

# GROUP INSURANCE PLAN

insured by



**PUBLIC COLLEGES AND  
PRIVATE SCHOOLS**

**Contract: 1008-1010**

January 2008

**GROUP INSURANCE PLAN  
FOR ALL ACTIVE MEMBERS AND AFFILIATES OF THE FNEEQ-CSN**

- - -

**FÉDÉRATION NATIONALE  
DES ENSEIGNANTES ET DES ENSEIGNANTS DU QUÉBEC - CSN**

- - -

**Public colleges and  
Private schools**

**INSURER:** La Capitale Civil Service Insurer Inc.

**CONTRACT MANAGER:** La Capitale Insurance and Financial Services Inc.

Please retain this brochure for future use.

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**AMENDMENTS AND ADDITIONS AS AT JANUARY 1, 2008**

***Health Insurance***

- pg. 9:** The 1st item has been changed.  
The 1st item under point 4 has been changed.
- pg. 11:** The 1st item has been changed and the 2nd item has been added.  
The 5th and 6th items under point 5 have been changed.
- pg. 12:** The 2nd item has been changed. The 3rd and 4th items have been added.

***Trip Cancellation Insurance***

- pg. 21:** Point n) has been added.
- pg. 24:** This paragraph has been added.

***Dental Care Insurance***

- pg. 25:** A change has been made to the title.

***Short Term Disability Insurance***

- pg. 39:** The last item has been added.

***Long Term Disability Insurance***

- pg. 43:** The last 2 items have been added.

***General Information***

- pg. 45:** The definition of "Disability or disabled" has been changed - 3rd and 4th paragraphs.
- pg. 46:** The definition of "Disability period" has been changed.
- pg. 47:** The definition of "Employee" has been changed.
- pg. 49:** The paragraph regarding dental care insurance has been changed.
- pg. 52 - 54:** Point 7, "Waiver of premiums", has been changed.
- pg. 64:** The "Health Insurance Reimbursements Schedule" has been added.
- pg. 67:** The "Checklist / Notes" page has been added.

## **IMPORTANT**

The Policyholder may at any time, following agreement with the Insurer, make changes to the contract with respect to the categories of eligible persons, the scope of the coverages, and the cost-sharing between categories of insureds. Such changes may then apply to all insureds.

Because this document is not as explicit as the contract with respect to the clauses regarding definitions, eligibility, enrolment, termination of insurance and other specifications, you can obtain these details by referring to the contract available from your employer or union.



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## SCHEDULE OF INSURANCE

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

<b>Benefit</b>	<b>Coverage</b>
<p><b>Health Insurance</b> (pg. 7)</p> <p>Hospitalization and long-term care</p> <p>Travel insurance</p> <p>Trip cancellation insurance</p> <p>Prescription drugs</p> <p>Electronic claims payment</p> <p>Other eligible expenses</p> <p style="padding-left: 20px;"><i>Psychiatrists, psychoanalysts, guidance counsellors, psychologists and social workers</i></p> <p>Healthcare professionals</p>	<p><b>Mandatory</b></p> <p>100% - semi-private room</p> <p>100% - \$1,000,000 lifetime maximum</p> <p>100% - \$5,000 maximum per trip</p> <p>Generic: 90% - non-generic: 80%</p> <p>Deferred</p> <p>80%</p> <p><i>50% of the 1st \$1,400 of eligible expenses and 100% of the next \$1,400 of eligible expenses. Maximum reimbursement of \$2,100 per year, per insured, for all of these professionals combined</i></p> <p>80% - maximum reimbursement of \$30/treatment, maximum \$400/year</p>
<p><b>Dental Care Insurance</b> (pg. 25)</p> <p>Preventive services</p> <p>Basic restorative services</p> <p>Major restorative services</p> <p>Maximum reimbursement</p> <p>Deductible</p>	<p><b>Mandatory for all employees of a college whose union has retained this benefit</b></p> <p>70%</p> <p>70%</p> <p>70%</p> <p>\$1,000 per calendar year</p> <p>\$25 per calendar year</p>
<p><b>Life Insurance</b> (pg. 33)</p> <p>Active participant under the age of 65</p> <p>Active participant 65 to 70 years of age</p> <p>Active participant over 70 years of age</p> <p><b>Accidental Death and Dismemberment</b> (pg. 33)</p> <p><b>Dependents' Life Insurance</b> (pg. 35)</p> <p>Spouse</p> <p>Dependent child</p>	<p><b>Optional</b></p> <p>2 times the annual salary, minimum \$20,000</p> <p>1 time the annual salary</p> <p>\$10,000</p> <p>Same amount as life insurance payable following the death of the participant</p> <p>Under the age of 65: \$10,000</p> <p>65 to 70 years of age: \$4,000</p> <p>70 years of age and older: \$2,000</p> <p>\$4,000 as of the age of 24 hours</p>

<b>Benefit</b>	<b>Coverage</b>
<b>Optional Life Insurance</b> (pg. 35) Participant Spouse	1 to 7 units of \$20,000 1 to 7 units of \$20,000
<b>Short Term Disability Insurance</b> (pg. 37) Elimination period Benefit period Benefit amount Cost-of-living adjustment	<i>Private colleges only</i> 30 days following the start of the disability 23 months 80% of the net salary, maximum \$5,000 per month Yes, based on QPP, maximum 3%
<b>Long Term Disability Insurance</b> (pg. 40)	<b><i>Mandatory</i></b>
Elimination period Benefit period Benefit rate Cost-of-living adjustment	After short term, or 104 weeks To the age of 65 80% of the net salary, max. \$5,000 per month Yes, based on QPP

## **HEALTH INSURANCE** *(Mandatory)*

***Eligible expenses are reasonable expenses justified by the severity of the case, current medical practice, and the usual rates for the region, excluding expenses that are not medically necessary, expenses payable under any other individual or group plan, and expenses for which the insured is entitled to compensation under the terms of the Act respecting industrial accidents and occupational diseases, the Automobile Insurance Act, or any other Canadian or foreign Act to the same effect.***

**1. The following expenses are eligible for reimbursement at 100%.**

### **Hospitalization**

When, upon recommendation of a physician, an insured is admitted to a hospital in Canada, following the effective date of his or her insurance, the Insurer shall pay, on behalf of this insured, the expenses established by the said hospital for a stay in a semi-private or private room, provided such insured is entitled to care as a hospitalized patient, but only up to a maximum of the amount that the said hospital is entitled to collect directly from the patient as payment for his or her stay in a semi-private room.

### **Chronic Patient Hospitalized for Long-Term Care**

When, upon recommendation of a physician and following the effective date of his or her insurance, an insured is admitted as a chronic patient for long-term care in a tuberculosis hospital, sanatorium, mental health hospital, rest home, home for the aged, or dispensary, and the institution is authorized by the *ministère de la Santé et des Services sociaux du Québec* to participate in the hospital care insurance plan introduced under the terms of that province's Hospital Insurance Act, the Insurer shall pay, on behalf of such insured, the expenses for the insured's stay as set out by the said institution, up to a maximum of 180 days of hospitalization for long-term care per calendar year, and up to a maximum of the amount that the said institution is entitled to collect directly from the patient as payment for the expenses of his or her stay in a semi-private room.

### **Travel Insurance**

(See the detailed description of the benefit on page 14.)

### **Trip Cancellation Insurance**

(See the detailed description of the benefit on page 20.)

2. **Expenses for prescription drugs are reimbursed at 90% except for non-generic drugs, which are reimbursed at 80%; however, if the total expenses for eligible prescription drugs (generic or not) exceeds \$1,000 per calendar year for the participant or his or her dependents, as applicable, the expenses for the prescription drugs exceeding this amount shall be eligible for reimbursement at 100%.**

### **Prescription Drugs**

The Insurer shall reimburse **prescription drugs** that can be obtained only by prescription from a physician or dentist and sold by a licensed pharmacist or duly authorized physician. Notwithstanding the exclusions appearing in point 6, by prescription drugs we mean products included in the most recent drug lists of the *Régie de l'assurance maladie du Québec* or in the drug lists of the *Association québécoise des pharmaciens propriétaires* (AQPP), with the exception of drugs coded "Z".

The Insurer shall also refund drugs obtained by medical prescription and whose therapeutic indication is directly related to the treatment of the following pathological conditions: cardiac disorders, pulmonary disorders, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis, and glaucoma.

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

- to limit this reimbursement according to the criteria stipulated in the by-law of the Act respecting prescription drug insurance, if it is registered as an exceptional drug on the list under the provisions of section 60 of the Act;
- to exclude it or establish the reimbursement criteria, if it is not registered on the said list.

Notwithstanding any of the definitions or exclusions herein, all prescription drugs that must be covered under the group contract pursuant to the *Act respecting prescription drug insurance* shall be considered eligible expenses.

3. **The following expenses are reimbursed at 80% and are subject to maximums.**

### **Other Eligible Expenses**

- Expenses for **homeopathic drugs that can be obtained only by prescription** from a homeopathic doctor and that are sold by a licensed pharmacist or duly authorized physician, up to a maximum reimbursement of \$400 per calendar year, per insured.
- Upon prescription from a physician, the expenses incurred for **serums and fluids injected for curative purposes**, including **injections for artificial insemination**.

- Upon prescription from a physician, expenses for the purchase of an **artificial limb** for an injury sustained during the insurance period, **prosthetic appliances** excluding dentures, **foot orthoses**, **orthopaedic appliances**, with the exception of orthopaedic shoes, and the fees for repairing the said appliances are also covered if the costs are lower.
- The fees for transportation by **ambulance**, including travel by plane or train (round-trip), in case of emergency.
- The services of **chiropractors**, up to a maximum reimbursement of \$30 per visit and a maximum of \$400 per calendar year, per insured. **Chiropractors' x-rays** shall be reimbursed up to a maximum of \$30 per calendar year, per insured. Only one treatment per day for the same patient is eligible for benefit.
- Expenses incurred in Canada or outside of Canada, for a stay in a **private, specialized clinic known for the treatment of alcoholism, drug addiction** (excluding, however, smoking) **or gambling**, up to a maximum of one course of treatment per calendar year, one reimbursement of \$3,500 per calendar year, and a lifetime maximum of 2 courses of treatment per insured.
- The purchase cost of **support hose**, up to a maximum of 6 pairs per calendar year, per insured.

**4. The following fees and services are reimbursed at 80% and are subject to maximums provided they are necessary to the treatment of the insured:**

- The services of **osteopaths or podiatrists**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, per insured, for all of these professionals combined.
- The professional services of **dental surgeons** for the repair of accidental damage to natural teeth sustained following the start of the insurance period and on condition that the care is provided less than one year following the date of the accident.
- The services of **acupuncturists**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, per insured.

- The purchase cost of a device intended for monitoring diabetes (**blood glucose monitor, dextrometer, or any device of the same nature**) and of the carrying case for its transportation, upon presentation of a complete report from the attending physician certifying that the insured is insulin-dependent and that his or her condition requires the use of such device. However, the maximum reimbursement is limited to \$200 per consecutive 5-year period, per insured.
- The purchase cost of an **insulin pump** intended for monitoring diabetes, upon presentation of a complete report from the attending physician certifying that the insured is insulin-dependent and that his or her condition requires the use of such device. However, the maximum reimbursement is limited to \$1,750 per consecutive 5-year period, per insured.
- Professional fees of **psychiatrists, psychoanalysts at an outpatient clinic, the services of psychologists, guidance counsellors in private practice, and social workers**. These professionals shall be reimbursed at 50% for the first \$1,400 of eligible expenses and at 100% for the next \$1,400 of eligible expenses. Maximum reimbursement of \$2,100 per calendar year, per insured, for all of these professionals combined, at a rate of one consultation per day. This maximum shall also apply in the case of marriage counselling for both spouses.

The reimbursed **psychiatrists' services** shall only be those rendered as psychoanalytic treatment and to the extent that these professionals are members of the Canadian Psychoanalytic Society.

The reimbursed **social workers' services** shall only be those rendered by professionals that are members of the *Corporation professionnelle des travailleurs sociaux du Québec*.

- The services of **physiotherapists or physical rehabilitation therapists**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, per insured, for all of these professionals combined.
- Professional fees for **dieticians**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, per insured. Only one treatment per day, per insured, is eligible for benefit.
- Professional fees for **homeopaths**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, per insured. Only one treatment per day, per insured, is eligible for benefit.

- The services of **naturopaths**, up to a maximum reimbursement of \$30 per treatment and 2 consultations per calendar year, per insured.
- The fees for **vaccines**, including preventative vaccines, administered by a physician or nurse.
- The occupancy expenses for a room, including meals, for at least 12 consecutive hours, in a **rehabilitation centre** in the sense of the Act respecting health services and social services and over and above the expenses payable by a governmental insurance plan, up to the cost of a semi-private room and an eligible maximum of \$75 per day, per insured, provided that the insured is admitted to such centre immediately following the end of his or her hospitalization; that the hospitalization lasted at least 3 days; and that it began during the insurance period. However, these expenses are limited to a maximum period of 15 days per hospitalization.

**5. The expenses for the services and supplies listed below are eligible for reimbursement at 80% and are subject to maximums. They must be prescribed by a physician and necessary to the treatment of the insured:**

- The professional services of a **registered nurse or certified nursing assistant**, excluding any person who usually resides in the insured's home or is a member of his or her family.
- The purchase cost of **orthopaedic shoes** (moulded shoes), after a deduction of \$20 per pair.
- **Corrective shoes** purchased from a specialty firm shall be reimbursed up to a maximum of 2 pairs per calendar year, per insured.
- The rental fee of a **wheelchair, iron lung, or therapeutic equipment**.
- **Respiratory therapy** services rendered under the supervision or prescription of a physician. However, the professionals rendering such services must be registered with the organizations that govern their profession.
- The professional fees of **speech therapists, occupational therapists and orthopedagogists**, up to a maximum reimbursement of \$30 per treatment and a maximum of \$400 per calendar year, **for all of these professionals combined**, per insured. Only one treatment per day, per insured, is eligible for benefit.
- The purchase or repair costs of **hearing aids** up to a maximum reimbursement of \$500 per consecutive 3-year period, per insured.

- The cost of **temporomandibular appliances** up to a maximum reimbursement of \$100 per 24-month period, per insured.
- When an insured is required to travel outside of his or her region to obtain advice or receive treatments from a specialist not available in his or her region, the following expenses are eligible and refundable up to a maximum of \$500:
  - If the situation requires travel of at least 280 kilometres (in total for a return trip) from the insured's place of residence, the cost of travel by public transportation (bus, plane, boat and train) or car; however, with respect to the expenses of travelling by car, the eligible expenses shall be equal to those that would have been incurred if the means of transportation used had been the bus.
  - Accommodation expenses incurred at a public facility, on condition that the consultation or treatment requires a stay.
  - The eligible expenses must be incurred obtain advice or treatment within the province of Québec and they shall be reimbursed upon presentation of receipted bills, except for the transportation, if done by car.
  - The eligible expenses must be incurred by and for the participant if he or she has individual coverage; if the participant has family or single-parent coverage, the eligible expenses must be incurred by and for the participant or his or her dependents; this coverage allows for the presence of an escort, if so justified by the situation.
- The purchase cost of an external **breast prosthesis** following a mastectomy, over and above the amount paid by the *Régie de l'assurance maladie du Québec*, to an eligible maximum of \$500 per calendar year, per insured.
- The purchase cost of a **hair replacement unit**, following chemotherapy treatments, to an eligible maximum of \$400 per calendar year, per insured.

**All of the healthcare professionals listed in this document must be members in good standing of their professional body, recognized by the legislative branch, or of their professional association, recognized by the Insurer.**

## 6. Exclusions

Without further limitations to the care, supplies and services described in points 1 to 5, no reimbursement shall be made by the Insurer for expenses incurred:

- For eye examinations or hearing tests, unless required as the result of an accident.
- If the insured is part of the active forces of the Army, the Marines, or the Air Force.
- As a result of any declared or undeclared war or active participation in an insurrection.
- As a result of active participation in a crime.
- For diet substances or foods.
- For prescription drugs or substances used in the treatment of impotence.
- Following termination of this contract without prejudice to the extension clause.
- For dentures, glasses, or contact lenses, unless required as the result of an accident.
- Which the insured would not be required to pay had he or she availed him or herself of the provisions of any public plan for which he or she was eligible.
- For surgery, treatments or prostheses for aesthetic purposes, except as the result of an accident.
- For periodic medical examinations, for employment or insurance purposes.

## TRAVEL INSURANCE

*(This benefit is included in the health insurance plan)*

The customary and reasonable expenses and services described hereafter are eligible if they are incurred following an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside his or her province of residence and provided that the insured is covered under the government health insurance plan of his or her province of residence.

Benefits are granted over and above, and not as a replacement of benefits provided under government programs. **The maximum lifetime reimbursement per insured is \$1,000,000.**

### **Eligible Expenses**

#### **a) Hospital, medical and paramedical expenses**

- Hospitalization expenses for a semi-private or private room, over and above that which is refunded or eligible for reimbursement under the government health insurance plan of the insured's province of residence.
- The fees (telephone, television, parking or otherwise) inherent to a hospitalization, upon presentation of supporting documents, up to a maximum of \$100 per hospitalization.
- Physicians' professional fees for medical, surgical, or anesthetization care other than professional fees for dental care; the expenses incurred are payable only for the portion of the fees over and above the benefits payable under the health insurance plan of the insured's province of residence.
- The cost of prescription drugs obtained by prescription from a physician in the context of emergency treatment.
- The professional fees of a graduate nurse for private care provided exclusively at the hospital when it is medically required and prescribed by the attending physician, up to a maximum reimbursement of \$3,000 per hospitalization. However, the nurse must in no way be related to the insured or be a travel companion.
- The rental of therapeutic equipment and the purchase of trusses, corsets, crutches, splints, plaster casts, and other orthopaedic equipment, when prescribed by the attending physician.
- The professional fees of a dental surgeon for accidental lesions to the natural teeth for an accident that occurred outside of the insured's province of residence, up to a maximum reimbursement of \$1,000 per accident; the expenses covered must be incurred in the 12 months following the accident.

## **b) Transportation expenses**

- Transportation expenses by air or surface ambulance to drive the insured to the nearest adequate medical facility. This service also includes the transfer between hospitals when the attending physician and the Assistor deem that the current facilities are inadequate for treating the patient or stabilizing his or her condition.
- Expenses for the repatriation of the insured via an adequate means of public transportation so that he or she may receive appropriate care in such place as soon as his or her condition of health so allows and to the extent that the means of transportation initially planned for the return cannot be used. If his or her condition of health so requires, the Assistor shall send a medical escort on site to accompany the insured during the repatriation. The repatriation must be approved and planned by the Assistor.
- When the insured is repatriated or transported, the Assistor shall organize and pay the expenses for the return, if applicable, of his or her spouse and their dependent children or of a travel companion of the insured, to the insured's province of residence, up to a maximum of a regular airline, train or bus ticket, if the means of return initially planned cannot be used.
- When the insured's state of health does not allow medical repatriation and hospitalization outside the province must extend beyond 7 days, the Assistor shall organize and pay round-trip transportation expenses for a close relative of the insured's family residing in his or her province of residence in order to allow the said relative to be at the insured's bedside. The maximum reimbursement is \$1,500. However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative who is 18 years of age or older, or if the need for the visit has not been confirmed by the attending physician, or if the visit has not been previously approved and planned by the Assistor.
- The Assistor shall make the necessary arrangements for children under the age of 18 accompanying the insured to return to their residence if, following the insured's accident or illness, the latter or another accompanying adult is unable to perform this task.
- When an insured is incapable of driving his or her vehicle as a result of an illness or accident that occurred during the trip, and no other passenger is able to drive the said vehicle, the Assistor shall pay the expenses incurred, via a sales office, to return the insured's personal or rental vehicle to his or her residence or to the nearest suitable rental agency, subject to a maximum reimbursement of \$1,000.

- In the event of the insured's death, when necessary, the Assistor shall organize and pay expenses for a round-trip economy class ticket via the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, provided that no close relative aged 18 years or over has accompanied the insured on the trip. The maximum reimbursement is \$1,500.
- In the event of the insured's death, the Assistor shall pay the cost of the preparation and return of the remains (excluding the cost of the casket) to the place of burial in the province of residence, subject to a maximum reimbursement of \$5,000, or the cost of cremation or burial on site, subject to a maximum reimbursement of \$3,000.

**c) Living expenses**

- Accommodation and meal expenses in a business establishment, when the insured must postpone his or her return due to illness or bodily injury that he or she personally sustained or was sustained by an accompanying close relative, or by a travel companion, subject to a maximum reimbursement of \$150 per day for 8 days.

**Travel Assistance Service**

The Assistor shall provide worldwide travel assistance service 24 hours a day, 365 days a year, to any insured who so requests it, excluding countries at war or in a known state of political instability, thereby making any intervention by the Assistor physically impossible.

- Cash advances for expenses covered under the travel insurance. Thereafter, the Assistor shall file a claim for reimbursement of the expenses incurred with 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 shall provide all medical information in the form of simple advice and information, as well as the contact information for a medical centre. If necessary, the Assistor shall facilitate the admission of the insured to an appropriate hospital or clinic.
- Without prejudice to these presents and in the event of illness or accident of the insured outside his or her province of residence, once notified, the Assistor shall organize the necessary contacts between its medical department, the attending physician, and eventually, the family physician, in order to make decisions that are best suited to the situation.
- The Assistor shall be responsible for transmitting urgent messages when the insured is personally incapable of doing so.

- The Assistor shall assume, insofar as possible, the dispatching of prescription drugs essential to the continuity of ongoing treatment, in the event that such drugs or their equivalent cannot be obtained on site. The cost of these prescription drugs shall, in all cases, be paid by the insured, to then be reimbursed by the Insurer, if eligible.
- Upon presentation of supporting documents, the Assistor shall reimburse the insured for telephone calls and other communication expenses incurred in order to obtain access to these services in the event of difficulty abroad.
- Upon the insured's request, the Assistor shall provide any information required in the event of significant problems during the insured's trip as a result of the loss of his or her passport, visa, credit card, or otherwise.
- The Assistor shall offer the insured who is experiencing difficulty abroad, a multilingual interpreters telephone service.
- In the event of legal proceedings resulting from a traffic accident, a highway code offence, or any other civil offence, the Assistor shall provide assistance by providing the names of lawyers. This service is only applicable in Canada or the United States.

### **Obligations of the Insured Person**

- a) **NOTICE:** The insured must notify the Assistor, as soon as possible, of the occurrence of the incident, accident or illness.
- b) **RESTRICTION:** The insured, as soon as he or she is capable of so doing, must obtain the prior consent of the Assistor before taking any initiative or incurring any expense. If the insured fails in this obligation, the Assistor shall be relieved of its obligations to the insured.
- c) **UNUSED TICKETS:** If an insured was repatriated under the terms of the travel assistance insurance, the Assistor reserves the right to request from the insured, the ticket that he or she holds and which was not used due to the services rendered by the Assistor.
- d) **SUBROGATION:** For the purposes of this insurance and for any funds advanced or reimbursed by the Assistor, the insured shall assign and subrogate the Assistor in all of its rights and recourses, to any reimbursement from which he or she shall benefit or claim to benefit under any public or private plan of services provided that are similar to those for which the advances or expenses were incurred by the Assistor. The insureds shall agree to sign any document and execute any deed required by the Assistor in order to give full and complete effect to the present assignment and subrogation and especially mandate the Assistor for this purpose as attorney and representative for submitting any claim and collecting any reimbursement.

## Exclusions

In addition to the exclusions and reductions of the basic health insurance, the Insurer or Assistor shall not pay any amount or provide any assistance to the insured in the following cases:

- a) When the loss occurred in the insured's province of residence.
- b) When the insured refuses, without any valid medical reason, to comply with the Assistor's recommendations regarding his or her repatriation, choice of hospital or required care; required care means the treatment needed to stabilize the insured's medical condition.
- c) If the Assistor was not contacted as soon as possible in the event of medical consultation or hospitalization, following a sudden accident or illness.
- d) When the expenses are incurred due to pregnancy and its resulting complications in the 12 weeks before the expected date of confinement;
- e) When the loss is due to any medical condition for which the insured has been hospitalized, for which he or she received medical treatment or had such treatment prescribed, or for which he or she consulted a physician in the 90 days prior to the departure date, unless it is proven to the Insurer's satisfaction that the insured's condition is stabilized. A change to a prescription drug, its dosage, or its use is considered medical treatment.
- f) When the loss is related to any of the insured's known conditions which are subject to periods of sudden aggravation and that cannot be controlled with medication or otherwise.

**The Insurer promises not to apply exclusions (e) and (f) unless the insured was informed, prior to his or her departure, that the condition is affected by the exclusion. It is strongly recommended that persons presenting with serious health problems communicate with the Insurer prior to their departure.**

- g) When the expenses incurred outside the insured's province of residence could have been incurred in his or her province of residence, without endangering the insured's life or health, with the exception of expenses required immediately following an emergency situation resulting from a sudden accident or illness. The mere fact that the quality of the care that can be provided in the province of residence is inferior to the care that may be provided outside of such province does not constitute, within the meaning of this exclusion, a danger to the insured's life or health.
- h) When hospital expenses are incurred in hospitals for the chronically ill, or in a department for the chronically ill in a public hospital, or for patients who are in long-term care homes or spas.

- i) For elective or non-urgent surgery or treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.
- j) For an accident that occurred while the insured participated in a sport for remuneration, in any kind of motor vehicles competition or any kind of speed contest, in gliding or sail flying, mountain climbing, parachuting whether or not in free fall, bungee jumping or any other dangerous activity. Activities other than those mentioned above and offered to the general public at vacation resorts shall not be considered dangerous (If you are unsure, contact the Insurer).
- k) When the loss occurs in a country at war, whether or not such war is declared; one that is experiencing known political instability; during a riot; common uprising; repression; restrictions on free circulation; strike; explosion; nuclear activity; radioactivity; or other cases involving an Act of God, making the Assistor's intervention physically impossible. **This exclusion applies to the travel assistance service only.**

The Insurer may, at any time and at its sole discretion, change the Assistor for the purposes of the travel insurance.

***IN CASE OF EMERGENCY***

Please note that the information on your service card is necessary when attempting to reach the Assistor, whose numbers are indicated below:

- |   |                       |
|---|-----------------------|
| <b>- In Canada and the United States:</b>       | <b>1 800 363-9050</b> |
| <b>- Elsewhere in the world (collect call):</b> | <b>1 514 985-2281</b> |

**TRIP CANCELLATION INSURANCE**  
*(This benefit is included in the health insurance plan)*

The Insurer shall pay, according to the terms and conditions set out hereunder, 100% of the expenses incurred by the insured following the cancellation or interruption of a trip to the extent that the expenses incurred are related to travel expenses paid in advance by the insured while this insurance is in force, and that the insured was not aware, at the time that the travel arrangements were finalized, of any event that could reasonably result in the cancellation or interruption of the planned trip. The expenses covered are limited to \$5,000 per insured, per trip.

**Causes for Cancellation or Interruption**

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

- a) An illness or accident preventing the insured or a close family member, his or her travel companion or close family member, or his or her business associate from performing his or her usual activities and that is reasonably serious enough to justify the cancellation or interruption of the trip.
- b) The death of the insured, his or her spouse, child or spouse's child, travel companion or business associate.
- c) The death of the insured's close family member, other than his or her spouse or child, or a close family member of the travel companion, if the funeral takes place during the planned period of the trip or in the 14 days preceding it.
- d) The death or emergency hospitalization of the host at destination.
- e) The ordering of the insured or his or her travel companion to report for jury duty or their subpoena to appear as a witness in a case to be heard during the period of the trip, provided that the subject is not a party to the dispute and has taken the necessary steps to have the hearing postponed.
- f) The putting of the insured or his or her travel companion into quarantine, except if such quarantine ends more than 7 days prior to the planned date of departure.
- g) The skyjacking of the airplane on which the insured is travelling.
- h) A loss that renders the primary residence of the insured, his or her travel companion, or the host at destination uninhabitable, provided that the residence is still uninhabitable 7 days prior to the planned date of departure or that the loss occurs during the trip.
- i) The transfer of the insured or his or her travel companion, for the same employer, to more than 100 kilometres away from his or her present home, if required within 30 days prior to the planned departure date.

- j) Terrorism or any other situation in the country to which the insured is travelling, provided that the government of Canada issues a recommendation advising Canadians not to travel to or in such country for a period covering the planned duration of the trip and that the recommendation is issued after the expenses had been incurred.
- k) A departure missed due to a delay in the means of transportation used to arrive at the departure point, provided that the schedule of the means of transportation used planned to arrive at least 3 hours prior to departure or at least 2 hours prior if the distance to be covered was less than 100 kilometres. The cause for the delay must be either weather conditions, mechanical difficulties (except for a private automobile), a traffic accident, or the emergency closing of a road; each of the last two causes must be backed by a police report.
- l) The weather conditions delaying the departure of the public carrier used by the insured, at the planned point of departure, by at least 30% (48 hours minimum) of the planned duration of the trip or preventing the insured from making a planned connection with another carrier insofar as this latter carrier is delayed for at least 30% (48 hours minimum) of the planned duration of the trip.
- m) A loss occurring at the place of business or on the physical premises where a business activity is scheduled to be held and thereby making it impossible to hold the activity such that written notice cancelling the activity is issued by the official organization responsible for organizing it.
- n) The involuntary loss of the insured's or his or spouse's permanent employment or the involuntary interruption of an employment contract prior to its expiry, provided that the person involved was employed with the same employer for more than one year.

### **Eligible Expenses**

The following expenses are eligible provided that they are in fact paid by the insured and are limited to \$5,000 per insured, per trip.

- a) In the event of cancellation prior to departure:
  - The non-refundable portion of the travel expenses paid in advance.
  - The additional expenses incurred by the insured who decides to travel alone in the event that his or her travel companion must cancel his or her trip for one of the reasons provided herein, subject to a maximum of the penalty for cancellation applicable to the insured at the time his or her travel companion must make the cancellation.
  - The non-refundable portion of the travel expenses paid in advance, up to a maximum of 70% of the said expenses, if the insured's departure is delayed due to weather conditions and he or she decides not to take the trip.

- b) If a departure is missed, at the beginning or during the trip, for one of the reasons provided herein, the additional cost required by a regularly scheduled public carrier for an economy class ticket via the most direct route to the planned destination.
- c) If the return is advanced or delayed:
  - The additional cost of a regular, economy class ticket via the most direct route for the return to the point of departure by the initially planned carrier, or if the latter cannot be used, the expenses required for economy class with a regularly scheduled public carrier for the most economical means of transportation, via the most direct route for the return to the planned point of departure; these expenses must be agreed to in advance with the Insurer.  
However, if the insured's return is delayed for more than 7 days due to illness or accident sustained by the insured or his or her travel companion, the expenses incurred are covered insofar as the person involved has been admitted to a hospital as an in-patient for more than 48 hours within the said 7-day period.
  - The unused and non-refundable portion of the land part of the travel expenses paid in advance.

## **Exclusions**

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

- a) If the trip is undertaken with the intention of receiving medical treatment or hospitalization services, whether or not the trip is taken on recommendation of a physician.
- b) If the trip is being undertaken for the purpose of visiting a person who is ill or has had an accident and the trip is cancelled or interrupted due to the death or deterioration of such person's medical condition.
- c) A war, whether or not declared, or the active participation in an insurrection, whether it is real or feared.
- d) The active participation of the insured or his or her travel companion in a criminal act or an act that is deemed to be criminal.
- e) Pregnancy or complications resulting from pregnancy in the 12 weeks prior to the expected date of confinement.
- f) An injury that the insured or his or her travel companion has intentionally inflicted upon him or herself, suicide or attempted suicide, whether or not the person is of sound mind.
- g) The voluntary and abusive consumption of prescription drugs, drugs, or alcohol and the ensuing conditions.

- h) The participation in a sport for remuneration, in any form of competition involving motor vehicles or any contest involving speed, gliding or hang-gliding, mountain climbing, parachute jumping whether or not in free-fall, bungee jumping or any other dangerous activity. Activities other than those mentioned above that are offered to the general public at vacation resorts shall not be considered dangerous.

#### **IMPORTANT**

- i) **A medical condition for which the insured or his or her travel companion has been hospitalized, has received or been prescribed medical treatment, or for which he or she has sought the advice of a physician within 90 days prior to the date on which the travel expenses were incurred, unless it is proven to the satisfaction of the Insurer that the condition of the subject had stabilized at the time the expenses were incurred. A change regarding a prescription drug, its dosage, or its use is considered medical treatment.**
- j) When the loss is related to any known condition of the insured or his or her travel companion that is subject to periods of sudden aggravation, which cannot be controlled by medication or otherwise.

#### **Deadline for Requesting Cancellation**

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

#### **Coordination of Benefits**

The benefits payable under the terms of this benefit shall be reduced by any amount payable under the terms of another group or individual insurance plan. Expenses incurred for which the insured is not required to pay in the absence of this benefit, are also excluded.

## **Trip Cancellation Insurance Claim**

At the time of a claim, the insured must provide the following supporting documents:

- Unused travel tickets.
- Official receipts for additional transportation expenses.
- Receipts for the land arrangements and other disbursements. The receipts must include the contracts officially issued via a travel agent or a registered business indicating the non-refundable amounts in the event of cancellation. Written proof of the insured's request to this effect as well as the results of his or her request must be sent to the Insurer.
- The official documents stating the cause of the cancellation. If the cancellation is due to medical reasons, the insured must provide a medical certificate completed by a legally authorized physician practicing in the region where the illness or accident occurred; the medical certificate must indicate the complete diagnosis confirming the insured's need to cancel, delay, or interrupt his or her trip.
- The police report when the delay in the means of transportation used by the insured is caused by a traffic accident or an emergency road closure.
- An official report issued by the appropriate authorities pertaining to weather conditions.
- Written proof issued by the official organizer of the business activity confirming that the event is cancelled and indicating the specific reasons for the cancellation of the event.
- Any other report required by the Insurer allowing the insured's claim to be justified.

## DENTAL INSURANCE

*(Mandatory for any employee of a college whose union has retained this benefit)*

When an insured incurs expenses for dental treatments as defined below, rendered and recommended by a dentist, the Insurer shall pay for all of these coverages up to a maximum reimbursement of \$1,000 per calendar year, per insured:

- **70% of expenses for preventive services;**
- **70% of expenses for basic restorative services;**
- **70% of expenses for major restorative services.**

A single annual \$25 deductible shall apply for the participant and his or her dependents, if applicable.

Eligible expenses are reasonably incurred expenses, recommended by a dentist and justified by the current practice of dentistry for the care described below, and whose cost does not exceed the rates contained in the fee guide of the *Association des chirurgiens dentistes du Québec* in effect at the time the services are rendered.

The codes used to describe the eligible expenses are taken from the document entitled "2001 Fee Guide for Dental Treatment Services" approved by the *Association des chirurgiens dentistes du Québec*. For subsequent years, these codes will be replaced by their equivalent in later documents approved by the Association. Any new code number for dental treatment services related to the expenses described below and added during the term of the contract shall be considered an integral part of the description of eligible expenses under the terms of this contract.

For the first year of insurance, the deductible is prorated to the number of months between the effective date and the end of the calendar year, unless there is an agreement to the contrary between the Policyholder and the Insurer. Furthermore, for the first year of insurance, the maximums shall be prorated to the number of months between the effective date and the end of the calendar year.

If there is more than one type of treatment for the insured's dental condition, the Insurer shall reimburse the least expensive normal and suitable treatment.

## 1. Eligible Expenses

### Expenses for Preventive Services

#### ***Diagnostic Services***

- Clinical oral examination:
  - a) complete examination, up to a maximum of one examination per consecutive 6-month period (01110, 01120, 01130)
  - b) recall or periodic examination, up to a maximum of one examination per consecutive 6-month period (01200)
  - c) dental examination for children under the age of 10, not payable under the Québec public health insurance plan, up to a maximum of one examination per consecutive 12-month period (01250)
  - d) emergency examination (01300)
  - e) examination of a specific aspect up to a maximum of one examination per consecutive 6-month period (01400)

Limitation: only one recall, periodic, complete, or specific examination per consecutive 6-month period is covered.

- X-rays:
  - a) intraoral x-rays
    - i) periapical x-ray (02111 to 02116)
    - ii) occlusal x-ray (02131, 02132)
    - iii) interproximal x-ray (02141 to 02144)
  - b) extraoral x-rays
    - i) extraoral film (02201, 02202)
    - ii) sinus examination (02304)
    - iii) sialography (02400)
    - iv) radio-opaque substance (02430)
    - v) temporomandibular joint (02504)
  - c) interpretation of x-rays from another source (02800)
  - d) tomography (02920, 02929)

Limitation: a maximum of one x-ray sitting per consecutive 6-month period shall be eligible for reimbursement, with the exception of the x-ray sitting performed during an emergency examination; furthermore, a complete series of periapical and interproximal films shall only be eligible for reimbursement once every consecutive 36-month period.

### ***Preventive services***

- polishing of the coronal portion of the teeth (prophylaxis), up to a maximum of one treatment per consecutive 6-month period (11100, 11200, 11300)
- periodontal scaling, up to a maximum of one treatment per consecutive 6-month period relative to all of these dental treatments (43411 to 43414, 43417, 43419)
- topical fluoride application for dependents 16 years of age or under, up to a maximum of one treatment per consecutive 6-month period (12400)
- finishing of fillings (13300)
- pit and fissure sealants for dependents 14 years of age and under (13401, 13404)
- tooth smoothing
  - a) interproximal tooth smoothing (13700)
  - b) prophylactic odontotomy and/or ameloplasty (13710)

### **Basic Restorative Services**

#### ***Restoration***

- primary teeth;
  - a) non-bonded amalgam, anteriors or posteriors (21101 to 21105)
  - b) bonded amalgam, anteriors or posteriors (21121 to 21125)
  - c) bonded composite anteriors (23311 to 23315)
  - d) bonded composite posteriors (23411 to 23415)
- permanent teeth;
  - a) non-bonded amalgam anteriors and bicuspid (21211 to 21215)
  - b) non-bonded amalgam molars (21221 to 21225)
  - c) bonded amalgam anteriors and bicuspid (21231 to 21235)
  - d) bonded amalgam molars (21241 to 21245)
  - e) bonded composite anteriors (23111 to 23115, 23118)
  - f) manufacture of veneer, chairside (anteriors and bicuspid) (23122)
  - g) bonded composite bicuspid, up to a maximum of the amount payable for bonded amalgam bicuspid (23211 to 23215)
  - h) bonded composite molars, up to a maximum of the amount payable for bonded amalgam molars (23221 to 23225)
- retention pins, for restoration in amalgam or composite (21301 to 21304)
- top-up of amalgam or composite restorations, below the clasp of a partial denture (21501, 23701)

## ***Oral Surgery***

- removal of erupted teeth, uncomplicated (71101, 71111)
- surgical removal
  - a) erupted teeth (complex) (72100)
  - b) impacted teeth (72210, 72220, 72230, 72240)
  - c) residual roots (72300, 72310, 72320)
  - d) surgical exposure of teeth (72410 to 72412)
  - e) surgical displacement of teeth (72430 to 72440)
  - f) enucleation (72450)
- remodeling and recontouring of oral tissues
  - a) alveolectomy (73020)
  - b) alveoloplasty (73100, 73110)
  - c) stomatoplasty (73123)
  - d) osteoplasty (73133 to 73135, 73140)
  - e) tuberoplasty (73150, 73151)
  - f) removal of hyperplasic tissue (by radiosurgery or dissection) (73171 to 73176)
  - g) removal of excess mucosa (by radiosurgery or dissection) (73181 to 73186)
  - h) alveolar process reconstruction with biocompatible synthetic 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)
- removal of a tumor or cyst
  - a) removal of a tumor (74108, 74109)
  - b) removal and curettage of a cyst or intraosseous granuloma (74408 to 74410)
- surgical incision and drainage (75100, 75101, 75110)
- removal of a foreign body from bone tissue or soft tissue (75301, 75361)
- frenectomy (77801 to 77803)
- hemorrhage control (79400, 79401)

## ***General Additional Services***

- local anesthesia (92110, 92120)
- conscious sedation by inhalation (92310, 92311)
- professional visits (94100, 94200, 94400)

## **Major Restorative Services**

### ***Endodontics***

- caries / trauma / pain control
  - a) sedative dressing / indirect capping (20111, 20121)
  - b) smoothing and polishing of a traumatized tooth (20131)
- endodontic emergency
  - a) pulpotomy (32201, 32202, 32210)
  - b) opening and drainage (separate emergency procedure)
    - i) opening through a natural tooth (39201, 39202)
    - ii) opening through a metal or porcelain crown (39211, 39212)
  - c) pulpectomy (separate emergency procedure) (39901 to 39903)
  - d) selective smoothing to relieve a traumatic occlusion (39970)
  - e) reimplantation of an avulsed tooth (39981)
  - f) repositioning of a traumatically displaced tooth (39985)
- preparation of the tooth for treatment (39100, 39110, 39120)
- root canal therapy
  - a) root canal
    - i) one canal (33100 to 33102, 33110)
    - ii) two canals (33200 to 33202, 33210)
    - iii) three canals (33300 to 33302, 33310)
    - iv) four canals (33400 to 33402, 33410)
  - b) apexification
    - i) one canal (33521, 33531, 33541)
    - ii) two canals (33522, 33532, 33542)
    - iii) three canals (33523, 33533, 33543)
- periapical endodontic surgery
  - a) apectomy (as a separate procedure from the root canal) (34101 to 34104)
  - b) apectomy and root canal performed in conjunction with endodontic treatment, with or without retrofilling (34111, 34112, 34114, 34115)
  - c) apectomy and retrofilling (as a separate procedure from the root canal) (34201 to 34203, 34212, 34215)
  - d) root amputation (34401, 34402)
  - e) intentional reimplantation (34451 to 34453)
  - f) hemisection (39230)
  - g) intraosseous endodontic stabilizer (39715, 39725)
- in office bleaching of a tooth performed by the dentist, to a combined maximum of 10 sessions per year, per insured, for all teeth
  - a) devitalized teeth (39410)
  - b) vital teeth, in office (39420, 39421)

### ***Periodontics***

- management of acute infections and other lesions (41200)
- application of a desensitization agent to a combined maximum of 10 visits per year, per insured for all teeth (41300)
- periodontal surgery;
  - a) curettage and root planing (42000, 42001)
  - b) gingivoplasty and/or gingivectomy (42003, 42010)
  - c) fibrotomy (42330, 42331)
  - d) flap approach with osteoplasty and/or osteoectomy (42100)
  - e) graft
    - i) soft tissue (42200, 42300, 42560, 42561)
    - ii) bone tissue (42611, 42700, 42711)
  - f) interproximal wedge (mesial or distal) (42400)
  - g) exploratory surgery, flap approach (42441)
  - h) clinical crown lengthening with flap approach and correction via osteoplasty and/or osteoectomy (42451)
  - i) follow-up postoperative visit for dressing change (42720)
- adjunctive periodontal procedures
  - a) splinting or ligation, temporary (43200, 43211, 43212, 43260, 43280)
  - b) occlusal equilibration (43300, 43310)
  - c) periodontal appliances (appliance for bruxism) (43611, 43612, 43622, 43631)
  - d) intraoral appliance for temporomandibular joint (occlusal guard) (43711, 43712, 43732, 43741)
  - e) periodontal irrigation, subgingival (49211)

### ***Denture Adjustments***

- minor adjustments, provided that these adjustments are made more than 6 months after the initial insertion of the denture (54250, 54251)
- remount and equilibration of complete or partial dentures (54300 to 54302)

### ***Complete or Partial Denture Repairs***

- repair of a complete denture without impression (55101 to 55104)
- repair of a complete denture with impression (55201 to 55204)
- structure additions to the partial denture (55520, 55530)
- resetting of teeth (56602)
- vertical dimension recuperation by addition of acrylic to an existing denture (56631)

### ***Rebasing and Relining***

- relining of a complete or partial denture (56200, 56202, 56210, 56212, 56220 to 56222, 56230 to 56232)
- rebase (jump) (56260 to 56263, 56280, 56290)
- therapeutic temporary packing (56270 to 56273)

### ***Restriction Regarding Rebasing and Relining***

These dental services are eligible for reimbursement if performed more than 6 months after insertion of the denture and if at least 36 consecutive months have elapsed since the last relining or rebasing, whichever applies.

However, these services shall not be refundable if they are performed on a transitional denture.

## **2. Exclusions**

The following dental procedures are excluded from coverage and are not eligible for reimbursement by the Insurer:

- Dental care that is free of charge or that the insured is not required to pay, as well as care for which he or she would not be required to pay had or she invoked the provisions of any public or private, individual or group plan, for which the insured would be eligible or would not be required to pay in the absence of this contract.
- Dental treatments for which the insured is entitled to a refund under the Act respecting industrial accidents and occupational diseases, the Québec Automobile Insurance Act or any other Canadian or foreign act having the same effect; dental treatments payable by a health insurance plan in which the insured has enrolled.
- Dental treatments and supplies which, in accordance with accepted dentistry standards, are not required from a dental viewpoint or which do not meet accepted dentistry standards
- Dental treatments performed mainly for aesthetic purposes, including the transformation or extraction and replacement of healthy teeth in order to modify appearance.
- Dental treatments required following an injury that the insured wilfully inflicted upon him or herself, whether or not of sound mind, as a result of war, or of active participation in a real or feared insurrection.
- Professional fees billed by a dentist for an appointment missed by the insured or for the completion of claim forms required by the Insurer, or for additional information required by the Insurer; also for travel time, transportation costs and advice provided by any means of telecommunication.

- The professional fees billed by a dentist for a treatment plan, for extra time spent on explanations due to the complexity of the treatment, or when the insured requires this extra time for explanations, or when the diagnostic material comes from another source; for consultation with the insured; for consultation with another dentist.
- The professional fees billed by a dentist for analysis of the diet and the recommendations for initial oral hygiene instruction and reinstruction, and for a dental plaque control program; for all oral protective appliances.
- Dental treatments related to implants.
- Expenses incurred while insurance under this benefit is not in force.

Furthermore, the benefits of any insured referring to the care received under a treatment plan established prior to the effective date of this benefit shall not be eligible under this insurance.

**LIFE INSURANCE**  
***(Optional benefit)***

**1. Participant's Life Insurance**

**a) Amount of Basic Insurance**

The amount of basic insurance payable upon the participant's death is the following:

- Two times the annual salary, previously rounded to the nearest \$500, if the death occurs before the 65th birthday, or the effective date of retirement, whichever comes first; the minimum amount of basic insurance is \$20,000;
- One time the annual salary rounded to the nearest \$500 if the death occurs on or after the 65th birthday, for a participant who is not retired;
- \$10,000 if the death occurs on or after the 70th birthday, for a participant who is not retired.

**Any change to the insurance amount shall be made on the latest of the following dates:**

- the effective date of the salary change, or if later;
- the date of an agreement to this effect between the Policyholder and the Insurer.

**b) Compensation in the Event of Accidental Death and Dismemberment**

If a participant under the age of 65 sustains, as the result of an accident and within the 365 days following the date of that accident, any of the losses listed in the schedule below, the Insurer shall pay, for the loss incurred, compensation equal to the percentage of the amount of basic insurance payable at the participant's time of death, as indicated hereunder; the amount determined based on the said schedule, for all losses resulting from the same accident, shall not exceed the amount of basic insurance.

<b>Loss</b>	<b>Percentage</b>
- of life	100%
- of both hands or both feet	100%
- of sight in both eyes	100%
- of one hand and one foot	100%
- of one hand or one foot and sight in one eye	100%
- of one hand or one foot	50%
- of sight in one eye	50%

The loss of one hand or one foot means the complete and definitive loss of use. The loss of sight must be complete and irreparable. This coverage shall apply 24 hours a day, whether or not the insured is at work.

The benefit stipulated in the event of accidental death and dismemberment shall be doubled if the participant sustains the accident:

- While travelling as a passenger in or on a public transportation vehicle (including the platforms, steps, or sidewalks of a train or subway car) normally assigned to the service of passengers by a licensed driver (such as a bus, taxi, subway, train, boat, or commercial plane).
- During an accident on an escalator or elevator (with the exception of mine elevators).
- During a fire in a public building provided that the participant was there at the time the fire started and it is not his or her usual place of work.
- During the collapse of an outside wall of a public building while the participant was inside the building and it is not his or her usual place of work.
- By lightning, or by the explosion or rupture of a steam boiler.
- By a hurricane or cyclone as reported by the weather station of the district in which the accident took place.

***Exclusions***

The Insurer shall not pay the compensation amount for accidental death and dismemberment if the participant sustains one the losses listed in the schedule of losses:

- While performing or attempting to perform any of the duties of a member of a commercial or private aircrew, unless he or she is acting as an employee of a flying school whose union is affiliated with the FNEEQ and as set out in the collective agreement or in his or her personal employment contract.
- As a result of declared or undeclared war, or of his or her active participation in an insurrection.
- As a result of suicide or voluntary injury or mutilation, whether or not the participant is of sound mind.
- As a result of his or her active participation in a crime.
- If the insured is part of the Army, the Marines, or the Air Force.
- While the insurance on the life of a participant is extended without the payment of premiums, as the result of a disability.

## 2. Dependents' Life Insurance

The dependents' amount of life insurance is the following:

- **Spouse:**

\$10,000 if he or she dies prior to his or her 65th birthday; \$4,000 if he or she dies on or after his or her 65th birthday and before his or her 70th birthday; and \$2,000 if he or she dies on or after his or her 70th birthday.

- **Dependent child:**

\$4,000 as of the age of 24 hours, provided he or she meets the definition of dependent child.

## 3. Optional Life Insurance

Any participant covered under the basic life insurance benefit may add, for him or herself or for his or her spouse only, optional life insurance on the conditions described below:

- The participant must not be retired.
- The participant who wishes to obtain optional life insurance for his or her spouse must already have dependents' life insurance and must be under the age of 65 years.
- The participant and/or his or her spouse may take out 1 to 7 units of optional life insurance with each unit being equal to \$20,000.
- The coverage shall end at 70 years of age or on the effective date of retirement, whichever is first.

- The waiver of premiums follows the same rules as for basic life insurance according to the following terms and conditions:
  - in the event of the participant's disability, his or her premium and that of his or her spouse, if applicable, shall be waived;
  - in the event of the spouse's disability, the spouse's premium shall not be waived.
- Evidence of insurability is required.
- The rates are provided by gender and for the smoker and non-smoker categories (the eligibility criterion for the second category is to not have smoked cigarettes in the past year).
- The same rate basis is used for the spouse.

**SHORT TERM DISABILITY INSURANCE**  
*(Mandatory benefit for an employee of the private sector  
who meets the eligibility criteria)*

Upon receipt and approval by the Insurer of evidence determining that the participant became disabled under the terms of the contract, and following the expiry of the elimination period, the Insurer shall pay a monthly benefit as outlined below.

**1. Elimination Period**

The elimination period means the 30-day period following the start of the disability and during which time no disability benefit is payable.

**2. Benefit Period**

The first benefit payment is payable as of the 31st day following the expiry of the elimination period defined above and the subsequent payments shall be made monthly thereafter, for as long as the participant remains disabled, subject to a maximum period of 23 months.

The monthly benefit payment shall cease no later than the last week of the month in which the participant turns 65 years of age.

**3. Benefit Amount**

The initial amount of the monthly benefit payable in the event of disability of a participant is equal to 80% of his or her net salary; the net salary is that established at the time of depletion of the sick leave. However, the benefit is limited to \$5,000 per month.

**4. Cost-of-living Adjustment**

While, and for as long as the participant is disabled, the monthly benefit amount shall be adjusted on January 1 of each year, pursuant to the same terms and conditions as those that apply to benefits payable under the terms of the Québec Pension Plan. However, the annual adjustment is limited to 3%.

**5. Rehabilitation**

A participant who participates in a rehabilitation program shall receive from the Insurer the monthly rehabilitation benefit described below. Payment of this benefit shall end upon expiry of a 12-month period following the start of the rehabilitation period, or upon interruption of the rehabilitation period, or upon withdrawal of the Insurer's approval of the rehabilitation program.

The monthly rehabilitation benefit shall be equal to the amount of the benefit paid had there not been a rehabilitation program, less 50% of the remuneration for the work performed during the rehabilitation program.

If the participant's income from the rehabilitation benefit and the remuneration for the work performed during the rehabilitation program exceeds 100% of the net monthly base salary that the participant would have received if he or she had been active, the monthly rehabilitation benefit shall be reduced by that excess amount.

Furthermore, the rehabilitation program may include a gradual return to work. This program must be approved by the Insurer and is subject to a maximum period of 12 months.

## **6. Exclusions**

No compensation shall be payable under the terms of this benefit for any disability resulting, directly or indirectly, from any of the following causes:

- While performing any of the duties of a commercial aircrew, unless he or she is acting as an employee of a flying school whose union is affiliated with the FNEEQ and as set out in the collective agreement or in his or her personal employment contract.
- Declared or undeclared war, or his or her active participation in an insurrection.
- Voluntary injury or mutilation, whether or not the participant is of sound mind.
- His or her active participation in a crime.
- Alcoholism, drug addiction, or gambling, unless it is a disability period during which the participant is receiving treatment or ongoing medical care with a view to rehabilitation.
- While the insured is part of the active forces of the Army, the Marines, or the Air Force.

## **7. Coordination of Benefits**

If the disabled participant is entitled to other income during his or her disability period, the benefit shall be reduced:

- By the initial amount of any base benefit, under the terms of the Québec Pension Plan, the Act respecting industrial accidents and occupational diseases, the Québec Automobile Insurance Act, the Employment Insurance Act, the pension plan and any other public plan or group insurance contract, without taking into account future increases in the base benefits resulting from indexation.
- By 95% of the net amount of all disability benefits received under the terms of the pension plan.

- By any benefits payable under the terms of any income replacement or sick leave policy.
- By 50% of the gross amount of the pension benefit paid under the terms of a public or parapublic pension plan for a disabled participant who retires after June 30, 1996.
- By 50% of the gross amount of the Québec Pension Plan pension benefit, which is effectively paid to the participant.

**LONG TERM DISABILITY INSURANCE**  
*(Mandatory benefit)*

Upon receipt and approval by the Insurer of evidence determining that the participant became disabled under the terms of the contract, and following the expiry of the elimination period, the Insurer shall pay a monthly benefit as outlined below.

**1. Elimination Period**

The elimination period means the 104-week period following the start of the disability plus the depletion of the sick leave reserve, if applicable.

For a participant of the **private sector**, the elimination period begins when he or she becomes disabled and shall end on the last day for which short term disability benefits are payable.

**2. Benefit Period**

The first benefit payment is payable on the 31st day following expiry of the elimination period defined above and subsequent payments shall be made every month thereafter.

Furthermore, entitlement to benefits shall cease no later than the last week of the month in which the participant turns 65 years of age.

**3. Benefit Amount**

**Participant who became disabled before July 1, 1996**

The initial amount of the monthly benefit payable in the event of disability of a participant is equal to 70% of the first \$2,500 of the participant's monthly salary and 50% of the excess; the benefit amount is limited to a monthly maximum of \$5,000. Salary means the amount to which the insured would have been entitled at the start of the long term disability insurance payments.

**Participant who became disabled after June 30, 1996**

The initial amount of the monthly benefit payable in the event of disability of a participant is equal to 80% of his or her net monthly salary, and the net salary is that which the participant would have received at the end of the elimination period as stipulated in his or her collective agreement had he or she not become disabled. However, the benefit is limited to \$5,000 per month.

#### **4. Cost-of-living adjustment**

While, and for as long as the participant is disabled, the monthly benefit amount shall be adjusted on January 1 of each year, pursuant to the same terms and conditions as those that apply to the benefits payable under the terms of the Québec Pension Plan. However, the annual adjustment is limited to 6% for a participant whose disability start date is on or after January 1, 1981, and 4% for a participant whose disability start date is prior to January 1, 1981.

#### **5. Rehabilitation**

A participant who participates in a rehabilitation program shall receive from the Insurer the monthly rehabilitation benefit described below. Payment of this benefit shall end upon expiry of a 24-month period following the start of the rehabilitation period, or upon interruption of the rehabilitation period, or upon withdrawal of the Insurer's approval of the rehabilitation program.

Monthly rehabilitation benefits are equal to the amount of the participant's monthly benefit prior to his or her registration in the rehabilitation program, reduced by a sum equal to 50% of the remuneration for work performed during the rehabilitation program.

If the participant's income from the rehabilitation benefit and remuneration for the work performed during the rehabilitation program exceeds 100% of the net monthly base salary received from the employer at the start of the elimination period, the monthly rehabilitation benefit shall be reduced by that excess amount.

Furthermore, the rehabilitation program may include a gradual return to work. This program must be approved by the Insurer and is subject to a maximum period of 12 months.

#### **6. Exclusions**

The Insurer shall not assume any obligation towards any disability period of a participant resulting from:

- The performance any of the duties of a commercial aircrew, unless he or she is acting as an employee of a flying school whose union is affiliated with the FNEEQ and as set out in the collective agreement or in his or her personal employment contract.
- A declared or undeclared war, or of his or her active participation in an insurrection.
- A voluntary injury or mutilation, whether or not the participant is of sound mind.

- His or her active participation in a crime.
- Alcoholism, drug addiction, or gambling, unless it is a disability period during which the participant is receiving treatment or ongoing medical care with a view to rehabilitation.
- While the insured is part of the active forces of the Army, the Marines, or the Air Force.

## **7. Coordination of Benefits**

If the disabled participant is entitled to other income during his or her disability period, the benefit shall be reduced:

- By the initial amount of any base disability benefit under the terms of the Québec Pension Plan which is effectively paid or which would have been paid to the participant if a claim had been filed and approved, unless proof is submitted in due form to the Insurer demonstrating that such claim had been denied. A negative response from the Québec Pension Plan shall in no way deprive the participant of his or her entitlement to benefits.

A participant has the obligation to file such claim for disability benefits with the authority concerned if the Insurer so requires it, and the participant's failure to do so shall result in the reduction of the benefit as described in the preceding paragraph.

Future increases of the base benefits resulting from indexation shall not be considered.

- By 95% of the net amount of all disability benefits received under the terms of the pension plan.
- By any benefits payable under the terms of any income replacement or sick leave policy.
- By 50% of the gross amount of the pension benefit paid under the terms of a public or parapublic pension plan for a disabled participant who retires after June 30, 1996.

The Insurer may ask the disabled participant to file a claim with the authority concerned if the disabled participant meets one of the following three criteria:

- a) is entitled to a pension benefit with no actuarial reduction;
- b) has completed of the elimination period for the disability pension plan;
- c) has obtained the Insurer's guarantee that the Insurer will no longer question the state of disability.

In the event that the disabled participant refuses to file such claim, the pension plan used to reduce the disability benefit shall be estimated as follows:

- a) based on the pension statement ; this statement must be provided by the participant; or
- b) 70% of the effective salary at the start of the disability.

The pension benefit estimated in this manner may be corrected retroactively for a maximum period of 6 months should the disabled participant decide to file his or her claim for pension benefits or to provide the Insurer with his or her pension statement.

- By the initial amount of all base disability benefits under the terms of the Act respecting industrial accidents and occupational diseases, the Québec Automobile Insurance Act, the Employment Insurance Act, and any other public plan or group insurance contract, without taking into account future increases in the base benefits resulting from indexation.
- By 50% of the gross amount of the Québec Pension Plan pension benefit, which is effectively paid to the participant.
- If the disabled participant is entitled to other income during his or her disability period beginning ***on or after January 1, 2008***, the benefit shall be reduced by 50% of the gross amount derived from gainful employment performed by a disabled participant following the start of his or her disability. The gross amount subject to coordination of benefits shall be determined based on the ensuing income tax return and notice of assessment which the disabled participant sends to the Insurer.

## GENERAL INFORMATION

### 1. Definitions

#### **Accident**

Any bodily injury confirmed by a physician and resulting from the sudden and unforeseeable action of an intervening force, directly and independently of any other cause.

#### **Assistor**

CanAssistance travel assistance firm or any other assistance company appointed by the Insurer.

#### **Business associate**

The person with whom the insured is associated in business in the context of a company of 4 joint shareholders or less or a profit-making corporation comprised of 4 partners or less.

#### **Close relative**

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

#### **Commercial activity**

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

#### **Dependent child**

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

- a person under the age of 18 years over whom the participant or his or her spouse exercises parental authority, including a child for whom adoption procedures have been undertaken; such person shall be considered a dependent child until his or her 21st birthday on condition that he or she does not have a spouse and that the participant or his or her spouse largely tends to the person's needs;
- a person, without a spouse, 25 years of age or under, who attends, on a full-time basis, as a duly registered student, a recognized educational institution, and over whom the participant or his or her spouse would exercise parental authority if the dependent child were a minor;

- a person of full age who lives with the participant, without a spouse, over whom the participant or his or her spouse would exercise parental authority if the dependent child were a minor, and who is totally disabled or suffers from a functional deficiency as set out in a government regulation and which occurred while he or she met the criteria of one of the two preceding paragraphs.

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

### **Disability or disabled**

#### ***For a disability that began prior to July 1, 1991***

A state of incapacity resulting from an illness or accident that requires ongoing medical care and which, during the elimination period of the long term disability insurance and for the 5 years that follow, completely prevents the participant from performing the usual tasks of his or her regular occupation and, following this period, completely prevents the participant from engaging in any gainful employment for which he or she is reasonably qualified based on his or her education, training, and experience; however, for a disability that began prior to January 1, 1990, the words "5 years" above shall be replaced by "24 months".

#### ***For a disability that began on or after July 1, 1991, but before July 1, 1995***

A state of incapacity resulting from an illness or accident that requires ongoing medical care and which, during the elimination period of the long term disability insurance and for the 5 years that follow, completely prevents the participant from performing the usual tasks of his or her regular occupation; after this period and to the age of 60 years, completely prevents the participant from engaging in any gainful employment for which he or she is reasonably qualified based on his or her education, training, and experience; as of 60 years of age, it completely prevents the participant from performing the usual tasks of his or her regular occupation.

#### ***For a disability that began on or after July 1, 1995, but before January 1, 2008***

A state of incapacity resulting from an illness, accident, or surgical procedure directly related to family planning, that requires ongoing medical care and which, during the elimination period of the long term disability insurance and for the 5 years that follow, completely prevents the participant from performing the usual tasks of his or her regular occupation; after this period and to the age of 60 years, completely prevents the participant from engaging in any gainful employment for which he or she is reasonably qualified based on his or her education, training,

and experience; as of 60 years of age, it completely prevents the participant from performing the usual tasks of his or her regular occupation.

***For a disability that began on or after January 1, 2008***

A state of incapacity resulting from an illness, accident, or surgical procedure directly related to family planning, that requires ongoing medical care and that completely prevents the participant from performing the usual tasks of his or her regular occupation.

Furthermore, a disability cannot be denied solely on the basis that the participant, at the end of the elimination period, is in a gradual return to work or rehabilitation program, under the terms of his or her collective agreement.

*In the event of disagreement between the Insurer's physician and the participant's physician with respect to the participant's disability, the two physicians shall agree on the choice of a third physician whose decision shall be final, without possible appeal. The Insurer shall be responsible for the cost of the examination. In such cases, as well as in cases where the expert assessment of a third physician is necessary as stipulated in the clauses relative to the collective agreement in effect (section 5.5.26 of the FNEEQ 2000-2002 collective agreement), the participant shall receive benefits between the date the Insurer receives the opinion of the participant's physician or the employer's physician, as applicable, and the date of the decision, however this shall not exceed 6 months if, at the end of this period, no decision has been issued. A decision in favour of the Insurer shall not result in the reimbursement of benefits received by the participant during the said period. Furthermore, the employer must report to the Insurer, upon the Insurer's request, any disability which has lasted more than 6 months with respect to disabled participants of the public sector.*

***N.B.: See the complete provisions in the contract.***

**Disability period**

*For the first 24 months of disability*

Any ongoing period of disability, or subsequent periods of disability resulting from the same illness or accident, separated by a period of remission of at least 8 workdays (must be read as "32 workdays" if the disability period is greater than 3 months), unless the disability, for a period, is the result of an illness or accident that is completely independent of the illness or accident that caused the disability during the previous period and that the disability only begins upon the return to work.

### *Thereafter*

Any ongoing period of disability, or subsequent periods of disability resulting from the same illness or accident, separated by a period of remission of at least 180 workdays, unless the disability, for a period, is the result of an illness or accident that is completely independent of the illness or accident that caused the disability during the previous period and that the disability only begins upon the return to work.

### **Employee**

The expression "Employee" includes the following categories:

- any person hired by the employer on a full-time basis and covered by the accreditation certificate issued in favour of a union affiliated with the FNEEQ-CSN, with the exception of lecturers;
- any person hired by the employer on a part-time basis for a minimum contract of 20% of one task per session and covered by the accreditation certificate issued in favour of a union affiliated with the FNEEQ-CSN, with the exception of lecturers;
- any person or category of persons approved by the Policyholder and set out by the contract (ref. : contract);
- any lecturer set out by the contract (ref. : contract).

### **Illness**

Any deterioration in the health or disorder of the organism recognized by a physician, including pregnancy and any resulting complications.

### **Participant**

An employee who is admitted to the insurance.

### **Spouse**

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

- is married or joined by civil union to the participant; or,
- is neither married nor in a civil union and has been cohabiting in a conjugal relationship with the participant for at least one year, or for less than one year if he or she is the father or mother of a child of the participant; or
- is neither married nor in a civil union and is cohabiting in a conjugal relationship with the participant and had previously cohabited with the participant for an entire period of at least one year.

It being specified that a judgment of divorce between the participant and the spouse in the case of a marriage; the legal separation of at least 90 days in the case of a common-law union; or the dissolution of the civil union by notarized agreement or court ruling in the case of a civil union, shall terminate this spousal status.

**Traveling companion**

The person with whom the insured shares a room or apartment at the destination or whose transportation expenses were paid along with those of the insured.

**Travel expenses paid in advance**

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

**Trip**

*(This definition applies to the trip cancellation insurance only.)*

A tourist or pleasure trip or commercial activity involving the insured's absence from his or her place of residence for a period of at least 72 consecutive hours and requiring travel of at least 400 kilometres (round trip) from his or her place of residence; a cruise with a planned duration of at least 72 hours under the responsibility of an accredited firm is also considered to be a trip.

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

**2. Eligibility**

The employee is eligible for insurance as of the effective date of this contract in the case of an employee insured under previous contracts. In the case of all other employees, he or she is eligible as of the effective date of this contract or, if later, the date of hire with the employer.

However, a non-permanent employee is eligible for long term disability insurance upon the signature of each contract, whether it is contiguous or non-contiguous. However, a non-permanent employee who has contiguous contracts may enrol in long term disability insurance without providing evidence of insurability in his or her first three contracts, with the first being the one signed on the date of hire with the employer. Evidence of insurability to the satisfaction of the Insurer must be provided at the expense of the participant for subsequent contracts. For the purposes of the application of this provision, a contract shall be interpreted as a minimum contract of 0.5 ETC per session, i.e., 1/2 load per session or 1/4 of the task per year.

Furthermore, for the application of this contract, an employee who becomes permanent shall be considered having become eligible on the date on which he or she becomes permanent, on condition that the employee is actively employed on that date. Otherwise, he or she shall be eligible upon his or her return to active employment.

### **3. Enrolment**

#### **Health Insurance**

Enrolment is mandatory and based on the same coverage (with no dependents; with no spouse, but with one or more dependent children; with spouse, but no dependents) for public and private sector employees who meet the eligibility criteria.

As of January 1, 1997, the plan shall cover all eligible prescription drugs for active employees and their spouses, including those 65 years of age and over. **In the case of the latter, insureds must inform the *Régie de l'assurance-maladie du Québec* that they are insured under a group plan for their prescription drugs if they do not want to be required to pay the premium for their governmental plan.**

#### **Dental Care Insurance**

Enrolment is mandatory for all college employees whose union has retained the dental care insurance benefit and who meet the eligibility requirements. Insurance for dependents is optional. This coverage is intended for active employees only.

#### **Life Insurance and Optional Life Insurance for the Participant and His or Her Spouse**

Enrolment is optional for public and private sector employees who meet the eligibility requirements.

#### **Short Term Disability Insurance**

Enrolment is mandatory for **private sector** employees only, who meet the eligibility requirements.

#### **Long Term Disability Insurance**

Enrolment is mandatory as soon as a teacher becomes permanent, without being required to provide evidence of insurability. In the 30 days that follow, the employer must forward to us, the duly signed enrolment form.

Any employee who became permanent on or after August 15, 2001, must enrol in **long term disability insurance** by completing an enrolment form prior to the expiry of a 30-day period following the date on which he or she became eligible.

Any employee who became permanent prior to August 15, 2001, and who chose not to enrol in the **long term disability insurance** before October 31, 2001, may not change his or her choice thereafter.

Enrolment is optional for non-permanent employees.

#### **4. Exemption**

An employee or his or her dependents may however, via written notice to the employer, decline or terminate enrolment in the **health insurance benefit** provided he or she certifies to being insured under a group insurance plan that provides similar coverage. They must, however, enrol as of the date on which they are no longer eligible under the other group plan.

However, an employee who declined or terminated enrolment, may choose to enroll at the time he or she becomes permanent even if he or she continues to be eligible under another group plan. He or she must then file an application within the 30 days following the date on which he or she became permanent.

Similarly, an employee may, via written notice to his or her employer, decline or terminate enrolment in the **dental care insurance benefit, if applicable**, provided that he or she certifies to the satisfaction of the Insurer, that he or she is insured under a group insurance plan with similar coverage. Such employee who declined or terminated enrolment in the dental care insurance benefit may enroll in it without being required to present evidence of insurability by establishing to the satisfaction of the Insurer: that he or she was previously insured under the terms of the contract as a dependent or under the terms of any other group insurance plan with similar coverage; that it became impossible for him or her to continue to be insured; and that he or she is filing his or her application in the 31 days following the termination of his or her insurance.

#### **5. Application for Enrolment and Evidence of Insurability**

##### **a) Mandatory benefits:**

The eligible employee must complete an enrolment application.

**b) Optional benefits:**

The participant who would like to enroll in **life insurance benefits** must complete an enrolment application. If this application is completed after the expiry of a 30-day period following the date on which he or she became eligible, the participant must provide evidence of insurability to the satisfaction of the Insurer. The date on which the employee becomes eligible, for an employee who was eligible under the terms of previous contracts and who did not cease to be employed, is the date on which he or she became eligible for the previous contract and not the effective date of this contract.

The participant can also enrol in **life insurance benefits** without providing the evidence of insurability by completing an enrolment application in the 30 days following the adoption of a child, the birth of a first child, or the date on which the participant marries under the definition of spouse herein.

The employee or any eligible spouse who wishes to either enrol in optional life insurance benefits or add a new unit of optional life insurance, must provide evidence of insurability that the Insurer deems satisfactory.

Non-permanent employees who wish to enrol in **long term disability insurance benefits** must complete an enrolment application. If this application is completed after the expiry of a 30-day period following the date on which he or she became eligible, the employee must provide evidence of insurability to the satisfaction of the Insurer. The date on which the employee becomes eligible, for an employee who was eligible under the terms of previous contracts and who did not cease to be employed, is the date on which he or she became eligible for the previous contract and not the effective date of this contract.

**c) Change of marital status:**

**Health insurance:** Given the obligation to insure his or her dependents, the employer must be informed as soon as there is a change in marital status.

For the **life insurance** benefit, any participant who wishes to insure his or her dependents must complete an enrolment application to this effect within 30 days following the event, i.e.: the birth of a first child, the adoption of a child, or the date on which the participant marries. If this period is not respected, evidence of insurability will be required for the person to be covered.

#### **d) Attainment of permanent status:**

Within 30 days of becoming permanent, an employee:

- may enrol in life insurance without evidence;
- may choose to return an exemption in health and dental care insurance, if applicable;
- may insure his or her dependents according to the same rules had he or she been a new employee;
- must mandatorily enrol in the long term disability insurance benefit.

In all cases, enrolment to the insurance plan must take place at the time of the event and not upon signing of the contract or confirmation of permanent status.

### **6. Beneficiary**

A participant may name a beneficiary or change a previously named beneficiary, or declare that the insurance is payable to the successors, upon written declaration, signed and filed with the Insurer's head office, and subject to the provisions of the Act. The Insurer is not liable for the legal validity of any change of beneficiary.

The rights of a beneficiary who dies before the participant shall return to the participant. If, at the time of the participant's death, he or she has not named a beneficiary in writing, the insurance amount shall be payable to the participant's successors.

### **7. Waiver of Premiums**

#### ***7.1 For a disabled person of the public sector***

##### **Health and dental care insurance benefits, if applicable**

The insurance of a participant (and his or her dependents, if applicable) who becomes disabled prior to the effective date of retirement shall be kept in effect without payment of premiums for the duration of the disability, provided that the contract remains in effect and that such disabled participant has not reached 65 years of age.

However, the waiver of premiums shall only apply from the moment a disabled participant becomes eligible for long term disability benefits, i.e. following an elimination period of 104 weeks plus, if applicable, the depletion of the sick leave bank.

### **Life insurance benefits**

#### **(basic life – dependents' life - optional life)**

if, prior to the effective date of retirement, a participant becomes disabled while his or her insurance is in effect, the coverage, with the exception of compensation in the event of accidental death and dismemberment, shall remain in effect without payment of premiums for the duration of such disability.

#### ***For a disability that began prior to January 1, 2008***

The waiver of premiums shall only apply at the time the disabled participant becomes eligible for long term disability benefits or following an elimination period of 104 weeks plus, if applicable, the depletion of the sick leave bank.

#### ***For a disability that began on or after January 1, 2008***

The waiver of premiums shall apply upon expiry of a 30-day period following the start of the disability.

Proof of disability must be provided, at the request of the Insurer, but the Insurer pledges to not request such proof more than once per year.

For participants who became disabled on or after July 1, 1989, the waiver of premiums shall end at age 65.

### **Long term disability insurance benefit**

#### ***For a disability that began prior to January 1, 2008***

The premiums shall be waived as of the first long term disability benefit payment.

#### ***For a disability that began on or after January 1, 2008***

The waiver of premiums shall apply upon expiry of a 30-day period following the start of the disability.

## ***7.2 For a disabled person of the private sector***

### **Health and dental care insurance benefits, if applicable**

The insurance of a participant (and his or her dependents, if applicable) who becomes disabled prior to the effective date of retirement shall be kept in effect without payment of premiums for the duration of the disability, provided that the contract remains in effect and that such disabled participant has not reached 65 years of age.

However, the waiver of premiums shall only apply from the moment a disabled participant becomes eligible for long term disability benefits, i.e. following an elimination period of 104 weeks plus, if applicable, the depletion of the sick leave bank.

**Life insurance benefits**

**(basic life - dependents' life - optional life)**

If, prior to the effective date of retirement, a participant becomes disabled while his or her insurance is in effect, the coverage, with the exception of compensation in the event of accidental death and dismemberment, shall remain in effect without payment of premiums for the duration of such disability.

***For a disability that began prior to January 1, 2008***

The waiver of premiums shall apply at the time that a disabled participant becomes eligible for benefits under the short term disability insurance benefit.

***For a disability that began on or after January 1, 2008***

The waiver of premiums shall apply upon expiry of a 30-day period following the start of the disability.

Proof of disability must be provided, at the request of the Insurer, but the Insurer pledges to not request such proof more than once per year.

For participants who became disabled on or after July 1, 1989, the waiver of premiums shall end at age 65.

**Short term disability insurance benefit**

The premiums shall be waived as of the first short term disability benefit payment.

**Long term disability insurance benefit**

***For a disability that began prior to January 1, 2008***

The premiums shall be waived as of the first short term disability benefit payment.

***For a disability that began on or after January 1, 2008***

The waiver of premiums shall apply upon expiry of a 30-day period following the start of the disability.

## 8. Conversion

The basic life insurance and optional life insurance, if applicable, of a participant who leaves his or her occupation for a reason other than retirement may be converted to whole or term life insurance according to the plans offered by the Insurer, on condition that the application is made within 31 days following the termination of employment.

The amount of the spouse's life insurance (basic and optional) is convertible at the participant's time of death or upon termination of employment, if such event occurs prior to the participant's retirement age.

## 9. Extension of Coverage for Dependents of a Deceased Participant

Following the death of a participant, the basic and additional health insurance and the dental care insurance, if applicable, shall be maintained without payment of premiums for a period of 90 days. After 90 days, a conversion privilege to an individual health insurance policy as a supplement to the drug plan with the *Régie de l'assurance maladie du Québec*, including the reimbursement of prescription drugs not covered by the RAMQ is possible for the surviving dependents (spouse or their children).

Furthermore, the may remain insured for all of the life insurance benefits that the participant held for his or her dependents, provided they inform the Insurer of their intention within 90 days following the date of death.

The applicable premium rates are those described in the page entitled "Total Unit Premium" for the benefits concerned. **Please note that the employer's portion shall then be assumed by the insured.** The Insurer shall send out the invoice to be paid on an annual basis.

## 10. Maintenance During Leave

Without prejudice to the provisions of the collective agreement, a participant on leave shall remain insured for the health insurance benefit with payment of premiums. As for the other benefits, a participant on leave may keep one or more benefits in effect at the start of the leave by paying the total premium, including the employer's portion. The amount of life insurance, accidental death and dismemberment insurance, disability pension, and the amount of the premium for these insurances shall then be determined based on the participant's annual base salary at the time of his or her departure. No total disability pension shall be paid out prior to the expected termination date of the unpaid leave.

If the participant has not kept his or her benefits in effect, he or she shall only be eligible to resume the benefits he or she held at the time the leave began upon his or her return to active employment. The benefits shall be reinstated without evidence of insurability if the participant applies within 30 days of his or her return to active employment.

During a voluntary reduction of employment, the participant may keep his or her life insurance and disability insurance in effect. The amount of life insurance, accidental death and dismemberment insurance, disability pension, and the amount of the premium for these insurances shall then be determined based on the participant's annual base salary immediately before participation in such a program.

A participant on unpaid leave, maternity leave, parental leave, or leave for adoption must remain insured for the dental care insurance benefit by paying the total premium, including the employer's portion, if applicable.

#### **11. Deferred or Advanced Pay Leave and Phased Retirement**

The insurance for a participant who is participating in a deferred or advanced pay leave program or in a phased retirement program shall remain in effect; the amount of life insurance, accidental death and dismemberment insurance, and disability pension as well as the premium for these insurances shall then be determined based on the annual base salary that the participant would have received had he or she not participated in such program. Any disability occurring during such leave shall be assumed to have begun on the same date as that set out by the application of the collective agreement for the determination of the salary insurance period.

#### **12. Layoff**

A participant who has been laid off pursuant to his or her collective agreement or to the provisions set out by law, shall reserve his or her right to the insurance; the amount of coverage to which he or she is entitled shall be based on the salary that he or she would have received had he or she not been laid off; however, the participant may, by informing his or her employer in writing within 30 days of his or her layoff, reduce his or her coverage amount based on his or her salary, which has been reduced as a result of his or her layoff. No other application shall be accepted.

### **13. Maintenance During Leave, Layoff, Strike, Lock-Out, or Dismissal**

When a participant temporarily ceases to be employed as the result of a leave, layoff, strike, or lock-out the insurance shall remain in effect provided the regular premiums continue to be paid; a participant's dismissal contested legally or by a grievance shall, for the purposes of the insurance, be considered a temporary layoff that shall end on the date of the final ruling of the matter at issue.

### **14. End of Insurance**

#### **Life Insurance**

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and "conversion privilege", a participant's insurance shall end on the first of the following dates:

- The date on which the contract or benefit is terminated.
- The date prior to the due date of any unpaid premium.
- The date on which the participant ceases to be employed, except in the event of disability; however, the transfer or appointment of a participant from one employer to another whose insurance contract comes under the Policyholder, shall not be considered a termination of employment.  
A non-permanent employee as defined in the collective agreement shall be considered terminated on the first day of the session following that of his or her contract, without exceeding 2 months from the termination date of his or her contract, unless he or she does not abandon his or her coverage, in which case his or her insurance shall end on the termination date of his or her contract.
- The date on which the Insurer receives written notice from a participant who wishes to terminate his or her insurance under the terms of this benefit or on the termination date indicated on such notice, which ever is later.
- The effective date of his or her retirement or phased retirement for the basic life insurance benefit.
- The the date of his or her 70th birthday or his or her retirement, whichever comes first, for the optional life insurance benefit.
- The end of the 5-year period following the termination of his her disability; for a rehabilitated disabled employee in an occupation that does not include coverage similar to that which he or she held.

**Accidental Death and Dismemberment Insurance** shall end on the first of the following dates:

- The termination date of the basic life insurance.
- The date prior to his or her 65th birthday or the effective date of retirement, whichever comes first.

If the contract ends, no extension shall apply to this benefit.

### **Health Insurance**

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and "conversion privilege", the insurance of any participant shall end on the first of the following dates:

- The termination date of the contract.
- In the event that the premium is unpaid, 30 days following delivery of a notice to this effect by the Insurer to the participant's last known address.
- The date on which the participant ceases to be employed, except in the event of disability; however, the transfer or appointment of a participant from one employer to another whose insurance contract comes under the Policyholder, shall not be considered termination of employment.

For a non-permanent employee, the insurance shall be maintained until the first day of the next session, without exceeding 2 months from the termination date of his or her contract.

- The effective date of his or her retirement or phased retirement.
- The end of the 5-year period following the termination of his her disability; for a rehabilitated disabled employee in an occupation that does not include insurance coverage similar to that stipulated herein.

### **Dental Care Insurance, if applicable**

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and "conversion privilege", the participant's insurance shall end on the first of the following dates:

- The date on which the contract or this benefit is terminated.
- The date on which the participant ceases to be employed, except in the event of disability; however, the transfer or appointment of a participant from one employer to another whose insurance contract comes under the Policyholder, shall not be considered termination of employment.

For a non-permanent employee, the insurance shall be maintained until the first day of the next session, without exceeding 2 months from the termination date of his or her contract.

- The due date of any unpaid premium.
- The effective date of retirement or phased retirement.
- The date on which the participant is transferred or appointed to a college that has not retained the dental insurance benefit.

### **Short Term Disability Insurance (Private colleges only)**

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and "conversion privilege", the insurance of any participant shall end on the first of the following dates:

- The date on which the contract or benefit is terminated.
- The date on which the participant ceases to be employed, except in the event of disability; however, the transfer or appointment of a participant from one employer to another whose insurance contract comes under the Policyholder, shall not be considered termination of employment.

For a non-permanent employee as defined in the collective agreement, he or she shall be considered terminated on the first day of the session following that of his or her contract, without exceeding 2 months from the termination date of his or her contract, unless he or she does not abandon his or her benefit, in which case his or her insurance shall end on the termination date of his or her contract.

- The effective date of retirement or phased retirement.
- The date prior to the due date of any unpaid premium.
- The end of the 5-year period following the termination of his her disability; for a rehabilitated disabled employee in an occupation that does not include insurance coverage similar to that stipulated herein.

### **Long Term Disability Insurance**

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and "conversion privilege", the insurance of any participant shall end on the first of the following dates:

- The date on which the contract or benefit is terminated.
- The date on which the participant ceases to be employed, except in the event of disability; however, the transfer or appointment of a participant from one employer to another whose insurance contract comes under the Policyholder, shall not be considered termination of employment.

For a non-permanent employee as defined in the collective agreement, he or she shall be considered terminated on the first day of the session following that of his or her contract, without exceeding 2 months from the termination date of his or her contract, unless he or she does not abandon his or her benefit, in which case his or her insurance shall end on the termination date of his or her contract.

- The effective date of retirement or phased retirement.
- The date prior to the due date of any unpaid premium.
- The date of receipt by the Insurer of written notice from the participant or on the termination date indicated in such notice, whichever is later, for the participant who wishes to terminate his or her insurance, under the terms of the long-term disability insurance benefit, in the 2 years prior to his or her eligibility for retirement without actuarial reduction.
- The end of the 5-year period following the termination of his her disability; for a rehabilitated disabled employee in an occupation that does not include insurance coverage similar to that stipulated herein.

Without prejudice to the provisions regarding the "waiver of premiums", "extension" and the "conversion privilege", the insurance of a dependent shall end on the first of the following dates:

**Life Insurance**

- The termination date of the participant's insurance.
- The date on which the person ceases to be considered a dependent.
- The date of the participant's 70th birthday or that of the spouse's, for the spouse's optional life insurance benefit.
- The date on which the person ceases to meet the definition of "spouse".

**Health Insurance**

- The termination date of the participant's insurance.
- The date on which the person ceases to be considered a dependent according to the definition of "dependent".
- The date on which the participant converts his or her family, single-parent, or couple coverage to individual coverage.

**Dental Care Insurance**

- The termination date of the participant's insurance.
- The date on which the person ceases to be considered a dependent according to the definition of "dependent".
- The date on which the participant converts his or her family, single-parent, or couple coverage to individual coverage.

## CLAIMS

### **Health Insurance**

#### **Prescription Drugs: Deferred Electronic Claims Payment**

For the purchase of prescription drugs, the insured shall present to the pharmacist, his or her services card which indicates his or her user number. The claim is automatically sent to the Insurer, however the insured must pay the cost of the prescription drugs being purchased in full. La Capitale shall reimburse the participant on the earliest of the following circumstances: the accumulation of \$75 of expenses claimed or following a period of 14 days.

#### **Other Expenses**

The participant shall send, to the Insurer's head office, the duly completed, dated, and signed claim form. It is important to follow the instructions indicated on the form and to enclose the original invoices and official receipts for the expenses being claimed. Please keep your copies of receipts because the originals will not be returned. With respect to hospital expenses, the insured shall present his or her services card to the hospital, who will then send the claim directly to the Insurer. You must provide the participant's group, employer and Social Insurance Number. You must submit the claim within the 12 months following the date on which the expenses were incurred. We suggest submitting a claim every 3 months.

#### **Hospital or Medical Expenses Resulting from an Occupational Injury**

In the event of an occupational injury, please note that all ensuing medical or hospital expenses are eligible for reimbursement by the CSST. These expenses should be filed with the CSST and not with La Capitale.

#### **Dental Care Insurance (If Applicable)**

The claim form includes 2 parts: the first part is to be completed by the dentist and the other by the participant. When both parts are complete, the participant is to return the form to the Insurer. All claims must be filed with the Insurer within the 12 months following the date on which the expenses were incurred.

#### **Direct Deposit of Health and Dental Benefits (If Applicable)**

Subscribing to this service couldn't be easier. Simply complete the application form available from your employer and return it to us. Once your claim has been approved, the benefits will be deposited to your account. A statement will be issued to you confirming the amount deposited and the date your claim was processed.

**Life Insurance**

The beneficiary is responsible for claiming the insured amount by contacting the Insurer, who will send out the required forms. In the event of dismemberment, the participant must also contact the Insurer to obtain the required claim forms.

**Disability Insurance**

The monthly benefits are payable to the participant upon expiry of the elimination period. The claim form must be completed by the participant, the employer, and the attending physician and be submitted to the Insurer as soon as possible.

**TOTAL UNIT PREMIUM**  
*Per 14-day period from January 1, 2008 to December 31, 2008*

<b>Health Insurance</b>	<u>Public and Private Sector*</u>
- Individual plan	\$33.46
- Single-parent plan	\$56.86
- Family plan	\$90.43
- Couple plan	\$66.91

*\*For private colleges, the employer's portion is to be deducted from the total premium indicated.*

<b>Dental Care Insurance</b>	
- Individual plan	\$8.87
- Single-parent plan	\$16.63
- Family plan	\$25.50
- Couple plan	\$17.74

<b>Life Insurance</b>	
(Rate per \$1,000 of insurance)	\$0.1236

<b>Dependents' Life Insurance</b>	
(Premium per family, single-parent, or couple contract)	\$0.80

<b>Accidental Death and Dismemberment</b>	
(Rate per \$1,000 of insurance)	\$0.0138

<b>Short Term Disability Insurance</b>	
<i>Private colleges only</i>	
(Rate per \$1,000 of insurance)	\$0.458

<b>Long Term Disability Insurance</b>	
(Rate per \$1,000 of insurance)	\$0.387

**Optional Life Insurance**  
**Rate per \$1,000 of insurance per 14-day period**

Age	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
Under 25 years	\$0.023	\$0.033	\$0.013	\$0.017
25 to 29 years	0.023	0.033	0.013	0.017
30 to 34 years	0.023	0.036	0.013	0.017
35 to 39 years	0.031	0.039	0.017	0.020
40 to 44 years	0.045	0.067	0.023	0.034
45 to 49 years	0.074	0.109	0.034	0.051
50 to 54 years	0.115	0.171	0.065	0.077
55 to 59 years	0.182	0.282	0.098	0.154
60 to 64 years	0.307	0.444	0.151	0.227
65 to 69 years	0.424	0.692	0.237	0.356

**Taxes of 9% are to be added to the rates indicated herein.**

## HEALTH INSURANCE REIMBURSEMENTS SCHEDULE

Benefits	Reimbursement Scales	Medical Prescription
<b>Homeopathic drugs</b>	80% Maximum \$400 / calendar year / insured	Yes
<b>Serums and fluids injected for curative purposes</b> (including injections for artificial insemination)	80%	Yes
<b>Artificial limb, prosthetic device, foot orthosis and orthopaedic appliance</b>	80%	Yes
<b>Ambulance</b>	80%	No
<b>Chiropractor</b>	80% Maximum reimbursement \$30 / treatment, \$400 /calendar year / insured and \$30 / x-ray / calendar year / insured	No
<b>Private clinic (treatment for alcoholism, drug addiction, or gambling)</b>	80% Maximum one course / calendar year, maximum reimbursement of \$3,500 / calendar year and lifetime maximum of 2 courses / insured	No
<b>Support hose</b>	80% Maximum 6 pairs / calendar year / insured	No
<b>Osteopath or podiatrist</b>	80% Maximum reimbursement \$30 / treatment and maximum \$400 / calendar year / insured for all of these professionals combined	No
<b>Dental surgeon following an accident</b>	80%	No
<b>Acupuncturist</b>	80% Maximum reimbursement \$30 / treatment and maximum \$400 / calendar year / insured	No
<b>Blood glucose monitor, dextrometer or other similar device</b>	80% Maximum reimbursement \$200 / consecutive 5-year period / insured	Yes
<b>Insulin pump</b>	80% Maximum reimbursement \$1,750 / consecutive 5-year period / insured	Yes
<b>Psychiatrist, psychoanalyst at an outpatient clinic, psychologist, guidance counsellor in private practice, and social worker</b>	50% of the 1st \$1,400 of eligible expenses and 100% of the next \$1,400 of eligible expenses, maximum reimbursement of \$2,100 / calendar year / insured for all of these professionals combined	No
<b>Physiotherapist and physical rehabilitation therapist</b>	80% Maximum reimbursement \$30 / treatment and maximum \$400 / calendar year / insured for all of these professionals combined	No
<b>Dietician</b>	80% Maximum reimbursement \$30 / treatment and maximum \$400 / calendar year / insured	No

<b>Benefits</b>	<b>Reimbursement Scales</b>	<b>Medical Prescription</b>
<b>Homeopath</b>	80% Maximum reimbursement \$30 / treatment and maximum \$400 / calendar year / insured	No
<b>Naturopath</b>	80% Maximum reimbursement \$30 / treatment and 2 consultations / calendar year / insured	No
<b>Vaccines (including preventative vaccines)</b>	80%	No
<b>Rehabilitation centre</b>	80%	No
<b>Registered nurse or certified nursing assistant</b>	80%	Yes
<b>Orthopaedic shoes</b>	80% Eligible for reimbursement after deduction of a deductible of \$20 / pair	Yes
<b>Corrective shoes</b>	80% Maximum 2 pairs / calendar year / insured	Yes
<b>Wheelchair, iron lung or therapeutic equipment</b>	80%	Yes
<b>Respiratory therapy</b>	80%	Yes
<b>Speech pathologist, occupational therapist and orthopedagogue</b>	80% Maximum reimbursement \$30 / treatment and \$400 maximum / calendar year / insured for all of these professionals combined	Yes
<b>Hearing aids</b>	80% Maximum reimbursement \$500 / consecutive 3-year period / insured	Yes
<b>Tempormandibular appliances</b>	80% Maximum reimbursement \$100 / 24-month period / insured	Yes
<b>Expenses for travel outside of the region to obtain advice or receive treatments from a specialist not available in the region</b>	80% Maximum \$500	Yes
<b>Breast prosthesis</b>	80% Eligible maximum \$500 / calendar year / insured	Yes
<b>Hair replacement unit</b>	80% Eligible maximum \$400 / calendar year / insured	Yes

**TO CONTACT LA CAPITALE INSURANCE AND FINANCIAL SERVICES INC.**

**Quebec City**

Delta II Building  
2875 Laurier Blvd, Suite 100  
Quebec QC G1V 2M2  
418 644-4200

**Montreal**

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

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

**This document is for information purposes only and in no way changes the terms and conditions of the contract.**

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**CHECKLIST / NOTES**

**Group number: 1008-1010**

**Employer number:**

**Identification number:**

**Person contacted:**

**Telephone:**

**Fax:**

**Email:**

