Insurer.

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

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

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

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

3. Obligations of the insureds

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

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

UNUSED TICKETS: When an insured has benefited from repatriation under the terms of this Travel Insurance benefit, the Assistor reserves the right to claim any ticket held by the insured that was not used due to services provided by the Assistor.

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

4. Exclusions and reduction of Travel Insurance coverage

In addition to the exclusions and reduction of coverage specified for the Basic Health Insurance Plan, the Insurer and the Assistor will issue no reimbursement nor provide any assistance to the insured in the following cases:

- When the loss occurs in the insured's province of residence.
- When the insured refuses without any valid medical reason to comply with the Assistor's recommendations with regard to repatriation or the choice of hospital or required care; by required care is meant the treatment needed to stabilize the insured's medical condition.
- If the insured fails to contact the Assistor as soon as possible in the event of a medical consultation or hospitalization following an accident or sudden illness.
- When expenses are incurred due to pregnancy, and any related complications, within eight (8) weeks preceding the expected date of delivery.
- When the expenses incurred outside the insured's province of residence could have been incurred in the province of residence, without danger to the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from an accident or sudden illness. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a lesser quality than that available outside the province does not constitute a danger to the insured's life or health.
- When expenses are incurred for insureds in hospitals for the chronically ill, services for the chronically ill in public hospitals, extended care homes or thermal spas.
- For elective or non-emergency surgery or treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip was taken on the recommendation of a physician.
- For an accident occurring while the insured is practising any sporting activity involving remuneration, motor vehicle competition or any speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity. Activities offered to the public at tourist resorts, other than the above-mentioned activities, including alpine skiing and scuba diving, are not considered as dangerous.
- Following voluntary abusive consumption of alcohol, drugs or medication and the ensuing consequences.

– For repatriation or travel assistance services, when the loss occurs in a country that is at war, whether declared or not, is known to be in a state of political instability or for which the Government of Canada has issued a warning that Canadians should not travel in that country, or during a riot, uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other emergency events 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 this benefit.

EMERGENCY CONTACT INFORMATION
To obtain assistance services, be sure to have the information shown on your service card handy, and contact the Assistor by telephone at one of the following numbers: **In Canada and the United States: 1 800 363-9050** **Worldwide (collect call): 1 514 985-2281**

BEFORE LEAVING
Make sure you take your service card with you, as you will need it in order to communicate with the Assistor.

TRIP CANCELLATION INSURANCE

In accordance with the following conditions, the Insurer will reimburse 100% of the expenses incurred by the insured following the cancellation or interruption of a trip, insofar as the expenses incurred are related to travel expenses paid in advance by the insured ("prepaid travel expenses") and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip. The expenses covered are limited to $5,000 per trip, per insured.

1. Causes of cancellation or interruption

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

- 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.
- 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.
- 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.
- Death or emergency hospitalization of the host at destination.
- 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.
- Quarantine of the insured or travel companion, except if quarantine ends seven days or more before the scheduled date of departure.
- Hijacking of the airplane on which the insured is travelling.
- 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.

- Transfer of the insured or travel companion, by the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required within the 30 days preceding the scheduled date of departure.
- Terrorism or any other situation in the country to which the insured is travelling, provided the Government of Canada issues a warning that Canadians should not travel in that country during the time of the planned trip and that the warning was issued after travel expenses were incurred.
- 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.
- Atmospheric conditions that delay the departure of the public carrier used by the insured, at the point of departure of the planned trip, by at least 30% (minimum 48 hours) of the planned duration of the trip, or that prevent the insured from making a scheduled connection with another carrier, provided the connection is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip.
- 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.
- Involuntary loss of the wage-earner's or spouse's employment, provided the person in question had been working for the same employer for at least one year.

2. Expenses covered

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

- In the event of cancellation prior to departure:

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

b) Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the eligible reasons for cancellation provided hereunder and the insured decides to proceed with the trip as initially planned; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.

c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's departure is delayed due to atmospheric conditions and the insured decides not to proceed with the trip.

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

– If the return is earlier or later than planned:

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

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

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

3. Exclusions applicable to Trip Cancellation Insurance

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

– 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.

– Any trip taken to visit or be at the bedside of a person who is ill or has suffered an accident, insofar as the cancellation or interruption of the trip is due to a change in the medical condition or the death of such person.

- War, whether declared or not, or active participation in an insurrection, whether real or apprehended.
- Active participation of the insured or travel companion in a criminal act or an act deemed to be criminal.
- Pregnancy, and any related complications, within eight (8) weeks preceding the expected date of delivery.
- Suicide or attempted suicide by the insured or travel companion, or intentional self-inflicted injury or self-mutilation, whether or not the person is of sound mind.
- If the insured has consumed toxic quantities of alcohol, drugs or medication.
- Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity.
- A medical condition for which the insured or travel companion has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date on which travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the person in question is stable at the time expenses are incurred. Any change in medication, including use and dosage, is considered to be a medical treatment.
- Any loss related to a known condition of the insured or travel companion that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.
- Any trips for purposes of fishing or hunting.

4. Deadline for cancelling

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

5. Coordination

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

IF YOU MUST CANCEL OR INTERRUPT YOUR TRIP
It is essential that you contact the Assistor at one of the numbers below before incurring any expenses. **In Canada and the United States: 1 800 363-9050** **Worldwide (collect call): 1 514 985-2281**

CONTACT US

LA CAPITALE CIVIL SERVICE INSURER INC.

Quebec City
625 Jacques-Parizeau St
Quebec QC G1R 2G5
418 644-4200

Montreal
Suite 820
425 de Maisonneuve Blvd W
Montreal QC H3A 3G5
514 873-6506

Our mailing address:
PO Box 1500
Quebec QC G1K 8X9

Toll free: 1 800 463-4856

Fax: 418 644-5226
Email: collectif@lacapitale.com
La Capitale mobile application

TRAVEL INSURANCE

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

Worldwide (collect call): **514 985-2281**

MEMORY AID

Group No.: **6000**

Employer No.:

Identification No.:

Person contacted:

Telephone No.:

Fax No.:

Email address:

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