La Capitale
Insurance and
Financial Services

Taking care of what counts

GROUP INSURANCE PLAN
Contract 6000 – FTQ

La Capitale
Insurance and
Financial Services

(Insurer)

FTQ

Intersectorial Parity Committee FTQ
(Policyholder)

GROUP INSURANCE PLAN
Contract 6000 – FTQ

offered to employees
represented by

Union des employés et employées de service
SECTION LOCALE 800

CUPE Canadian Union of Public Employees

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

SEPB QUÉBEC

Plan modified on January 1, 2008

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

— **HEALTH AND SOCIAL SERVICES SECTOR**

Canadian Union of Public Employees (CUPE)

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

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

— **ELEMENTARY AND HIGH SCHOOL EDUCATION SECTOR**

Canadian Union of Public Employees (CUPE)

Service Employees Union (UES-800)

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

— **COLLEGE EDUCATION SECTOR**

Canadian Union of Public Employees (CUPE)

— **ORGANIZATIONS**

SOCIÉTÉ IMMOBILIÈRE DU QUÉBEC (SIQ)

SOCIÉTÉ DE DÉVELOPPEMENT DES ENTREPRISES CULTURELLES (SODEC)

LA CORPORATION D'URGENCES-SANTÉ

CONSEIL DES SERVICES ESSENTIELS

MUSÉE NATIONAL DES BEAUX-ARTS DU QUÉBEC

SOCIÉTÉ QUÉBÉCOISE D'INFORMATION JURIDIQUE (SOQUIJ)

LA FÉDÉRATION DES COMMISSIONS SCOLAIRES DU QUÉBEC (FCSQ)

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

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

WORKING IN ESTABLISHMENTS REPRESENTED BY :

— **HEALTH AND SOCIAL SERVICES SECTOR**

Ministère de la Santé et des Services sociaux (MSSS)

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

Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanes (FQCRPAT)

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

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

Fédération québécoise des centres de réadaptation en déficience intellectuelle (FQCRDI)

Association des centres jeunesse du Québec (ACJQ)

Health and social services agencies

— **ELEMENTARY, HIGH SCHOOL AND COLLEGE EDUCATION SECTORS**

Ministère de l'Éducation, du Loisir et du Sport (MELS)

La Fédération des commissions scolaires du Québec (FCSQ)

Quebec English School Board Association (QESBA)

Fédération des cégeps

OR FOR THE FOLLOWING ORGANIZATIONS :

– SOCIÉTÉ IMMOBILIÈRE DU QUÉBEC (SIQ)
– SOCIÉTÉ DE DÉVELOPPEMENT DES ENTREPRISES CULTURELLES (SODEC)
– LA CORPORATION D'URGENCES-SANTÉ
– CONSEIL DES SERVICES ESSENTIELS
– MUSÉE NATIONAL DES BEAUX-ARTS DU QUÉBEC
– SOCIÉTÉ QUÉBÉCOISE D'INFORMATION JURIDIQUE (SOQUIJ)
– LA FÉDÉRATION DES COMMISSIONS SCOLAIRES DU QUÉBEC (FCSQ)
– INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC (INSPQ)
– RÉGIE DE L'ÉNERGIE

YOUR GROUP INSURANCE PLAN

IMPORTANT

The policyholder may, at any time following an agreement with the Insurer, make modifications to the contract concerning the classes of persons eligible, scope of coverages, and the sharing of costs between classes of insured persons, Any such changes may then be applied to all insureds, whether they be active, disabled or retired.

This document does not mention all the clauses relating to the definitions, eligibility, enrolment, termination of insurance and other miscellaneous provisions. Nonetheless, you may learn more about the contents by consulting the administrative guide available from your employer or obtain a copy of the policy by contacting the local union representative.

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

TABLE OF CONTENTS

Insurer: La Capitale Civil Service Insurer Inc.
Contract administrator: La Capitale Insurance and Financial Services Inc.

INSURANCE PLANS

Schedule of Insurance

The following tables present a summary of the coverage provided under the group insurance plans offered to active participants and retirees, as well as a summary of benefits payable under Contract 6000. For a complete description of the plans, please see the related pages.

ACTIVE PARTICIPANT	
Basic Health Insurance Plan (page 11) (Mandatory)	
Hospitalization	100%, semi-private room
Travel insurance and trip cancellation insurance	100%
Prescription drugs and oher expenses	80% of the first $2,500 in eligible expenses and 100% of the remainder
Electronic claims payment	Deferred
Additional Health Insurance Plan (Option I) (page 15) (Optional participation for a minimum of 36 months)	
Psychologist, psychiatrist, psychoanalyst and social worker	50%, maximums apply.
Other health professionals, ultrasounds, radiography and thermography	80%, maximums apply.
Dental Care Insurance Plan (Option II) (page 17) (Optional participation for a minimum of 36 months)	
Diagnostic, preventive, basic restorative and major restorative services	80%, up to a maximum reimbursement of $1,000 per calendar year per insured
Removable prosthesis	80%, up to a maximum reimbursement of $1,000 per calendar year per insured, 1 replacement every period of 4 consecutive years
Electronic claims payment	Direct

ACTIVE PARTICIPANT (cont'd)

Life Insurance Plan (Option III) (page 24)
(Optional participation)

Participant's Basic Life Insurance	Under age 65: 1 time the annual salary or wages Over age 65: 1/2 times annual salary or wages
Participant's Accidental Death and Dismemberment Insurance	Under age 65: 1 time the annual salary or wages Over age 65: 1/2 times annual salary or wages
Participant's Optional Life Insurance	1 to 5 times annual salary or wages
Participant's Spouse's/Dependent Children's Basic Life Insurance	$5,000/$2,500
Participant's Spouse's Optional Life Insurance	1 to 20 units of $5,000

This plan covers accelerated payment of benefits in the event of terminal illness.

RETIRED PARTICIPANT

Individual Health Insurance – 3995 Series
(Optional participation)

A participant who retires and is not eliglbe for another group health insurance plan (covering reimbursement of medication expenses) must register with the Régie de l'assurance maladie du Québec (RAMQ).

The participant can also take out an individual health insurance policy – 3995 series to obtain the following coverage, among others: hospitalization, medications not reimbursed by the Régie de l'assurance maladie du Québec, health professionals, travel insurance and trip cancellation insurance.

A **brief** description of the policy can be found in the booklet:
INDIVIDUAL HEALTH INSURANCE – 3995 SERIES.

Life Insurance Plan (Option III) (page 26)
(Optional participation)

Retiree's Basic Life Insurance	1 to 20 units of $5,000, up to the amount held prior to retirement
Retiree's Spouse's/Dependent Children's Basic Life Insurance	$5,000/$2,500
Retiree's Spouse's Optional Life Insurance	1 to 20 units of $5,000, up to the amount held prior to retirement

This plan covers accelerated payment of benefits in the event of terminal illness.

Upon retirement, the participant may retain the group life insurance plan and sign up for the Individual Health Insurance Plan – 3995 Series. He or she must previously have the life and health insurance plans and file an application within 30 days following his or her retirement.

BASIC HEALTH INSURANCE PLAN

Mandatory participation

Eligible expenses are expenses reasonably incurred justified by the seriousness of the case and current medical practice, incurred by an insured person as the result of an accident, sickness, pregnancy or surgery related to family planning.

1. The following expenses are reimbursed at 100%:

a) Hospital expenses

Hospital expenses incurred in Canada in excess of what is payable by any state insurance plan, up to the cost of semi-private accommodations for each day of hospitalization, at the rates in effect in the province in which they are incurred, without a limit on the number of days.

b) Glucometer, reflectometer or dextrometer

The costs incurred for the rental, purchase or repair of a glucometer, reflectometer or dextrometer, up to a maximum reimbursement of $250 per period of 60 consecutive months, per insured, on presentation of a full report from the attending physician attesting that the insured is insulin-dependent and his or her condition requires the use of this type of device.

c) Hearing aid or aural prosthesis

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

d) Withdrawal treatment

In the event of withdrawal treatment related to alcoholism or substance abuse, with the exclusion of treatment related to the use of tobacco, eligible expenses are provided for a stay in an officially recognized treatment facility, subject to a maximum refund of $40/day and $1000 per calendar year per insured.

e) IUCDs

Expenses for the purchase of an intrauterine contraceptive device (IUCD), up to an eligible maximum of $100 per period of 24 consecutive months, per insured.

f) Travel Insurance

A complete description of this coverage appears on page 45 of the booklet. Maximums apply.

g) Trip Cancellation Insurance

A complete description of this coverage appears on page 49 of the booklet. Maximums apply.

2. The following expenses are reimbursed at 80% for the participant and his or her dependents, if any, then at 100% when the total of such expenses exceeds $2,500 in the course of a single calendar year:

a) Expenses for **medication prescribed** by a physician or dentist, sold by a licensed pharmacist or by a duly authorized physician, subject to the exclusions that appear below. Medication means the products that appear on the Régie de l'assurance maladie du Québec (RAMQ) drug list or the Association québécoise des pharmaciens propriétaires (AQPP) list of medications, except for medications coded "V" or "Z".

The following products are not considered to be medications:

– Products considered to be food substitutes, cosmetic products, soaps, tanning oils, skin emollients, shampoos and other products for scalp treatment, except on a medical recommendation that the Insurer deems to be satisfactory.

– Dietetic foods or substances.

– Homeopathic medicines.

– Substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams.

– Preventive vaccines.

– Injections administered within a weight loss program.

– Non-prescription laxatives and stomach antacids, except on a medical recommendation the Insurer deems satisfactory.

– Medication or substances used to treat impotence.

– Medications administered primarily for preventive purposes.

– Anti-tobacco products (unless they appear on the RAMQ list).

– Medications administered for cosmetic purposes, unless required due to an accident.

Notwithstanding any definition or exclusion stipulated hereunder, all medications that the group contract must cover in conformity with the Act respecting prescription drug insurance are considered to be eligible.

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

– Limit the refund therefore in accordance with the criteria set out in the regulation for the Act respecting prescription drug insurance, if it is listed as an exceptional medication to the list under Section 60 of the Act.

– Exclude it or establish refund criteria if it does not appear on the list.

b) In the event of an emergency or where medically required, transportation by **ambulance** (to and from hospital), including air or rail transportation.

c) Costs to purchase or replace **artificial limbs, prostheses, trusses, special bandages (major burns), corsets, crutches, splints, plaster casts, artificial eyes, support hose** with compression of 13 mm Hg or higher (maximum of 4 pairs per calendar year), incurred on medical advice and required by the insured's physical condition.

d) Costs to purchase, rent or replace any **supplies or equipment required by the insured's physical condition**, made by an orthotics or prosthesis maker or other professional that specializes in making this type of equipment or supplies and prescribed by a physician (for example: compression garment for burn victims, foot orthoses, knee brace, device for asthmatics).

e) Rental or purchase costs, if the latter is less expensive, for a **wheelchair**, **hospital bed** (excluding mattress) and **breathing apparatus**.

f) Expenses incurred for the following supplies and services rendered under medical supervision and not otherwise reimbursable:

- **Speech therapy**
- **Occupational therapy**
- **Oxygen therapy**
- **Audiology**
- **Laboratory tests**
- **Strips, syringes and needles for diabetes**
- **Sera and injections**

g) Expenses for the substance used for **sclerosing injections** if the treatment is medically necessary, subject to an eligible maximum of $20 per treatment and 10 treatments per calendar year, per insured.

h) The professional services of a **dentist**, to repair accidental damage to natural teeth occuring after insurance comes into effect, provided that services are rendered within 12 months following the date of the accident.

i) Costs to purchase **orthopaedic shoes** designed and custom-made for a person from a mold for the purpose of correcting a foot deficiency, open shoes, in-flare or out-flare shoes, as well as shoes required for use with Denis Browne braces. The cost of **orthopaedic appliances** and **additions or modifications to shoes** is also eligible. The equipment must be manufactured by a specialized orthopaedic laboratory licensed under the Public Health Protection Act (R.S.Q., Chapter P.35).

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

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

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

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

– Expenses for accommodation incurred at a commercial establishment, up to an eligible amount of $60 per day, provided that the consultation or treatment requires an overnight stay.

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

If the participant has an Individual plan, eligible expenses must be incurred for the participant and apply explicitly to him or her.

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

The plan allows for the presence of a person accompanying the insured, if justified by the situation.

The expenses reimbursed are the expenses in excess of those reimbursed by the Régie de l'assurance maladie du Québec (RAMQ).

3. Exclusions

Subject to the provisions of Quebec's Act respecting prescription drug insurance, no benefits are payable for expenses incurred:

– To purchase dental prostheses, eyeglasses, contact lenses or adjustments thereto.

– For hearing examinations .

– For periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or health trips.

– Due to voluntary mutilation, in any state whatsoever.

– For cosmetic surgery other than surgery described above.

– Due to any condition arising while the insured is on active duty with the armed forces.

– For care, services or supplies that the insured is not required to pay for.

– For expenses payable under any individual or group, public or private plan.

– In a country that is at war, whether declared or undeclared, in a state of known political instability or for which the Government of Canada has issued a warning that Canadians should not travel in that country, insofar as the expenses are related to the conflict situation in the country and were incurred after the warning was issued, or by reason of active participation in a real or apprehended insurrection.

– Subsequent to the insured's participation in a criminal act.

– In the event of hospitalization for extended care. Expenses for a stay in a reception centre, including hospital centres providing the same type of service (accommodation) or any other establishment are not eligible for reimbursement.

– Any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this benefit.

These exclusions also apply to the Travel Insurance benefit and are in addition to the coverage that appears in the description of the latter.

OPTIONAL ADDITIONAL HEALTH INSURANCE PLAN – Option I

Optional participation for a minimum of 36 months

Eligible expenses are expenses reasonably incurred justified by the seriousness of the case and current medical practice, incurred by an insured person as the result of an accident, sickness, pregnancy or surgery related to family planning.

NOTE: The health professionals must be members in good standing of their professional order or a professional association or recognized by the Committee and the Insurer. They must practice within the limits of their competence within the meaning of the law.

1. The following expenses are reimbursed at 80%:

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

The initial examination performed by the chiropractor is eligible in the same capacity as a treatment; however, only one of these two services provides entitlement to benefits if both are received on the same day.

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

c) The professional services of a **physiotherapist** or **physical rehabilitation therapist**, up to a maximum refund of $20 per treatment and $400 per calendar year per insured, for all such specialists. Only one treatment per day, per the same insured, is eligible for reimbursement.

d) The professional services of a **homeopath**, **osteopath**, **naturopath**, **acupuncturist** or **deititian**, for a maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, per specialist. Only one treatment per day per specialist, per the same insured, is eligible for benefits.

e) The professional services of a **podiatrist** or **foot care nurse**, up to a maximum refund of $20 per treatment and $400 per calendar year per insured, for all such specialists. Only one treatment per day, per the same insured, is eligible for reimbursement.

f) The professional services of a **kinesitherapist**, **orthotherapist**, **kinotherapist**, or **massage therapist**, for a maximum reimbursement of $20 per treatment and $400 per calendar year, per insured, for all such specialists. Only one treatment per day per specialist, per the same insured, is eligible for benefits.

g) Fees for **radiography** required for the treatment provided by a specialist covered by the Basic Health Insurance plan or Option I plan up to a maximum reimbursement of $40 per calendar year, per insured.

h) Expenses for **ultrasonography** and **thermography**, except for fetal ultrasonography, up to a maximum reimbursement of $400 per calendar year per insured, if incurred due to a medical prescription.

2. The following expenses are reimbursed at 50%:

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

3. Exclusions

The exclusions listed in the Basic Health Insurance plan also apply to the Additional Health Insurance plan.

OPTIONAL DENTAL CARE INSURANCE PLAN – Option II

Optional participation for a minimum of 36 months

Eligible expenses under this benefit are expenses that are reasonably incurred and recommended by a dentist, up to the amount of the fees specified in the fee guide of the Quebec association of dental surgeons (ACDQ) in effect in the year before the time at which services were rendered.

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

The Insurer reimburses 80% of expenses for dentures. These expenses are eligible up to a maximum reimbursement of $1,000 per calendar year per insured. *See restrictions page 23.*

The codes used in the description originate in the 2003 fee guide of the Quebec association of dental surgeons (ACDQ). For subsequent years, the codes are replaced by their equivalent in later Association documents. Any new code number for a dental act that is added during the contract period that affects the expenses described below is automatically recognized.

1. Eligible expenses

Description of diagnostic fees

– Clinical oral examination

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

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

  c) Dental examination for dependent children under age 10, if not covered under the Quebec public health insurance plan, up to one examination per period of 12 consecutive months (01250)

  d) Emergency examination (01300)

  e) Specific oral examination, up to a maximum of one examination per period of 9 consecutive months (01400)

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

Limitation: Only one recall, specific, periodic or complete oral examination per period of 9 consecutive months is covered. However, an examination performed by a specialist on the recommendation of a dental surgeon (eligible under the dental surgeon's fees) is not subject to this limitation.

– Radiographs

  a) Intraoral radiographs:

    i) Periapical radiograph (02111 to 02116)

    ii) Occlusal radiograph (02131, 02132)

    iii) Bitewing radiograph (02141 to 02144)

  b) Extraoral radiographs

    i) Extraoral film (02201, 02202)

    ii) Sinus examination (02304)

    iii) Sialography (02400)

    iv) Radiopaque dyes (02340)

v) Temporomandipular joint (02504)

vi) Panoramic film (02600)

vii) Cephalometric film (02701, 02702)

c) Interpretation of radiographs from another source (02800)

d) Request of a duplicate of an X-ray or file (02910)

e) Hand and wrist X-rays as a diagnostic aid for dental treatment (02915)

f) Tomography (02920, 02929)

Limitation: A maximum of one X-ray session will be reimbursable per period of 9 consecutive months, with the exception of X-rays taken during an emergency exam or during an examination performed by a specialist as a result of a recommendation from a dental - surgeon. Moreover, the complete series of periapical and bitewing films shall only be reimbursable once per period of 36 consecutive months.

– Laboratory tests and examinations

  a) Bacteriological culture to identify pathological agents (04100)

  b) Bacteriological culture to determine susceptibility to cavities (04201)

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

  d) Cytology tests (04401, 04402)

– Diagnostic casts

  a) Unmounted (04500)

  b) Mounted (04510, 04520)

  c) Diagnostic wax-up (04730)

– Presentation of case/treatment plan (05101)

– Consultation (05200)

Description of preventive expenses

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

– Periodontal scaling, up to one treatment per period of 9 consecutive months for all related dental procedures (43411 to 43414, 43417, 43419)

– Topical fluoride application, up to one treatment per period of 9 consecutive months (12400)

– Nutritional counselling (13100)

– Oral hygiene counselling (13200, 13210)

– Plaque control program (13220)

– Finishing of restoration (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

  a) Band type (15108 to 15111, 15120)

  b) Stainless steel crown type (15200, 15210)

c) Removable appliance (15400, 15410)
d) Acid etched bonded type (15420)

Description of basic restorative services

RESTORATION:

- Primary teeth
  a) Non-bonded amalgam, anterior or posterior (21101 to 21105)
  b) Bonded amalgam, anterior or posterior (21121 to 21125)
  c) Bonded composite anterior (23311 to 23315)
  d) Bonded composite posterior (23411 to 23415)
- Permanent teeth
  a) Non-bonded amalgam, anterior and premolar (21211 to 21215)
  b) Non-bonded amalgam molar (21221 to 21225)
  c) Bonded amalgam, anterior and premolar (21231 to 21235)
  d) Bonded amalgam molar (21241 to 21245)
  e) Bonded composite anterior (23111 to 23115, 23118)
  f) Veneer (anterior and premolar) (23121 to 23123)
  g) Bonded composite premolar (23211 to 23215)
  h) Bonded composite molar (23221 to 23225)
- Retentive pins (amalgam or composite (21301 to 21304)
- Surcharge for a restoration (amalgam or composite) to an existing partial denture clasp (21501, 23701)
- Gold foil (24101, 24102)
- Inlays
  a) Metal (25100, 25200, 25300, 25500)
  b) Porcelain, resin or ceramic (25121 to 25123, 25521)
- Retentive pins in the inlay (25601 to 25604)

ORAL SURGERY

- Removal of erupted teeth (uncomplicated) (71101, 71111)
- Surgical removals
  a) Erupted tooth (complex) (72100)
  b) Impacted tooth (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 to 72440)
  g) Enucleation of a tooth (72450)
- Remodelling and recontouring of oral tissues
  a) Alveolectomy (73020)
  b) Alveoloplasty (73100, 72110)
  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 tumour (74108, 74109)

b) Removal and curettage of intra-osseous 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)

– Hemmorrhage control (79400, 79401)

GENERAL ADDITIONAL SERVICES

– Local anaesthesia (92110, 92120)

– General anaesthesia (anaesthetic cost only) (92201, 92202)

– Conscious sedation by inhalation (92310, 92311)

– Professional visits (94100, 94200, 94400)

Description of fees for major restorative services

ENDODONTICS

– Caries/trauma/pain control

a) Sedative filling/indirect pulp capping (20111, 20121)

b) Smoothing and polishing 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 a 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 therapy

i) One canal (33100 to 33102, 33110 to 33112)

ii) Two canals (33200 to 33202, 33210 to 33212)

iii) Three canals (33300 to 33302, 33310 to 33312)

iv) Four canals (33400 to 33402, 33410 to 33412)

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 (separate procedure from the root canal) (34101 to 34104)

b) Apectomy and root canal performed together with or without retrofilling (34111, 34112, 34114, 34115)

c) Apicoectomy 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, subject to an overall maximum of 10 sessions per calendar year, per insured, for all teeth

a) Non vital teeth (39410)

b) Vital teeth, in office (97101, 97102)

PERIODONTICS

– Management of acute infections and other oral legions (41200)

– Desensitization, subject to an overall maximum of 10 applications per calendar year per insured for all teeth (41300)

– Peridontal 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) Graft

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, temporary (43200, 43211, 43212, 43260, 43280)

b) Permanent splint (43290, 43295)

c) Occlusal equilibration (43300, 43320)

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 prostheses

REMOVABLE PROSTHESIS

- Complete prosthesis
  a) Standard (51100, 51110, 51120)
  b) Equilibrated (51201 to 51203)
- Immediate full prosthesis (51300, 51310, 51320)
- Immediate complete prosthesis (transitional) (51600, 51610, 51620)
- Complete hybrid prosthesis
  a) Standard (51701 to 51703)
  b) Equilibrated (51711 to 51713)
- Partial acrylic prosthesis (immediate, transitional or permanent) (52101 to 52103, 52120 to 52124, 52129, 52230 à 52232)
- Partial denture cast, frame/connector of chrome-cobalt, cast and/or fashioned rests and clamps (52400, 52410, 52420, 52500, 52510, 52520, 53131 to 53133, 53150, 53221 to 53223)
- Complete prosthesis with partiable removable prosthesis on opposing arch, cast, chrome-cobalt, with or without free base (52530, 52541)
- Removable cast partial prosthesis with precision attachments (52600, 52610, 52620)
- Semi-precision cast partial prosthesis (52601, 52611, 52630)
- Hybrid partial prosthesis, cast (52701, 52702)

PROSTHESIS ADJUSTMENT

- Minor adjustments, provided that adjustments are made more than 6 months after the initial insertion of the prosthesis (54250, 54251)
- Remount and equilibration of complete or partial prosthesis (54300 to 54302)

COMPLETE OR PARTIAL PROSTHESIS REPAIR

- Repair of a complete prosthesis without impression (55101 to 55104)
- Repair of a complete prosthesis with impression (55201 to 55204)
- Structure additions to a partial prosthesis (55520, 55530)
- Resetting of teeth in a prosthesis (56602)
- Vertical dimension recuperation by addition of acrylic to existing prosthesis (56631)

PROSTHESIS CLEANING AND POLISHING (55700)

DUPLICATE OF A PROSTHESIS (56100, 56101)

REBASING AND RELINING

- Relining of a complete or partial prosthesis (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 PROSTHESIS (using existing metal structure or frame) (56411 to 56413)

Restrictions concerning removable prostheses

– Any replacement of a prosthesis or addition of teeth to a removable prosthesis is reimbursable as long as satisfactory proof is provided that:

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

  b) at least 4 years have elapsed since the prosthesis was initially inserted.

Limitations on eligible expenses

The Insurer provides no reimbursement for the following dental procedures:

– Dental care provided free of charge or for which the insured does not have to pay.

– Dental care for which the insured is entitled to compensation under the Workers' Compensation Act, the Automobile Insurance Act or any other Canadian or foreign law to this effect.

– Dental care that is payable by a health insurance plan in which the insured has enrolled.

2. Exclusions

No benefits are payable for dental care expenses incurred:

– For a third party.

– During cosmetic surgery, including the transformation, extraction or replacement of healthy teeth in order to change their appearance.

– Any condition occurring while the insured is on active duty with the armed forces.

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

Optional participation

1. Active participants

a) Participant's Basic Life Insurance

The basic life insurance amount payable on the participant's death is equal to:

– 1 times his or her annual earnings, rounded to the nearest multiple of $5, for a participant under age 65.

– ½ his or her annual earnings, rounded to the nearest multiple of $5, for a participant age 65 and over.

b) Participant's Optional Life Insurance

NOTE: Participation in the coverage is conditional on participation in Basic Life Insurance coverage.

The participant may choose an additional amount of life insurance coverage equal to 1 to 5 times his or her annual salary, at his or her discretion. The product is rounded to the nearest $5.

This coverage is subject to evidence of insurability that is deemed satisfactory by the Insurer at the time of enrolment or the addition of a new unit of life insurance.

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

c) Participant's Accidental Death and Dismemberment Insurance

NOTE: Participation in the coverage is conditional on participation in Basic Life Insurance coverage.

When the 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 annual salary indicated hereafter, without exceeding 100% of salary for all losses related to the same accident. This percentage is cut in half when the participant reaches age 65.

TABLE OF LOSSES	PERCENTAGE OF ANNUAL SALARY
– Loss of life	100%
– Loss of both hands or both feet or loss of sight in both eyes	100%
– Loss of one hand and one foot	100%
– Loss of a hand or a 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, for a hand, foot or finger, total and irrecoverable loss of use; with respect to eyesight, it means the total, definitive and irrecoverable loss of eyesight. In the event of a loss sustained by a disabled person, the percentage of annual salary remains that established at the beginning of the disability. For insurance purposes, a disabled person is deemed to be a retiree as of his or her 65th birthday.

This coverage does not apply if the loss was sustained in the following circumstances:

– While carrying out any of the duties of an airplane crew, except as required in the course of his or her duties as stipulated in the collective agreement or individual labour contract.

– Due to a war, whether declared or undeclared, or active participation in an insurrection.

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

– Due to the insured's participation in a criminal act, including operating a motor vehicle with a blood alcohol level in excess of the prescribed legal limit.

– While the participant is on active duty with the armed forces.

– Subsequent to an illness or affliction that does not result from an accident and becomes apparent at the time of an accident.

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

NOTE: Participation in the coverage is conditional on the participant's participation in Basic Life Insurance coverage.

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

– $2,500 for an insured dependent child age 24 hours or older.

– $5,000 for the insured spouse.

e) Participant's Spouse's Optional Life Insurance

NOTE: Participation in the coverage is conditional on the spouse's or dependent child's participation in Basic Life Insurance coverage.

The participant may choose an additional amount ranging from 1 to 20 units of $5,000 on the life of his or her spouse. This coverage is subject to evidence of insurability that is deemed satisfactory by the Insurer at the time of enrolment or the addition of a new unit of life insurance.

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

2. Retired participants

a) Retiree's Basic Life Insurance

As of the date of retirement, the participant continues to be insured without evidence of insurability for an amount of up to 20 units of $5,000, at the participant's discretion, but no more than the amount held as an active participant, as long as the participant makes the application to the Insurer within 30 days following the retirement date.

However, for a part-time participant or participant on unpaid leave without maintaining participation, for whom the amount of coverage in effect immediately prior to the retirement date is less than $5,000, said amount is deemed to be equal to $5,000.

The participant may eventually reduce the amount of insurance chosen , but cannot increase it. Moreover, the participant can terminate coverage at any time, in which case he or she will no longer be able to participate.

A retired participant who returns to work can retain the coverage amount held as a retiree. In such case, any new amount of life insurance for the participant or his or her dependents to which the participant is entitled when he or she once again retires is added to the insurance amount he or she already has. The total of such amounts forms a single insurance amount for the purposes of applying the maximums stipulated under this coverage (retiree and dependents).

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

The retired participant may keep the coverage he or she held in the active participant's plan for his or her spouse and dependent children, if applicable, provided that he or she takes out Retiree's Basic Life Insurance coverage.

Enrolment must occur at the same time for all life insurance coverage offered to the retiree.

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

– $2,500 for an insured dependent child age 24 hours or older.

– $5,000 for the insured spouse.

c) Retiree's Spouse's Optional Life Insurance

The retired participant may keep some or all of the Optional Life Insurance coverage that he or she held on his or her spouse in the active participant's plan, i.e. from 1 to 20 units of $5,000, provided that he or she takes out Retiree's Basic Life Insurance coverage and Spouse's and Dependent Children's Basic Life Insurance coverage.

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

Enrolment must occur at the same time for all life insurance coverage offered to the retiree.

3. Accelerated benefit payment in the event of terminal illness

A person who is insured under life insurance plan coverage and whose life expectancy is no more than 12 months can obtain accelerated payment of a benefit by submitting a written request to the Insurer, along with the appropriate medical evidence and the beneficiary's written acceptance.

GENERAL INFORMATION

1. Definitions

a) Committee

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

b) Disability of 48 months or less

- **In the health and social services sector and for the Institut national de santé publique**, disability means a state of disability that results either from sickness, including an accident or complication resulting from pregnancy, tubal ligation, vasectomy or similar cases relating to family planning, from donation of an organ or bone marrow requiring medical attention which makes the wage-earner totally incapable of carrying out the ordinary tasks of his or her employment, or any equivalent employment offered by the employer that pays similar remuneration.
- **For the Société Immobilière du Québec (SIQ), Corporation d'urgences-santé, and Musée national des beaux-arts du Québec**, disability means a state of disability that results either from sickness, including an accident or complication resulting from pregnancy, tubal ligation, vasectomy or similar cases relating to family planning, from donation of an organ or bone marrow requiring medical attention which makes the wage-earner totally incapable of carrying out the ordinary tasks of his or her employment, or any equivalent employment offered by the employer that pays similar remuneration.
- **In the school board sector**, disability means a state of disability resulting from sickness, including an accident but excluding an employment injury, requiring medical care or surgery related to family planning, such state of disability rendering the wage-earner totally incapable of carrying out the ordinary tasks of his or her employment or any equivalent employment offered by the employer with similar remuneration.
- **In the college education sector, for the Société de développement des entreprises culturelles (SODEC), Régie de l'énergie and the Société québécoise d'information juridique (SOQUIJ)**, disability means a state of disability resulting from sickness or an accident, or complication resulting directly from a pregnancy or interruption of pregnancy prior to the 20th week preceding the estimated date of birth, requiring medical care that makes the wage-earner totally incapable of carrying out the ordinary tasks of his or her position or any equivalent position offered by the employer that pays similar remuneration. Disability also covers a disability resulting from hospitalization for surgery or a medical intervention in a doctor's office that is related to family planning.
- **For the Conseil des services essentiels**, disability means a state of incapacity resulting from an illness, including an accident, a serious complication of pregnancy or surgery directly related to family planning, requiring medical care, which renders the wage-earner incapable of carrying out the normal functions of his or her job or any other employment offered by the employer with similar remuneration.

c) Disability longer than 48 months

Disability means a state of incapacity which renders the person completely incapable of performing any gainful occupation for which he or she is reasonably suited given 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 where the disability is recognized to the Insurer's satisfaction. In the event of a disability due to mental illness, the disabled participant must be under the care of a psychiatric specialist, except in the event of stationary cases where the disability is recognized to the Insurer's satisfaction.

d) Participant

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

e) Disability period

– **In the health and social services sector, and for the Institut national de santé publique,**

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

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

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

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

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

– **For the Corporation d'urgences santé**

For the first 36 months, a period of disability is any continuous period of disability or series of successive periods of disability separated by less than 15 days of effective full-time work or availability for full-time work, unless the the wage-earner establishes to the satisfaction of his or her employer or their representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

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

– **For the school board sector**

During the first 104 weeks, a period of disability is any contiuous period of disability or series of successive periods separated by less than 40 days (read 8 days instead of 40 days if the continuous period of disability that precedes the return to work is greater than 3 calendar months) of effective full-time work or availability for full-time work unless the wage-earner establishes to the satisfaction of the employer or his or her representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

At the end of the 104th week, a period of disability is any continuous period of disability which may be interrupted by less than six months of effective full-time work or availability for full-time work, if the same disability is involved.

– **For the Société immobilière du Québec (SiQ)**

During the first 104 weeks, a period of disability is any continuous period of disability or 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 the return to work is greater than 3 calendar months) of effective full-time work or availability for full-time work unless the wage-earner establishes to the satisfaction of the employer or his or her representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

At the end of the 104th week, a period of disability is any continuous period of disability which may be interrupted by less than six months of effective full-time work or availability for full-time work, if the same disability is involved.

– **In the college education sector**

A period of disability is any continuous period of disability or series of successive periods separated by less than 8 days (read 32 days instead of 8 days if the continuous period of disability that precedes the return to work is greater than 3 months) of effective full-time work or availability for full-time work unless the wage-earner establishes to the satisfaction of the employer or his or her representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

– **For the Société de développement des enterprises culturelles (SODECO and the Régie de l'énergie**

A period of disability is any continuous period of disability or 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 the return to work is greater than 3 months) of effective full-time work or availability for full-time work unless the wage-earner establishes to the satisfaction of the College or his or her representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

– **For the Conseil des services essentiels and the Musée national des beaux-arts du Québec**

A period of disability is any continuous period of disability or series of successive periods of disability separated by less than 15 days of effective full-time work or availability for full-time work, unless the wage-earner establishes to the satisfaction of his or her employer or their representative that a subsequent period is due to an illness or accident that is completely unrelated to the previous cause of disability.

Notwithstanding the previous paragraph, any period for which the wage-earner must be absent from work to undergo treatment prescribed by a physician that is related to a previous disability is considered to be part of the same disability. To this end, such a period cannot be recorded on an hourly basis.

At the end of the 104th week, a period of disability is any continuous period of disability which may be interrupted by less than 6 months of effective full-time work or availability for full-time work, if the same disability is involved.

– **For the Société québécoise d'information juridique (SOQUIJ)**

Unless the participant establishes to the employer's satisfaction that a subsequent period is due to an illness or accident that is completely unrelated to the cause of the previous disability, a period of disability is:

- If it is less than 52 weeks, any period of continuous disability or series of successive periods of disability separated by less than 15 days of effective full-time work or availability for full-time work.
- If it is 52 or more weeks, any period of continuous disability or series of successive periods of disability separated by less than 30 days of effective full-time work or availability for full-time work.

Notwithstanding the foregoing, any period for which the employee must be absent from work to undergo treatment prescribed by a physician that is related to a previous disability is considered to be part of the same disability. To this end, such a period cannot be recorded on an hourly basis.

NOTE FOR ALL SECTORS

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

f) Insured

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

g) Dependent

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

– **Spouse**

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

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

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

c) has been living as husband or wife with the participant for at least a year.

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

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

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

– **Dependent child**

Refers to any of the following persons:

- A person under 18 years of age over whom the participant or spouse exercises parental authority.
- A person age 25 or under who has no spouse, attends a recognized educational institution as a duly registered full-time student, and over whom the participant or spouse would exercise parental authority if a minor.
- A person of full age, without a spouse, domiciled with the participant, over whom the participant or spouse would exercise parental authority if he or she were a minor, impaired by a total disability or functional deficiency listed in a government regulation that occurred prior to the age of 18.
- A person of full age, without a spouse, impaired by a functional deficiency defined in the Regulation respecting the Basic Prescription Drug Insurance Plan that occurred before he or she reached 18, who receives no benefits under a last resort assistance plan provided under the Act respecting income security, who is domiciled in the participant's home and over whom the participant or spouse would exercise parental authority if the person was a minor.

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

In the school board sector, college education sector, for the Société de développement des enterprises culturelles (SODEC) and the Régie de l'énergie, the child of the spouse, participant, or both includes a child for whom legal adoption proceedings have been undertaken.

h) Wages or salary

– **In the health and social services sector and Corporation d'urgences-santé**

Salary to scale increased, if applicable, by longevity pay and regional differentials, including the additional remuneration for continuing education stipulated under the special provisions for nurses, but excluding payments for overtime and any lump-sum payments.

– **In the college education sector**

Salary increased by regional differential allowances, if applicable, but excluding payments for overtime.

– **For the Société immobilière du Québec (SIQ)**

Salary for a regular work week including regional differential allowances (isolation, retention), except for any bonus, allowance, additional remuneration, adjustment, etc.

– **For the school board sector**

The salary rate including regional differential allowances (isolation, remoteness, retention).

– **For the Musée national des beaux-arts du Québec**

The hourly rate according to classification, excluding any lump-sum amount, raise, extra earnings, additional remuneration, bonus, allowance, etc.

– **For the Société de développement des enterprises culturelles (SODEC)**

The level of earnings increased, if applicable, by the team leader bonus and availability allowance.

– **For the Conseil des services essentiels**

Regular earnings excluding any bonus, lump sum amount or additional remuneration.

– **For the Régie de l'énergie and Société québécoise d'information juridique (SOQUIJ)**

Pay within the scales excluding any bonus and additional remuneration.

i) Health and social services sector

The health and social services sector includes all centres operated by public institutions under the meaning of the Act respecting health and social services (R.S.Q. C. S-4.2), private institutions contracted under the meaning of this law, and any organization that provides services to a centre or users in compliance with the act and declared by the government to be an establishment within the meaning of the Act respecting health and social services and represented by the employers groups Association québécoise d'établissements de santé et de services sociaux, Association des centres jeunesse du Québec, Association des établissements privés conventionnés – santé et services sociaux, Association des établissements de réadaptation en déficience physique du Québec, Fédération québécoise des centres de réadaptation en déficience intellectuelle, Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanes, health and social services agencies, and Institut national de santé publique du Québec.

2. Eligibility

a) Wage-earners

– **In the health and social services sector, Corporation d'urgences-santé and Institut national de santé publique**

- A wage-earner working either full time or 70% or more of a full-time schedule
  - Permanent position: After 1 month of continuous service.
  - Temporary position: After 3 months of continuous service.
- Wage-earner hired on a part-time basis working less than 70% of a full-time schedule: After 3 months of continuous service

  After 3 months of continuous service, the wage-earner is covered by paragraph i) or ii), depending on the percentage of a full-time schedule worked over the three months until the January 1 that immediately follows it.

– **For the 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): As of when he or she begins to work for the employer.
  - Temporary wage-earner who has worked for at least 6 continuous months since being hired or in the framework of 2 or more immediately consecutive hirings: As of the application of the abovementioned 6-month period.
  - Wage-earner working with handicapped students who are partially or fully integrated into regular classes as well as wage-earners providing daycare service (excluding casual wage-earners): As of when they begin work.
  - Wage-earner who works solely within the framework of sessions of adult education courses: Under the conditions stipulated in the collective agreement.

  Notwithstanding the foregoing, a wage-earner working 15 or fewer hours a week is not eligible.
– **In the college education sector and Société de développement des enterprises culturelles (SODEC)**
  - Regular wage-earner: Eligibility begins on the date of hiring.
  - Substitute or casual wage-earner: Eligibility begins after 6 months of continuous service.
– **For the Société immobilière du Québec (SiQ) and the Musée national des beaux-arts du Québec**
  - Wage-earner working either full time or 70% or more of a full-time schedule: After 1 month of continuous service
  - Wage-earner working more than 25% and less than 70% of a full-time schedule: After 3 months of continuous service
– **For the Conseil des services essentiels**
  - Wage-earner eligible upon the date of hiring.
– **For the Régie de l'énergie**
  - Any wage-earner is eligible after 1 month of continuous service.
– **For the Société québécoise d'information juridique (SOQUIJ)**
  - An employee whose normal work week is more than 25% of full-time is eligible after 1 month of service.

b) Dependents

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

c) Retirees

Any wage-earner becomes eligible for retiree's life insurance coverage as of the date of retirement if covered by the active participant's plan on that date.

For the health and social services sector, an active participant who is rehired on or after May 14, 2006 remains covered by the retiree's life insurance plan and the individual health insurance plan, if he or she had enrolled prior to retirement. This participant is not eligible for any of the group insurance plans for active participants.

3. Participation in insurance

a) Basic Health Insurance

Participation is mandatory for any eligible wage-earner under the age of 65 and for his or her dependents, if any, subject to the exemption entitlement.

– **Exemption entitlement**

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

– **Termination of the exemption entitlement**

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

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

– **Participant age 65 and over**

A participant age 65 or over can be exempted from the Basic Health Insurance plan if he or she opts to enrol in the RAMQ's Basic Prescription Drug Insurance Plan. This decision is irreversible. The participant can participate in the Individual Health Insurance policy (3995) if desired.

b) Optional plans

– **Additional Health Insurance (Option I)**
Dental Care Insurance (Option II)

Participation in each plan is optional. No evidence of insurability is required when the wage-earner enrols within 30 days following eligibility.

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

The minimum participation period for a participant and any dependents is 36 months from the effective date of the insurance. After this period, the participant can cease participation in the plans at any time by notifying his or her employer.

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

ACTIVE PARTICIPANTS

- **Participant's Basic Life Insurance**

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

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

  The wage-earner may also participate in Participant's Basic Life Insurance without providing evidence of insurability by filling out an application within 30 days following the adoption or birth of a first child, or the date on which the wage-earner takes a spouse in accordance with the definition of spouse set out in the contract.

  In the event of abandonment, evidence of insurability must be provided to the Insurer's satisfaction in the event of another application.

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

  Participation in the coverage is optional but conditional on the participant's participation in Basic Life Insurance coverage.

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

  In the event of abandonment, evidence of insurability must be provided to the Insurer's satisfaction in the event of another application.

  For Participant's Optional Life Insurance, all insurance amounts are subject to evidence of insurability.

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

  Participation is optional but conditional on participation in Basic Life Insurance by the participant and spouse and dependents.

  All optional life insurance amounts are subject to evidence of insurability.

RETIRED PARTICIPANTS

- **Retiree's Basic Life Insurance**

  Participation is optional. A retired participant can decide to take out this coverage by submitting an application within 30 days following his or her retirement date. No applications are accepted after this period. However, if the participant should die before the 30 day period is up, he or she is assumed to have taken out the coverage, retaining the amount of life insurance held immediately prior to retirement, but no more than $50,000.

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

  Participation in the coverage is optional but conditional on the retiree's participation in Basic Life Insurance coverage.

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

  In the event of abandonment, evidence of insurability must be provided to the Insurer's satisfaction in the event of another application.

Special provisions for the health and social services sector and Corporation d'urgences-santé

Participation in optional plans is optional for part-time wage-earners who work up to 25% of full time as follows:

Following the period of 3 months of continuous service, a new part-time wage-earner who works up to 25% of full-time can agree to be covered by the optional plans. Acceptance must be provided via written notice within 10 calendar days of receiving written notice from the employer indicating the percent of time worked during the 3 first months of employment.

On January 1 of each year, a wage-earner whose work schedule has declined to 25% of full time or less during the period from November 1 to October 31 of the previous year may cease coverage by the optional plans unless the 36-month period required by optional plans I and II has not elapsed. Termination must be provided via written notice within 10 calendar days of receiving written notice from the employer indicating the percent of time worked during the previous period.

However, a wage-earner cannot be subject to a downward revision if the reduction in work time during the reference period is due to maternity leave.

A wage-earner working 25% or less of full time may, on January 1 of each year, decide to be covered, not covered or cease coverage under the optional plans. The change must be reported by written notice sent to the employer within the first 10 days of the year. However, participation in optional plans I and II cannot be terminated until the minimum 36-month participation period is complete.

Any eligible wage-earner who does not hold a position and has not signed up for the optional plans may do so without proof of insurability by filling out an application form in the first 30 days following the date on which he or she obtains a first permanent part-time or full-time position.

c) Individual, Single-Parent and Family coverage

– Basic Health Insurance

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

However, a participant with no dependent children and whose spouse is age 65 or over may opt to replace Family coverage with Individual coverage status. A participant who does so cannot subsequently modify the coverage to cover the spouse.

– Optional plans

A participant who is insured by Individual coverage can opt to take out Family coverage (spouse, participant and dependent children) or Single Parent coverage (dependent children only) as soon as he or she has dependents or the dependents are no longer eligible for a group insurance plan offering similar coverage. Coverage of dependents begins at that time providing that a new application has been filled out by the wage-earner and received by the Insurer in the 30 following days.

If the application reaches the Insurer after the 30-day period, the participant must, at his or her own expense, provide proof of insurability for his or her dependents, to the Insurer's satisfaction. Insurance then takes effect on the date on which the Insurer accepts the proof of insurability.

A wage-earner who has exercised his or her exemption entitlement for the Basic Health Insurance plan may opt to take out coverage for him or herself and dependents under the optional plans by filling out an application in the 30 days following the date on which the dependents become eligible.

A participant may not be covered by Single-Parent or Family coverage under the optional plans if that participant has Individual coverage under the Basic Health Insurance plan. A participant who is covered by Single-Parent or Family coverage under the Basic Health Insurance plan may, however, take out Individual coverage under the optional plans.

Following examination of the evidence of insurability, the Insurer may grant Family or Single-Parent coverage but exclude a family member from coverage.

In addition, participation (Individual, Single-Parent, Family) in the optional plans must be the same.

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

4. Evidence of insurability

a) Optional Life Insurance for the participant and spouse

All optional life insurance amounts are subject to evidence of insurability.

b) Participant's Basic Life Insurance
Participant's Accidental Death and Dismemberment Insurance
Participant's Spouse's and Dependent Children's Basic Life Insurance
Retiree's Spouse's and Dependent Children's Basic Life Insurance

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

In the event of abandonment, evidence of insurability must be provided to the Insurer's satisfaction in the event of another application.

c) Additional Health Insurance (Option I)
Dental Care Insurance (Option II)

When the Insurer receives the application more than 30 days after the eligibility date on date on which the participant loses coverage under another group insurance plan he or she was covered by, he or she must provide evidence of insurability for himself or herself and dependents to the Insurer's satisfaction.

5. Effective date of insurance

a) Wage-earner and dependents

WAGE-EARNER

– **Basic plan**

  A wage-earner is covered as of the date on which he or she becomes eligible.

– **Optional plans**

  A wage-earner is covered as of the date on which he or she becomes eligible as long as he or she is at work or was at work on the last day he or she would usually have been at work, otherwise the day on which the wage-earner returns to work, as long as the wage-earner fills out an application within 30 days following that date.

  If the application is filled out after this period, the wage-earner is covered on the date on which the Insurer approves the evidence of insurability, as long as the wage-earner is at work or was at work on the last day he or she would usually have been at work, otherwise on the day on which the wage-earner returns to work.

DEPENDENTS

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

– The date they become eligible.
– The date the Insurer approves the dependent's evidence of insurability, if required.
– The date on which they cease to be eligible for another group insurance plan, as long as the application is submitted within 30 days of termination of the coverage under the other plan.

b) Retiree and dependents

RETIREE

Coverage for a retiree begins the date on which the person becomes eligible as long as he or she fills out an application form within 30 days following that date.

DEPENDENTS

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

– The date they become eligible.

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

6. Conversion privilege

a) Basic Health Insurance

Any participant whose coverage under the terms of the Basic Health Insurance plan ceases because that person is no longer eligible, or any wage-earner age 65 or over who has opted to cease participation in the plan may, without evidence of insurability, in the 31 days following the coverage termination date, obtain an individual health insurance policy of a type then issued by the Insurer under the circumstances. This plan does not include reimbursement for the medications covered by the Basic Prescription Drug Insurance Plan provided by the Régie de l'assurance maladie du Québec (RAMQ); anyone who enrolls for this plan must sign up with the RAMQ.

b) Additional Health Insurance

Any participant whose coverage ceases because he or she is longer eligible may, without evidence of insurability, in the 31 days following the date on which coverage terminates, obtain individual health insurance coverage of a type then issued by the Insurer under the circumstances.

c) Dental Care Insurance

Any participant under age 65 whose coverage ceases because he or she is longer eligible for a reason other than retirement may, without evidence of insurability, in the 31 days following the date on which coverage terminates, obtain an individual dental care insurance policy of a type then issued by the Insurer under the circumstances.

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

When a participant's eligibility ceases for a reason other than retirement, if he or she applies in writing to the Insurer within 31 days following the termination of coverage, he or she is entitled, without evidence of insurability, to convert all or some of the insurance coverage held into an individual whole life or term life insurance policy, without accessory coverage, of a type then issued by the Insurer under the circumstances.

The maximum amount the participant may convert is equal to the difference between the amount in force at the time coverage is terminated and any amount provided in another group insurance plan for which the participant has become eligible at the time of exercising the conversion privilege. A participant who leaves the insured group to enter active service in the armed forces of any country may not exercise this conversion privilege.

e) Spouse's and Dependent Children's Basic Life Insurance Spouse's Optional Life Insurance

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

The converted coverage amount is no more than the total of Basic Life and Optional Life Insurance amounts that person held under the current plan, less the amount of coverage held under another group insurance plan for which the person became eligible at the time of exercising his or her conversion privilege.

7. Maintaining insurance during a temporary interruption of work

a) In the event of **temporary absence without pay of more than 30 days,** participation in the plans is suspended, with the exception of participation in the Basic Health Insurance plan; coverage automatically resumes without evidence of insurability upon return to active work with pay. The participant must personally pay the total premium stipulated for the Basic Health Insurance plan, except where the *Act respecting labour standards* obliges the employer to pay its contribution. However, the participant may take advantage of the opportunity to maintain participation in his or her other plans by paying the full requisite premium personally.

If during a leave a participant does not pay his or her premiums for the optional plans, such plans will be cancelled until the participant returns to work. He or she can enrol for the plans once more by presenting evidence of insurability that the Insurer deems satisfactory.

b) A participant who takes a **partial leave without pay as an extension of parental leave** remains eligible for the plans as if he were not taking such leave.

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

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

e) For other cases of **temporary leave with pay,** participation in all plans is maintained. For parental leave, participation is maintained and life insurance amounts are determined based on the situation that prevailed prior to the beginning of the leave.

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

g) **In the health and social services sector and for the Corporation d'urgences santé,** for a part-time wage-earner who maintains participation in the Optional Life Insurance plan during a temporary leave without pay, the premium and benefit payable in the event of death are based on a proportion of his or her salary established on a prorata basis of the time paid in relation to time paid on a full-time basis over the 12 months before the beginning of the temporary leave or parental leave for which no period of disability, parental leave or unpaid leave was authorized. The period over which the average time is calculated cannot, however, precede the onset of the participant's employment. In this case, the

calculations are done using the reduced period. If disability arises during this period, the wage-earner is entitled to a waiver of premiums; in the event of death, the benefit payable is based on the exempted insurance amount.

In sectors other than those listed in the above paragraph, for a wage-earner who does not work full time and maintains participation in the Optional Life Insurance plan during temporary unpaid leave, the premium and benefit payable in the event of death are based on the proportion of salary earned the day before his or her departure. If disability arises during this period, the wage-earner is entitled to a waiver of premiums; in the event of death, the benefit payable is based on the exempted insurance amount.

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

i) For **unpaid leave,** life insurance amounts are determined based on the situation that prevailed prior to the beginning of the leave.

8. Extension

a) Basic Health Insurance
Additional Health Insurance (Option I)
Dental Care Insurance (Option II)

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

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

9. Waiver of premiums in the event of total disability

a) Start of waiver

– For the participant

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

HEALTH AND SOCIAL SERVICES SECTOR AND CORPORATION D'URGENCES-SANTÉ:

- The 8th working day for full-time wage-earners, or
- The 6th working day for full-time wage-earners working 4 days a week in the framework of a program to reduce working time, or
- The 9th calendar day for part-time wage-earners

OTHER SECTORS:

- The 8th working day.

  When a participant is the victim of an employment injury which is excluded from the definition of disability, the above time period applies if the participant is entitled to an income replacement indemnity from the CSST. In this case, the waiver ends on the date on which the employment injury is consolidated at the latest.

– **For the employer**

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

b) End of waiver

The waiver of premiums terminates at midnight on the earliest of the following dates:

– The date on which the participant is no longer disabled.

– The date on which the participant reaches age 65.

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

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

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

The waiver of premiums does not apply:

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

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

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

c) Provisions regarding employment injury

– **Non-consolidated employment injury**

When a participant suffers an employment injury, cannot return to work, and the injury is still not consolidated according to the attending physician, the participant is exempted from payment of premiums and coverage is maintained for a maximum of one year as of the end of the income replacement indemnities paid by the CSST.

– **Temporary assignment**

- ASSIGNMENT BEGINNING BEFORE JANUARY 1, 2006

  When a participant who has suffered an employment injury is temporarily assigned to a position, he or she is exempted from payment of premiums for the assignment period.

- ASSIGNMENT BEGINNING ON OR AFTER JANUARY 1, 2006

  A disabled paticipant on temporary assignment is not exempted from payment of premiums for any period during which he or she is not receiving an income replacement indemnity. This provision applies to any temporary assignment period that began on or after January 1, 2006, regardless of the date on which disability began.

– **Employment injury with right to rehabilitation**

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

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

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

d) Preventive withdrawal

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

e) Filing a grievance related to disability

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

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

f) Progressive return to work

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

10. Termination of coverage

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

– The date on which the contract terminates or, for each plan, their respective termination dates.

– The date on which the participant ceases to meet the eligibility criteria.

– The date on which the participant leaves his or her employment, except for the conversion privilege for Participant's Life Insurance coverage and enrolment in the Retiree's Life Insurance plan.

– The date on which coverage under another group insurance plan begins for a participant who has terminated coverage under the Basic Health Insurance plan because or she has exercised his or her right of exemption, if the application is made within 30 days, or else on the date received by the Insurer.

– The date of receipt by the Insurer of written notice from a participant who wishes to terminate his or her coverage under a plan other than the Basic Life Insurance plan or coverage, or the termination date entered on the notice, whichever comes after, subject to the obligation to maintain coverage for 36 months for optional plans I and II.

– The date listed in the Committee's written notice confirming the termination of union affiliation of the group of wage-earners to which the person on disability belonged, except for the life insurance plan.

– The date on which the employee/employer relationship of a participant on disability is terminated.

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

– The termination date of the participant's insurance, subject to the stipulated extension for basic plans and optional plans I and II.

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

– The date on which the Insurer receives written notice from a participant who wishes to be insured individually, subject to the obligation to cover dependents in the basic plan and obligation to maintain the plan for 36 months in the case optional plans I and II.

– The date on which coverage under another group insurance plan begins for dependents who terminate coverage under the Basic Health Insurance plan because they have exercised their right of exemption, if the application is made within 30 days, otherwise on the date received by the Insurer.

11. Dependent child age 18 to 25 inclusive

To continue to be insured, a dependent child age 18 to 25 inclusive must be a **full-time student** at a recognized educational institution. As a result, should the participant fail to send evidence of attendance to the Insurer, a dependent child who has turned 18 automatically ceases to be covered on that date. Evidence of attendance must be provided every term. To do so, the participant can simply fill out and sign Part 2 of the claim form and return it to the Insurer.

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

The rates for Participant's and Spouse's Optional Life Insurance are provided for the "smoker" and "non-smoker" categories. To be eligible for the "non-smoker" category, a person must not have smoked cigarettes in the past year. Anyone who modifies their smoking habits after the statement of insurability **must inform the Insurer in writing within 30 days following the change**.

CLAIMS PROCEDURE

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

a) Hospitalization, medical and paramedical expenses subsequent to an employment or motor vehicle accident

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

b) Hospitalization expenses

The insured must present his or her group insurance service card upon admission to a hospital. The establishment will send the claim directly to the Insurer.

c) Prescription drugs (Deferred electronic claims payment)

When making prescription drug purchases, insureds present their service card with their identification number to the pharmacist. The insured pays the full cost of the prescription drugs being purchased, and the claim is automatically sent to the Insurer. There is thus no claim form to fill out. The Insurer issues a reimbursement to the participant when the first of the following occurs:

– Claimed expenses reach $75.

– 14 days have elapsed.

d) Dental expenses (Direct electronic claims payment)

The insured presents his or her service card when going to the dentist. The system validates eligibility and confirms whether the dental treatment is covered as well as the reimbursement applicable. There is no need to fill out a claims form since the insured portion of treatment expenses is claimed directly by the dentist from the Insurer.

The insured only pays for the uninsured portion of dental care. If your dentist does not offer this service, you must pay the treatment expenses in full, and submit a claim to the Insurer. Note that you can always present a claim in the usual manner, using the appropriate form.

e) Dental expenses (treatment plan)

Before starting major treatment, participants must find out what expenses will be reimbursed by the Insurer. To do so, fill out the Canadian Dental Association form available from the dentist, or the Insurer's Dental Claim Form, entering "Treatment plan".

f) Medical and paramedical expenses

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

– HEALTH PROFESSIONALS

An official receipt must be presented to the Insurer when making a claim for the services of health care professionals such as physiotherapists, psychologists, etc.

The receipt can be the back of the "Medical Expenses Claim Form"; in this case, it must bear the professional's stamp or seal along with his or her signature, license number and specific dates of services, along with the name of the person receiving the treatments. Professionals' electronic and customized receipts are also accepted as long as they contain the abovementioned information.

– OTHER ELIGIBLE EXPENSES

Any other claim for health insurance benefits must be filed using the "Medical Expenses Claim Form." The participant must provide all information needed to review the claim, attaching original invoices or official receipts for the expenses being claimed. The participant must keep a copy of the invoices sent to the Insurer as no originals will be returned.

The Insurer reimburses the expenses claimed as per the terms of the contract. Upon payment, a blank Medical Expenses Claim Form is sent to the participant.

g) Life Insurance

It is the beneficiary's responsibility to claim the insured amount by contacting the Insurer, who will send out the required form.

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

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

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

A person who is insured under life insurance plan coverage whose life expectancy is no more than 12 months can obtain accelerated payment of a benefit by submitting a written request to the Insurer, along with the appropriate medical evidence and the beneficiary's written acceptance.

The amount paid is limited to 25% of the insured's life insurance amount (Basic and Optional), without exceeding $50,000. The amount of life insurance used to calculate the accelerated benefit excludes any amount or fraction of an amount expiring in accordance with the provisions of the contract during the 24 months following the date of the application and cannot be replaced with another life insurance benefit. After the date of payment, the premium, if any, continues to be calculated on the full insurance amount as if there had been no accelerated payment. At death, the amount payable by the Insurer is reduced by the amount paid as an accelerated benefit plus interest accrued on this amount at the annual rate of 6%. The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid. Furthermore, this benefit ceases upon termination of the contract, even for participants who have been granted a waiver of premiums.

i) Direct deposit

Participants who so desire can receive their reimbursements for medical expenses and dental care by preauthorized direct deposit. A statement will be issued confirming the amount deposited and date on which the claim was processed. To this end, participants must fill out the Direct Deposit form and attach a sample cheque with VOID written on it.

TRAVEL INSURANCE

La Capitale will reimburse the customary and reasonable expenses for the services described hereafter, if incurred subsequent to an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the government health insurance plan of the province of residence.

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

1. Eligible expenses

a) Hospitalization, medical and paramedical expenses

– Expenses for hospitalization in a semi-private or private room, in excess of the amounts reimbursed or eligible for reimbursement under the government health insurance plan of the insured's province of residence.

– Incidental expenses (telephone, television, parking, etc.) related to hospitalization, upon presentation of supporting documents, up to a maximum of $100 per hospitalization.

– Professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care; expenses incurred are payable only for the portion of expenses in excess of the benefits payable under the government health insurance plan of the insured's province of residence.

– The cost of drugs obtained on prescription by a physician in an emergency treatment situation.

– Professional fees of a registered nurse for private nursing care dispensed exclusively in a hospital centre, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $3,000. The nurse must not be related to the insured nor be a travel companion.

– Rental of therapeutic devices and purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices, when prescribed by the attending physician.

– Professional fees of a dentist for treatment of accidental injury to natural teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident; to be covered, expenses must be incurred within 12 months following the accident.

b) Expenses for transportation

– Expenses for transportation of the insured by air or surface ambulance to the nearest medical centre where adequate medical care is available. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing the patient's condition.

– Repatriation expenses for the insured to return to the place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as the insured's health condition so allows and insofar as the means of transport initially planned for the return cannot be used.

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

– When the insured is repatriated or transported, the Assistor organizes and pays expenses for the insured's spouse and dependent children or the insured's travel companion, as applicable, to return to

the insured's province of residence, up to the cost of a regularly scheduled airline flight, train or bus ticket, if the means of transport initially planned for the return cannot be used.

– When the insured's health condition does not allow medical repatriation and hospitalization outside the province must extend beyond 7 days, the Assistor will organize and pay round-trip transportation expenses to enable a close relative of the insured, residing in the insured's province of residence, to be at the bedside of the insured. The maximum reimbursement is $1,500. However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative age 18 or over, if the necessity of a visit is not confirmed by the attending physician, or if the visit is not approved in advance and planned by the Assistor.

– The Assistor will make necessary arrangements to return home any children under age 18 accompanying the insured if, following the insured's accident or illness, the insured or another accompanying adult is unable to do so personally.

– If the insured is unable to drive the automobile used for a trip following an illness or accident that occurs during the trip and no other passenger is able to drive the vehicle, the Assistor will pay the expenses incurred by a commercial agency to return the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency, subject to a maximum reimbursement of $1,000.

– In the event of the insured's death, when necessary, the Assistor will organize and pay expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing that no close relative age 18 or over is accompanying the insured on the trip. The maximum reimbursement is $1,500.

– In the event of the insured's death, the Assistor will pay for the cost of preparing and returning the remains of the insured (excluding the cost of the coffin or casket) to the place of burial in the province of residence, subject to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

c) Living expenses

– Expenses for accommodation and meals in a commercial establishment, when an insured is obliged to postpone the return home due to an illness or bodily injury suffered by the insured, a close relative accompanying the insured or a travel companion, subject to a maximum reimbursement of $150 per day for a maximum of 8 days.

2. Travel assistance service

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

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

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

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

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

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

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

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

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

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

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

3. Obligations of insureds

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

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

UNUSED TICKETS: When an insured has benefited from repatriation or transportation for medical purposes under the terms of this travel insurance benefit, the Assistor reserves the right to claim any ticket held by the insured that was not used due to services provided by the Assistor.

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

4. Exclusions, limitations and reduction of Travel Insurance coverage

In addition to the exclusions and reduction relating to the Basic Health Insurance plan, the Insurer and the Assistor will issue no reimbursement nor provide any assistance to the insured in the following cases:

– When the loss occurs in the insured's province of residence.

– When the insured refuses without any valid medical reason to comply with the Assistor's recommendations with regard to repatriation or the choice of hospital or required care; by required care is meant the treatment needed to stabilize the insured's medical condition.

– If the insured fails to contact the Assistor as soon as possible in the event of a medical consultation or hospitalization following an accident or sudden illness.

– When expenses are incurred due to pregnancy, and any related complications, within 12 weeks preceding the expected date of delivery.

– When the loss is due to a medical condition for which the insured has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date of departure, except if it is proven to the satisfaction of the Insurer that the insured's condition is stable. Any change in medication, including use and dosage, is considered to be a medical treatment.

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

– When the loss is related to a known condition of the insured that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.

– When the expenses incurred outside the insured's province of residence could have been incurred in the province of residence, without danger to the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from an accident or sudden illness. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province does not constitute a danger for the insured's life or health.

– When expenses are incurred in hospitals for the chronically ill, or service for the chronically ill in public hospitals, or for patients in extended care homes or thermal spas.

– For elective or non-emergency surgery or treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.

– For an accident occurring while the insured is practising any sporting activity involving remunerity, any motor vehicle competition or speed contest, gliding or hang gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping, or any other dangerous activity; activities other than the aforementioned that are offered to the general public in resort areas are not considered to be dangerous, such as downhill skiing and scuba diving.

– Following voluntary abusive consumption of medication, drugs or alcohol and the ensuing consequences.

– For repatriation or travel assistance services, when the loss occurs in a country that is at war, whether declared or undeclared, experiencing notorious political instability or for which the Government of Canada has issued a warning that Canadians should not travel in that country, or during a riot, common uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving an Act of God making any intervention by the Assistor physically impossible, even if the insured's condition does not result from any such events or situations.

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

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

TRIP CANCELLATION INSURANCE

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

1. Definitions

COMMERCIAL ACTIVITY

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

BUSINESS PARTNER

A person with whom the insured is associated for business purposes as part of a company comprised of 4 shareholders or fewer, or a profit-making corporation comprised of 4 partners or fewer.

TRAVEL COMPANION

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

PREPAID TRAVEL EXPENSES

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

HOST AT DESTINATION

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

CLOSE RELATIVE

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

TRIP

For the purposes of trip cancellation insurance, the term "trip" means a trip for tourism or recreational purposes, or a commercial activity, entailing the insured's absence from home for a period of at least 72 consecutive hours and requiring travel of at least 400 kilometres (round trip) from the insured's place of residence. A cruise with a planned duration of at least 72 consecutive hours operated by an accredited firm is also considered to be a trip.

RESTRICTION: Any trips for purposes of hunting or fishing are excluded.

2. Eligible causes of cancellation or interruption

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

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

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

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

– Death or emergency hospitalization of the host at destination.

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

– Quarantine of the insured or travel companion, except if quarantine ends 7 days or more before the scheduled date of departure.

– Hijacking of the airplane on which the insured is travelling.

– Damage rendering the principal residence of the insured, of the travel companion or of the host at destination uninhabitable, provided the residence remains uninhabitable 7 days or fewer prior to the scheduled date of departure, or the damage occurs during the time of the trip.

– Transfer of the insured or travel companion, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required within the 30 days preceding the scheduled date of departure.

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

– Missed departure due to a delay in the means of transportation used to reach the point of departure, provided that the means of transportation used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure, or at least 3 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by weather conditions, mechanical problems (except for a private automobile), a traffic accident or an emergency road closure, each of the latter two causes requiring confirmation by a police report.

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

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

– Involuntary loss of employment of the wage-earner or spouse, provided the person in question has been working for the employer for at least one year.

3. Expenses covered

The following expenses are covered, provided they are incurred 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 prepaid travel expenses.

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

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

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

– If the return is earlier or later than planned:

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

  b) However, if the return is delayed by more than 7 days due to an accident or illness suffered by the insured or travel companion, expenses incurred are eligible, provided the person in question was admitted to hospital as an inpatient for more than 48 hours within the 7-day period.

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

4. Exclusions applicable to Trip Cancellation Insurance

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

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

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

– Due to war, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.

– Active participation of the insured or travel companion in a criminal act or an act deemed to be criminal.

– Pregnancy, and any related complications, within twelve weeks preceding the expected date of delivery.

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

– If the insured has consumed toxic quantities of alcohol, drugs or medication.

– Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity.

– A medical condition for which the insured or travel companion has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date on which travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the person in question is stable at the time expenses are incurred. Any change in medication, including use and dosage, is considered to be a medical treatment.

– Any loss related to a known condition of the insured or travel companion that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.

– If the activity involved is hunting or fishing.

5. Notice of cancellation

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

6. Coordination of benefits

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

TABLE OF PREMIUMS

Per 14-day period
from January 1, 2008 to December 31, 2008

ACTIVE PARTICIPANT'S PLAN

FOR 26 PAY PERIODS

*** Please note that the employer's contribution, which varies by collective agreement, must be subtracted from the total employee/employer premium.**

These premium rates apply as of the first full pay period that immediately follows or coincides with January 1, 2008.

	Individual coverage	Single-Parent coverage	Family coverage
BASIC PLAN **Health Insurance** – Total premium	$31.67 *	$41.18*	$72.60*
OPTION I **Additional Health Insurance**	$3.87	$4.84	$7.35
OPTION II **Dental Care Insurance**	$13.11	$22.61	$30.13
OPTION III **Participant's Basic Life Insurance** (per $1,000 of insurance). For participants age 65 and over, the percentage rate must be divided by 2.	$0.168 or 0.437% of salary		
Participant's Accidental Death and Dismemberment Insurance (per $1,000 of insurance). For participants age 65 and over, the percentage rate must be divided by 2.	$0.013 or 0.034% of salary		
Participant's Spouse's and Dependent Children's Basic Life Insurance (per family)	$0.80		

ACTIVE PARTICIPANT'S PLAN (cont'd)

OPTIONAL LIFE INSURANCE

FOR 26 PAY PERIODS

The rate for Spouse's Optional Life Insurance is determined **based on the participant's age and the spouse's gender and smoking habits.**

PARTICIPANT'S AND SPOUSE'S OPTIONAL LIFE INSURANCE

Rate per $1,000 of insurance, per 14 days

(for participants who are paid weekly, divide the rates given in dollars by 2)

	Male		Female	
Age	**Smoker**	**Non-smoker**	**Smoker**	**Non-smoker**
Under age 30	$0.027	$0.027	$0.027	$0.027
Age 30 to 34	$0.027	$0.027	$0.027	$0.027
Age 35 to 39	$0,054	$0.027	$0.027	$0.027
Age 40 to 44	$0.090	$0.054	$0.063	$0.027
Age 45 to 49	$0.153	$0.090	$0.090	$0.063
Age 50 to 54	$0.234	$0.153	$0.153	$0.090
Age 55 to 59	$0.396	$0.234	$0.234	$0.153
Age 60 to 64	$0.621	$0.387	$0.360	$0.216
Age 65 and over	$0.765	$0.468	$0.567	$0.351

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Rate as a percentage of salary per 14 days, per unit of 1 x salary

	Male		Female	
Age	**Smoker**	**Non-smoker**	**Smoker**	**Non-smoker**
Under age 30	0.070%	0.070%	0.070%	0.070%
Age 30 to 34	0.070%	0.070%	0.070%	0.070%
Age 35 to 39	0.140%	0.070%	0.070%	0.070%
Age 40 to 44	0.234%	0.140%	0.164%	0.070%
Age 45 to 49	0.398%	0.234%	0.234%	0.164%
Age 50 to 54	0.608%	0.398%	0.398%	0.234%
Age 55 to 59	1.030%	0.608%	0.608%	0.398%
Age 60 to 64	1.615%	1.006%	0.936%	0.562%
Age 65 and over	1.989%	1.217%	1.474%	0.913%

Notes:

The rates per age group apply according to the participant's age at the time of enrolment. Subsequently, changes to the rate arising from changes in age take effect with the pay period that coincides with or immediately follows the participant's birthday.

ACTIVE PARTICIPANT'S PLAN

FOR 20 PAY PERIODS

*** Please note that the employer's contribution, which varies by collective agreement, must be subtracted from the total employee/employer premium.**

These premium rates apply as of the first full pay period that immediately follows or coincides with January 1, 2008.

	Individual coverage	Single-Parent coverage	Family coverage
BASIC PLAN **Health Insurance** – Total premium	$41.17*	$53.53*	$94.38*
OPTION I **Additional Health Insurance**	$5.03	$6.29	$9.56
OPTION II **Dental Care Insurance**	$17.04	$29.39	$39.17
OPTION III **Participant's Basic Life Insurance** (per $1,000 of insurance). For participants age 65 and over, the percentage rate must be divided by 2.	$0.218 or 0.459%(1) of salary		
Participant's Accidental Death and Dismemberment Insurance (per $1,000 of insurance). For participants age 65 and over, the percentage rate must be divided by 2.	$0.017 or 0.036%(1) of salary		
Participant's Spouse's and Dependent Children's Basic Life Insurance (per family)	$1.04		

(1) This group insurance premium will be collected over 20 pay periods even if salary is spread over 21 pay periods.

ACTIVE PARTICIPANT'S PLAN (cont'd)

OPTIONAL LIFE INSURANCE

FOR 20 PAY PERIODS

The rate for Spouse's Optional Life Insurance is determined **based on the participant's age and the spouse's gender and smoking habits.**

PARTICIPANT'S AND SPOUSE'S OPTIONAL LIFE INSURANCE

Rate for $1,000 of insurance, per 14 days

	Male		Female	
Age	**Smoker**	**Non-smoker**	**Smoker**	**Non-smoker**
Under age 30	$0.035	$0.035	$0.035	$0.035
Age 30 to 34	$0.035	$0.035	$0.035	$0.035
Age 35 to 39	$0.070	$0.035	$0.035	$0.035
Age 40 to 44	$0.117	$0.070	$0.082	$0.035
Age 45 to 49	$0.199	$0.117	$0.117	$0.082
Age 50 to 54	$0.304	$0.199	$0.199	$0.117
Age 55 to 59	$0.515	$0.304	$0.304	$0.199
Age 60 to 64	$0.807	$0.503	$0.468	$0.281
Age 65 and over	$0.995	$0.608	$0.737	$0.456

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Rate as a percentage of salary, per 14 days, per unit of 1 times salary
(given that the annual salary is spread over 21 pay periods and the premium is collected over 20 pay periods)

	Male		Female	
Age	**Smoker**	**Non-smoker**	**Smoker**	**Non-smoker**
Under age 30	0.074%	0.074%	0.074%	0.074%
Age 30 to 34	0.074%	0.074%	0.074%	0.074%
Age 35 to 39	0.147%	0.074%	0.074%	0.074%
Age 40 to 44	0.246%	0.147%	0.172%	0.074%
Age 45 to 49	0.418%	0.246%	0.246%	0.172%
Age 50 to 54	0.638%	0.418%	0.418%	0.246%
Age 55 to 59	1.082%	0.638%	0.638%	0.418%
Age 60 to 64	1.696%	1.056%	0.983%	0.590%
Age 65 and over	2.088%	1.278%	1.548%	0.959%

Notes:

The rates per age group apply according to the participant's age at the time of enrolment. Subsequently, changes to the rate arising from changes in age take effect with the pay period that coincides with or immediately follows the participant's birthday.

RETIREE'S LIFE INSURANCE PLAN

Monthly rates

RETIREE'S BASIC LIFE INSURANCE

The first unit of $5,000 is offered at $5.00 (participant only);
the remainder is offered at the following rates:

RATES PER $1,000 OF INSURANCE FOR THE AMOUNT OVER $5,000

Age	Male	Female
Under age 50	$0.21	$0.11
Age 50 to 54	$0.44	$0.22
Age 55 to 59	$0.74	$0.35
Age 60 to 64	$1.24	$0.54
Age 65 to 69	$1.96	$0.92
Age 70 to 74	$3.14	$1.43
Age 75 to 79	$4.22	$2.47
Age 80 and over	$8.48	$5.46

Retiree's Spouse's and Dependent Children's Basic Life Insurance

Monthly rate per family: $8.24

Retiree's Spouse's Optional Life Insurance

The rates applicable are the rates established for the retired participant's Basic Life Insurance for the amount in excess of $5,000, depending on the participant's age and the spouse's gender.

9% provincial tax must be added to the rates specified in this document.

Note:

Note:

La Capitale
Insurance and
Financial Services

CONTACT US

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Montreal QC H3A 3G5
514 873-6506

Toll free: 1 800 463-4856
www.**lacapitale**.com

TRAVEL INSURANCE

You can contact the Assistor at the following numbers:

In Canada and the United States: 1 800 363-9050
Elsewhere in the world (collect call): (+1) 514 985-2281

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