GROUP INSURANCE PLAN

CONTRACT 6000

insured by

La Capitale
Insurance and Financial Services

offered
to wage-earners
of the

Intersectorial Parity Committee FTQ

(POLICYHOLDER)

Updated as of January 1, 2004

(Please keep this folder for future reference)

This plan is offered
to wage-earners working in
institutions represented by:

THE HEALTH AND SOCIAL SERVICES SECTOR

SCHOOL BOARD AND CEGEP SECTORS

SOCIÉTÉ IMMOBILIÈRE DU QUÉBEC (SIQ)

SOCIÉTÉ DE DÉVELOPPEMENT DES ENTREPRISES CULTURELLES (SODEC)

LA CORPORATION D'URGENCES-SANTÉ DE LA RÉGION DE MONTRÉAL MÉTROPOLITAIN (URGENCES SANTÉ)

CONSEIL DES SERVICES ESSENTIELS

MUSÉE DU QUÉBEC

RÉGIE DE L'ÉNERGIE

SOCIÉTÉ QUÉBÉCOISE D'INFORMATION JURIDIQUE (SOQUIJ)

and members of one of the following FTQ affiliated unions

- **The Syndicat canadien de la fonction publique (SCFP)**

- **The Syndicat québécois des employés et employées de service, section locale 298**

- **The Syndicat des employées et des employés professionnels-les et de bureau - Québec (SEPB)**

- **The Union des employés et des employées de service, section locale 800**

- **The Syndicat des officiers de la marine marchande (SCOM)**

IMPORTANT

The policyholder may, at any time following an agreement with the Insurer, make modifications to the contract concerning the classes of persons eligible, the scope of coverages and the sharing of costs between classes of insured persons. Such modifications can also apply to all insured persons, whether they be active, disabled or retired.

This document does not mention all the clauses relating to definitions, eligibility, participation, termination of insurance and other miscellaneous provisions. Nonetheless, you may be informed of its contents by consulting the employer's guide available from your employer or obtain a copy of the policy by contacting the local union representative.

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

When used, the masculine gender is intented to facilitate the reading of this document; it designates both women and men.

CONTENTS

Insurer : La Capitale Civil Service Insurer Mutual.

Administrator : La Capitale Insurance and Financial Services.

SUMMARY

This outline table briefly sums up the coverages found in each of the group insurance plans. For a full description of benefits, please consult the pages dealing with this subject.

BASIC HEALTH INSURANCE

-Hospitalization :	100 %, semi-private room
-Travel insurance and travel cancellation insurance :	100 %
-Drugs and other fees :	80 % of the first 2 500 $ of eligible expenses and 100 % of the excess
Automated payment service :	Deferred

OPTIONAL SUPPLEMENTARY HEALTH INSURANCE

-Psychologist, psychiatrist, psychoanalyst and professionnal social worker	50 % Specific maximums apply
-Other health care professionals, ultrasounds, X-rays and thermographies	80 % Specific maximums apply

OPTIONAL DENTAL CARE INSURANCE

-Preventive services :	80 %
-Basic restorative services :	80 %
-Major restorative services :	80 %
Maximum of refund :	$1,000 per calendar year per insured person
-Removable prosthesis :	80 %
Maximum of refund :	$1,000 per calendar yeau per insured person

OPTIONAL ACTIVE PARTICIPANT'S LIFE INSURANCE

-Active Participant's Basic Life Insurance :	Under age 65 : 1 time annual wages 65 or over : 1/2 times annual wages
-Accidental death or dismemberment insurance:	1 time annual wages
-Active Participant's Additional Life Insurance :	1, 2 or 3 times annual wages
-Spouse's or dependent's Life Insurance:	
. dependent child :	$2,500
. spouse :	$5,000
-Spouse's Additional Life Insurance :	1 to 10 $5,000 units

OPTIONAL RETIREE'S LIFE INSURANCE

-Retiree's Life Insurance :	1 to 10 $5,000 units
-Basic Life Insurance for a Retiree's dependent(s) :	
. dependent child :	$2,500
. Spouse :	$5,000
-Spouse's Additional Life Insurance :	1 to 10 $5,000 units

DESCRIPTION OF PLAN

A - BASIC HEALTH INSURANCE (Mandatory coverage)

1. Eligible Expenses

Eligible expenses are expenses reasonably incurred and justify by the the seriousness of the case, paid by the insured person following an accident sickness, pregnancy or surgery related to family planning.

EXPENSES 100 % REFUNDABLE

a) Hospital expenses incurred in Canada and in excess of that which is payable by any state insurance plan, up to the cost of **semi-private accommodations** for each day of hospitalization, based on the rates in force in the province in which they are incurred, without any limit as to the number of days.

b) Upon presentation of a complete report by the attending physician attesting that the insured person is insulin dependent and that his or her condition requires the use of such an apparatus, expenses incurred for the rental, purchase or repair of a **glucometer, reflectometer, or dextrometer**, up to a maximum refund of $250 per 60 month consecutive period per insured.

c) Expenses incurred for the rental, purchase or repair of a **hearing aid**, up to a maximum refund of $500 per 36-month consecutive period per insured person.

d) In the case of a **withdrawal treatment** related to alcoholism or drug usage, with the exclusion of any treatment related to the use of tobacco, eligible expenses are provided for a stay in an establishment officially recognized for such purpose, subject to a maximum refund of $40 per day and $1,000 per calendar year per insured person.

e) Expenses for the purchase of intra-uterine device up to a maximum refund of $100 per 24-month consecutive period, per insured person.

f) **Travel Insurance and travel cancellation insurance**
Expenses pertaining to theses coverages are 100 % refundable with an exempted deductible. A full description of these coverages may be found at the end of your brochure.

THE FOLLOWING ELIGIBLE EXPENSES ARE FIRST REFUNDED AT 80%, FOR A PARTICIPANT AND FOR HIS OR HER DEPENDENTS, IF APPLICABLE, THEN AT 100% WHEN ALL SUCH EXPENSES EXCEED $2,500 DURING THE SAME CALENDAR YEAR.

a) Expenses for **prescribed medicines** ordered by a physician or a dentist, sold by a licensed pharmacist or a duly authorized physician subject to the exclusions appearing hereafter. Medication includes the list of products published by the *Régie de l'assurance-maladie du Québec* or the list of medication by the *Association Québécoise des Pharmaciens Propriétaires* (The A.Q.P.P.), excepting medicines coded "V" or "Z".

   The following products are not covered:

   - products considered to be food substitutes, cosmetic substances, soaps, skin colour oils, epidermal emollients, shampoos and other substances for scalp treatment, excepting upon medical recommendation deemed to be satisfactory by the Insurer;

   - dietetic foods or substances;

   - homeopathic medicines;

   - any substance used for the purpose of insemination, contraceptive and prophylactic jellies and foams;

   - preventive vaccines;

   - injections administered within a weight loosing program;

   - non-prescription laxatives and stomach antacids, excepting upon medical recommendation deemed to be satisfactory by the Insurer;

   - medication or substances used for treating infertility or impotence;

   - medication administered primarily for preventive purposes;

   - anti-tobacco products (except those who appears on the list of product published by the Régie de l'assurance-maladie du Québec);

   - medication administered for esthetic purposes except if required following an accident.

Nothwithstanding any definition or exclusion stipulated hereunder, all medication that the group contract must cover in conformity with the Act respecting prescription drug insurance, is considered as being eligible.

For any new medications approved after January 1, 1997, the Insurer reserves the right, upon agreement with the committee, to :

- limit the refund thereof in accordance with criteria provided by regulation under the *Act respecting prescription drug insurance*, if such medication is listed as an exceptional medication under Section 60 of the Act;

- to exclude or establish refund criteria, if such medication is not listed in the said list.

b) In the event of an emergency or when medically required, expenses incurred for **ambulance** transportation (to and from hospital), including air or railway transportation.

c) Expenses incurred for the purchase or replacement of **artificial limbs, prosthetic appliances, trusses, special bandages (serious burns), corsets, crutches, splints, plaster casts, artificial eyes, elastic support stockings** with a 13 mm Hg compression rate and over (maximum of 4 pairs per calendar year), purchased following medical recommendation and required by the physical condition of the insured person.

d) Expenses incurred for the purchase, rental or replacement of **any supplies or equipment required by the physical condition** of the insured person, made by an orthotics or prothesis maker or some other professionnal specilized in the making of such equipment or supplies and prescribed by a physician (examples: compress dressings for burn victims, orthopedic prosthesis, knee brace, device for asthmatics).

e) Expenses incurred for the rental of **wheel chair, hospital bed** (basic model, excluding the mattress) and iron lung.

f) Expenses incurred for the following services given under medical surveillance or prescription and not otherwise refundable:

- **speech therapy;**
- **ergotherapy;**
- **oxygen treatments;**
- **audiology**;
- **laboratory tests including strips, syringes and needles in the case of diabetics**;
- **serums and injections**.

g) Expenses for the substance used in **sclerotic injections** if required for medical purposes up to an eligible maximum of $20 per treatment and a maximum of 10 treatments per calendar year per insured person.

h) The professional services of a **dentist** to repair accidental damage to natural teeth suffered following the beginning of the insurance and providing such services be rendered within 12 months following the date of the accident.

i) Expenses incurred for the purchase of **orthopedic shoes** designed and custom-made for a person, from a mold, for purposes of correcting a foot deficiency, and open, widened or straight shoes, as well as those needed for maintaining so-called Denis Browne braces; the cost of **orthopedic appliances and additions or modifications made to shoes** is also eligible. These equipments must be manufactured by a specialized orthopedic laboratory licensed under the Public Health Protection Act (R.S.Q., chap. P.35).

j) Expenses for an **eyesight examination** performed by an ophthalmologist or an optometrist, for insureds aged 18 to 64, up to a maximum refund of $40 per insured person, per period of 24 consecutive months.

2. Exclusions

The described products and services are excluded hereunder and no refund is made by the Insurer for expenses incurred at the time of the following events, subject to the provisions of the Act respecting prescription drug insurance:

- for the purchase of dental prostheses, eyeglasses, contact lenses or their adjustment;
- for the examination of hearing;
- for a periodic medical examination, or for a medical examination for employment purposes, for admission to an academic institution, for insurance purposes or for travelling for health purposes;
- due to voluntary mutilation in any state whatsoever;
- for esthetic surgery care other than those previously described;
- for a condition occurring while the insured person is on active duty in the armed forces;
- for care, services or supplies for which the insured person would not be required to pay in the absence of this plan;
- for expenses under any public or private, individual or group plan;
- due to any war whether or not declared, or active participation in a real insurrection;
- following participation by the insured person in a criminal act;
- in the event of hospitalization for extended care, lodging and living expenses in an extended care facility or any institution including, hospital centres, providing the same type of service (lodging) are not eligible for a refund;
- for any user fee, deductible or coinsurance required by any public plan for admissible products and services under this coverage;

- these exclusions also apply to the travel insurance coverage in addition to exclusions in the travel insurance description.

B - OPTIONAL SUPPLEMENTARY HEALTH INSURANCE (Option 1) (Optional participation with a 36-month minimal duration)

NOTE : Health care professionals must be members in good standing of their professional order or professional association, or must be recognized by the Committee and the Insurer. They must carry on their activities within the limits of their qualifications as stipulated in the law.

1. Eligible expenses

THE FOLLOWING ELIGIBLE EXPENSES INCURRED AFTER AN ACCIDENT, SICKNESS, PREGNANCY OR SURGERY RELATED TO FAMILY PLANNING ARE REFUNDED AT A RATE OF 80 %

a) The services of a **chiropractor**, for a maximum refund of $20 per day, only one treatment per day, up to a maximum refund of $400 per insured person, per calendar year.

   The initial examination performed by a chiropractor is eligible in the same way as a treatment is, it being understood that only one of these services provides entitlement to benefits if both are received during the same day.

b) The professional services of a **nurse or an authorized nurse's assistant**, for medical care dispensed at the home of the insured, excluding any person who ordinarily lives with the wage-earner or who belongs to his or her family, for a maximum refund of $200 per day up to a maximum refund of $4,000 per insured person per calendar year.

c) The professional services of a **physiotherapist or a therapist in physical rehabilitation** excluding any person who ordinarily lives with the wage-earner or who belongs to his or her family, for a maximum refund of $20 per day up to a maximum refund of $400 per insured person per calendar year, for all such specialists.

d) The professional services of a **homeopath, osteopath, naturopath, podiatrist or acupuncturist**, for a maximum refund of $20 per day up to a maximum refund of $400 per insured person per calendar year, per specialist.

e) The professional services of a **kinestherapist, orthotherapist, kinotherapist and massage therapist**, for a maximum refund of $20 per day up to a maximum refund of $400 per insured person per calendar year, for all such specialists.

f) Expenses incurred for x-rays required for treatment given by a specialist covered by the basic health insurance plan or by the optional plan I with a maximum refund of $40 per insured person per calendar year.

g) Expenses incurred for **ultrasounds and thermographies**, with the exclusion of ultrasounds on a fetus, subject to a maximum refund of $400 per insured person per calendar year if they are supported by a medical prescription.

THE FOLLOWING ELIGIBLE EXPENSES ARE REFUNDED AT A RATE OF 50 %

The services of a **psychologist, psychiatrist, psychoanalyst or a professional social worker**, are refunded up to a maximum refund of $500 per insured person, per calendar year **for all such specialists**. Services of psychiatrists will only be those rendered as psychoanalytic treatments and insofar as these professionals are members of the Canadian Psychoanalytic Society.

2. Exclusions

Exclusions to basic health insurance coverage also apply to the supplementary health insurance coverage.

C - OPTIONAL DENTAL CARE INSURANCE
(Option II)
(Optional participation with a 36-month minimal duration)

1. Eligible expenses

Eligible expenses are expenses that are reasonably incurred, recommended by a dentist and justified by the current practice of dental art, and whose cost does not exceed the rates in force at the time when the services are dispensed.

The following codes originate in the document entitled "2003 Fee Guide for Dental Treatment Services" approved by the Quebec Dental Surgeons Association. For subsequent years, these codes will be replaced by their equivalent in later documents approved by the Association. Any new code number for a dental act relating to expenses described hereafter, which is added during the contract period, is considered as eligible fee.

The insurer refunds 80 % of expenses for diagnostic, preventive, basic restorative and major restorative services as described hereafter, up to a refund of $1,000 per insured person per calendar year for all such expenses.

The Insurer refunds 80% of expenses for the removable appliances described hereafter following the extraction of teeth after the initial fitting of the appliance or providing that at least four (4) years have elapsed prior to

its replacement. These expenses are eligible up to a refund of $1,000 per insured person, per calendar year.

Description of diagnosis fees

Clinical oral examination :

a) complete oral examination, up to one examination per consecutive 9-month period (01110, 01120, 01130);

b) recall or periodic examination, up to one examination per consecutive 9-month period (01200);

c) dental examination for children under the age of 10, not payable under Quebec public health insurance plan (RAMQ), up to one examination per consecutive 12-month period (01250);

d) emergency examination (01300);

e) specific oral examination up to one examination per consecutive 9-month period (01400);

f) complete periodontal examination, up to one examination per consecutive 36-month period (01500).

Limitation: only one recall, periodic or complete oral examination per consecutive 9-month period is covered. Nonetheless, an examination performed by a specialist following a recommandation by a dental surgeon (eligible according to dental surgeon's rate schedule) is not subject to this limitation.

Radiographs :

a) intraoral radiographs;

i) periapical radiographs (02111 to 02116)
ii) occlusal film (02131, 02132)
iii) bitewing film (02141 to 02144)

b) extraoral radiographs;

i) extraoral film (02201,02202)
ii) sinus examination (02304)
iii) sialography (02400)
iv) radiopaque dyes (02430)
v) temporomandibular joint (02504)

vi) panoramic films (02600)
vii) cephalometrics films (02701, 02702)

c) interpretation of radiographs from another source (02800);

d) request for a duplicate of an X-ray or a file (02910);

e) hand and wrist X-rays as diagnostic aid for dental treatment (02915);

f) tomography (02920, 02929).

Limitation: a maximum of one radiograph sitting per consecutive 9-month will be refundable, excepting for a radiograph sitting performed during an emergency examination or performed during an examination by a specialist following a recommendation by a dental surgeon; furthermore, a complete series of periapical and bitewing films is only refundable once per consecutive 36-month period.

Laboratory tests and examination :

a) bacteriologic cultures for the determination of pathologic agents (04100);

b) bacteriologic cultures for the determination of dental caries susceptibility (04201);

c) biopsy of soft tissue or hard tissue (04302, 04311, 04312);

d) cytological tests (04401, 04402).

Diagnostic casts :

a) unmounted (04500);

b) mounted (04510, 04520);

c) diagnostic wax-up (04730).

Case presentation / treatment plan (05101);

Consultation (05200).

Description of preventive expenses

Polishing of coronal portion of teeth (prophylaxis) up to one treatment per consecutive 9-month period (11100, 11200, 11300);

Periodontal scaling up to one treatment per consecutive 9-month relating to all these dental procedures (43411 to 43414, 43417, 43419);

Topical application of fluoride up to one treatment per consecutive 9-month (12400);

Nutritional counselling (13100);

Oral hygiene instructions (13200, 13210);

Plaque control program (13220);

Finishing restorations (13300);

Pit and fissure sealants (13401, 13404);

Mouth guard (13510);

Tooth grinding :

a) interproximal discing of teeth (13700);

b) prophylactic odontotomy and/or enameloplasty (13710).

Space maintainers :

- band type (15108 to 15111, 15120);
- stainless steel crown type (15200, 15210);
- removable appliance (15400, 15410);
- acid etched bonded type (15420).

Description of basic restorative services

Restorations :

- primary teeth;
  - a) non-bonded amalgam, anteriors or posteriors (21101 to 21105)
  - b) bonded amalgam, anteriors or posteriors (21121 to 21125)
  - c) bonded composite anteriors (23311 to 23315)
  - d) bonded composite posteriors (23411 to 23415)

- permanent teeth ;

  a) non-bonded amalgam anteriors and bicuspids (21211 to 21215)

  b) non-bonded amalgam molars (21221 to 21225)

  c) bonded amalgam anteriors and bicuspids (21231 to 21235)

  d) bonded amalgam molars (21241 to 21245)

  e) bonded composite anteriors (23111 to 23115, 23118)

  f) veneer applications (anteriors and bicuspids) (23121 à 23123)

  g) bonded composite bicuspids (23211 to 23215)

  h) bonded composite molars (23221 to 23225)

- retentive pins (amalgam or composite) (21301 to 21304);

- restaurations, amalgam, composite, made to an existing partial denture clasp or rest (21501, 23701);

- gold foil (24101, 24102);

- inlays :

  a) metal (25100, 25200, 25300, 25500)

  b) porcelaine, resin or ceramic (25121 à 25123, 25521)

- retentive pins in inlays (25601 à 25604)

Oral surgery :

- removal of erupted teeth (uncomplicated) (71101, 71111);

- surgical removals ;

  a) erupted teeth (complex) (72100)

  b) impacted teeth (72210, 72220, 72230, 72240)

  c) residual roots (72300, 72310, 72320)

  d) removal of fragment(s) of a fractured tooth, per tooth (72350)

e) surgical exposure of teeth (72410 to 72412)

f) surgical movement of teeth (72430, 72440)

g) enucleation (72450)

- remodeling 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 bone tissue or soft tissue (75301, 75361);

- frenectomy (77801 to 77803);

- hemorrhage control (79400, 79401).

Adjunctive general services:

- local anesthesia (92110, 92120);
- general anesthesia (anesthetic cost only) (92201, 92202);
- conscious sedation by inhalation (92310, 92311);
- professional visits (94100, 94200, 94400).

Description of major restorative services

Endodontics :

- caries / trauma / pain control;
  a) sedative filling/indirect pulp capping (20111, 20121)
  b) smoothing of traumatized tooth (20131)
- endodontic emergency;
  a) pulpotomy (32201, 32202, 32210)
  b) open and drain (separate emergency procedure from root canal treatment)
     i) opening through natural tooth (39201, 39202)
     ii) opening through an metal or porcelain crown (39211, 39212)
  c) pulpectomy (separate emergency procedure from root canal treatment) (39901 to 39905)
  d) relieving traumatic occlusion (39970)
  e) reimplantation of avulsed tooth (39981)
  f) repositioning of traumatically displaced tooth (39985)
- preparation of tooth for treatment (39100, 39110, 39120);
- root canal therapy;
  a) root canal
     i) one canal (33100 to 33102, 33110 to 33112)
     ii) two canals (33200 to 33201, 33210 to 33212)
     iii) three canals (33300 to 33302, 33310 to 33312)
     iv) four canals (33400 to 33402, 33410 to 33412)

b) apexification

i) one canal (33521, 33531, 33541)
ii) two canals (33522, 33532, 33542)
iii) three canals (33523, 33533, 33543)

- periapical endodontic surgery;

a) apectomy as a separate procedure from the root canal (34101 to 34104)

b) apectomy and root canal performed in conjunction with endodontic treatment with or without retrofilling (34111, 34112, 34114, 34115)

c) apectomy and retrofilling (as a separate procedure from root canal) (34201 to 34203, 34212, 34215)

d) root amputation (34401, 34402)

e) intentional reimplantation (34451 to 34453)

f) hemisection (39230)

- bleaching of tooth, in office, up to an overall maximum of 10 sessions per calendar year per insured person 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 visits per calendar year per insured person for all teeth (41300);

- periodontal surgery;

a) periodontal curettage and root planing (42000, 42001)

b) gingivoplasty and/or gingivectomy (42003, 42010)

c) fibrotomy (42330, 42331)

d) flap approach with osteoplasty and/or ostoectomy (42100)

e) grafts

i) soft tissue (42200, 42300, 42560, 42561)

ii) osseous tissue (42611, 42700, 42711)

f) proximal Wedge (mesial or distal) (42400)

g) exploratory surgery, flap approach (42441)

h) postoperative visit for dressing change (42720)

- adjunctive periodontal procedures;

a) splinting or ligation, provisional (43200, 43211, 43212, 43260, 43280)

b) splint permanent (43290, 43295)

c) occlusal equilibration (43300, 43310)

d) periodontal appliances (appliance for bruxism) (43611, 43612, 43622, 43631)

e) intraoral appliance for temporo mandibular joint (occlusal guard) (43711, 43712, 43732, 43741)

f) periodontal irrigation, subgingival (49211)

g) intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents (49221, 49229)

Description of fees for removable prosthesis

Removable prosthodontics :

- complete denture;
  a) standard (51100, 51110, 51120)
  b) equilibrated (51201 to 51203)

- immediate complete denture (51300, 51310, 51320);

- immediate complete denture (transitional) (51600, 51610, 51620);

- complete denture, overdenture;
  a) standard (51701 à 51703)
  b) equilibrated (51711 à 51713)

- partial denture, acrylic (immediate, transitional or permanent) (52101 to 52103, 52120 to 52124, 52129, 52230 to 52232);

- partial denture cast (frame/connector of chrome-cobalt with cast and/or fashioned rests and clasps) (52400, 52410, 52420, 52500, 52510, 52520, 53131 to 53133, 53150, 53221 to 53223);

- complete denture with partial denture (opposing arch), chrome-cobalt, with or without free end base (52530, 52541);

- removable cast partial denture with precision attachments (52600, 52610, 52620);

- semi-precision cast partial denture (52601, 52611, 52630);

- hybrid partial dentures, cast (52701, 52702);

Denture adjustments:

- minor adjustments, provided that these adjustments be made more than 6 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:

- repairs of a complete denture without impression (55101 to 55104);

- repairs of a complete denture with impression (55201 to 55204);

- structure additions to the partial denture (55520, 55530);

- resetting of teeth (56602);

- vertical dimension recuperation by addition of acrylic to existing prosthesis (56631);

Denture cleaning and polishing (55700);

Duplicate of a denture (56100, 56101).

Rebasing and relining:

- reline removable 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 of a partial denture (using existing framework) (56411 to 56413).

Restrictions concerning removable prosthesis

- The replacement of a prosthesis or the addition of teeth to a removable or extensive fixed prosthesis will be refundable provided satisfactory evidence may establish :

  a) That the replacement or addition of teeth necessary following the removal of teeth after the initial insertion of the denture, or

  b) This denture has been inserted while the present additional dental care coverage was in force, that at least 4 years have gone by prior to the replacement.

Limitation to eligible fees

The following dental procedures are excluded from this coverage and the insurer makes no refund for them :

- Dental care that is free or charge or that the insured is not required to pay.

- Dental treatments for which the insured is entitled to a refund under the Act respecting industrial accidents and occupational diseases, the Quebec Automobile Insurance and occupational diseases, the Quebec Automobile Insurance Act or any other Canadian or foreign act having the same effect; dental treatments payable by a health insurance plan in which the insured participates.

Exclusions

No benefit is payable for dental care :

- To a third person;

- For esthetic surgery, including especially the transformation or extraction and the replacement of healthy teeth for purpose of modifying the appearance thereof;

- Due to a condition occuring while the insured person is on active duty in the armed forces.

D - OPTIONAL ACTIVE PARTICIPANT'S AND RETIREE'S LIFE INSURANCE (Option III) (Optional coverage)

1. ACTIVE PARTICIPANT

Participant's Basic Life Insurance

The basic amount of life insurance payable at the time of the death of the participant is equal to:

- one time his or her annual wages, rounded to the nearest $5, for a participant under age 65;

- 1/2 times his or her annual wages, rounded to the nearest $5, for a participant age 65 or over.

Participant's Additional Life Insurance

Note : Participation under this benefit depends on signing up for the basic life insurance coverage.

A participant may, at his or her discretion, choose an additional amount of life insurance equal to 1, 2 or 3 times his or her annual wages.

The product is rounded to the nearest $5.

This coverage is subject to evidence of insurability deemed satisfactory by the Insurer at the time of adhesion and the adding on of a new unit of additional life insurance for the participant.

This coverage does not apply if the employee dies due to suicide or due to any attempted suicide during the first year that follows the effective date of this coverage, of its reinstatement, or any increase in the amount of the coverage, whether or not said employee is of sound mind at the time of the suicide or attempted suicide. The insurance or the increase, as applicable, is null and void the liability of the Insurer is limited to the refund of collected premiums.

Participant's Accidental Death or Dismemberment Insurance

Note : Participation under this benefit depends on signing up for the basic life insurance coverage.

When a participant sustains one of the losses listed hereafter, and such loss occurs within 365 days of the accident, providing the participant is covered by this insurance on the date of the accident, the Insurer pays the percentage

of the annual wages indicated hereafter, without exceeding 100 % of the wages for all losses relating to the same accident. This percentage is reduced by one-half when a participant, reaches age 65.

Table of losses	Percentage of annual wages
- Loss of life	100 %
- Loss of both hands, both feet or sight in both eyes	100 %
- Loss of one hand and one foot	100 %
- Loss of one hand or one foot with the loss of sight in one eye	100 %
- Loss of one hand or one foot	50 %
- Loss of sight in one eye	50 %
- Loss of each finger	10 %

The word “loss” means, when involving a hand or a foot, the total and final loss of use; when involving sight, the total and irrecoverable loss of eyesight. In the event of a loss sustained by a disabled person, the coverage remains as established at the beginning of the disability. For insurance purposes, the disabled person is deemed to be a retiree as of his or her 65th birthday.

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

- while he or she carries out any of the duties of an airplane crew, except if he or she is required to do so as provided in his or her collective agreement and in his or her individual labour contract;

- due to a war, whether or not declared, or his or her participation in a real insurrection;

- due to attempted suicide or suicide of the insured, or an injury or mutilation that the participant voluntarily inflicted upon him or helfself, whether or not of sound mind;

- during participation in a criminal act, including the act of driving a motorized vehicle while having a blood alcohol level exceeding the legal limit;

- while the insured is on active duty in the armed forces;

- following a sickness or ailment not resulting from an accident and which becomes apparent at the time of an accident.

Spouse's or Dependent Child's Basic Life Insurance

Note : Participation under this benefit depends on signing up for the basic life insurance coverage.

In the event of death, the benefits are equal to:

- $2,500 in the case of an insured dependent child age 24 hours or more.

- $5,000 in the case of an insured spouse.

Spouse's Additional Life Insurance

Note : Participation under this benefit depends on signing up for the basic life insurance coverage.

A wage-earner may choose an additional amount varying from 1 to 10 $5,000 units on the life of his or her spouse. This coverage is subject to evidence of insurability deemed satisfactory by the Insurer at the time of adhesion and the adding on of a new unit of additional life insurance.

This coverage does not apply if the employee dies due to suicide or due to any attempted suicide during the first year that follows the effective date of this coverage, of its reinstatement, or any increase in the amount of the coverage, whether or not said employee is of sound mind at the time of the suicide or attempted suicide. The insurance or the increase, as applicable, is null and void and the liability of the Insurer is limited to the refund of collected premiums.

2 - RETIREE

Retiree's Life Insurance coverage

Beginning on the effective date of retirement, the participant continues to be insured without evidence of insurability, depending on his or her choice, with coverage extending from 1 to 10 units of $5,000, without however exceeding the amount held immediately before the date of his or her retirement, providing this is applied for with the Insurer during the 30-day period following the date of his or her retirement.

Nonetheless, for a participant working part time or on unpaid leave without participation, whose amount of coverage in force immediately before the date of his or her retirement is under $5,000, the said amount is deemed to be $5,000.

A retiree may eventually reduce the chosen insured amount, but he or she may not increase it. In addition, the participant may terminate the insurance, in which case he or she may not return to the optional life insurance plan thereafter.

An insured retiree who returns to work may keep his or her coverage as a retiree. In such a case, any new amount of life insurance for the retiree or his or her dependents to which he or she is entitled when once again ceasing to be active, is added to the insured amount that he or she already holds. The total of these amounts then constitutes one insured amount for the purposes of applying the maximums provided under the retirees' plan (retiree and dependents).

Retiree's Spouse or Dependents Basic Life Insurance

The participant may keep the coverage he or she held in the active plan for his or her spouse and dependent children, if applicable, providing he or she takes out for him or herself the retiree's life insurance coverage.

Applying for participation must take place at the same time for all coverages offered to retirees.

In the event of a death, the benefits are equal to:

- $2,500 in the case of an insured dependent child age 24 hours or more.

- $5,000 in the case of an insured spouse.

Retiree's Spouse Additional Life Insurance

The participant may keep in all or in part the additional life insurance coverage that he or she held on his or her spouse under the active plan, namely between 1 and 10 units of $5,000, providing that he or she takes out the retiree's life insurance coverage and the spouse's and dependent children's basic life insurance.

Same rates as for retirees, according to the participant's age and the spouse's gender. Applying for participation must take place at the same time for all coverages offered to retirees.

Early payment in the case of terminal phase illness
A person insured by one of the coverages under optional plan III whose life expectancy is 12 months at the most, may obtain the payment of an early benefit by presenting a written request to the Insurer, accompanied with appropriate medical evidence and the written acceptance of the beneficiary.

GENERAL INFORMATION

1. Definitions

"**Committee**"
The Intersectorial Parity Committee - Fédération des travailleurs et travailleuses du Québec (CPI - FTQ)

"**Disability of 48 months and less**"

a) **In the health and social services sector as well as the Société Immobilière du Québec (SIQ), the Corporation d'urgences-santé de la région de Montréal Métropolitain and the Musée du Québec,** by disability is meant a state of disability resulting either from sickness, including an accident or some complication during pregnancy, or from a tubal ligature, a vasectomy or similar cases related to family planning, the donation of an organ, requiring medical attention and which makes the wage-earning person totally incapable of carrying out the ordinary tasks of his or her employment or of any other equivalent employment offered to him or her by the employer and that pays similar remuneration.

b) **In the school board sector**, by disability is meant a state of disability resulting from sickness, including an accident but excluding a professional injury, requiring medical care as well as surgery related to family planning, such state of disability making the wage-earning person totally incapable of carrying out the ordinary tasks of his or her employment or any other equivalent employment offered to him or her by the employer and that pays similar remuneration.

c) **In the collegiate educational sector, for the Société de développement des entreprises culturelles (SODEC), for the Régie de l'énergie as well as the Société québécoise d'information juridique (SOQUIJ)**, by disability is meant a state of disability resulting from sickness or accident or resulting directly from some complication during pregnancy or interruption of pregnancy prior to the 20th week preceding the estimated date of birth, requiring medical care and that makes the wage-earning person totally incapable of carrying out the ordinary tasks of his or her position or any other equivalent position and paying similar wages that is offered to him or her by the employer. Disability also covers a disability resulting from a hospitalization for surgery or some medical act performed in the physician's office, related to family planning.

d) **For the Conseil des services essentiels (CSE)**, disability means a state of incapacity resulting from an illness, including an accident, a serious complication from pregnancy or surgery related directly to family planning, requiring medical care and that makes the wage-earner incapable of performing the ordinary duties of his or her employment or any other employment providing similar remuneration offered to him or her by the employer.

"**Disability for more than 48 months**"

By disability is meant a state which makes the person totally incapable of performing any gainful activity for which he or she is reasonably suited due to his or her education, training and experience.

The participant 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 practice medicine except in stationary cases in which the disability is recognized to the satisfaction of the Insurer. In the case of disability due to mental illness, the disabled participant must be in the care of a specialist in psychiatry except in stationary cases in which the disability is recognized to the satisfaction of the Insurer.

"**Insured person**"
A participant or one of his or her dependents insured under one of the plans.

"**Participant**"
A wage-earner or a retiree insured under the plan.

"**Period of disability**"

a) **In the health and social services sector as well as the Corporation d'urgences-santé de la région de Montréal Métropolitain :** During the first 36 months, a period of disability is any continuous period of disability or a series of successive periods separated by less than 15 effective full-time working days or of availability for full-time work, unless the wage-earning person establishes to the satisfaction of his or her employer or his or her representative that a subsequent period is due to sickness or accident completely foreign to the cause of the preceding disability.

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

b) **In the school board sector and for the Société Immobilière du Québec (SIQ) :** During the first 104 weeks, a period of disability is any continuous period of disability or a series of successive periods separated by less than 22 days (read 8 days instead of 22 days, if the continuous period of disability that precedes his or her return to work is equal to or less than 3 calendar months) of effective full-time work or of availability for full-time work unless the wage-earning person establishes to the satisfaction of his or her employer or his or her representative that a subsequent period is due to sickness or accident completely foreign to the cause of the preceding disability. After the 104th week, a period of disability is any continuous period that may be interrupted by less than 6

months of effective full-time work or of availability for full-time work, if it involves the same disability.

c) **In the collegiate educational sector, the Société de développement des entreprises culturelles (SODEC) as well as the Régie de l'énergie :** A period of disability is any continuous period of disability or a series of successive periods separated by less than 22 days (read 8 days instead of 22 days, if the continuous period of disability that precedes his or her return to work is more than 3 calendar months) of effective full-time work or of availability for full-time work unless the wage-earning person establishes to the satisfaction of his or her employer or his or her representative, that a subsequent period is due to sickness or accident completely foreign to the cause of the preceding disability.

d) **For the Conseil des services essentiels and the Musée du Québec :** a period of disability means any continuous period of disability or a series of successive periods separated by less than 15 days of effective work on a full-time basis or availability for full-time work, unless the wage-earner establishes for the satisfaction of the employer or its representative that a subsequent period is due to some illness or accident totally distinct from the cause of the preceding disability.

Despite the preceding paragraph, any period for which the wage earner must be absent from his or her work in order to undergo treatments prescribed by a physician and relative to some previous disability, is considered to be a part of the same disability, for this purpose, such a period may be counted on an hourly basis.

At the end of the 104th week, a disability period that may be interrupted by less than six (6) months of effective work on a full-time basis, if it involves the same disability.

e) **For the Société québécoise d'information juridique (SOQUIJ) :** Unless established by the participant to the employer's satisfaction that a subsequent period is attributable to an illness or accident completely foreign to the cause of the preceding disability, the disability period is :

- in the case where it is less than fifty-two (52) weeks, any continuous period of disability or any series of successive periods seprarated by less than fifteen (15) days of effective work on a full time basis or availability for full-time work.

- in the case where it is equal to or greater than fifty-two (52) weeks, any continuous period of disability or any series of successive periods separated by less than thirty (30) days of effective work on a full time basis or availability for full-time work.

Despite the preceding, any period for which the employee must be absent from his or her work in order to undergo treatments prescribed by a physician and related to some previous disability, is considered to be a part of the same disability. For this purpose, such a period may be counted on a hourly basis.

Note applying to all sectors
A period of disability resulting from sickness or injury that has voluntarily and personally been caused by the wage-earning person, alcoholism or substance abuse, active participation in a riot, an insurrection or criminal acts, or service in the armed forces is not recognized as a period of disability for the purposes of these presents. However, the period of disability resulting from alcoholism or substance abuse during which the wage-earning person receives treatment or medical care for rehabilitation purposes is recognized as a period of disability.

"**Dependent**"
The spouse or dependent child of a participant as defined hereafter.

- **Spouse**
  A person of the same gender or the opposite gender who, on the date of the event providing an entitlement to benefits :

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

  b) has been living as husband and wife with a participant for less than one year if he is the father or she is the mother of a participant's child, or

  c) has been living as husband and wife with a participant and had already lived as husband and wife with a participant for a full period of at least one year.

  The status of spouse is lost on the occurence 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 marriage.
  - De facto sepraration for at least 90 days in the case of a de facto union.
  - Dissolution of the union by a notarized act or by a court decision in the case of a civil union.

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

- **Dependent child**

The expression “dependent child” designates either of the following persons:

- a person under 18 years of age over whom the participant or his or her spouse exercises parental autority;

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

- a person of full age, without a spouse, who is domiciled with the participant and over whom the participant or his or her spouse would exercise parental authority if the dependent child were minor, an who is impaired by a total disability or a functional deficiency, referred to in a government regulation, that occured before 18 years of age.

- a person of full age, without a spouse, suffering from a functional deficiency as defined in the Regulation respecting the General prescription drug insurance plan and occurring before he or she has reached age 18, who does not receive any benefit under a last resort assistance plan provided under the *Act respecting income security*, who is domiciled in the participant’s home and upon whom the participant or his or her spouse would exercise parental authority if this person were a minor.

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.

In the collegiate educational sector, the Société de développement des entreprises culturelles (SODEC) as well as the Régie de l’énergie, a child of the participant, spouse or both, includes any child for whom adoption procedures have been initiated.

“Wages or salary”

a) **In the health and social services sector as well as the Corporation d’urgences-santé de la région de Montréal Métropolitain :** salary to scale, increased, if applicable, with longevity pay and regional disparities, as well as additional remuneration for continuing education provided under the declarations for nurses, but excluding payments for overtime and any lump-sum payment.

b) **In the collegiate educational sector :** the salary, increased by regional differential allowances, if applicable, but excluding payments for overtime.

c) **For the Société immobilière du Québec :** the wages are those to which the wage-earner is entitled for an ordinary working week including regional differential allowances (isolation, retention), excluding however any premium, allotment, additional remuneration, adjustment, etc.

d) **For the school board sector:** the level of earnings that he or she receives at work, also including allowances for regional disparities (isolated work, remote work and containment).

e) **For the Musée du Québec :** the level of earnings for the wage-earner is the hourly rate corresponding to his or her classification, excluding any lump-sum amount, increase in earnings, extra earnings, additional earnings, bonus, allowance, etc.

f) **For the Société de développement des entreprises culturelles (SODEC) :** the level of earnings, increased if appropriate, for the team leader bonus, and the availability allowance.

g) **For the Conseil des services essentiels :** the ordinary earnings of the wage-earner, excluding any bonus, lump-sum amount or additional remunerations.

h) **For the Régie de l'énergie as well as the Société québécoise d'information juridique (SOQUIJ) :** the salary set forth on pay scales with the exclusion of any bonus and additional remuneration.

"The Health and Social Services Sector

The Health and Social Services Sector encompasses all centres operated by public institutions within the meaning of the Act respecting health services and social services (R.S.Q., ch. S-4.2), private institutions party to an agreement within the meaning of this Act and any organization that provides services to a centre or to users in compliance with this Act and is declared by the government to be assimilated into an institution as set forth in the Act respecting health services and social services and represented by the employers groups. The Association des hôpitaux du Québec (AHQ), the Association des centres jeunesse du Québec, the Association des centres locaux de services communautaires et des centres d'hébergement et de soins de longue durée du Québec, the Association des établissements privés conventionnés du Québec, the Association des établissements de réadaptation de déficience intellectuelle, the Fédération québécoise des centres de réadaptation pour les personnes alcooliques et autres toxicomanes, the regional authorities for health and social services and the Institut national de santé publique du Québec.

2. Eligibility

2.1 Wage earner

a) **The health and social services sector as well as the Corporation d'urgences-santé de la région de Montréal Métropolitain**

i) Full-time wage earner or at 70 % of a full-time schedule:

· permanent employment : after 1 month of continuous service
· temporary employment : after 3 months of continuous service.

ii) Part-time wage earner, less than 70 % of a full time schedule : after 3 months of continuous service.

After 3 months of continuous service, the wage earner then comes under paragraph i) or ii) depending on the percentage of time worked in comparison with full time work during these three months untill the 1st of January immediately following.

b) **School board sector**

- Full-time wage-earner (70 % or more of an ordinary work week) and part-time wage-earner (less than 70 % of an ordinary work week) : when his or her work with the employer begins.

- Temporary wage earner having worked continuously at least 6 months since his or her hiring or within the the framework of 2 or more immediately continuous hirings: on the application of the 6 month time period.

- A wage-earner working with handicapped students partially or totally integrated into regular classes as well as wage-earners providing day care service (excluding occasional wage-earners) : beginning at the time he or she comes on duty.

- A wage-earner working exclusively within the framework of sessions of adult education courses : under conditions provided in the collective agreement.

c) **The collegiate educational sector as well as the Société de développement des entreprises culturelles (SODEC)**

- Regular wage-earner : eligibility takes place starting on the date of his or her hiring.

- Substitute or occasional wage-earner; eligibility takes place after 6 months of continuous service.

d) **Société immobilière du Québec as well as the Musée du Québec**

- Full-time wage-earner or at 70 % or more of a full-time schedule : after 1 month of continuous service.

- Wage-earner working at more than 25 % and less than 70 % of a full-time schedule : after 3 months of continuous service.

e) **Conseil des services essentiels**

- Eligibility takes place starting on the date of his or her hiring.

f) **Régie de l'énergie**

- Any wage earner is eligible after one month of continuous service.

g) **Société québécoise d'information juridique (SOQUIJ)**

- An employee whose ordinary workweek is more than 25 % of full time work is eligible after one (1) month of longevity.

2.2 Dependent

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

2.3 Retiree

Any wage-earner becomes eligible for the retirees' plan starting on the date of his or her retirement if he or she was covered in the actives' plan on such date.

3. Participation

3.1 Basic health insurance

Participation is compulsary for any wage earner eligible as well as for his or her dependents, if applicable, subject to a right of exemption.

Right of exemption

A wage earner may refuse or cease participation for him or herself and any dependents, if applicable, under this plan provided that they are insured under a group insurance plan with similar coverages.

The choice of the wage earner may also apply only to dependents and in such cases, the same provisions apply. Such a choice remains irreversible for as long as the wage earner and his or her dependents, if applicable, remain eligible under the other plan.

End of the right of exemption

A participant who has exempted him or herself from the basic health insurance plan for him or herself and dependents, if applicable, may reinstated provided he or she establishes th the Insurer's satisfaction :

i) that previously, he or she and the dependents, if applicable, were insured under this group insurance plan or any other plan granting similar coverages.

ii) that it has become impossible for him or her to be insured.

3.2 Optional plans

A) Supplemental health care insurance (option I) and dental care insurance (option II)

Participation is optional for each one of those plans with a minimum duration of 36 months for all participants and their dependents, if applicable, beginning on the effective date of their insurance. After this period, the participant may at any time cease participating in this plan by notifying his or her employer.

B) Active participant's and retiree's life insurance

1 - Active participant

Participant's basic life insurance

Participation is optional.

Participant's additional life insurance and accidental death and dismemberment insurance and basic life insurance for the participant's spouse and dependent child

Participation is optional for each of these coverages, but conditional to adhesion to the participant's basic life insurance.

Additional life insurance for the participant's spouse

Participation is optional but conditional to adhesion to the participant's basic life insurance and the spouse's or dependent child's basic life insurance.

2 - Retiree

Retiree's life insurance

Participation is optional. However, in the event of the retiree dies prior to the expiry of the 30 days period during which he or she is eligible, he or she is deemed to have adhered to this coverage while keeping the amount of life insurance that he or she held immediatly prior to his or her retirement, without exceeding the maximum amount of $50,000.

Basic life insurance for retiree's spouse and dependent child and additional life insurance for retiree's spouse

Participation is optional for each of these coverages, but conditional to adhesion to the retiree's life insurance.

Specific provisions for the health and social services sector as well as for the Corporation d'urgence-santé de la région de Montréal Métropolitain

Participation is optional for wage earners on a part-time basis who work 25 % or less than full time as follows :

After a period of 3 months of continuous service, the new part-time wage earner who works 25 % of less than full time may accept being covered under the optional plans. This acceptation must be dispatched in writing within 10 calendar days of the receipt of a written notice from the employer indicating the percentage of time worked during the 3-month period of continuous service.

On January 1st of each year, the wage earner whose time on the job has decreased to 25 % of a full-time basis or less during the period from November 1st to October 31st of the previous year, may cease being covered under the optional plans, except if he or she has not completed the 36 month period required in the case of optional plans I et II. This suspension must be notified by a written notice within 10 calendar days of the receipt of a written notice from the employer indicating the percentage of time worked during the preceding period.

A wage earner may not, however, be subjected to a downward revision if the reduction in her work time during the reference period is due to maternity leave.

A wage earner working 25 % or less than full time may on January 1st of each year decide to be covered, or not to be covered, or to cease being covered under the optional plans. The modification must notified by a written notice sent to the employer within the first ten days of the year. Nonetheless, participation under optional plans I and II may only be terminated after the minimum 36-month period of participation.

Any eligible wage earner who does not occupy a position and has not signed up for 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 for the first time a permanent part-time or full-time position.

3.3 Individual, single parent or family coverage

Basic health insurance

A participant's insurance entails the insuring of his or her dependents, if he or she has chosen to be insured with the spouse and dependent children (family coverage) or with dependent children (single parent coverage) by filling out an application within 30 days following the date on which the dependents become eligible.

Nonetheless, it is possible for a participant without any dependents, whose spouse is age 65 and over, to convert his or her family coverage to individuel coverage. A participant who makes such a choice cannot modify his or her coverage thereafter in order to cover the spouse.

Optional plans

A participant insured alone may choose to be insured with the spouse and dependent children (family coverage) or with dependent children (single parent coverage) once he or she acquires dependent children or once his or her dependent children cease being eligible for a group insurance plan providing similar benefits; the insurance of dependents takes effect at such time providing a new application is completed by the wage-earner and is received by the Insurer within the following 30 days.

If the application reaches the Insurer after the expiry of 30 days, the participant must provide to the satisfaction of the Insurer and at his or her own expense, evidence of insurability for his or her dependents. The insurance then takes effect on the acceptance date by the Insurer of the evidence of insurability.

Any wage-earner who has opted for the exemption entitlement under the basic health insurance plan may choose to be insured and to insure his or her dependents under the optional plans by filling out an application form within 30 days following the date on which such persons become eligible.

A participant cannot be insured for single parent or family coverage under the optional plans if he or she is insured for individual coverage under a basic health insurance plan. A participant insured under single parent or family coverage under the basic health insurance plan may, however, be insured for individual coverage under the optional plans.

The insurer may grant family or single-parent while excluding a member of the family following the examination of evidence of insurability.

In addition, (individual, single parent, family) participation under the optional plans must be the same.

Please note that single parent coverage is only offered to participants who do not have a spouse.

4. Evidence of insurability

Additional life insurance coverages for the participant and his or her spouse

All insured amounts of additional life insurance are subject to evidence of insurability.

The supplemental health care insurance plan (option I) and dental care insurance (option II) as well as basic life insurance and participant's accidental death or dismemberment insurance, basic life insurance for the participant's spouse and dependent children and life insurance for the retiree's spouse and dependent children

When the Insurer receives the application form more than 30 days after the eligibility date, the participant must, to the Insurer's satisfaction, furnish evidence of insurability for him or herself and any dependents.

In the event that any one of his or her plans or any coverage is cancelled, evidence of insurability must be furnished, to the Insurer's satisfaction, for a new application for insurance.

5. Effective date of insurance

5.1 Wage earner and dependents

Wage earner

Basic plan :
Any wage earner becomes insured on the date on which he or she becomes eligible.

Optional plans :
Any wage earner becomes insured on the date on which he or she becomes eligible, provided he or she is then at work or was so on the last day when he or she should ordinarily have been at work, otherwise the day of the return to work, provided he or she completes an application within 30 days of that date.

If the application is completed after this deadline, the wage earner becomes insured on the acceptance date of the evidence of insurability by the Insurer, provided the wage earner is at work or was so on the last day that he or she should have ordinarily been at work, otherwise on the day of his or her return to work.

Dependent

A dependent's insurance begins on the last of the following dates :

- the date on which he or she becomes eligible;
- the acceptance date of the evidence of insurability by the Insurer, if applicable;
- the date on which he or she ceases to be eligible under another contract provided the application is presented within 30 days of the termination of the insurance under the other contract.

5.2 Retiree and his or her dependents

Retiree

All retirees become insured on the date on which they become eligible provided they complete an application form within 30 days of that date.

Dependent

A dependent's insurance begins on the last of the following dates :

- the date on which he or she becomes eligible;
- the acceptance date of the evidence of insurability by the Insurer, if applicable.

6. Conversion Privilege

Basic health insurance - Complementary health insurance
Any participant who ceases to be insured under the terms of the basic plan because he or she ceases to be eligible, may within 31 days following the date of the termination of his or her eligibility obtain without evidence of insurability an individual insurance contract of the kind then issued by the

Insurer in such circumstances. Since this plan does not encompass reimbursements for medication provided under the General prescription drug insurance plan, any one who participates must register with the Régie de l'assurance maladie du Québec (RAMQ).

Dental care
Any participant under age 65 who ceases to be insured because he or she ceases to be eligible for some reason other than retirement, may within 31 days following the date of the termination of his or her eligibility obtain without evidence of insurability an individual insurance contract of the kind then issued by the Insurer in such circumstances.

Basic life insurance and participant's additional life insurance
When a participant ceases to be eligible for this coverage for some reason other than retirement, he or she is entitled, provided he or she so requests in writing from the Insurer within 31 days of the cessation of his or her eligibility, to convert without evidence of insurability all or part of this coverage into an individual whole-life or term insurance contract, without accessory coverage, of the kind then issued by the Insurer in such circumstances.

The maximum amount that the insured may convert is equal to the difference between the amount in force at the time of the termination of the insurance and any amount provided in another collective contract to which he or she has become eligible at the time of exercising his or her conversion privilege. Any military forces of any country cannot exercise this conversion privilege.

Basic life insurance for spouse and dependent's children and optional life insurance for spouse
When a spouse or dependent child of an active participant ceases to be eligible for this coverage due to the termination of the insured wage-earner's insurance following his death, termination of employment (for a reason other than retirement) or belonging to the group or due to the fact that the spouse or dependent child no longer satisfies the definition of dependent, such person is entitled, provided he or she so requests in writing from the head office of the Insurer within 31 days of the cessation of his or her eligibility, to convert without evidence of insurability this coverage into an individual whole-life or term insurance contract, without accessory coverage, of the kind then issued by the Insurer in such circumstances. The converted life insurance amount is equal to or less than the sum of the amounts of basic insurance and additional life insurance that he or she holds under this plan, less the amount of insurance provided under another group contract to which he or she has become eligible at the time of exercising his or her conversion entitlement.

7. Continuity of insurance in the event of work interruption

In the case of a **temporary absence without pay whose duration exceeds 30 days**, participation in the plans is suspended, with the exception of participation in the basic health insurance plan, and it is automatically reinstated without evidence of insurability upon return to active work with pay. The participant must then personally pay the total premium provided for the basic health insurance coverage, *except in the case of absences or unpaid leaves of absence for family or parental reasons provided under the Act respecting labour standards in which the employer is required to pay its contribution*. Nonetheless, the participant may opt for the possibility of maintaining his or her participation in force under the other plans in which he or she participates by personally paying the total requisite premium.

A participant who benefits from **partial leave of absence without pay as an extension of parental leave** remains eligible for plans as if he or she had not benefited from such leave of absence.

A participant who benefits from a **progressive retirement** as provided under his or her agreement must continue participating in the various plans. The premium as well as the amount of coverage are determined on the basis of the wages that he or she would receive if he or she had not participated in such a program.

A participant who participates in a **differed remuneration leave of absence** as provided under his or her agreement must continue participating in the basic health insurance plan. In addition, this participant may also continue participating in the other plans. The premium as well as the amount of coverage are determined on the basis of the wages that he would receive if he did not participate in such a program

Participation is maintained in the other cases of **temporary leave of absence with pay**. In parental leave of absence, participation is maintained and the amounts of coverage are determined in conformity with the prevailing situation prior to the beginning of the leave of absence.

When a participant is dismissed or suspended and challenges the **dismissal or suspension** by means of a grievance or recourse to arbitration under the collective agreement governing him or her, he or she must maintain participation in the basic health insurance plan by paying the premiums. He or she may also maintain participation in the other plans in which he or she participates by paying through the employer the total premium provided under the contract until the decision is handed down. In the case where the dismissed or suspended participant wins his or her case and he or she has not maintained participation in the other plans, his or her participation in these plans is reinstated on the date when the decision is made and the application of the provisions relating to these plans continues.

In the health care and social services sector as well as the Corporation d'urgences-santé de la région de Montréal Métropolitain, for a part-time wage-earner who maintains participation in the optional life insurance plan during temporary absence without pay, the premium is based upon a proportion of his or her wages established on a prorata basis of the paid time as compared with the paid time on the basis of full time over the 12 months preceding the beginning of the temporary absence or parental leave of absence for which no period covering disability, parental leave of absence or a leave of absence without pay has been authorized. The period over which the average time is calculated cannot, however, precede the participant's beginning at work. In this case, the calculations are made on the reduced period. If a condition of disability occurs during this period, the wage earner benefits from the entitlement to an exemption of the premium and if death occurs thereafter, the benefit payable is based upon the exempted insured amount.

In sectors other than those mentioned in the preceding paragraph, for a wage-earner who does not work on a full-time basis and who maintains participation in the optional life insurance plan during a temporary leave of absence without pay, the premium and benefits in the case of death are based, if applicable, upon the proportion of wages earned the day before his or her departure. If a condition of disability occurs during this period, the wage earner benefits from the entitlement to an exemption of the premium and if death occurs thereafter, the benefit payable is based upon the exempted insured amount.

In the case where a participant temporarily ceases to be at work following a **strike or lock out,** participation in the basic health insurance plan is maintained by payment of the premium for a 30-day period. Thereafter, participation in the basic health insurance plan remains in effect if the regular premiums are paid or if there is an agreement between the Insurer and the union part of the Committee. Moreover, insurance under other plans also remain in effect if the regular premiums are paid or if there is an agreement between the Insurer and the union part of the Committee, insofar as participation in the basic health insurance plan is maintained.

In the case of a **leave of absence without pay**, the amounts of life insurance are determined according to the situation prevailing prior to the beginning of the leave of absence.

8. Extension

Basic health insurance, complementary health and dental care coverage

Upon the death of a participant, the insurance of his or her dependents is extended without payment of premiums up to the nearest of the following dates :

- 12 months after the death of the participant;
- the date on which the dependent's insurance would have ended if the participant were still alive;
- the date of termination of the contract;
- the date indicated on the written notice from the Committee confirming the termination of the union affiliation of the group of wage earners of which the deceased participant was a member.

9. Waiver of premiums

For the participant

A - Beginning of exemption

In the case of disability, a partifcipant's insurance also covering dependents, if any, is kept in force without premium payments for as long as the disability last.

In the health and social services sector as well as the Corporation d'urgences-santé de la région de Montréal Métropolitain, beginning on :

- the 8th working day for full-time wage-earners; or

- the 5th working day for full-time wage-earners who work 4 days per week in a reduced time at work program; or,

- the 9.8th calendar day for part-time wage-earners;

For the Société québécoise d'information juridique (SOQUIJ), at the least beginning on the 8th working day, at the most beginning on the 9.5 working day.

In the other sectors, beginning on :

- the 8th working day.

  In these sectors, when a participant is the victim of an occupational injury and such injury is excluded from the definition of disability, the preceding paragraph applies when such participant is entitled to an income replacement indemnity from the C.S.S.T. In such a case, the waiver ceases by the latest on the consolidation date of the occupational injury.

In all sectors

Not consolidated occupational injury
When a participant is a victim of an occupational injury and he or she is unable to return to his or her employment and whose injury is still not

consolidated according to the attending physician, he or she benefits from the waiver of premium payment for a maximum period of one year starting from the end of the income replacement indemnities paid by the C.S.S.T.

Temporary assignment owing to a professional injury
When a participant is a victim of an occupational injury and is temporarily assigned to a task, he or she benefits from a waiver of premium for as long as such temporary assignment lasts.

Professional injury with entitlement to rehabilitation
When a participant is a victim of an occupational injury and is entitled to rehabilitation, as provided under section 145 et seq. of the Act respecting industrial accidents and occupational diseases, he or she benefits from the waiver of premium and his or her coverages are maintained in the following cases:

- the participant is searching for employment in the case of the rehabilitation program;
- the participant occupies an employment that is not his or her usual employment with his or her original employer;
- the participant occupies an employment with another employer.

Nonetheless, the waiver of premium terminates and its coverages end once the participant has completed 48 months of disability. In such a case, the participant who occupies an employment with his or her original employer, becomes eligible once more for the coverages that he or she had before such disability began.

Disciplinary action following the contesting of disability
A participant who is the subject of disciplinary action following the contesting of his or her disability, remains exempt from premium payments during the grievance proceedings for his or her participation in all coverages for as long as he or she has not returned to work.

Progressive return to work
When a person who is exempt from premium payments makes a progressive return to work, as provided under the collective agreement, such person remains exempt until he or she can perform all the duties relating to his or her position, without however exceeding the maximum period provided under the collective agreement.

B - Termination of the exemption entitlement

The exemption of the premium payment terminates at midnight, on the first 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 entitlement to long-term disability insurance benefits terminates;

- For the health insurance and dental care insurance plans :

  - the contract termination date or the date indicated on the written notice from the Committee confirming the termination of the union affiliation of the group of wage earners of which the disabled participant was a member.

  The exemption entitlement does not apply :
  - to a participant who benefits from a preventive withdrawal approved by CSST owing to pregnancy;
  - to the retiree's life insurance coverages, the retiree's spouse's and dependent children's life insurance and the additional life insurance of the retiree's spouse.

  IMPORTANT: In all cases, the participant is exempt beginning on the first full pay period following the date on which he or she becomes entitled to the waiver. At the end of the waiver, adjustments are made on the first full pay period following the date of the end of the waiver.

  For the employer
  The employer is only exempted from paying its share of the premium 2 years after the beginning of the disability.

10. Termination of insurance

Subject to the waiver of premiums in the event of disability, a participant's insurance terminates at 12 midnight on the first of the following dates :

- The date on which the contracts terminates or for each of the plans, their respective dates of termination;

- The date on which he or she ceases to meet the eligibility conditions;

- The date on which the participant leaves his or her employment, subject to the conversion privilege for life insurance and participation in the retirees' life insurance plan;

- The date on which the insurance begins, owing to the other group insurance plan, for a participant who terminates his or her insurance under the basic health insurance plan because he or she has taken advantage of his or her right of exemption;

- The date on which the Insurer receives the written notice from a participant who wishes to terminate his or her insurance under a plan or a benefit, other than the basic health insurance plan, or the date of termination on such a notice, whichever comes after, subject to the obligation to maintain insurance 36 months in the cases of optional plans I and II;

- The date indicated on the Committee's written notice confirming the termination of the union affiliation of the group of wage earners of which the participant was a member.

Dependents' insurance terminates at 12 midnight on the first of the following dates:

- The participant's insurance termination date subject to the extension provided for the basic and optional plans I and II;

- The date on which he or she ceases to be a dependent;

- The date on which the Insurer receives the written notice from a participant who wishes to be insured alone subject to the obligation to cover dependents under the basic plan and the obligation to maintain insurance 36 months in the cases of optional plans I and II;

- The date on which the insurance begins, owing to the other group insurance plan, for dependents who terminate their insurance under the basic health insurance plan because they have taken advantage of the right of exemption.

11. Dependent child age 18 to 25 inclusively

To continue being insured, a dependent child age 18 to 25 inclusively must be a full-time student in a recognized educational institution. As a result, should the participant fail to send evidence of attendance to the Insurer, a dependent child who reaches age 18 ceases to be automatically insured on the date when he or she reaches age 18. This evidence must be produced each semester.

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

The rates for participant's and spouse's additional life insurance are provided for the "smoker" and "non-smoker" categories. The eligibility criteria for the second category is not to have smoked cigarets during the past year. Any person who changes his or her smoking habits after the statement of insurability, **must inform the Insurer in writing within 30 days following such change.**

13. Procedure for making a claim

Coordination of benefits
If an insured is entitled to similar benefits under an individual or group contract underwritten by an insurer, benefits payable under the various health insurance and dental care plans are reduced by the benefits payable under any other contract.

Health Insurance :
Medication : Automated deferred payment service
For purchasing medication, the insured person presents his or her group insurance certificate bearing the user number to the pharmacist. The claim is forwarded automatically to the Insurer. However, the insured person must pay in its entirety the cost of medication he or she purchases. La Capitale will then issue the participant a refund upon the occurrence of the first of the following : an accumulation of $75 of expenses claimed or after a 14-day period.

Other fees
The adherent must send to the head office of the Insurer a duly completed, dated and signed notice of claim form. It is important that instructions on the form be followed closely and that all original receipts and official vouchers for expenses being claimed be carefully attached thereto.

Please keep all your copies of receipts and vouchers since the originals will not be returned to you. As for hospitalization expenses, the insured presents his or her certificate to the hospital which, in turn, will file the claim directly with Insurer. It is necessary to mention the group number, the employer number and the insured's identification number.

When making claims for care from professionals such as physiotherapists, psychologists or others, an official receipt must be filed with the Insurer.

This receipt may be the reverse side of our claims form and in such a case, the professional's stamp or seal must be affixed to it as well as his or her signature, licence number and the exact dates of the treatments along with the name of the person to whom the treatments were given. Professionals' computerized receipts and personalized receipts are also accepted insofar as the previous information is provided therein.

You must make your claim within the 12 months following the date expenses were incurred. It is suggested that claims be updated every three months.

Dental Care Insurance
The notice of claim form includes 2 parts : the first one must be filled out by the dentist and the second one by the insured. When the 2 parts are filled out, the insured must return the form to the Insurer. You must make your claim within the 12 months following the date expenses were incurred.

Direct deposit of health and dental care benefits
If you have signed up for this service, upon acceptance of your claim for benefits, the latter will be deposited in your account. A statement will be issued to you, confirming the amount deposited and the processing date of your claim.

Life Insurance
It is the beneficiaries responsibility to claim the insured amount by contacting the Insurer who then will send appropriate forms to the beneficiary.

Early payment in the case of terminal phase illness
A person insured under this plan whose life expectancy is a maximum of 12 months, may obtain the payment of an early benefit by presenting a written request to the Insurer, accompanied with appropriate medical evidence and the written acceptance of the beneficiary.

The sum of the amounts paid is limited to 25% of the insured's (basic and additional) life insurance, without exceeding $50,000. The amount of life insurance used to calculate the benefit excludes any amount or fraction of amount ending in accordance with the provisions of the contract during the 24 months following the date of the request and that cannot be replaced by some other coverage. After the date of payment, the premium, if applicable, continues to be calculated on the full amount of insurance as if there had not been an early payment. Upon the death of the insured, the amount payable by the Insurer is reduced from the amount paid as an early benefit and interest accrues at an annual rate of 6 %. The Insurer does not assume any liability regarding taxation formalities resulting from the benefit. Moreover, this advantage ceases upon the termination of the contract, even for participants whose premiums have been waived.

TRAVEL INSURANCE COVERAGE

La Capitale will refund ordinary and reasonable expenses and services described hereafter if incurred following an emergency situation resulting from an accident or illness occurring while the insured person is temporarily outside his or her province of residence and providing the insured person is covered by the Health Insurance Board of his or her province of residence.

Benefits are granted over and above and not as a replacement for benefits provided under government programs. The maximum amount granted is limited to a $5,000,000 lifetime refund per insured person.

ELIGIBLE EXPENSES

Hospital, medical and paramedical expenses
- Hospitalization expenses for a semi-private or private room in excess of that which is refunded or refundable by the Health Insurance Board of the insured's province of residence.

- Out-of-pocket expenses (telephone, television, parking, etc.) owing to hospitalization upon presentation of vouchers up to a maximum of $100 per hospitalization.
- 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 Health Insurance plan of the insured's province of residence.
- The cost of medication obtained by prescription from a physician in an emergency treatment situation.
- Nurses' fees for a licensed nurse for private nursing care dispensed exclusively at the hospital, when medically required and prescribed by the attending physician up to a maximum refund of $3,000. The nurse must not be a member of the insured's family, nor be a travelling companion.
- 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.
- Professional fees of a dental surgeon for accidental injury to natural teeth due to an accident occurring outside the insured's province of residence up to a maximum refund of $1,000 per accident; insured expenses must be claimed within 12 months following the accident.

Transportation expenses

- 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.
- Repatriation expenses for the insured person 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.
- 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.
- When the insured's state 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 person 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.
- The insurer takes necessary steps to ensure the return of children under age fifteen accompanying the insured to their residence if, following an accident or illness incurred by the insured, he or she or another accompanying adult is unable to take care of this matter.
- Whenever an insured is unable to drive his or her vehicle following illness or an accident occurring during the trip and no other passenger is able to drive the said vehicle, the Assistor pays the expenses incurred by a commercial agency for the return of the insured's personal vehicle or of a rental vehicle to his or her residence or to the nearest appropriate rental agency, subject to a maximum refund of $1,000.
- In the event that the insured person dies, the Assistor organizes and pays expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing no close relative aged 18 years or over has accompanied the insured person on the trip. The maximum refund is $1,500.
- In the event that the insured person 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.

Subsistence allowances
- Expenses for lodging and meals in a commercial establishment, when the insured must postpone his or her return owing 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.

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 in a notorious state of political instability thereby making any intervention by the Assistor physically impossible.

- Cash advances for expenses covered under the travel insurance. Thereafter, the Assistor files a claim for the reimbursement of expenses incurred with the Health Insurance Board of the insured's province of residence and with the Insurer.
- 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 or clinic.
- Subject to these presents 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.

- The Assistor takes charge of transmitting urgent messages when the insured is personally incapable of transmitting them.
- 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.
- Upon presentation of vouchers, the Assistor refunds the insured for telephone call expenses and other communication expenses incurred by the insured in order to gain access to such services in case of difficulty abroad.
- 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.
- The Assistor offers to an insured in distress abroad, the service of multi-lingual interpreters.
- In the event of legal proceedings or following a traffic accident, a highway code offence or any other civil offence, the Assistor provides assistance by referring the names of lawyers. This service is only applicable in Canada and the United States.

Obligations of the Insured Person

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

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.

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

SUBROGATION: For purposes of the present coverage and for any moneys advanced or refunded by the Assistor, the insured assigns and subrogates the Assistor in all of his or her rights and recourses to any refund from which he or she benefits or claims to benefit 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.

Exclusions and Reduction of Coverage

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

- When the loss occurs in the province of residence of the insured person.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.
- If there was failure in contacting the Assistor as soon as possible in the event of medical or hospitalization consultation following a sudden accident or illness When expenses are caused by pregnancy and complications resulting therefrom within 12 weeks preceding the estimated date of birth.
- When the loss is due to any medical condition for which the insured has been hospitalized, for which he or she has received medical treatment or for whom medical treatment has been prescribed or for which he or she has consulted a physician within 90 days preceding the departure date, except if it is proven to the satisfaction of the Insurer that the insured's condition is stabilized. A change regarding medication, its dosage or its use is considered as being a medical treatment (1).

  (1) In such case, the insured must contact the insurer at least 7 days prior the departure to inform the latter of his or her medical condition.

- When the loss is related to any known condition of the insured and subject to periods of sudden aggravation which cannot be controlled by medication or any other means.
- When the expenses incurred outside the insured's province of residence could have been incurred in his or her province of residence, without endangering the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from a sudden accident or illness. The mere fact that the care given in the province of residence may be of lesser quality than that which may be received outside such province does not constitute, within the meaning of this exclusion, a danger for the insured's life or health.
- When hospitalization expenses are incurred in hospitals 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 thermal spas.
- For surgery or optional or non-urgent treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip is taken upon the recommendation of a physician.
- For an accident occurring during the insured's participation in a sport for consideration, in any kind of speed contest, in flying a glider or deltaplane, mountain climbing, parachuting whether or not in free fall, bungy jumping or any other dangerous activity. Activities other than the aforementioned

ones that are offered to the general public in resort areas are not considered dangerous, such as down-hill skiing and scuba diving.
- Following the voluntary abusive absorption of medication or drugs and the ensuing conditions.
- When the loss occurs in a country at war, whether or not declared, experiencing notorious political instability, 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.
- Owing to an injury or mutilation that the insured voluntarily inflicted upon him or herself, whether or not of sound mind.
- For care and services administered by a member of the insured's family or by a someone who resides with the insured.
- For a condition occurring while the insured is on active duty with the armed forces.
- Owing to war, whether or not declared, or active participation in an insurrection, whether real or apprehended.
- For a condition occurring during participation in an offence, whether criminal or deemed to be such.
- Furthermore, the exclusion extends to expenses payable under any other individual or group plan, plus expenses for which the insured is entitled to an indemnity under the Act respecting industrial accidents and occupational diseases, the Québec Automobile Insurance Act, the Québec Hospital Insurance Act, the Québec Health Insurance Act or any other Canadian or foreign statute having the same effect.
- The Insurer may at any time and at its sole discretion change the Assistor for the purposes of this coverage.

IN AN EMERGENCY

Please note that the information appearing on your insurance certificate are necessary whenever you wish to contact the Assistor's services whose numbers appear hereafter:

- **In Canada and the United States : 1-800-363-9050**
- **Worldwide by calling collect : 1-514-985-2281**

TRAVEL CANCELLATION INSURANCE

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

Definitions

Activity of a commercial nature : Meeting, congress, convention, exhibition, show or seminar, of a professional or commercial nature, such activity must be public, under the responsibility of an official organization and in compliance with the laws, regulations and policies in effect in the region in which the activity is scheduled to be held, and which is the only reason for the planned trip.

Business associate : The person with whom the insured is associated in business within a company having 4 co-shareholders or less, or a partnership for profit-making purposes made up of 4 associates or less.

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

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

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

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.

Trip : A trip for tourism or recreational purposes or an activity of a commercial nature entailing an absence of the insured from his or her place of residence for a period of at least 72 consecutive hours and requiring travel of at least

400 kilometers (round trip) from his or her place of residence; a cruise with a planned duration of at least 72 hours under the responsibility of an accredited firm is also considered to be a trip.

RESTRICTION: Trips for purposes of fishing or hunting are excluded.

1. Causes of cancellation or interruption

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

- An illness or accident preventing the insured or close family member, his or her travelling companion or close family member, or his business associate from performing his or her ordinary activities and which is reasonably serious to justify the cancellation or interruption of the trip.
- The death of the insured, his or her spouse, child or spouse's child, travelling companion or business associate.
- The death of an insured's close family member other than his or her spouse or child or a close family member of the travelling companion if the funeral takes place during the planned period of the trip or during the 14 days preceding it.
- The death or emergency hospitalization of the host at destination.
- The ordering of the insured or his or her travelling companion to report for jury duty or their subpoenaing to appear as a witness in a case to be heard during the period of the trip, providing that the person in cause is not a party to the litigation and has taken necessary steps for having the hearing postponed.
- The putting of the insured or his or her travelling companion into quarantine, except if such quarantine ends more than 7 days prior to the planned date of departure.
- The skyjacking of the airplane in which the insured is travelling.
- A loss making uninhabitable the main residence of the insured, that of his or her travelling companion or that 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.
- The transferring of the insured or his or her travelling companion, for the same employer, 100 or more kilometers from his or her present domicile, if required within 30 days preceding the planned departure date.
- 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.
- A departure missed owing to a delay in the means of transportation used for getting to the departure point, 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 kilometers. The cause for the delay must be atmospheric conditions,

mechanical difficulties (except for a private automobile), a traffic accident or the emergency closing of a road, each of the last two causes must be backed up by a police report.
- 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.
- 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 canceling the activity is issued by the official organization in charge of organizing it.

2. Covered Expenses

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

- In the event of cancellation prior to departure:
  a) the non-refundable portion of the expenses paid in advance;
  b) 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 must make the cancellation;
  c) the non-refundable portion of the travel expenses paid in advance, up to 70% of the said expenses, if the departure of the insured is delayed owing to atmospheric conditions and that he or she decides not to make the trip.

- 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.

- If the return is advanced or delayed:
  a) if the supplemental cost of a regular ticket in economy class by the most direct route for the return to the point of departure by the initially planned carrier, or if the latter cannot be used, the expenses required in economy class by a regularly scheduled public carrier for the most economical means by the most direct route for the return to the planned point of departure; these expenses must be agreed to in advance 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 in-patient for more than 48 hours within the said 7 day period.

b) The unused and non-refundable portion of the land part of travel expenses paid in advance.

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 :

- If the trip is undertaken with the intention of receiving medical treatment or hospitalization services, whether the trip has been recommended or not by a physician.
- If the trip has been 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.
- A war, whether or not declared, or the active participation in a real or apprehended insurrection.
- The active participation of the insured or his or her travelling companion in a criminal act or one deemed to be so.
- Pregnancy or complications resulting therefrom in the twelve weeks preceding the expected date of birth.
- 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.
- The voluntary and abusive absorption of medication, drugs or alcohol and the ensuing conditions.
- The participation in a sport for consideration, in any form of competition involving motor vehicles or any contest involving speed, gliding or hang-gliding, mountain climbing, parachute jumping whether or not in free-fall, bungee jumping or any other dangerous activity.
- 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 person in cause has stabilized at the time the expenses have been incurred. A change regarding medication, dosage or its use is considered to be a medical treatment.
- When the loss is related to any known condition of the insured or his or her traveliling companion and is subject to periods of sudden aggravation which cannot be controlled by medication or otherwise.
- For trips for purposes of fishing or hunting.

4. Deadline for requesting cancellation

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

5. Coordination

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

FOR COMPLETE INFORMATION

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TRAVEL INSURANCE

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In Canada and the United States : 1 800 363-9050
Worlwide by calling collect : (514) 985-2281