GROUP INSURANCE CONTRACT

NO. **001011**

LA CAPITALE INSURANCE AND FINANCIAL SERVICES INC.

Hereinafter called the “Insurer”

Issues contract number 001011 (the Contract) for participants who are members of the:

ASSOCIATION DES RETRAITÉES ET RETRAITÉS DE L’ENSEIGNEMENT DE LA FNEEQ (AREF)

Hereinafter called the “Policyholder”

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

Clauses and provisions specified in the following pages are an integral part of this contract as if they appeared above the affixed signatures.

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

Effective date: This contract comes into force on May 1, 2017.

This contract is a consolidated version of the contract which came into force on January 1, 2007 and the subsequent agreements and endorsements thereto. This contract does confer any rights retroactively, and the contract provisions applicable to any event giving entitlement to benefits remain the same as those in force on the date of such event.

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

Renewal date: January 1, 2018 and January 1 of each subsequent year.

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

IN WITNESS WHEREOF, this contract is hereby duly attested and signed by the representatives authorized for such purpose, on the dates and at the places indicated below.

In Québec on the 23 day of the month of january 2018.

Mario Albert

Pierre Marc Bellavance

FOR **LA CAPITALE INSURANCE AND FINANCIAL SERVICES INC.**

The Policyholder, through its representatives duly authorized for such purpose, accepts this contract in accordance with its clauses and conditions.

IN WITNESS WHEREOF, the Policyholder signs this document.

In Québec on the ___ day of the month of 01 février 2018.

Augustin Verstraelen
AREF Representative

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SCHEDULE OF INSURANCE

This summary table provides a brief description of the participant's group insurance contract. A full description of the benefits is provided on the following pages.

Participant's Basic Life Insurance	
Retiree under age 65	1 times the annual salary at the date of retirement, rounded up to the next $500
Reduction of benefit	$5,000 on the date of the participant's 65th birthday
Conversion privilege	60 days
Termination of insurance	Date of participant's death
Dependents' Basic Life Insurance	
Spouse	$10,000 if the spouse is under age 65
Reduction of benefit	$4,000 on the date of the spouse's 65th birthday
Second reduction of benefit	$2,000 on the date of the spouse's 70th birthday
Dependent child	$4,000
Extension of coverage for dependents of a deceased participant	90 days immediately following the participant's death
Conversion privilege	60 days
Termination of insurance	Date of participant's death

Participant's Optional Life Insurance	
Protection	Persons retired before January 1, 2004: - Retirees age 65 or over but under age 70: 1 to 8 units of $5,000 - Retirees age 70 or over on January 1, 2004: 1 to 2 units of $5,000 - Retirees who reach age 70 on or after January 1, 2004: can maintain the amount of Optional Life Insurance they held immediately before reaching age 70. Persons retired on or after January 1, 2004: - Retiree under age 65: 1 to 10 units of $5,000 - Retirees age 65 or over but under age 70: 1 to 10 units of $5,000 - Retirees age 70 or over: 1 to 8 units of $5,000
Conversion privilege	60 days
Termination of insurance	Date of participant's death

Health Insurance	
Care, services and supplies identified with an asterisk (*) require a medical prescription. The maximums indicated are per insured, unless otherwise specified.	
Automated payment service	Direct
Annual deductible	None
Expenses reimbursed at 100%	
Hospitalization	Semi-private room
Long-term care centre	Semi-private room, maximum of 180 days per calendar year
Travel Insurance and Assistance	Maximum stay: Same maximum period as the period of coverage allowed by the public health insurance plan of the insured's province of residence, lifetime maximum: $2,000,000
Trip Cancellation Insurance	Maximum per trip: $5,000
Prescription drugs expenses	
Reimbursement	According to the percentage of the Public Prescription Drug Plan Insurance (PPDIP) for the first $2,400 of eligible expenses, per calendar year, for the participant and dependents. The excess of $2,400 is reimbursed at 100%.
Clause	Standard (excluding eligible drugs by the Quebec Public Prescription Drug Insurance Plan)
Other eligible expenses (including healthcare professionals)	
Reimbursement	75%
	The maximums indicated below are maximum reimbursement amounts, unless otherwise specified.
Adult diapers for incontinence *	Eligible maximum of $500 per calendar year, per insured
Ambulance	Reasonable and customary expenses

Appliance for temporomandibular joint *	$100 per period of 24 consecutive months, per insured
Appliance used to manage diabetes * (blood glucose monitor, dextrometer or any other appliance of a similar nature for an insulin-dependent insured)	$200 per period of 5 consecutive years, per insured
Artificial limb *, prosthetic * and orthopedic equipment *	Reasonable and customary expenses
Capillary prosthesis (wig) following chemotherapy treatments *	Eligible maximum of $400 per calendar year, per insured
Corrective footwear (deep shoes) *	$100 per pair, 2 pairs per calendar year, per insured
Curative and preventive vaccines	Reasonable and customary expenses
Expenses for travel to receive treatment from a medical specialist not available in the insured's region of residence *	$500 per trip, per insured
External breast prosthesis following a mastectomy *	Eligible maximum of $500 per calendar year, per insured
Foot orthoses	Eligible maximum of $450 per calendar year, per insured
Hearing aid *	$500 per period of 3 consecutive years, per insured
Homeopathic medication *	$400 per calendar year, per insured
Insulin pump *	$1,750 per period of 5 consecutive years, per insured
Magnetic resonance imaging (MRI)	Eligible maximum of $500 per calendar year, per insured
Multiservices (home care and services) *	– Professional fees for nursing care: eligible maximum of $60 per day, per insured – Fees for home assistance services (to look after basic needs): eligible maximum of $60 per day, per insured – Transportation expenses for medical care or follow-up: eligible maximum of $30 per trip, maximum of 3 round trips per week, per insured

Orthopedic shoes (custom-made) *	Deductible of $20 per pair, maximum of 2 pairs per calendar year, per insured
Oxygen therapy * and laboratory tests *	Reasonable and customary expenses
Private clinic for alcoholism or drug addiction (excluding addiction to smoking)	1 admission per calendar year, $3,500 per calendar year, per insured, lifetime maximum of 2 admissions
Rehabilitation centre	Semi-private room, eligible maximum of $75 per day and 15 days per period of hospitalization, per insured
Serums and fluids injected for curative purposes * (including injections for artificial insemination)	Eligible maximum of $20 per drug and $60 per injection, per insured
Support stockings	6 pairs per calendar year, per insured
Wheelchair*, iron lung * or other therapeutic appliances *	Reasonable and customary expenses
X-rays, mammographies and ultrasound examinations (other than fetal)	Eligible maximum of $500 per calendar year, per insured
Healthcare professionals	**The maximums indicated below are maximum reimbursement amounts.**
Acupuncturist	$40 per treatment, maximum of $500 per calendar year, per insured
Chiropractor	$40 per treatment or consultation, maximum of $500 per calendar year, per insured
Chiropractor X-rays	$40 per calendar year, per insured
Dentist required following an accident	Treatment must be provided within 12 months following the date of the accident
Dietician *	$40 per treatment, maximum of $500 per calendar year, per insured
Naturopath	$40 per treatment, maximum of $500 per calendar year, per insured
Nutritionist *	$40 per treatment, maximum of $500 per calendar year, per insured

Osteopath	$40 per treatment, maximum of $500 per calendar year, per insured
Physiotherapist and physical rehabilitation therapist	$40 per treatment, maximum of $500 per calendar year, per insured, for all of these healthcare professionals
Podiatrist	$40 per treatment, maximum of $500 per calendar year, per insured
Psychologist *, psychiatrist, psychoanalyst in an outpatient clinic, social worker * and guidance counsellor in private practice *	30 consultations per calendar year, $40 per consultation, maximum of $1,200 per calendar year, per insured, for all of these healthcare professionals. (These maximums also apply in the case of marital therapy for both spouses.) **These expenses are reimbursed at 50%.**
Registered nurse or nursing assistant*	$200 per day, maximum of $2,000 per calendar year, per insured
Speech therapist and occupational therapist	$40 per treatment, maximum of $500 per calendar year, per insured, for all of these healthcare professionals
Extension of coverage for dependents of a deceased participant	90 days immediately following the participant's death
Conversion privilege	60 days
Termination of insurance	Date of participant's death

SECTION 1 – **DEFINITIONS**

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

1.1 "**Accident**": Any bodily injury confirmed by a physician and directly resulting from a sudden and unforeseeable action of an exterior cause, and independent of any other cause. Any bodily injury resulting from an attempted suicide is not an accident.

1.2 "**Age**": The age of an insured, at his or her last birthday when it is calculated or the day that an event provided in the contract occurs.

1.3 "**AREF**": The *Association des retraitées et retraités de l'enseignement de la FNEEQ*.

1.4 "**Assistor**": Canassistance or any other travel assistance provider designated by the Insurer.

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

1.6 "**Care insured for inpatient**": Care that an insured person is entitled to receive free of charge under the applicable provincial act or that is covered in accordance with the provisions of this act.

1.7 "**Close relative**": The spouse, children, father, mother, brother, sister, stepfather, father-in-law, stepmother, mother-in-law, brother-in-law, sister-in-law, stepdaughter, daughter-in-law, son-in-law, grandparents and grandchildren of the insured.

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

1.9 "**Date of retirement**": The date on which a participant under a group insurance contract retires in accordance with an applicable retirement plan. However, if the date of retirement with a pension is later, this date will be considered as the effective date of retirement.

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

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

1.10 “**Dependent**”: The spouse or dependent child of a participant, as defined hereafter.

1.10.1 Spouse: The person who, on the date of the event giving entitlement to benefits:

i) is married or joined by a civil union to the participant; or,

ii) has been living in a conjugal relationship with the participant for at least one year, or for less than one year if that person is the parent of the participant’s child (“common-law union”); or,

iii) has been living in a conjugal relationship with the participant and had already lived in a conjugal relationship with the participant for an entire period of at least one year (“common-law union”).

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

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

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

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

i) be under the age of 18, if the child is not a full-time student, including a child for whom adoption procedures have been undertaken; or,

ii) be age 25 or under, if attending a recognized educational establishment as a full-time student. In such a case, the participant must provide the Insurer with evidence that the child is registered in such an establishment at the beginning of each school year; or,

iii) have reached the age of majority and be afflicted with a total disability or functional impairment recognized by the competent authorities in the participant’s province of residence. The disability or impairment must have begun while the child was meeting one of the above criteria, and must have persisted since that date. In addition, the child must reside with the participant, or the participant’s spouse, who would exercise parental authority over the child or be his or her legal guardian if the child were a minor. The Insurer may request evidence of the disability or impairment at any time.

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

1.11 "**Due date of premium**": The invoicing date coinciding with the first day of the month.

1.12 "**FAC**": The *Fédération autonome du collégial.*

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

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

1.14.1 Any hospital centre located in Canada that is a federal hospital centre, an hospital centre holding an operating licence, or recognized as an hospital centre by the public organization in charge of issuing such operating licences in the territorial jurisdiction where the hospital centre is located, or recognized by the Quebec *ministre de la Santé et des Services sociaux* when there is no public organization in charge of issuing operating licences.

1.14.2 Any hospital centre located abroad for which the Quebec *ministre de la Santé et des Services sociaux* authorizes payments for care given in that hospital centre, in accordance with the applicable act.

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

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

1.16 "**Host at destination**": The person whose main residence must serve as the place of accommodations for the insured in accordance with a prior agreement.

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

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

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

1.20 “**Participant**”: An eligible retiree who is eligible for insurance and is insured under this contract.

1.21 “**Physician**”: A physician duly licensed to practice medicine in the place where the services are provided.

1.22 “**Policyholder**”: The *Association des retraitées et retraités de l’enseignement de la FNEEQ*.

1.23 “**PPDIP**”: The *Public Prescription Drug Insurance Plan* administered by the *Régie de l’assurance maladie du Québec*.

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

1.25 “**Previous contract**”: The group insurance contract(s) in force immediately prior to the effective date of this contract, covering the retirees and their dependents, if applicable.

1.26 “**RAMQ**”: The *Régie de l’assurance maladie du Québec*.

1.27 “**Retiree**”: A participant who is a member of the FNEEQ whose date of retirement has been reached.

1.28 “**Travelling companion**”: The person with whom the insured shares the room or apartment at the destination or whose transportation expenses were paid with those of the insured.

1.29 “**Trip**”: A trip for the purposes of tourism or leisure, a trip for the purposes of humanitarian aid or cooperative work that is supervised by an organization, a commercial activity or an occasional business trip.

A business trip is considered to be occasional when carried out on an exceptional and not on a regular basis. No other trip, including a trip during which a person accompanies students at the request of a previous employer, is covered under this benefit, unless the Policyholder and the Insurer have agreed otherwise. Furthermore, the trip must entail the insured’s absence from the province of residence.

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

1.30 “**Wage or salary**”: The wage or salary of the participant, as defined in the group insurance contract, in force at the time of his or her retirement.

SECTION 2 – **CONDITIONS OF INSURANCE**

2.1 **Eligibility**

2.1.1 Eligibility for Health Insurance Benefit

2.1.1.1 All persons who, the day preceding their date of retirement, satisfy the two following conditions:

a) were members of the *Fédération nationale des enseignantes et des enseignants du Québec (FNEEQ – CSN)* or of the *Fédération autonome du collégial (FAC)*;

b) were covered under the health insurance benefit of a group insurance contract.

2.1.2 Eligibility for Life Insurance Benefit

2.1.2.1 All persons who, the day preceding their date of retirement, satisfy the two following conditions:

a) were members of the *Fédération nationale des enseignantes et des enseignants du Québec (FNEEQ – CSN)* or of the *Fédération autonome du collégial (FAC)*;

b) were covered under the Life Insurance Benefit of a group insurance contract.

2.1.3 Date of eligibility

2.1.3.1 All retirees who satisfy the eligibility conditions above become eligible for insurance as of:

a) the effective date of this contract if they are members of the AREF and were insured under the previous contract, in accordance with the transfer provisions;

b) the date on which they became members of the AREF, if later, and were insured under another group insurance contract;

c) their date of retirement, if they were members of the FNEEQ and were insured under another group insurance contract. However, they must become members of the AREF.

In all three cases, to remain eligible for insurance, retirees must continue to be members of the AREF.

2.1.3.1.1 Subject to the provisions regarding participation, all retirees:

a) who retired prior to January 1, 2004 are eligible for Optional Life Insurance on reaching age 65;

b) who retired on or after January 1, 2004 are eligible for Optional Life Insurance as of their date of retirement.

2.1.3.1.2 All retirees who are insured under the contract offered by the AREF and who are rehired as employees become eligible for the contract offered by the FNEEQ-CSN under the eligibility provisions of this contract, with the exception of the Life Insurance Benefit, which remains in force under this contract.

2.1.3.1.3 All retirees who are or subsequently become members of the AREF must be permanent residents of Canada.

2.1.3.2 All dependents of a participant become eligible for insurance as of:

a) the same date as the participant if they are already a dependent; or

b) the date on which they subsequently become dependents;

2.1.3.2.1 AREF membership is not mandatory for dependents, subject to the provisions applicable to the *Extension of coverage for dependents of a deceased participant.*

2.1.3.2.2 All dependents must be permanent residents of Canada.

2.2 **Participation**

2.2.1 Participation of retirees

2.2.1.1 Participation in the Life and Health Insurance Benefits is optional for all retirees. However, the decision not to enroll in either benefit is irrevocable.

However, any retiree insured under another group health insurance contract may enroll in the Health Insurance Benefit provided under this contract, subject to eligibility provisions. However, they must submit an application form to the Insurer within 30 days following the termination of their other group insurance contract.

2.2.1.2 All retirees wishing to enroll in Optional Life Insurance must be insured under the Basic Life Insurance Benefit.

2.2.1.3 All eligible retirees wishing to enroll in the benefits available under this contract must submit an application form to the Insurer within 30 days following the date on which they become eligible.

2.2.2 Participation of dependents

2.2.2.1 Participation in the Life and Health Insurance Benefits is optional for all dependents.

2.2.2.2 Participants who wish to insure their dependents under Dependent's Basic Life Insurance must be covered under the Participant's Basic Life Insurance.

2.2.2.3 Participants who opt to insure their dependents under this contract must submit an application form to the Insurer within 30 days following the date on which their dependents become eligible. This 30-day limit applies also to any request to change coverage status made by participants after one of the following events: the participant's marriage or civil union; divorce, de facto separation for at least 90 days or dissolution of the civil union, the birth or adoption of a first child; or the termination of insurance of a dependent insured under another group insurance contract.

2.2.3 Provisions applicable for retirees reaching age 65

The Insurer writes to retirees prior to the date of their 65th birthday to inform them of the available options as of that age. Retirees must inform the Insurer of the selected option within 30 days following the receipt of this letter.

2.3 **Effective date of insurance**

2.3.1 Participants

Subject to the provisions above, all retirees become insured under the Life and Health Insurance Benefits as of the date they become eligible, provided that they submit an application form to the Insurer within the specified period.

2.3.2 Dependents

Subject to the provisions above, all dependents become insured under the Life and Health Insurance Benefits on the latest of the following dates:

2.3.2.1 the effective date of the participant's insurance;

2.3.2.2 the date on which they become eligible;

2.3.3.3 the date on which the participant changes his or her Individual coverage status to Family coverage, subject to the participation provisions.

2.4 **Transfer provisions**

2.4.1 For participants insured alone or with dependents under a previous contract, the Insurer guarantees continuity between this contract and the previous contract in compliance with any act or regulation respecting insurance, to avoid participants and their dependents, where applicable, sustaining any harm due to a change in contract, regardless of whether they are at work.

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

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

2.4.2 In the case of a participant who, prior to his or her application for participation, was insured under a previous contract, the Insurer is not liable for the payment of benefits which may be payable by the preceding insurer under an extension, conversion or other clause.

SECTION 3 – **HEALTH INSURANCE BENEFIT**

According to the coverage indicated in the *Schedule of Insurance,* eligible expenses are those reasonably incurred and justified by the seriousness of the case as well as by current medical practice and the customary charges in force in the area, as described below.

Expenses incurred for eligible services and supplies are reimbursed in accordance with the reimbursement percentage and the maximums indicated in the *Schedule of Insurance*.

3.1 **Health Insurance**

3.1.1 **Hospitalization**

When an insured is admitted to a hospital centre in Canada after the effective date of his or her insurance, the Insurer pays for the insured the fees charged by the hospital for the stay, as long as the insured is eligible for the insured care as an inpatient.

3.1.2 **Long-term care centre**

When an insured is admitted as a chronic care inpatient to a tuberculosis hospital, a sanatorium, a home for the mentally ill, a nursing home, a retirement home or a dispensary after the effective date of his or her insurance, and this establishment is authorized by the Quebec *ministre de la Santé et des Services sociaux* to register with the hospitalization insurance plan introduced under the applicable provincial act, the Insurer pays for the insured the fees charged by the establishment for the stay.

3.1.3 **Prescription drugs expenses**

3.1.3.1 Terms of reimbursement

Drugs expenses described hereinafter are reimbursed according to the percentage of the Public Prescription Drug Insurance Plan (PPDIP) as of January 1st of each year, up to an eligible amount of $2,400 per calendar year for the participant and his or her dependents, if applicable. Any excess fees are reimbursed at 100%.

If the Public Prescription Drug Insurance Plan's percentage increases during the year, the coinsurance of this contract is adjusted as of the same date. If the PPDIP's percentage decreases, the adjustment becomes effective on January 1st of the following year.

3.1.3.2 Eligible drugs

The prescription drugs reimbursed by the Insurer must meet all of the following conditions:

a) They must bear a valid Drug Identification Number (DIN) issued by Health Canada and are available in the insured's province of residence.

b) They must be obtained from a pharmacy only and dispensed by a legally authorized healthcare professional.

c) They must be prescribed in accordance with the manufacturer's directions for use, or in the absence of such directions, with the directions for use approved by the competent authorities in the insured's province of residence.

The Insurer reimburses prescription drugs and pharmaceutical services that may only be obtained on prescription from a healthcare professional legally authorized to prescribe such drugs. Also eligible for reimbursement are drugs obtained on prescription with directions for use specifically related to treatment of the following pathological conditions: heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma.

However, eligible drugs under the *Quebec Public Prescription Drug Insurance Plan* are not covered under this contract.

EXCLUSIONS AND REDUCTION:

- eligible drugs under the *Quebec Public Prescription Drug Insurance Plan*;
- products considered to be food substitutes, cosmetic products, soaps, tanning oils, skin emollients, shampoos and other products for scalp treatment;
- dietetic substances or foods, anti-obesity products;
- drugs administered primarily for preventive purposes; for the purposes of this exclusion, a drug used to stabilize or regulate a pathological condition diagnosed by a healthcare professional is not considered to be used for preventive purposes;
- over-the-counter laxatives and antacids;
- products used to treat hair loss, wrinkles or any other treatment administered primarily for aesthetic purposes;
- smoking cessation products;

- drugs or substances used for the treatment of infertility or erectile dysfunction;
- any substances used for the purpose of artificial insemination, contraceptive and prophylactic jellies and foams;
- drugs provided during a period of hospitalization;
- any treatments or drugs of an experimental nature;
- items related to the use of injectable drugs, such as rubbing alcohol, cotton swabs, automatic jet injectors or other similar equipment.

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

In the event that Health Canada approves a new drug that may substantially affect the cost of coverage under this benefit, the Insurer reserves the right to, subject to the Policyholder's consent, exclude such drug from coverage in compliance with any legislative provisions of the insured's province of residence or modify the applicable premium as of the drug's date of approval.

3.1.4 **Other eligible expenses**

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

3.1.4.1 Expenses for the purchase of **adult diapers for incontinence** required following a surgery causing a total and irrecoverable loss of bladder or bowel function.

3.1.4.2 Transportation expenses by **ambulance** to the nearest hospital centre that can provide required care, including round-trip air or train transportation in case of an emergency.

3.1.4.3 Expenses for the purchase of **appliance for temporomandibular joint**.

3.1.4.4 Expenses for the purchase of an **appliance used to manage diabetes** (blood glucose monitor, dextrometer or any other appliance of a similar nature) as well as the travel case for transporting it, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of this appliance.

3.1.4.5 Expenses for the purchase of an **artificial limb** for an event occurring while insurance is in force, **prosthetic equipment** excluding dental prostheses and **orthopedic equipment** except orthopedic shoes. Expenses for the repair of such equipment are also covered if the cost is less expensive than the purchase cost.

3.1.4.6 Expenses for the purchase of a **capillary prosthesis (wig)** required following chemotherapy treatments.

3.1.4.7 Expenses for the purchase of **corrective footwear (deep shoes)**. These shoes must be sold by a specialized laboratory or establishment licensed and authorized under all applicable legislation in the insured's province of residence.

3.1.4.8 Expenses incurred for **curative and preventive vaccines** administered by a physician or a nurse.

3.1.4.9 **Expenses for travel to receive treatment from a medical specialist not available in the insured's region of residence**

If an insured is required to travel outside of his or her region of residence to consult or receive treatment from a medical specialist not available in his or her region of residence, the following expenses are eligible for reimbursement:

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

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

Eligible expenses must be incurred for consultations or treatments in the province of Quebec and are reimbursed on production of paid invoices, except if the trip had been made by automobile.

Eligible expenses must be incurred by and for the participant if the participant has Individual coverage status; if the participant has Family coverage status, eligible expenses must be incurred by and for the participant or his or her dependents. This coverage also permits the presence of an accompanying person if justified by the situation.

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

3.1.4.11 Expenses for the purchase of **foot orthoses** added to ordinary shoes, made by a specialized orthopedic laboratory licensed under applicable provincial legislation.

3.1.4.12 Expenses for the purchase or repair of a **hearing aid**.

3.1.4.13 Expenses for the purchase of **homeopathic medication** supplied by a homeopath or a licensed pharmacist on prescription by a homeopath.

3.1.4.14 Expenses for the purchase of an **insulin pump** for controlling diabetes, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of such appliance.

3.1.4.15 Expenses for **magnetic resonance imaging (MRI)** tests carried out outside a hospital centre for diagnostic purposes.

3.1.4.16 **Multiservices** – Home Care and Services

Expenses for the services described hereinafter when recommended by a physician and deemed necessary following hospitalization or one-day surgery are eligible for reimbursement, for all of these expenses, provided the expenses are incurred within 30 days following the hospitalization or discharge from the one-day surgery or day medicine unit and the services cannot be provided by a person who resides with the insured. Hospitalization after childbirth is not included unless there are complications and the stay lasts four days or more.

a) Professional fees of a registered nurse or nursing assistant for nursing care provided in the insured's home. The nurse must not be a person who usually resides in the participant's home or a close relative of the participant. Nursing care includes:

- coaching after surgery;
- monitoring blood pressure and vital signs;
- changing dressings and treating wounds;
- administering medication and monitoring solutions;
- removing sutures and staples;
- taking blood and other samples.

b) Fees for home assistance services for purposes of washing, feeding, dressing, transferring and looking after the insured's basic hygienic needs. These services must be provided at the insured's home and the home care service provider must not be a person who usually resides in the participant's home or a close relative of the participant. Home assistance services include:

- personal care (assistance with bathing, dressing and undressing, general hygiene, feeding, transferring, etc.);
- housekeeping (regular housework, dishwashing, laundry);

- general home maintenance (snow removal, lawn mowing, etc.);
- meal preparation;
- accompanying to medical appointments.

The term home care service provider means a person working for remuneration for a cooperative or an incorporated or registered agency that is specialized in home care; a self-employed worker who has a contract with such a cooperative or agency; as well as a self-employed worker in the absence of such a cooperative or agency in the region.

c) Transportation expenses for the insured to benefit from medical care or follow-up following hospitalization or one-day surgery.

3.1.4.17 Expenses for the purchase of **orthopedic shoes (custom-made)**. These shoes must be sold by a specialized laboratory or establishment licensed and authorized under all applicable legislation in the insured's province of residence.

3.1.4.18 The following services not otherwise eligible for reimbursement: **oxygen therapy** and **laboratory tests**.

3.1.4.19 Expenses incurred within or outside of Canada for a stay in a **private clinic** specialized in the treatment of alcoholism or drug addiction and recognized as such, excluding addiction to smoking.

3.1.4.20 Expenses for occupying a room, including meals, for at least 12 consecutive hours in a **rehabilitation centre**, provided that the insured is admitted to the centre immediately following hospitalization and that hospitalization lasted at least three days and began while insurance was in force.

3.1.4.21 Expenses for **serums** and **fluids injected for curative purposes**, including injections for artificial insemination.

3.1.4.22 Expenses for the purchase of **support stockings**.

3.1.4.23 Expenses for the rental of a **wheelchair**, an **iron lung** or other **therapeutic appliance**.

3.1.4.24 Expenses for **X-rays**, **mammography** and **ultrasound examinations** (other than fetal) carried out outside a hospital centre.

3.1.5 **Healthcare professionals**

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

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

3.1.5.1 Professional fees of an **acupuncturist**.

3.1.5.2 Professional fees of a **chiropractor** and **X-rays** taken by a chiropractor.

3.1.5.3 Professional fees of a **dentist** to repair accidental damage to natural teeth occurring after the effective date of insurance.

3.1.5.4 Professional fees of a **dietician**.

3.1.5.5 Professional fees of a **naturopath**.

3.1.5.6 Professional fees of a **nutritionist**.

3.1.5.7 Professional fees of an **osteopath**.

3.1.5.8 Professional fees of a **physiotherapist** and a **physical rehabilitation therapist**.

3.1.5.9 Professional fees of a **podiatrist**.

3.1.5.10 Professional fees of a **psychologist**, a **psychiatrist**, a **psychoanalyst** in an outpatient clinic, a **social worker** and a **guidance counsellor** in private practice.

The only services of psychiatrists considered eligible for reimbursement are those rendered as psychoanalytic treatments, insofar as these professionals are members of the Canadian Psychoanalytic Society.

3.1.5.11 Professional fees of a **registered nurse** (R.N.) or a **nursing assistant** excluding any person who usually resides in the insured's home or is a member of the insured's family.

3.1.5.12 Professional fees of a **speech therapist** and an **occupational therapist.**

3.2 Travel Insurance

3.2.1 Travel Insurance

The customary and reasonable expenses and services described hereafter are eligible for reimbursement, 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 public health and hospitalization insurance plans of the province of residence.

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

Expenses are subject to the maximum reimbursement indicated in the *Schedule of Insurance*.

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.

3.2.1.1 Eligible expenses

a) Hospitalization, medical and paramedical expenses

i) Hospitalization expenses for a semi-private or private room in excess of the amounts refunded or refundable by the public health and hospitalization insurance plans of the insured's province of residence.

ii) Out-of-pocket expenses (telephone, television, parking, etc.) related to hospitalization upon presentation of supporting documents up to a maximum of $100 per hospitalization.

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

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

v) Nurses' fees for a registered nurse, member in good standing of a professional association recognized by a legislative authority, for private nursing care dispensed exclusively at the hospital centre, when medically required and prescribed by the attending physician up to a maximum refund of $3,000 per hospitalization. The nurse must not be a member of the insured's family, nor be a travelling companion.

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

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

b) Transportation expenses

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

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

iii) When the insured is repatriated or transported, the Assistor organizes and pays return expenses, depending on circumstances, for his or her spouse and dependent children or for the insured's travelling companion, to the insured's province of residence and up to the cost of a regularly scheduled airline flight, train or bus ticket, if the initially planned means for return cannot be used.

iv) When the insured's condition of health does not allow medical repatriation and hospitalization outside the province must extend beyond 7 days, the Assistor organizes and pays round-trip transportation expenses for a close relative of the insured's family residing in his or her province of residence in order to allow the said relative to be at the insured's bedside. The maximum refund is $1,500. These expenses are not eligible for refund if the insured was already accompanied by a close relative aged 18 or over, or the necessity of a visit is not confirmed by the attending physician, or the visit is not previously approved and planned by the Assistor.

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

vi) Whenever an insured is unable to drive the automobile used during a trip following an illness or accident that occurred during the trip and no other accompanying person who can drive the vehicle, the Assistor pays the expenses incurred by a commercial agency to return the insured's personal vehicle or a rental car to his or her residence or to the office of a vehicle rental agency closest to the location of the occurrence, subject to a maximum refund of $1,000.

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

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

c) Living expenses

Expenses for lodging and meals in a commercial establishment, when the insured must postpone his or her return due to illness or bodily injury that he or she suffers personally or is suffered by a close relative who accompanies him or her or by a travelling companion, subject to a maximum refund of $150 per day for 8 days.

3.2.1.2 Travel assistance service

The Assistor provides worldwide travel assistance service on a 24 hours a day, 365 days a year basis to any insured who so requests, excluding countries at war or under a travel advisory thereby making any intervention by the Assistor physically impossible.

a) Cash advances for expenses covered under the travel insurance. Thereafter, the Assistor files a claim for the reimbursement of expenses incurred with the public health and hospitalization insurance plans of the insured's province of residence and with the Insurer.

b) In the event of illness or accident abroad, the Assistor provides all medical information in the form of straightforward advice as well as the location of a medical centre. If necessary, the Assistor facilitates the admission of the insured to an appropriate hospital centre or clinic.

c) Subject to the provisions herein and in the event of the insured's illness or accident outside his or her province of residence, once notified, the Assistor organizes necessary contacts between its medical service, the attending physician, and eventually the family physician, in order to make decisions that are best adapted to the situation.

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

e) The Assistor assumes, insofar as possible, the dispatching of indispensable medication for uninterrupted ongoing treatment in the case where it is impossible to procure such medication on site or to obtain an equivalent. In all cases, medication is paid by the insured and is then refunded by the Insurer, if eligible.

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

g) Upon the insured's request, the Assistor provides any information required in the event of important problems during the insured's trip following the loss of his or her passport, visa, credit card, etc.

h) The Assistor offers to an insured in distress abroad, a phone service of multilingual interpreters.

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

3.2.1.3 Obligations of the insured

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

b) RESTRICTION: The insured, as soon as he or she is capable of so doing, must obtain the previous consent of the Assistor before taking any initiative or incurring any expense. If the insured fails in this obligation, the Assistor will be relieved of its obligations to the insured.

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

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

3.2.1.4 Exclusions and reduction of travel insurance coverage

In addition to exclusions and reduction of coverage specified for the Health Insurance Benefit, no refund is made nor any assistance is given to the insured by the Insurer or the Assistor in the following cases:

a) when the loss occurs in the province of residence of the insured;

b) when the insured refuses without any valid medical reason to comply with the Assistor's recommendations regarding his or her repatriation, choice of a hospital or required care; by required care is meant the treatment needed to stabilize the insured’s medical condition;

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

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

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

f) when hospitalization expenses are incurred in hospital for the chronically ill, or in a service for the chronically ill in a public hospital, or for patients who are in extended care homes or spa resorts;

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

h) for an accident occurring during the insured's participation in a sport for remuneration, in any kind of motor vehicle's competition or any kind of speed contest, in flying a glider or deltaplane, mountain climbing, parachuting whether or not in free fall, bungee jumping or any other dangerous activity. Activities other than those previously listed offered to the general public in resort areas are not considered dangerous activities;

i) if the insured has consumed medication, alcohol or drugs in toxic quantities;

j) for repatriation or travel assistance services, when the loss occurs in a country at war, whether or not declared, under a travel advisory, during a riot, common uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other cases involving an Act of God which make an intervention by the Assistor physically impossible.

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

3.2.2 **Trip Cancellation Insurance**

The Insurer pays, according to the provisions and conditions specified hereunder and according to the percentage indicated in the *Schedule of Insurance*,, the expenses incurred by the insured following the cancellation or interruption of a trip insofar as the expenses incurred are related to prepaid travel expenses by the insured while this coverage is in force, and the insured was not aware at the time of finalizing the travel arrangements of any event that might reasonably lead to the cancellation or interruption of the planned trip.

Expenses are subject to the maximum reimbursement indicated in the *Schedule of Insurance*.

3.2.2.1 Causes of cancellation or interruption

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

a) an illness or accident preventing the insured or close relative, his or her travelling companion or close relative, or his business partner from performing his or her ordinary activities and which is reasonably serious to justify the cancellation or interruption of the trip;

b) the death of the insured, his or her spouse, child or spouse's child, travelling companion or business partner;

c) the death of an insured's close relative other than his or her spouse or child or a close relative of the travelling companion if the funeral takes place during the planned period of the trip or during the 14 days preceding it;

d) the death or emergency hospitalization of the host at destination;

e) the insured’s or his or her travelling companion’s summon for jury duty or subpoena to appear as a witness in a case to be heard during the period of the trip, providing that the person involved is not a party to the litigation and has taken necessary steps for having the hearing postponed;

f) the quarantine of the insured or his or her travelling companion, except if such quarantine ends more than 7 days prior to the planned date of departure;

g) the skyjacking of the airplane in which the insured is travelling;

h) a loss making uninhabitable the principal residence of the insured, of his or her travelling companion or of the host at destination, providing that the residence is still uninhabitable 7 days prior to the planned date of departure or that the loss occurs during the trip;

i) the transfer of the insured or his or her travelling companion, for the same employer, 100 or more kilometres from his or her present domicile, if required within 30 days preceding the planned departure date;

j) terrorism or any other situation in the country to which the insured is travelling, providing that the Government of Canada issues a recommendation advising Canadians not to travel to or in such country for a period covering the planned duration of the trip and that the recommendation be issued after the expenses had been incurred;

k) a departure missed due to a delay in the means of transportation used to get to the point of departure, providing that the schedule of the means of transportation used provided an arrival of at least 3 hours before the departure or at least 2 hours if the distance to be covered is less than 100 kilometres. The cause for the delay must be atmospheric conditions, mechanical difficulties (except for a private automobile), a traffic accident or the emergency road closure, each of the latter two causes must be supported by a police report;

l) the atmospheric conditions delaying the departure of the public carrier used by the insured, at the planned point of departure, at least 30% (48 hours minimum) of the planned duration of the trip or preventing the insured from making a planned connection with another carrier insofar as this latter carrier be delayed for at least 30% (48 hours minimum) of the planned duration of the trip;

m) a loss occurring at the place of business or on the physical premises where an activity of a commercial nature is scheduled to be held and thereby making impossible the holding of the activity such that a written notice cancelling the activity is issued by the official organization in charge of organizing it;

n) the involuntary loss of permanent employment of the insured or the insured's spouse, provided that the person in question has occupied a permanent position with the employer for more than one year.

3.2.2.2 Covered Expenses

The following expenses are covered providing that they are effectively paid by the insured.

a) In the event of cancellation prior to departure:

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

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

c) If the return is advanced or delayed:

- the supplemental cost of a regular ticket in economy class by the most direct route for the return to the point of departure by the means of transportation initially planned, or if the latter cannot be used, the expenses required in economy class by a regularly scheduled public carrier for the most economical means by the most direct route for the return to the planned point of departure; these expenses must be agreed to in advance with the Insurer.
- Nonetheless, if the insured's return is delayed for more than 7 days following an illness or accident sustained by the insured or his or her travelling companion, incurred expenses are covered insofar as the person involved has been admitted to a hospital centre as an inpatient for more than 48 hours within the said 7-day period.
- The unused and non-refundable portion of the land part of prepaid travel expenses.

3.2.2.3 Exclusions to travel cancellation insurance coverage

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

a) if the trip is undertaken with the intention of receiving medical treatment or hospitalization services, whether the trip is taken upon the recommendation of a physician;

b) if the trip is undertaken for purposes of visiting a person who is ill or has had an accident and the cancellation or interruption of the trip results from the death or deterioration of the medical condition of such person;

c) a war, whether or not declared, or the active participation in an insurrection, whether real or foreseeable;

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

e) pregnancy, and any related complications, within 8 weeks preceding the expected date of delivery;

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

g) if the insured has consumed medication, alcohol or drugs in toxic quantities;

h) the participation of the insured in a sport for remuneration, in any kind of competition involving motor vehicles or any contest involving speed, gliding or hang gliding, mountain climbing, parachute jumping whether or not in free-fall, bungee jumping or any other dangerous activity. Activities other than those previously listed offered to the general public in resort areas are not considered dangerous activities;

i) a medical condition for which the insured or his or her travelling companion has been hospitalized, or has received or has been prescribed medical treatment of for which he or she has consulted a physician within 90 days preceding the date on which the travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the subject has stabilized at the time the expenses have been incurred. Any change in medication, including use and dosage, is considered to be a medical treatment;

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

3.2.2.4 Deadline for requesting cancellation

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

3.2.2.5 Coordination

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

3.2.2.6 Claims under Trip Cancellation Insurance

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

- Unused travel tickets.
- Official receipts for additional transportation expenses.

- Receipts for ground travel arrangements and other expenses paid. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation. Written proof that the insured has requested a reimbursement of travel expenses must be forwarded to the Insurer, along with the reply received as to the outcome of such request.
- Official documents certifying the cause for cancellation. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip.
- An official police report, if the means of transportation by the insured used is delayed because of a traffic accident or emergency road closure.
- An official report issued by the appropriate authorities pertaining to weather conditions.
- Written proof issued by the official organizer of an activity of a commercial nature confirming that the event is cancelled and the specific reasons why.
- Any other report required by the Insurer in support of the insured's claim.

3.3 Exclusions and reduction of the Health Insurance Benefit

Without further limitation to care, supplies and services described under eligible health insurance expenses, and subject to the provisions of the applicable provincial act, the Insurer will not reimburse the following expenses:

3.3.1 hearing examinations, except if required following an accident;

3.3.2 eye examinations, except if required following an accident;

3.3.3 dentures, except for the initial purchase if required following an accident;

3.3.4 eyeglasses or contact lenses, or any related adjustments, except if required following an accident;

3.3.5 expenses incurred for care, services or supplies that the insured is not required to pay, that the insured would not be required to pay if the insured is entitled to an indemnity under any public health insurance plan, or that the insured would not have had to pay in the absence of this coverage;

3.3.6 surgery for aesthetic purposes, except following an accident;

3.3.7 treatments or prostheses for aesthetic purposes, except following an accident;

3.3.8 periodic medical examination or medical examination for the purposes of employment, for purposes of admittance to an educational institution, for insurance or health travelling purposes;

3.3.9 condition occurring while the insured is on active duty with the armed forces of any country;

3.3.10 due to a declared or undeclared war or his or her active participation in an insurrection, whether real or foreseeable;

3.3.11 condition occurring during the insured's participation in a criminal act or one deemed to be so.

3.4 Application for benefits

The Insurer is required to pay under the present coverage if there has been a claim for benefits presented within the 12 months following the date on which the eligible expenses were incurred. Expenses are considered as being incurred on the date on which services were rendered or supplies were furnished.

This deadline stipulated here above is imperative. However, if the participant proves to the satisfaction of the Insurer that it was impossible for him or her to act prior to the expiration of the deadline, and that the claim was submitted as soon as the impairment ceased, then the insured may benefit from this insurance coverage.

3.5 Information

The Insurer may demand any information, details and files, including the case history concerning the diagnosis, the treatment provided or services rendered to each insured either before or after his or her insurance came into effect. The insured agrees, as a condition of the Insurer's liability under this coverage, to disclose or have disclosed to it all information, details and files and authorizes any hospital, or any person rendering or having rendered these services to disclose provide them directly to the Insurer. All such information is considered as strictly confidential by the Insurer.

3.6 Extension of the dependents' coverage of a deceased participant

Following the death of the participant, dependents remain insured under the Health Insurance Benefit, without payment of premiums, for the period specified in the *Schedule of Insurance*.

After this period, they may continue to be insured, with payment of premiums, if the spouse becomes a member of the AREF and if the spouse informs the Insurer during the extension period.

3.7 **Dependents' coverage following a divorce, a separation for at least 90 days in the case of a common-law union or dissolution of the union of the participant**

In case of a divorce, a separation for at least 90 days in the case of a common-law union or dissolution of the union of the participant, the spouse may remain insured under the Health Insurance Benefit upon payment of premiums and by becoming a member of the AREF.

3.8 **Method of payment**

The insured can use the direct electronic claims payment card for the purchase of prescription drugs.

3.9 **End of insurance**

3.9.1 The Health Insurance Benefit for any participant terminates on the earliest of the following dates:

3.9.1.1 the date of the end of the contract or the benefit, subject to the provisions of the "Conversion privilege";

3.9.1.2 the due date of any unpaid premium, subject to the provisions of the "Conversion privilege", 30 days following the dispatching of a written notice to this effect by the Insurer to the participant's last known address;

3.9.1.3 the date of the reception by the Insurer of the written notice by a participant who wishes to terminate his or her coverage under the Health Insurance Benefit;

3.9.1.4 the date of the participant's death;

3.9.1.5 the date on which the participant ceases to be a member of the AREF;

3.9.1.6 the date on which the participant ceases to be a permanent resident of Canada. Health Insurance Benefit therefore terminates on the expiry date of the maximum period for a stay outside of the country allowed for by the public health insurance of the participant's province of residence. This period begins on the date the participant leaves his or her province of residence.

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

3.9.2.1 the termination date of the participant's insurance, subject to the provisions of the "Extension of the dependents' coverage of a deceased participant";

3.9.2.2 the date on which he or she ceases to be a dependent;

3.9.2.3 the date on which the participant converts his or her family coverage status to an individual coverage status;

3.9.2.4 the date on which the dependent ceases to be a permanent resident of Canada. Health Insurance Benefit therefore terminates on the expiry date of the maximum period for a stay outside of the country allowed for by the public health insurance of the dependent's province of residence. This period begins on the date the dependent leaves his or her province of residence.

3.10 **Conversion privilege**

Insureds who are no longer eligible for coverage under this benefit may apply, without evidence of insurability, for an individual health insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within the deadline specified in the *Schedule of Insurance*. The insured's individual health insurance policy will be effective as of the date of termination of their collective Health Insurance Benefit, provided that a written request is submitted within the specified period.

SECTION 4 – **LIFE INSURANCE BENEFIT**

4.1 **Participant's Basic Life Insurance**

4.1.1 Amount of benefits

Upon the death of the participant while this coverage is in force, the Insurer pays the beneficiary an indemnity equal to the amount indicated in the *Schedule of Insurance*, subject, however, to the reductions and maximums provided within the *Schedule*.

4.2 **Dependents' Basic Life Insurance**

4.2.1 Amount of benefits

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

4.3 **Participant's Optional Life Insurance**

4.3.1 Amount of benefits

4.3.1.1 Persons retired before January 1, 2004

Participants can subscribe for the amount specified in the *Schedule of Insurance*, based on their age.

4.3.1.2 Persons retired on or after January 1, 2004

Participants can subscribe for the amount indicated in the *Schedule of Insurance* if they have reached retirement age or age 65.

When the amount of Basic Life Insurance is reduced due to age, retirees may obtain the equivalent amount in units of Optional Life Insurance coverage, without, however, exceeding the number of units available for their age group.

The Insurer writes to retirees prior the date of their 65th birthday, as provided under *Provisions applicable for retirees reaching age 65.*

4.3.1.3 Retirees can reduce the number of units of Optional Life Insurance at any time, but may not increase it.

4.3.1.4 For retirees who reached age 65 but were less than 70 years of age on July 1, 1993, the total amount payable under the Basic and Optional Life Insurance Benefits may not exceed the amount in force on June 30, 1993.

4.4 Beneficiary

Subject to the provisions of applicable legislation, any participant may designate a beneficiary or change a beneficiary already designated by means of a written statement filed at the head office of the Insurer. The Insurer is not liable for the validity of any change of beneficiary. The rights of a beneficiary, who dies before the participant, revert to the said participant. If, at the time of the participant's death, said participant has not designated a beneficiary in writing, the amount of insurance becomes a part of the participant's estate.

4.5 Payment of insurance

Benefits are based on the amount of insurance in force at the time of the death of the participant or an insured dependent. In the event of the death of the participant, benefits are payable to the designated beneficiary. In the event of the death of a participant's spouse or dependent child, benefits are payable to the participant.

The claimant must provide the evidence required by the Insurer, in order to establish, besides the rights of the claimant, the death of the insured and its cause, as well as the accuracy of the date of birth stated by the participant. The payment is only made if the insurance is in force on the date of death.

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

4.6 Extension of the dependents' coverage of a deceased participant

Following the death of the participant, dependents remain insured under the Life Insurance, without payment of premiums, for the period specified in the *Schedule of Insurance*.

After this period, they may continue to be insured, with payment of premiums, if the spouse becomes a member of the AREF and if the spouse informs the Insurer during the extension period.

4.7 **End of insurance**

4.7.1 The Life Insurance Benefit for any participant terminates on the earliest of the following dates:

4.7.1.1 the date of the end of the contract or the benefit, subject to the provisions of the “Conversion privilege”;

4.7.1.2 the due date of any unpaid premium, subject to the provisions of the “Conversion privilege applicable to Participant's Basic Life Insurance, Dependents’ Basic Life Insurance and Optional Life Insurance” and subject to any legislated grace period in the applicable provincial jurisdiction;

4.7.1.3 the date of the reception by the Insurer of the written notice by a participant who wishes to terminate his or her coverage, or on the termination date indicated in such notice, whichever is later;

4.7.1.4 the date of the participant's death;

4.7.1.5 the date on which the participant ceases to be a member of the AREF;

4.7.1.6 the date on which the participant ceases to be a permanent resident of Canada.

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

4.7.2.1 the termination date of the participant's insurance, subject to the provisions of the “Extension of the dependents’ coverage of a deceased participant” and “Conversion privilege applicable to Participant's Basic Life Insurance, Dependents’ Basic Life Insurance and Optional Life Insurance”;

4.7.2.2 the date on which he or she ceases to be a dependent;

4.7.2.3 the date of the reception by the Insurer of the written notice by a participant who wishes to terminate the insurance of his or her spouse or dependent children under the Dependents’ Basic Life Insurance Benefit;

4.7.2.4 the date on which the dependent ceases to be a permanent resident of Canada.

4.8 Conversion privilege applicable to Participant's Basic Life Insurance, Dependents' Basic Life Insurance and Optional Life Insurance

4.8.1 Termination of the AREF membership

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

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

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

To exercise this conversion option, participants must apply in writing to the Insurer before the expiry of the period indicated in the *Schedule of Insurance*, following the date on which their AREF membership terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, without, however, exceeding the period specified in the *Schedule of Insurance*. Any reduction in the amount of insurance due to age does not give entitlement to the conversion privilege.

4.8.2 Expiry of the contract

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

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

To exercise this conversion option, participants are not required to provide evidence of insurability but must apply in writing to the Insurer within the period specified in the *Schedule of Insurance,* following the expiry of this contract. Any reduction in the amount of insurance due to age does not give entitlement to the conversion privilege.

4.8.3 Coverage available upon conversion

Participants who exercise their conversion privilege according to the aforementioned provisions may obtain an individual whole life or term life insurance policy, without accessory coverage, of the type issued at that time by the Insurer in such circumstances and in accordance with the *Regulation under the Act respecting insurance*.

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

SECTION 5 – **PREMIUM RATES – PREMIUM PAYMENTS – GRACE PERIOD**

5.1 **Monthly premium rates**

5.1.1 Health Insurance Benefit

$38.37 for individual coverage;

$76.74 for family coverage;

Participants under age 65 who have previously opted for a couple or a single-parent coverage status will have a family coverage status on May 1st, 2017.

5.1.2 Life Insurance Benefit

5.1.2.1 Participant's Basic Life Insurance

$0.5795 per $1,000 of insurance

5.1.2.2 Dependents' Basic Life Insurance

$2.35 per family for a participant under age 65

$5.67 per family for a participant aged 65 or over

5.1.2.3 Participant's Optional Life Insurance

The premium rates per $5,000 of Optional Life Insurance are ~~as follows~~:

Age of participant	Men	Women
Under age 55	$1.029	$0.552
55 to 59	$1.842	$0.998
60 to 64	$2.924	$1.458
65 to 69	$5.071	$2.760
70 to 74	$7.704	$4.635
75 to 79	$11.814	$7.777
80 to 84	$19.186	$15.041
85 to 89	$20.165	$15.808
90 or over	$20.972	$16.440

These rates can be modified by the Insurer on each renewal date of the contract, but no modification is allowed without 90 days of prior written notice.

5.2 Change of government policy

If the federal or provincial governments pass or amend laws or regulations or any other item which could influence the Insurer's rates, the Insurer reserves the right to adjust premium rates, upon an agreement with the Policyholder, for the benefits involved at the time such an act or amendment or item comes into effect.

5.3 Premiums payments

All premiums are monthly payable, in the legal tender of Canada, at the Head Office of the Insurer who provides a 31-day grace period for their payment. The contract remains in force during this period if the payment is made prior to expiry of the grace period. Otherwise, the contract ends retroactively at the due date of premiums unless proof is provided that no payment of premiums resulted from an administrative error or omission not by the participant itself.

The amount of premiums payable under this contract is the total of the premiums payable for each participant.

The premiums for each participant do not vary during a contract period, except for a change in coverage or a change in age for benefits which the premium varies according to the age.

The amount of premiums actually received or receivable by the Insurer for a participant determines his or her coverage and establishes whether or not his or her spouse or dependent children are insured.

The amount of the premiums is not due by the participant who becomes insured on a date other than the first day of a month. However, the amount of premium is payable in full at the end of a participant’s insurance on a date other than the last day of a month.

5.4 Grace period

The Insurer grants the retiree a 30-day grace period following the date on which any premium becomes payable. In the event of the retiree's failure to pay premiums prior to expiry of the grace period, the Insurer reserves the right to terminate this contract as permitted by provincial legislation.

SECTION 6 – **TERMINATION OF THIS CONTRACT**

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

SECTION 7 – **MODIFICATIONS TO THE CONTRACT**

The Policyholder may at all time, following agreement with the Insurer, make changes to the contract regarding the categories of eligible persons, the scope of coverages and the sharing of costs between the categories of insureds. Such changes may then be applied to all insureds.

No provision of this contract may be excluded, modified or otherwise transformed unless carried out a written signed agreement to that effect with an authorized representative of the Insurer.

SECTION 8 – **MISCELLANEOUS PROVISIONS**

8.1 Notice or advance notice

Any notice or advance notice given by the Insurer to the Policyholder is sufficient if the Insurer sends it by mail to the Policyholder at its address as it appears in the Insurer's files. Any notice or advance notice given by the Policyholder is sufficient if it is sent by mail to the Insurer at the address of its Head Office in Quebec City. No insurance representative nor agent of the Insurer is authorized to make any modifications to this contract nor to remove any of its provisions. Any modification must be approved in writing by the Insurer.

8.2 Legal action or proceedings against the Insurer

No legal action or proceedings can be taken against the Insurer regarding any benefit claims:

a) in the 60 days following the expiry of the deadline to submit benefit claims, subject to the applicable statutory deadlines.

b) in the 60 days following the deadline indicated by the Insurer when evidence of insurability or additional information are required, subject to the applicable statutory deadlines.

c) after expiry of the statutory deadlines applicable in the insured’s province of residence or in the province where the action or proceedings is instituted.

d) for Ontario residents, every action or proceeding against the Insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

8.3 Certificates of insurance

The Insurer must provide insurance certificates to all participants covered under this contract.

8.4 Subrogation of the participant's rights

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

8.5 Errors, omissions, fraud or attempted fraud

Any errors or omissions affecting the amount of the premium are corrected as soon as they are discovered and the required premium adjustments are made. However, for any errors or omissions affecting the validity of insurance or the amount of insurance in force, the true facts are used to determine whether insurance is in force and establish the

amount of insurance in force in accordance with the clauses and conditions of this contract.

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

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

8.6 Payments under this contract

All payments under this contract are made at the Head Office of the Insurer in the legal tender of Canada. All payments of benefits under this contract are made in the legal tender of Canada.

8.7 Non-assignability of the insured's rights

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

8.8 Access to documents

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

Upon specific request and in exchange of reasonable fees other than those listed in the retention formula, the Insurer is required to provide any information or report deemed necessary by the Policyholder.

SECTION 9 – **SCOPE OF THE CONTRACT**

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

The use of titles, paragraphs, sections and subparagraphs are used indicative and reference purposes only and may not be interpreted as restricting the rights of the parties in the interpretation of this contract, which must always be interpreted in its entirety and as a whole.

Furthermore, this contract should be considered as a consolidated version and, occasionally, a reformulated version of endorsements, written agreements and the initial contract 1010, which came into force on January 1, 1976. This contract does confer any rights retroactively and the contract provisions applicable to any covered event remain the same as those in force on the date on which such event occurs.

Furthermore, April 30, 2017 should not be considered the termination date of the contract, for all legal purposes, but a date of renewal.