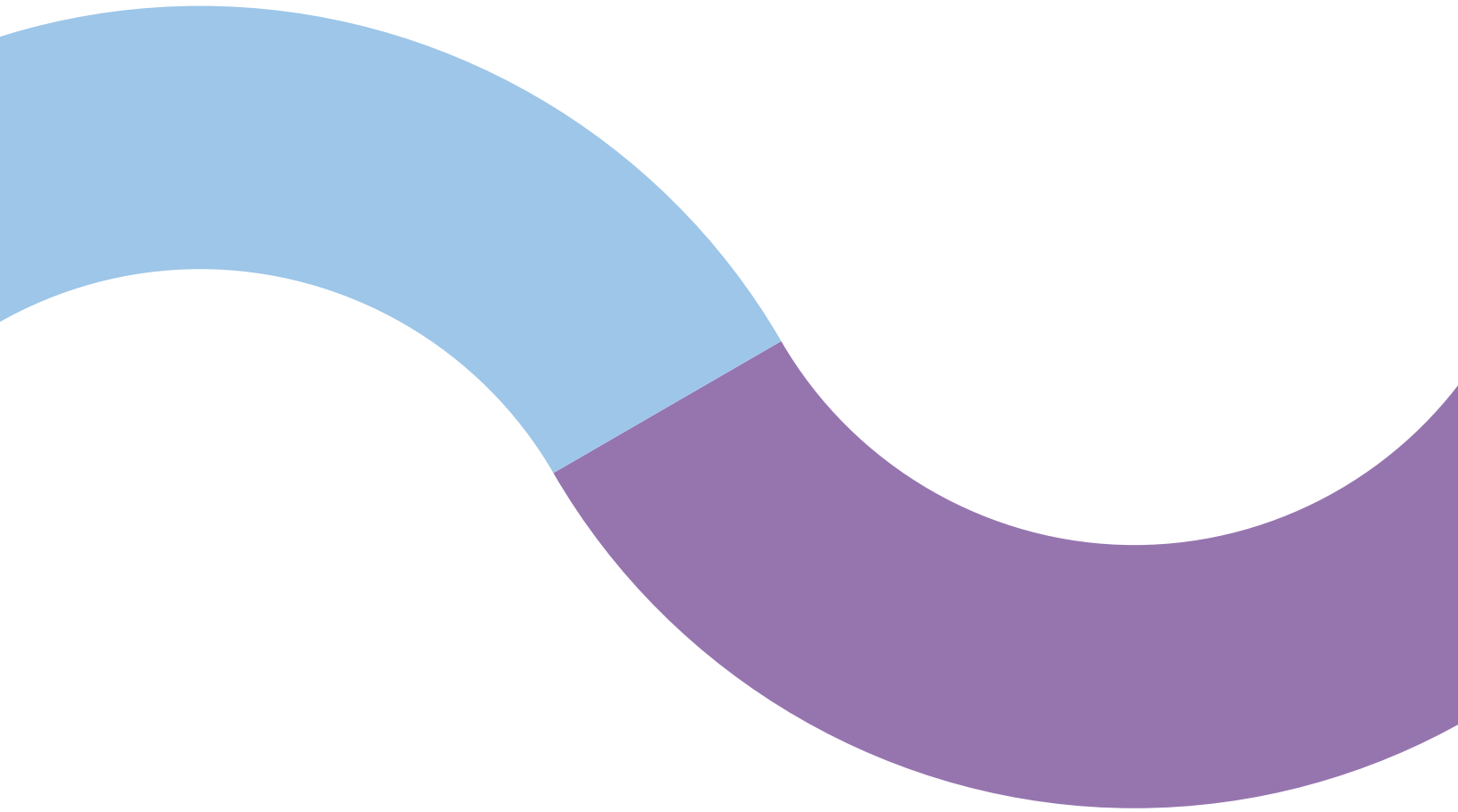
fneeq CSN

Group insurance contract 001008-001010

Administrative version
on January 1, 2026



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GROUP INSURANCE CONTRACT

NUMBER **001008-001010**

LA CAPITALE CIVIL SERVICE INSURER INC.

(the “Insurer”)

Issues contract No. 001008-001010 (the “contract”) on behalf of participants who are members of the:

FÉDÉRATION NATIONALE DES ENSEIGNANTES ET DES ENSEIGNANTS DU QUÉBEC-CSN

(the “Policyholder”)

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

The provisions and conditions of the following pages, including the table of rates and Schedules I to IX are an integral part of this contract, as if they appeared above the signatures.

Any amendments to this contract must be approved by the Insurer and the Policyholder and be subject to an endorsement signed by the authorized representatives of both parties.

Effective date: This contract is effective as of January 1, 2026.

This contract is a consolidated version of the contract which came into effect on January 1, 2025, and any subsequent contracts, consolidated contracts, agreements and endorsements. This contract does not confer any rights retroactively, and the contract provisions applicable to any event giving entitlement to benefits remain the same as those in force on the date of such event.

Contract year: The period between the contract’s effective date and the renewal date that immediately follows, as well as any 12-month period between two renewal dates.

Renewal date: January 1, 2027, and January 1 of each subsequent year.

Effective time: Insurance takes effect, is amended or terminates at 12:01 a.m. at the Insurer's head office on the date that events set out in this contract occur.

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SECTION 1 **– DEFINITIONS**

For the purposes of interpreting this contract, and unless otherwise stipulated, the following terms mean:

1.1 "**Accident**": Any bodily injury confirmed by a physician and directly resulting from a sudden and unforeseeable action of an external cause, and independently of any other cause.

1.2 "**Age**": The age of a person at the time it is calculated for the purposes of the contract or at the time an event provided for in the contract occurs.

1.3 "**Assistor**": CanAssistance Inc. or any other assistance company designated by the Insurer.

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

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

1.6 "**College**": A general and vocational college established under the *General and Vocational Colleges Act*, including private educational institutions.

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

1.8 "**Committee**": The union committee that administers the insurance plans.

1.9 "**Deductible**": The portion of eligible expenses for which the insured is not entitled to any reimbursement from the Insurer.

1.10 "**Default**": Insolvency or bankruptcy of the travel services provider, whether voluntary or involuntary, that prevents the insured from following through on the travel arrangements and that exposes the insured to a financial loss.

1.11 "**Dentist**": A member of the *Ordre des dentistes du Québec* or another professional association recognized by legislative authority having jurisdiction where the dentist practises.

1.12 "**Dependent**": The spouse or the dependent child of a participant as defined below.

1.12.1 Spouse: The man or the woman who, on the date of the event giving entitlement to benefits:

i) Is married to or civilly united with the participant; or

ii) Is not married or civilly united and who has been cohabiting in a conjugal relationship with the participant, who is not married or civilly united, for one year or for less than one year if he or she is the father or mother of a child of the participant; or

iii) Is not married or civilly united and who has been cohabiting in a conjugal relationship with the participant, who is not married or civilly united, and had previously cohabited with the participant for an entire period of at least one year.

Note that the status of spouse is forfeited in the event of the following situations:

- A judgment of divorce between the participant and the spouse in the case of a marriage;

- De facto separation for at least 90 days in the case of a common-law union;

- Dissolution of the union by a notarized act or court decision in the case of a civil union.

1.12.2 Dependent child: The term "**dependent child**" designates any of the following persons:

i) A person under age 21 for whom the participant or spouse exercises parental authority, including children for whom adoption procedures have been undertaken;

ii) A person age 25 or under, who has no spouse and is attending a recognized educational institution as a duly registered full-time student, and for whom the participant or spouse would exercise parental authority if a minor;

iii) A person who has reached the age of majority, who has no spouse and is domiciled at the participant's home, for whom the participant or spouse would exercise parental authority if a minor, and who is afflicted with a total disability or functional impairment, as defined in applicable legislation, that occurred when he or she met one of the conditions set out in either of the two preceding paragraphs.

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

1.13 "**Disability or disabled**":

1.13.1 For a disability that started prior to July 1, 1991

A state of incapacity resulting from an illness or an accident that requires continuous medical care, and which, during the Long-Term Disability Insurance benefit elimination period and the following five years, completely prevents the participant from carrying out the usual duties of his or her regular employment and, after this period, completely prevents the participant from carrying out any gainful activity for which he or she is reasonably qualified due to education, training or experience. However, for a disability that started before January 1, 1990, the words "five years" above are replaced by "24 months".

1.13.2 For a disability that started on or after July 1, 1991, but before July 1, 1995

A state of incapacity resulting from an illness or an accident that requires continuous medical care, and which, during the Long-Term Disability Insurance benefit elimination period and the following five years, completely prevents the participant from carrying out the usual duties of his or her regular employment; after this period and up to the participant's 60th birthday, completely prevents the participant from carrying out any gainful activity for which he or she is reasonably qualified due to education, training or experience; as of age 60, completely prevents the participant from carrying out the usual duties of his or her regular employment.

1.13.3 For a disability that started on or after July 1, 1995, but before January 1, 2008

A state of incapacity resulting from an illness, an accident or a surgical procedure directly related to family planning that requires continuous medical care, and which, during the Long-Term Disability Insurance benefit elimination period and the following five years, completely prevents the participant from carrying out the usual duties of his or her regular employment; after this period and up to the participant's 60th birthday, completely prevents the participant from carrying out any gainful activity for which he or she is reasonably qualified due to education, training or experience; as of age 60, completely prevents the participant from carrying out the usual duties of his or her regular employment.

1.13.4 For a disability that started 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 continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment.

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

Medical care is not required if the disability is the result of loss of limbs or loss of sight and such loss can be definitively established to the Insurer's satisfaction.

1.14 "**Disability period**":

For the first 24 months of disability:

Any uninterrupted disability period, or successive disability periods resulting from the same illness or the same accident, separated by a period of remission of fewer than eight days[1] of work unless the disability for a given period results from an illness or accident that is entirely independent of the illness or accident that caused the disability of the previous period, and the disability only starts upon the participant's return to work.

[1] "32 days" of work if the disability period is more than three months

Thereafter:

Any uninterrupted disability period, or successive disability periods resulting from the same illness or the same accident, separated by a period of remission of fewer than 180 days of work unless the disability for a given period results from an illness or accident that is entirely independent of the illness or accident that caused the disability of the previous period, and the disability only starts upon the participant's return to work.

1.15 "**Due date of the premium**": The invoicing date coinciding with the first day of a pay period.

1.16 "**Effective date of retirement**": The date the participant retires in accordance with the applicable pension plans; however, if the date of retirement with a pension is later, the later date constitutes the effective date of retirement. The term "retirement" also includes phased retirement.

In the case of a participant who retires because he or she is unable to carry out his or her duties due to disability, the effective date of retirement is the earliest of the following dates:

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

1.17 "**Elimination period**": A period that begins at the start of a disability period during which disability benefits are not payable.

1.18 "**Employee**":

- A person hired by the employer on a full-time basis and who is covered by the bargaining certificate issued for a union affiliated with the FNEEQ-CSN and covered under this contract;

- A person hired by the employer on a part-time basis under a contract for a minimum of 33% of the workload and who is covered by the bargaining certificate issued for a union affiliated with the FNEEQ-CSN and covered under this contract. For colleges, the percentage of the workload is determined at the beginning of each session while for primary and secondary institutions, this percentage is determined on the first and the 101st days of the school year.

- Any individuals or classes of individuals approved by the Policyholder and indicated in Schedules I to IX.

1.19 "**Employer**":

- An educational institution or one related to education where employees have formed a union affiliated to the FNEEQ-CSN or that is certified by the FNEEQ-CSN for the purposes of this contract;
- Any employer approved by the Policyholder.

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

1.21 "**Full-time teaching professional**": A teaching professional hired by the employer under a full-time contract in accordance with the collective agreement.

1.22 "**Hospital**": Any hospital, including auxiliary residences located in Quebec, that is authorized by the Quebec *Ministre de la Santé et des Services Sociaux* to register with the hospitalization insurance plan introduced under the province's *Hospital Insurance Act* and the regulations applicable under this act, as well as the following hospitals located outside Quebec:

1.22.1 Any hospital located in Canada that is a federal hospital, a hospital with an operating licence or that is certified as a hospital by a public agency responsible for issuing such operating licences in the territorial jurisdiction where the hospital is located or is certified by the *Ministre des Affaires Sociales* where a public agency for issuing such operating licences does not exist.

1.22.2 Any hospital located abroad if the *Ministre des Affaires Sociales* authorizes the payment of funds for care provided in the hospital in accordance with the *Hospital Insurance Act*.

The term "hospital" does not include tuberculosis hospitals or sanatoriums, hospitals for the mentally ill, rest homes, retirement homes, treatment centres or other establishments whose purpose is to provide supervisory care.

1.23 "**Hospitalization**": Occupation of a room in a hospital as an inpatient confined to a bed.

1.24 "**Host at destination**": The person in whose main residence the insured will stay, as agreed to in advance.

1.25 "**Illness**": Any health condition or bodily disorder diagnosed by a physician, including pregnancy and any related complications.

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

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

1.28 "**Insured hospital care for inpatients**": The care that an insured is entitled to receive free of charge under the Quebec *Hospital Insurance Act* or that is covered under the provisions of this act.

1.29 "**Invoicing period**": The period corresponding to a pay period of 14 consecutive days.

1.30 "**Net wages or salary**": A participant's wages or salary, after deduction of the following amounts:

a) For participants who became disabled prior to January 1, 2025:

- Contributions to the Quebec Pension Plan;
- Contributions to Human Resources and Skills Development Canada (Employment Insurance);
- Contributions to the Quebec Parental Insurance Plan;
- Federal and provincial taxes in accordance with the tax exemption form submitted to the employer.
- Health Insurance premiums under this contract based on the coverage held at the start of Long-Term Disability Insurance benefit payments.

b) For participants who became disabled on January 1, 2025, or after:

- Contributions to the Quebec Pension Plan;
- Contributions to Human Resources and Skills Development Canada (Employment Insurance);
- Contributions to the Quebec Parental Insurance Plan;
- Federal and provincial taxes in accordance with the tax exemption form submitted to the employer.

1.31 "**Participant**": An employee who is enrolled in the insurance.

1.32 "**Part-time teaching professional**": A teaching professional hired by the employer under a part-time contract in accordance with the collective agreement.

1.33 "**Period of remission**": A period during which a participant who was disabled ceases to be disabled.

1.34 "**Physician**": A physician, surgeon or doctor of medicine who is duly licensed to practise medicine according to the regulations governing the practice of medicine in the location where services covered by this contract are provided.

1.35 "**Policyholder**": The *Fédération nationale des enseignantes et des enseignants du Québec (FNEEQ-CSN).*

1.36 "**Prepaid travel expenses**": The amount paid in advance by the insured to:

1.36.1 Purchase a trip from a travel service provider, including tickets from a public carrier, rental of a motor vehicle and lodging.

1.36.2 Reserve travel arrangements usually included in a package trip, whether the reservations are made by the insured or by a travel services provider.

1.36.3 Registration fees for a commercial activity.

1.37 "**Previous contract**": Any group insurance contracts that existed immediately prior to the effective date of this contract that covered the employer's employees and any of their dependents.

1.38 "**Public Prescription Drug Insurance Plan**": The Public Prescription Drug Insurance Plan administered by the *Régie de l'assurance maladie du Québec*.

1.39 "**Start date of the session**": The date of the first day of the availability period of the school calendar.

1.40 "**Teaching professional**": A person hired by the employer to teach, including flight dispatchers for pilot schools.

1.41 "**Travel companion**": The person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the insured.

1.42 "**Travel service provider**": Travel agency, tour wholesaler, tour operator, public carrier, hotel, as well as any business or online sales or booking platforms accredited or authorized by competent authorities to operate such a business or to render such services.

1.43 "**Trip**": A trip for the purposes of tourism or recreation, a trip for the purposes of humanitarian aid or cooperative work that is supervised by an organization, a commercial activity or an occasional business trip. A business trip is considered to be occasional when carried out on an exceptional and not on a regular basis.

Any other type of trip, **including a trip where the teaching professional accompanies students as part of his or her duties**, is not covered under this benefit, unless otherwise agreed by the Policyholder and the Insurer. Furthermore, the trip must entail the insured's absence from the province of residence.

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

1.44 "**Wage or salary**": The participant's wage or salary for a given year, excluding bonuses, overtime pay, honoraria, accommodation and meal allowances, isolation pay or any lump-sum payments. However, additional income such as overtime pay and other bonuses are included when calculating the wage or salary when they are part of the participant's regular remuneration.

Any lump-sum payments provided for under the collective agreement between the F.P.P.S.C.Q. and the C.P.N.C. are also considered part of the wage or salary. Salary also includes any amount paid by a college to a teaching professional who is in charge of a sports team.

For an employee who is eligible in accordance with article 2.1.7, the participant's salary is that used or that would have been used for calculating Long-Term Disability Insurance benefits had he or she not been rehabilitated.

SECTION 2 – **CONDITIONS OF INSURANCE**

2.1 Eligibility

2.1.1 Any person hired by the employer or approved by the Policyholder is eligible as of the date they start working for the employer. Specific provisions apply to individuals or classes of individuals approved by the Policyholder and are indicated in Schedules I to IX attached to this contract.

Any hired teaching professional for a contract of at least 33% of the workload between the start of the fall semester and September 15th will be eligible for insurance as of the effective date of the contract. For the teaching professionals at the elementary and secondary levels, this minimum percentage will be established between the start of the school year and September 15th.

Any hired teaching professional for a contract of at least 33% of the workload between the start of the winter semester and February 15th will be eligible for insurance as of the effective date of the contract. For the teaching professionals at the elementary and secondary levels, this minimum percentage will be established between the 101st day of the school year and February 15th.

However, a person who does not have permanent employment is eligible for the Long-Term Disability Insurance benefit, subject to the provisions in article 2.2.5.

Any new employee who is already recognized as disabled by a private or public plan, such as the QPP, SAAQ, CSST, IVAC, etc., or who is subject to an amicable settlement with regard to a disability claim or who is receiving pension benefits is not eligible for the Short- and Long-Term Disability Insurance benefits.

2.1.2 Dependents of an employee become eligible for insurance on the date that the employee becomes eligible. If individuals become dependents of a participant after the date the participant became eligible, these dependents become eligible on the date that they meet the requirements of the definition of a “Dependent”.

2.1.3 Public sector employees are not eligible for the Short-Term Disability Insurance benefit.

2.1.4 Employees who became permanent before August 15, 2001 and who did not enrol in the Long-Term Disability Insurance benefit on October 31, 2001 are not eligible for the Long-Term Disability Insurance benefit.

2.1.5 Employees are eligible for the Optional Life Insurance benefit, for an amount of two times the annual salary, if they are insured under the Basic Life Insurance benefit.

2.1.6 The spouse of an employee is eligible for the Optional Life Insurance benefit if under age 65 and insured under the Dependents' Life Insurance benefit.

2.1.7 A disabled employee, who is rehabilitated in employment that is not covered by insurance similar to the coverage previously held, remains insured under the benefits that would otherwise not be available for a maximum period of five years from the date of the termination of the disability. For the purposes of interpreting this article, a public sector employee is considered as insured under the Short-Term Disability Insurance benefit.

2.1.8 Any retired teaching professional who is insured under the AREF contract and who is rehired becomes eligible for this contract again for the following benefits:

- Mandatory Health Insurance;
- Dental Care Insurance;
- Short-Term Disability Insurance;
- Long-Term Disability Insurance; however, retired teaching professionals who are rehired and who receive RREGOP pension benefits are not eligible for this benefit.

The conditions of insurance and all terms applicable to the insurance benefits for which this employee is eligible are those set out in this contract.

2.2 **Participation**

2.2.1 Health Insurance

Participation in Module A (Basic Coverage), B (Standard Coverage) or C (Enriched Coverage) of the Health Insurance benefit is mandatory for all eligible employees and their dependents.

Participation in this insurance benefit entails a minimum participation period, subject to the provisions of article 2.5 Change in Coverage – Health and Dental Care Insurance.

a) Application form

Eligible employees must complete an application form for themselves and their dependents within 30 days following the date they become eligible. If the application is submitted more than 30 days after this date, coverage becomes effective on the date the Insurer receives the application.

The same provisions apply in the event of a change to the family situation of participants who did not have dependents at the time they became eligible. Participants must then complete a new application form for their dependents within 30 days following the date the dependents become eligible.

b) Exemption and termination of exemption

Employees, participants or their dependents may waive or terminate coverage under the Health Insurance benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits. They must submit their application within 30 days following the date they become eligible under the other group insurance contract for the exemption to take effect from that date. If the application is submitted more than 30 days after this date, coverage becomes effective on the day the Insurer receives the application.

If, however, coverage under the other group insurance contract terminates, employees, participants and their dependents must enrol in the Health Insurance benefit under this contract or resume participation in this benefit, within 30 days of the date they are no longer eligible under the other group insurance contract. Eligible employees, participants or their dependents must also establish that it has become impossible for them to continue being insured under the other group insurance contract that allowed the right of exemption. Provisions applicable at the time of the initial application for insurance apply again.

When employees or participants, who refused or ceased coverage under the Health Insurance benefit, obtain permanent status, they may apply or resume participation, even if they remain eligible under another group insurance contract. Such employees must submit their application to the Insurer within 30 days following the date they obtain permanent status, provided that they are actively at work at that time.

c) Provisions applicable to participants age 65 or older

Participants age 65 or older may choose to insure prescription drugs, which are covered by the Public Prescription Drug Insurance Plan, under this contract. If participants wish to insure these prescription drugs, they must notify the Insurer within 30 days following the date they reach age 65. In this case, the participant must pay the additional premium stipulated in the rate table at the end of the contract. The additional premium becomes payable when the participant reaches age 65, in accordance with the coverage plan held at that time.

2.2.2 Dental Care Insurance

Participation in basic coverage (Option 1) or enriched coverage (Option 2) of the Dental Care Insurance benefit is optional for all eligible employees and their dependents.

Furthermore, coverage status (Individual, Single-Parent or Family) for the Dental Care Insurance benefit must be identical to that held for the Health Insurance benefit. Employees may, however, apply for the Dental Care Insurance benefit even if they exercised their right to opt out of the Health Insurance benefit.

Participation in the Dental Care Insurance benefit entails a minimum participation period of 36 months, subject to the provisions of article 2.5 Change in Coverage – Health and Dental Care Insurance.

a) Application form

Eligible employees must complete an application form for themselves and their dependents within 30 days following the date they become eligible. Otherwise, the provisions of article 2.5 Change in Coverage – Health and Dental Care Insurance apply.

b) Exemption and termination of exemption

Employees, participants or their dependents may waive or terminate coverage under the Dental Care Insurance benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits. They must submit their request within 30 days following the date they become insured under the other group plan in order that the exemption becomes effective as of that date. If the request is submitted after the expiry of the 30-day period, exemption becomes effective as of the date the Insurer receives the request.

However, if coverage under the other group insurance contract terminates, employees, participants or their dependents may apply for the Dental Care Insurance benefit under this contract or resume participation in this benefit, within 30 days as of the date they are no longer eligible under the other group insurance contract. Eligible employees, participants or their dependents must establish that it has become impossible for them to continue being insured under the other group insurance contract that allowed the right of exemption. Provisions applicable at the time of the initial application for insurance apply again.

2.2.3 Participant's Life Insurance and Critical Illness Insurance, Dependents' Life Insurance and Participant's and Spouse's Optional Life Insurance

Participation is optional for employees who satisfy the eligibility conditions.

Employees who wish to apply for the Basic Life Insurance benefits must complete an application form within 30 days following the date they become eligible. If the application is completed after expiry of the 30-day period, they will have to submit, at their own expense, evidence of insurability deemed satisfactory by the Insurer.

However, the participant can apply for the Life Insurance benefit without evidence of insurability by completing an application form within 30 days following the adoption or the birth of a first child or the date the participant takes a spouse, as defined in this contract.

Participation in the Participant's Basic Life Insurance benefit entails the automatic participation in the Participant's Critical Illness Insurance benefit since participation in these two benefits can't be dissociated.

Participation in the Participant's Basic Life Insurance benefit and the Dependent's Basic Life Insurance benefit is mandatory for employees who wish to apply for optional life insurance benefits for themselves or their spouse, if applicable.

Evidence of insurability deemed satisfactory by the Insurer is always required for employees or spouses when applying for the Optional Life Insurance benefit or adding Optional Life Insurance units.

2.2.4 Short-Term Disability Insurance

Participation is mandatory for eligible employees in the private sector, as well as eligible individuals or classes of individuals approved by the Policyholder that are indicated in Schedules I to IX

a) Application form

Eligible employees must complete an application form for themselves and their dependents within 30 days following the date they become eligible. If the application is submitted more than 30 days after this date, coverage becomes effective on the day the Insurer receives the application.

b) Exemption and termination of exemption under the Short-Term Disability Insurance benefit

Individuals who become eligible for Short-Term Disability Insurance benefits, may waive or terminate coverage under this benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits.

Individuals indicated in Schedule I, may also waive or terminate coverage under this benefit, if they certify that they will not accept any course load for a period of 6 months during the insurable calendar year.

However, if coverage under the other group insurance contract terminates, or if the individuals indicated in Schedule I obtain a total course load of 1 during the school year, these employees or participants must, with the exception of non-permanent employees for whom participation is optional, enroll in the Short-Term Disability Insurance benefit under this contract or resume participation in this benefit, within 30 days of the date they are no longer eligible under the other group insurance contract. Provisions applicable at the time of the initial application for insurance apply again.

2.2.5 Long-Term Disability Insurance

a) Permanent employees

Subject to the provisions related to the right to waive the Long-Term Disability Insurance benefit, participation is mandatory as of the date the teaching professional obtains permanent status. They must submit an application form to the Insurer within 30 days following the date they become eligible. If the application is submitted more than 30 days after this date, coverage becomes effective on the date the Insurer receives the application.

However, participants who obtained their permanent status on or before August 15, 2001, are not eligible for the Long-Term Disability Insurance benefit if they did not enrol in it or if they ended participation in this benefit during the 2001 fall enrolment campaign.

b) Non-permanent employees

Participation is optional for these employees. After obtaining their first three contracts of at least 33% of the workload, non-permanent employees can apply for this benefit without evidence of insurability provided the application form is submitted to the Insurer within 30 days following the date the employee becomes eligible. If the application is completed after expiry of the 30-day period, they will have to submit, at their own expense, evidence of insurability deemed satisfactory by the Insurer.

Satisfactory evidence of insurability will also have to be submitted to the Insurer, at the participant's own expense, for subsequent contracts.

This provision does not apply to employees who have been denied participation in this benefit following assessment of evidence of insurability by the Insurer.

However, subject to the provisions related to the right to waive the Long-Term Disability Insurance benefit, participation is mandatory for college teaching professionals on the contract start date after they have three years of seniority after the first eligible contract, in accordance with the official seniority list.

Specific provisions apply to any individuals or classes of individuals approved by the Policyholder and are indicated in Schedules I to IX attached to this contract.

c) Exemption and termination of exemption under the Long-Term Disability Insurance benefit

Individuals who become eligible for Long-Term Disability Insurance benefits, may waive or terminate coverage under this benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits.

Individuals indicated in Schedule I, may also waive or terminate coverage under this benefit, if they certify that they will not accept any course load for a period of 6 months during the insurable calendar year.

However, if coverage under the other group insurance contract terminates, or if the individuals indicated in Schedule I obtain a total course load of 1 during the school year, these employees or participants must, with the exception of non-permanent employees for whom participation is optional, enroll in the Long-Term Disability Insurance benefit under this contract or resume participation in this benefit, within 30 days of the date they are no longer eligible under the other group insurance contract. Provisions applicable at the time of the initial application for insurance apply again.

d) The right to waive participation under the Long-Term Disability Insurance benefit

Employees may waive coverage under the Long-Term Disability Insurance benefit within the 2 years preceding the date they become eligible for the employer's pension benefits without reduction. The employees referred to in Schedules III and IV may waive the coverage as of their 58th birthday or when they have 33 years of service.

The appropriate form must be completed and submitted to the employer. Waiver of this coverage is then irrevocable for as long as employees maintain the employment status under which they waived the coverage.

Coverage under the Long-Term Disability Insurance benefit terminates on the date corresponding to the start of the first complete pay period coinciding with receipt of the waiver request by the Insurer.

2.2.6 Coverage status

When employees enrol, they must select one of the coverage statuses available under this contract for the Health Insurance and Dental Care Insurance benefits, as applicable, in accordance with their family situation at that time. The various coverage statuses are:

a)	Individual	Participant only
b)	Single-Parent	Participant with dependent children, no spouse
c)	Family	Participant with spouse and dependent children, if applicable.

2.2.7 Extension of coverage for dependents of a deceased participant

On the participant's death, dependents remain insured under the Health Insurance and Dental Care Insurance benefits, without payment of premiums, for a period of 90 days following the date of death. Furthermore, dependents may remain insured under all of the Dependents' Life Insurance benefits held by the participant, if they advise the Insurer of their intention within 90 days following the date of death.

2.2.8 Rehiring or change of employer

If they are eligible, non-permanent employees who obtain a new teaching contract within 12 months following the date that their insurance terminated under the previous contract must resume the coverage levels they previously held for the Health Insurance and Dental Care Insurance benefits if the minimum participation periods have not been completed.

If they are eligible, non-permanent employees registered on the employment priority list who are rehired by the same employer resume participation in the Life Insurance and Disability Insurance benefits held at the time their contract ended, without evidence of insurability.

Employees hired at the end of a session by another college for the following session maintain the benefits they held with the previous college. However, employees of the new college must be eligible for insurance under this contract.

2.3 Effective date of coverage

2.3.1 Employees

2.3.1.1 Life Insurance becomes effective on the latest of the following dates:

a) The date they become eligible, provided the application form is submitted to the Insurer within 30 days following this date, subject to the provisions of article 2.4;

b) The date the Insurer approves any required evidence of insurability.

2.3.1.2 Long-Term Disability Insurance becomes effective on the latest of the following dates:

a) For non-permanent employees

- The date they become eligible, provided the application form is submitted to the Insurer within 30 days following this date, subject to the provisions of article 2.4;
- The date the Insurer approves any required evidence of insurability.

b) For permanent employees

- The date they become eligible, provided the application form is submitted to the Insurer within 30 days following this date.

2.3.1.3 Health Insurance becomes effective on the date employees become eligible. However, insurance for employees who used their exemption right becomes effective on the first day following the date of termination of the previous insurance.

2.3.1.4 Dental Care Insurance becomes effective on the date employees become eligible, provided the application form is submitted to the Insurer within 30 days following this date.

2.3.1.5 Short-Term Disability Insurance for employees in the private sector or of a university becomes effective on the date they become eligible.

Specific provisions apply to any individuals or classes of individuals approved by the Policyholder and are indicated in Schedules I to IX.

2.3.2 Dependents

2.3.2.1 Life Insurance becomes effective on the latest of the following dates:

a) The date dependents become eligible, provided the application form is submitted to the Insurer within 30 days following this date;

b) The date the Insurer approves any required evidence of insurability.

2.3.2.2 Health Insurance becomes effective on the latest of the following dates:

a) The date the participant's insurance becomes effective;

b) The date they become eligible;

c) The day after the termination of insurance under another contract allowing them to use their exemption right.

However, the Insurer must receive the application or termination of exemption form within 30 days. Otherwise, insurance becomes effective on the date the Insurer receives the form.

2.3.2.3 Dental Care Insurance becomes effective on the latest of the following dates:

a) The date the participant's insurance becomes effective;

b) The date they become eligible;

c) The day after the termination of insurance under another contract.

However, the Insurer must receive the application within 30 days. Otherwise, insurance becomes effective on the date the Insurer receives the form.

2.4 Acquisition of permanent status

Within 30 days following the date of written confirmation of the acquisition of permanent status, employees may take advantage of the following options:

a) Enrol in Basic Life Insurance without evidence of insurability;

b) Enrol in Dental Care Insurance;

c) Terminate their exemption from Health Insurance;

d) Insure their dependents according to the same rules as new employees.

It is mandatory for employees to enrol in the Long-Term Disability Insurance benefit.

Employees must be actively at work at the time of enrolling in any insurance benefit. Otherwise, they may apply within 30 days following the return-to-work date.

The Long-Term Disability Insurance benefit is effective retroactively to the start date of the session while other selected insurance benefits become effective on the date the Insurer receives the application form, if this form was submitted within 30 days following confirmation of permanent status.

If the application is submitted after this time period, the Health Insurance benefit and if applicable, the Dental Care Insurance benefit become effective on the date the Insurer receives the form. For Life Insurance, employees must submit evidence of insurability and insurance will become effective on the date the Insurer approves such evidence.

2.5 Change in coverage – Health Insurance and Dental Care Insurance

Any change in coverage will trigger the start of a new 36-month minimum participation period. However, in the event of a change in coverage status (Individual, Family or Single-Parent) for the same insurance benefit, the same 36-month minimum participation period continues.

2.5.1 Increases

Participants may make the following increases in their coverage at any time:

a) Health Insurance

- Change from Basic coverage (Module A) to Standard coverage (Module B)
- Change from Basic coverage (Module A) to Enriched coverage (Module C)
- Change from Standard coverage (Module B) to Enriched coverage (Module C)

b) Dental Care Insurance

- Change from Option 1 to Option 2.

2.5.2 Decreases

Participants may make the following decreases in coverage after a minimum participation period of 36 consecutive months:

a) Health Insurance

- Change from Enriched coverage (Module C) to Standard coverage (Module B)
- Change from Enriched coverage (Module C) to Basic coverage (Module A)
- Change from Standard coverage (Module B) to Basic coverage (Module A)

b) Dental Care Insurance

- Change from Option 2 to Option 1 or end participation in this benefit.

2.5.3 Life events

Participants can increase or decrease their coverage status when one of the following events occurs:

- Acquisition of permanent status;
- Birth or adoption of a first child;
- Marriage or its equivalent;
- Separation or divorce;
- The death of the spouse or a child.

However, none of these events entitle participants to end their participation in the Dental Care Insurance benefit.

Participants have a 30-day period as of the date of the event to change coverage status. The minimum participation rules of 12 or 36 months do not apply. Participants are free to choose benefits according to their new situation, as if they were enrolling for the first time.

The new coverage status becomes effective on the date of the event if the participant has submitted the application for change within 30 days following the date of the event. Otherwise, the Health Insurance benefit and if applicable, the Dental Care Insurance benefit become effective on the date the Insurer receives the request.

2.6 Transfer provisions

2.6.1 For participants insured alone or with dependents under a previous contract, the Insurer guarantees continuity between this contract and the previous contract in compliance with the *Act respecting Insurance* and the *Regulation under the Act respecting Insurance*, so that participants and any dependents do not sustain any harm due to a change in contract, whether or not the participants are at work.

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

Also, all persons insured under the previous contract are covered by right by this contract on cancellation of the previous contract if the termination of insurance is exclusively attributable to the cancellation and the participant belongs to a class of participants covered by this contract.

2.6.2 In the case of a participant who, prior to submitting an enrolment application, was not insured under this contract, the Insurer is not liable for any benefits that may be payable by the previous insurer under any extension of coverage, conversion or other clause.

2.7 Maintaining insurance during leaves

Subject to the provisions of the collective agreement, participants who are on leave remain insured, with payment of premiums, under the Health Insurance and Disability Insurance benefits by paying the full premium. They may also choose, at the beginning of the leave, to maintain all benefits in force by paying the full premium. Payment of the full premium by the participant must also include the employer's share, except in the case of a preventative withdrawal or a maternity, paternity or parental leave, in which case the employer maintains payment of its share.

The Life and Disability Insurance benefit amounts and the amount of premiums for these insurance benefits are based on the participant's basic annual salary at the beginning of the leave. No disability benefits will be paid prior to the scheduled end date of an unpaid leave.

Participants who have not maintained all their insurance benefits will not be entitled to reinstate the insurance benefits they held at the beginning of the leave until they are once again actively at work. The insurance benefits will be reinstated without evidence of insurability if the participant submits an application within 30 days of being actively at work.

2.8 Voluntary reduced workweek program

Participants who are on a voluntary reduced workweek program remain insured for all benefits.

The Life and Disability Insurance benefit amounts and the amount of premiums for these insurance benefits are based on the basic annual salary the participant would have received, if they were not participating in such a program.

Any disability that occurs during the voluntary reduced workweek program is deemed to start on the same date as that used by the collective agreement to determine a salary insurance period.

2.9 Salary advance or deferred salary leaves and phased retirement

Insurance of participants who take part in a salary advance or deferred salary leave program, or in a progressive retirement program, remains in force for all benefits.

The Life and Disability Insurance benefit amounts and the amount of premiums for these insurance benefits are based on the basic annual salary the participant would have received, if they were not participating in such programs.

Any disability that occurs during such a leave is deemed to start on the same date as that used by the collective agreement to determine a salary insurance period.

2.10 Short-term layoff

Participants who have been laid off in accordance with their collective agreement, or with provisions set out by law, remain insured, with payment of premiums, under the Health Insurance and Disability Insurance benefits by paying the full premium. They may also choose, at the beginning of the leave, to maintain all benefits in force by paying the full premium.

The amount of coverage to which they are entitled is based on the salary they would have received had they not been laid off. However, participants may decrease their amount of coverage based on their reduced salary following the layoff by sending a written notice to the employer within 30 days following the layoff. No other requests will be accepted.

2.11 Maintenance of insurance during layoffs, strikes, lockouts or dismissals

For participants who are temporarily absent from work due to a layoff, strike or lockout, insurance remains in force provided the regular premiums continue to be paid. The dismissal of a participant that is legally challenged or contested by grievance is deemed, for the purposes of insurance, to be a temporary layoff ending on the date of final ruling on the case.

2.12 Portability of coverage

Participants who are relocated to another college following a short-term layoff can apply, without providing evidence of insurability, for the same coverages they had with the previous employer, regardless of union affiliation, provided these benefits are available.

Participants who benefit from an exchange between colleges maintain their insurance coverages and pay premiums to the initial college as long as this exchange remains temporary. If the exchange becomes permanent, participants enrol in the insurance coverages with the new college.

SECTION 3 – **LIFE INSURANCE**

3.1 Basic amount of insurance

3.1.1 The basic amount of insurance payable in the event of the participant's death is the following:

a) Participant under age 65 (participant's choice):

- One times the annual salary, rounded to the nearest $500, if death occurs before the 65th birthday or the effective date of retirement, if earlier. The minimum basic amount of insurance is $75,000.

- Two times the annual salary, rounded to the nearest $500, if death occurs before the 65th birthday or the effective date of retirement, if earlier. The minimum basic amount of insurance is $75,000.

b) Participants age 65 to 69

- 50% of the life insurance that the participant held, depending on the selection made before age 65.

c) Participants age 70 and over

- $10,000, if death occurs on or after the 70th birthday, but before the date of retirement.

Following this reduction in the amount of insurance, the difference between the amount of Basic Life Insurance that any participant held prior to their 70th birthday and the new amount of $10,000, will be automatically converted into Optional Life Insurance, without evidence of insurability and up to a maximum of one or 2 units of $25,000. The remaining provisions of the participant's Optional Life Insurance apply.

3.1.2 Change in the basic amount of insurance

If the participant's salary is modified, including in the case of a temporary assignment, the change in the amount of life insurance becomes effective at the latest on the date the change in salary comes into force or on the date an agreement to this effect is reached between the Policyholder and the Insurer, if later.

For disabled participants, no change will be made after a 24-month disability period, extended by any unused credits in the participant's sick leave bank.

3.1.3 Termination of insurance

Subject to the provisions of articles 3.5 Waiver of Premiums, 3.6 Extension of Coverage and 3.7 Conversion Privilege, a participant's insurance terminates on the first of the following dates:

3.1.3.1 The date the benefit or this contract is cancelled.

3.1.3.2 The date the participant ceases to be employed, except in the case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is administered by the Policyholder is not considered a termination of employment.

Non-permanent employees as defined in the collective agreement are considered to have terminated employment on the first day of the session following the one covered by their contract, without exceeding two months after their contract termination date, unless they cancel their coverage, in which case the insurance terminates with their contract.

3.1.3.3 The day before the due date of any unpaid premium.

3.1.3.4 The date the Insurer receives written notice from a participant wishing to terminate coverage under this benefit, or on the date of termination indicated in such notice, whichever is later.

3.1.3.5 The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65.

3.1.3.6 The expiry of the five-year period following termination of the participant's disability for an employee who is eligible under article 2.1.7.

3.2 Participant's Critical Illness Insurance (a benefit linked to the Participant's Life Insurance benefit)

3.2.1 Coverage

If a participant undergoes a surgical procedure or is diagnosed with a critical illness for the first time, the Insurer agrees to pay the percentage of the amount of insurance specified for each of the illnesses and surgeries covered under this benefit.

To be eligible for benefits, the participant must be insured under this benefit on the date of the surgical procedure or diagnosis of the illness and must survive for a minimum period of 30 days following that date, provided the diagnosis remains unchanged during that period. However, in the event that the illness or surgery results directly from an accident, the date of the accident is considered to be the date of the diagnosis or surgery.

3.2.2 Amount of insurance

The applicable amount of insurance is $25,000.

The maximum amount payable for all surgical procedures and illnesses for which the participant submits a claim is subject to a lifetime limit of 100% of the amount of insurance.

3.2.3 Illness and surgeries covered

a) Multiple sclerosis – 100% of the amount of insurance

Unequivocal diagnosis of at least two well-defined neurological abnormalities, including one episode having lasted for a minimum period of six consecutive months. The diagnosis must be made by a neurologist and confirmed by medical imaging.

b) Muscular dystrophy – 100% of the amount of insurance

Degenerative hereditary disorder of the striated muscles, the unequivocal and final diagnosis of which is made by a duly qualified physician. The affliction must be severe enough that the participant is unable to carry out the activities of daily living usually associated with a person of the same age for a minimum period of six consecutive months. The diagnosis must be confirmed by an electromyography and a muscular biopsy.

c) Paralysis – 100% of the amount of insurance

Loss of motor skills of neurological origin of at least two limbs, resulting in the total and permanent loss of use of those limbs. The paralysis must have persisted for at least 180 consecutive days since the date of the accident or the illness at the origin of the paralysis, with no signs of improvement during that time.

d) Alzheimer's disease – 100% of the amount of insurance

Progressive neurodegenerative illness diagnosed by a neurologist or geriatric specialist, with the exception of any organic brain syndrome or psychiatric disorder. The participant must show signs of diminished intellectual faculties, especially pertaining to memory and judgment, such that his or her capacity to function in society is greatly reduced and he or she requires constant supervision.

e) Parkinson's disease – 100% of the amount of insurance

Idiopathic and degenerative Parkinson's disease diagnosed by a neurologist and characterized by at least two of the following symptoms:

- Rigidity
- Shaking
- Akinesia

Exclusions and reductions of coverage: Other types of parkinsonian syndromes are not covered.

f) Motor neuron disease – 100% of the amount of insurance

Unequivocal diagnosis by a neurologist of one of the following five illnesses:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal amyotrophy
- Progressive bulbar paralysis
- Pseudobulbar paralysis

g) Blindness – 100% of the amount of insurance

Total and irreversible loss of sight in both eyes diagnosed by an ophthalmologist. Corrected eyesight must be weaker than 20/200, or the visual fields must be less than 20 degrees, in both eyes.

h) HIV infection – 100% of the amount of insurance

Infection of the participant by the human immunodeficiency virus (HIV) occurring after the effective date of coverage under this benefit.

The Insurer must be notified of any situation likely to lead to HIV infection within 14 days following the date of the event. The participant must also have blood samples taken for HIV screening during this 14-day period, and tests must be negative. Blood samples must be retaken between three and six months following the date of the event and tests must be positive at that time. The Insurer is authorized to have blood samples analyzed by a laboratory of its choice and has the right to require additional samples to be taken.

The situation or event that may lead to HIV infection must be reported, assessed and documented.

No amount of insurance is payable in the event that the participant refuses to use a vaccine affording protection against the HIV virus that became available prior to the occurrence of the situation or event that caused the HIV infection.

Furthermore, if a curative treatment for AIDS were to become available after the effective date of this benefit, this HIV infection provision will automatically become null and void starting on the date such treatment becomes available.

i) Cerebrovascular accident (stroke) – 50% of the amount of insurance

Cerebrovascular accident, with the exception of an ischemic accident or vertebrobasilar insufficiency, diagnosed by a neurologist and resulting from thrombosis, intracranial hemorrhage or embolism from an extracranial source. The accident must have neurological sequelae, with paralysis or any other objective and measurable neurological deficit, persisting for at least 30 consecutive days following the accident.

j) Kidney failure – 50% of the amount of insurance

Permanent and irreversible failure of both kidneys diagnosed by a nephrologist and requiring regular treatment through hemodialysis or peritoneal dialysis.

k) Severe burns – 50% of the amount of insurance

Third-degree burns diagnosed by a plastic surgeon, covering at least 20% of the body.

l) Major organ transplant – 50% of the amount of insurance

Graft of one of the following organs due to chronic and irreversible failure:

- Heart
- Liver
- Bone marrow, excluding autografts
- Both lungs
- Both kidneys
- Pancreas

m) Myocardial infarction (heart attack) – 35% of the amount of insurance

Necrosis of part of the heart muscle as a result of the obstruction of the arteries ensuring its irrigation.

The diagnosis must be confirmed by both of the following elements:

- Presence of electrocardiographic modifications (ECG) indicating a myocardial infarction or a new clinical picture of typical pain symptoms, exclusively in cases where the electrocardiogram cannot be interpreted (complete bundle branch block, Wolff-Parkinson-White syndrome, cardiac stimulator); and

- Two occasions of elevated biological markers, including cardiac enzymes, troponins, CPK or MB-CPK at a level indicative of myocardial infarction.

Exclusions and reductions of coverage: Myocardial infarction that does not meet the criteria mentioned previously or myocardial infarction occurring within 48 hours following elective revascularization is not covered, unless accompanied by new pathological Q waves.

n) Cancer – 35% of the amount of insurance

Malignant tumor diagnosed by an oncologist, characterized by the uncontrolled development and spreading of malignant cells invading the tissue.

Exclusions and reductions of coverage: This benefit does not cover any cancer diagnosed in the first 90 days following the effective date of the participant's insurance, or if signs, symptoms or problems occur during this period.

The following types of cancer are also excluded:

- Any cancer classified as TX, TO or Tis (in situ) according to TNM classification, as well as a T1N0M0 classification for prostate cancer
- Pre-cancerous lesions, benign tumors or polyps
- Any type of skin cancer, except for malignant melanoma invading the dermis or deeper (more than one millimetre)
- Any tumor diagnosed for a participant infected with HIV

o) Coma – 35% of the amount of insurance

A deep state of unconsciousness, with no reaction by the participant to any external stimulus, persisting for at least 96 consecutive hours and diagnosed by a neurologist.

p) Coronary bypass – 35% of the amount of insurance

Surgery recommended by an internist or cardiologist and carried out by a surgeon in order to correct the narrowing or obstruction of one or more coronary arteries by means of anastomosis or bypass grafting.

Exclusions and reductions of coverage: This benefit does not cover non-surgical techniques such as angioplasty with a balloon-tip catheter, correction of an obstruction by laser or any other arterial technique not involving a bypass or anastomosis.

q) Deafness – 25% of the amount of insurance

Total and irreversible loss of hearing in both ears, diagnosed by an ear, nose and throat specialist, rendering the participant incapable of hearing sounds of 90 decibels or less.

r) Muteness – 25% of the amount of insurance

Total, permanent and irreversible loss of speech due to illness, bodily injury or accident which has persisted for a minimum period of 365 consecutive days. Muteness must be diagnosed by a physician duly qualified to make such a diagnosis and must not result from a psychological or psychiatric disorder.

3.2.4 Pre-existing conditions

The participant is not entitled to any amount of insurance for any critical illness or surgery resulting directly or indirectly from a pre-existing condition for which the participant consulted a physician or received treatment in the 24 months preceding the start date of his or her coverage under a critical illness insurance benefit.

However, this exclusion no longer applies if the unequivocal and final diagnosis of the critical illness is made for the first time more than 24 months after the effective date of the participant's insurance.

3.2.5 Exclusions and reductions of coverage

No amount of insurance is payable for an illness or surgical procedure that results directly or indirectly from any of the following causes:

a) Voluntarily self-inflicted injuries, or injuries due to self-mutilation or attempted suicide, whether or not the participant is of sound mind.

b) An injury sustained or illness contracted during a criminal act or an act deemed to be criminal that the participant commits or attempts to commit.

c) A condition resulting from driving a vehicle

- while having a blood alcohol level in excess of the prescribed legal limit where the accident occurred; or
- while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's directions for use or recommended dosage.

d) Abuse of alcohol, drug use or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.

e) Injury or illness due to war, whether declared or undeclared, or the participant's involvement or attempted involvement in a riot or insurrection.

f) Refusal or omission by the participant to receive appropriate treatment for his or her condition.

g) Active service of the participant in the armed forces of any country.

3.2.6 Termination of insurance

The participant's Critical Illness Insurance benefit ends on the same date as the participant's Life Insurance benefit.

Furthermore, participants who have received the maximum amount of benefits payable under this benefit may terminate participation in it by sending a request in writing to the Insurer.

3.3 Dependents' Basic Life Insurance

3.3.1 The amount of Dependents' Life Insurance is the following:

a) Spouse:

- $10,000 in the event of death occurring before the 65th birthday;
- $5,000 in the event of death occurring on or after the 65th birthday, but before the date of the participant's retirement.

b) Dependent child:

- $5,000 as of 24 hours of age, provided the child meets the definition of dependent child.

3.3.2 Termination of insurance

Subject to the provisions of articles 3.5 Waiver of Premiums, 3.6 Extension of Coverage and 3.7 Conversion Privilege, a dependent's insurance terminates on the first of the following two dates:

3.3.2.1 The insurance termination date of the insured participant associated with the dependent.

3.3.2.2 The date the person ceases to be considered a dependent.

3.4 Optional Life Insurance

3.4.1 Amount of Optional Life Insurance

a) Participant under age 70

The participant can take out from one to 10 units of $25,000 of Optional Life Insurance.

The maximum amount of Optional Life Insurance is $250,000, including any amount held before January 1, 2013.

Any employees participating in this benefit before January 1, 2013, maintain the amount of insurance held on that date (amount based on units of $20,000). However, if they wish to add or remove any units to or from the amount currently held, these units will be worth $25,000 and the new amount will be rounded to the nearest multiple of $25,000, up to the maximum amount of $250,000.

b) Participant age 70 and over

The participant can retain or take out one to 2 units of $25,000 of Optional Life Insurance.

As of age 70 and considering the conversion privilege of the Basic Life Insurance under article 3.1.1, the maximum amount of Optional Life Insurance is $50,000.

c) Spouse under age 70

The participant can take out from one to 10 units of $25,000 of Optional Life Insurance for his or her spouse.

The maximum amount of Optional Life Insurance is $250,000, including any amount held before January 1, 2013.

Any spouses covered by this benefit before January 1, 2013, maintain the amount of insurance held on that date (amount based on units of $20,000). However, if they wish to add or remove any units to or from the amount currently held, these units will be worth $25,000 and the new amount will be rounded to the nearest multiple of $25,000, up to the maximum amount of $250,000.

d) Spouse age 70 and over

The participant can take out from one to 2 units of $25,000 of Optional Life Insurance for his or her spouse, up to a maximum amount of $50,000.

3.4.2 Termination of insurance

3.4.2.1 Subject to the provisions of articles 3.5 Waiver of Premiums, 3.6 Extension of Coverage and 3.7 Conversion Privilege, a participant's insurance terminates on the first of the following dates:

a) The termination date of this contract or the benefit;

b) The date a participant ceases to be employed, except in the case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is administered by the Policyholder is not considered a termination of employment.

Non-permanent employees as defined in the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding two months after their contract termination date, unless they cancel their coverage, in which case the insurance terminates with their contract;

c) The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65;

d) The day before the due date of any unpaid premium;

e) The date the Insurer receives written notice from a participant wishing to terminate coverage under this benefit, or on the termination date indicated in such notice, whichever is later;

f) The expiry of the five-year period following the termination of disability for an employee eligible under article 2.1.7.

3.4.2.2 Subject to the provisions of articles 3.5 Waiver of Premiums, 3.6 Extension of Coverage and 3.7 Conversion Privilege, a spouse's insurance terminates on the first of the following dates:

a) The date the participant's Basic Life Insurance and the dependent's Basic Life Insurance are terminated;

b) The date the person ceases to meet the definition of "spouse".

3.5 Waiver of premiums

Insurance for a participant, including that for any dependents, who becomes disabled before the effective date of retirement is maintained in force, without payment of premiums, until the first of the following dates:

a) The date the participant's total disability ends;

b) The participant's retirement date. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65.

c) The date of the participant's 65th birthday;

d) The termination date of this contract or the Critical Illness Insurance benefit.

For participants who became disabled prior to January 1, 2025, waiver of premiums applies after the expiry of a 30-day period following the start of disability.

For participants who become disabled on January 1, 2025, or after, waiver of premiums applies after the expiry of a 52-week period following the start of disability.

Evidence of disability must be submitted upon the Insurer's request, but the Insurer agrees not to request such evidence more than once a year.

3.6 Extension of coverage

In case of termination of this contract or benefit, the Participant's Life Insurance (excluding Critical Illness Insurance), Optional Life Insurance and Dependent's Life Insurance benefits for which premiums are waived are maintained in force.

3.7 Conversion privilege

Participants whose Life Insurance coverage terminates under this benefit because they cease to work for the employer for a reason other than retirement or because they cease to be eligible in accordance with article 2.1.1 may, within 31 days following the date of termination of employment and without evidence of insurability, obtain a permanent or term individual life insurance policy, without accessory benefits, of the type offered by the Insurer in these circumstances.

In case of termination of employment or the participant's death, the spouse may, within 31 days following termination of this participant's Basic Life Insurance and without evidence of insurability, obtain a permanent or term individual life insurance policy, without accessory benefits, of the type offered by the Insurer in these circumstances.

The amount of insurance that can be converted to an individual policy must not exceed the amount of coverage that was terminated.

The participant's and spouse's coverage under this benefit remains in force for the 31-day period during which they may apply for an individual life insurance policy.

3.8 Beneficiary

Participants may designate a beneficiary, change a previously designated beneficiary or specify that insurance is payable to their successors by sending a written, signed statement to the Insurer's head office, subject to provisions of the law. The Insurer is not liable for the legal validity of any change of beneficiary.

All amounts of Dependents' Life Insurance are payable to the participant.

The rights of any beneficiary who predeceases the participant revert to the participant. If at the time of the participant's death, the participant has not designated a beneficiary in writing, the amount of insurance becomes a part of the participant's estate.

3.9 Payment of insurance

Benefits are based on the amount of insurance held at the time of an insured's death or the diagnosis of a participant's critical illness, as described under articles 3.1 to 3.4. In the event of a participant's death, benefits are payable to the designated beneficiary or the participant's estate. In the event of the death of the participant's spouse or dependent child, benefits are payable to the participant.

The claimant must provide the Insurer with the required evidence to establish, in addition to the claimant's rights, the death of the insured and cause of death, as well as the accuracy of the date of birth stated by the participant. Benefits are payable only if insurance is effective at the time of death.

SECTION 4 – **MANDATORY HEALTH INSURANCE**

Eligible expenses are those incurred for the care, supplies and services described below and are limited to the expenses reasonably justified by the seriousness of the case, current medical practice and the customary and reasonable charges in force in the area, subject to the exclusions indicated under the Quebec *Health Insurance Act*, the Quebec *Hospital Insurance Act*, or any other health or hospital insurance legislation in the insured's province of residence.

Expenses that are not medically necessary, expenses payable under any other individual or group insurance plan and expenses for which the insured is entitled to an indemnity under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, or any other similar federal or foreign legislation are excluded.

Direct automated payment services

When making prescription drug purchases, insureds present their service card to the pharmacist. The Insurer automatically issues payment for the insured portion of prescription drug expenses. There's no need to submit a claim form to the Insurer, and insureds pay only the uninsured portion of prescription drug expenses, including any applicable deductible.

4.1 Schedule of Insurance

Care, services and supplies identified with an asterisk (*) require a medical prescription. The maximums indicated are per insured, unless otherwise specified.

	Basic coverage (Module A)	**Standard coverage (Module B)**	**Enriched coverage (Module C)**
1. **Expenses are reimbursed at 100%.**			
Hospitalization in Canada	Semi-private room	Semi-private room	Semi-private room
Extended care	Semi-private room Maximum of 180 days per calendar year	Semi-private room Maximum of 180 days per calendar year	Semi-private room Maximum of 180 days per calendar year
Travel insurance	Lifetime maximum of $2,000,000	Lifetime maximum of $2,000,000	Lifetime maximum of $2,000,000
Trip cancellation insurance	Maximum of $5,000 per trip	Maximum of $5,000 per trip	Maximum of $5,000 per trip

	Basic coverage (Module A)	Standard coverage (Module B)	Enriched coverage (Module C)
2. **Prescription drugs***			
Prescription drug clause	RAMQ list	Standard list	Standard list
Reimbursement	**Up to the maximum annual contribution under the PPDIP**** The reimbursement percentage corresponds to the minimum reimbursement of the PPDIP and is adjusted on January 1 of each year *** **Excess:** 100$***	80% of eligible expenses, **up to a maximum annual contribution of 900$**** **Excess:** 100$***	85% of eligible expenses, **up to a maximum annual contribution of 600$**** **Excess:** 100$***
	** The spouse's maximum annual contribution is calculated separately from that of the participant. Eligible expenses incurred for dependent children are included in the participant's maximum annual contribution. *** For original drugs, the reimbursement percentage is applied on the basis of the price of the cheapest generic drug (forced substitution).		
Prescription drugs for the treatment of erectile dysfunction*	Not covered	Eligible maximum of $1,000 per calendar year	Eligible maximum of $1,000 per calendar year
Annual deductible	None	None	None
Automated payment services	Direct	Direct	Direct

	Basic coverage (Module A)	Standard coverage (Module B)	Enriched coverage (Module C)
3. **Other eligible expenses**			
Reimbursement	The reimbursement percentage corresponds to the minimum reimbursement of the PPDIP	80%	85%
Annual deductible	None	None	None
Ambulance	Covered	Covered	Covered
Artificial limbs,* prosthetic devices,*	Covered	Covered	Covered
Batteries for sleep apnea support devices (CPAP)	Not covered	Eligible maximum of $500 per period of 60 consecutive months	Eligible maximum of $500 per period of 60 consecutive months
Breast prosthesis*	Not covered	Eligible maximum of $500 per calendar year	Eligible maximum of $500 per calendar year
Continuous glucose monitoring device and accessories*	Not covered	Eligible maximum of $5,000 per calendar year	Eligible maximum of $5,000 per calendar year
Corrective footwear*	Not covered	Eligible maximum of $100 per pair and 2 pairs per calendar year	Eligible maximum of $100 per pair and 2 pairs per calendar year
Dental surgeon services following an accident	Not covered	Covered	Covered

Eye examination	Not covered	Eligible maximum of $100 per period of 24 consecutive months	Eligible maximum of $100 per period of 24 consecutive months
Foot orthoses* and orthopedic devices*	Not covered	Covered	Covered
Gender affirmation surgery *	Not covered	Maximum reimbursement of $5,000 per calendar year, up to a maximum of $10,000 per lifetime	Maximum reimbursement of $5,000 per calendar year, up to a maximum of $10,000 per lifetime
Glucometer,* dextrometer* or other similar device*	Not covered	Maximum reimbursement of $200 per period of 60 consecutive months	Maximum reimbursement of $200 per period of 60 consecutive months
Hair prosthesis (wig)*	Not covered	Eligible maximum of $700 per calendar year	Eligible maximum of $700 per calendar year
Hearing aid*	Not covered	Maximum reimbursement of $2,000 per period of 12 consecutive months, up to a maximum of $1,000 per hearing aid	Maximum reimbursement of $2,000 per period of 12 consecutive months, up to a maximum of $1,000 per hearing aid
Insulin pump*	Not covered	Maximum reimbursement of $6,000 per period of 60 consecutive months	Maximum reimbursement of $ 6,000 per period of 60 consecutive months
Insulin pump supplies and accessories*	Not covered	Eligible maximum of $4,000 per calendar year	Eligible maximum of $4,000 per calendar year
Intrauterine device (IUD)	Not covered	Covered	Covered

Medical cannabis*	Not covered	Maximum reimbursement of $1,500 per calendar year	Maximum reimbursement of $1,500 per calendar year
Medical reports	Not covered	Maximum reimbursement of $40 per report, up to a maximum of $500 per calendar year	Maximum reimbursement of $40 per report, up to a maximum of $500 per calendar year
Orthopedic shoes*	Not covered	Expenses for purchase, after a deductible of $20 per pair is applied	Expenses for purchase, after a deductible of $20 per pair is applied
Oxygen therapy *	Not covered	Covered	Covered
Private clinic for the treatment of alcoholism, drug addiction or compulsive gambling	Not covered	Maximum reimbursement of $3,500 per calendar year, up to one treatment per calendar year and 2 treatments per lifetime	Maximum reimbursement of $3,500 per calendar year, up to one treatment per calendar year and 2 treatments per lifetime
Registered nurse* or licensed practical nurse*	Not covered	Eligible maximum of $300 per day Maximum reimbursement of $10,000 per calendar year	Eligible maximum of $300 per day Maximum reimbursement of $10,000 per calendar year
Rehabilitation centre and convalescent home	Not covered	Semi-private room Eligible maximum of $75 per day and 15 days per hospitalization	Semi-private room Eligible maximum of $75 per day and 15 days per hospitalization

Serums and fluids injected for curative purposes* (including injections for artificial insemination)	Not covered	Covered	Covered
Support stockings	Not covered	Maximum of 6 pairs per calendar year	Maximum of 6 pairs per calendar year
Treatment by a medical specialist not available in the insured's area of residence*	Not covered	Maximum reimbursement of $750 per trip	Maximum reimbursement of $750 per trip
Vaccines (including preventive vaccines)	Not covered	Covered	Covered
Wheelchair,* iron lung* or therapeutic equipment*	Not covered	Covered	Covered

	Basic coverage (Module A)	Standard coverage (Module B)	Enriched coverage (Module C)
4. **Healthcare professionals**			
Reimbursement	N/A	80%	85%
Chiropractor	Not covered	Eligible expenses of $65 per treatment, consultation or X-ray, up to a maximum reimbursement of $600 per calendar year for all of these professionals	Eligible expenses of $65 per treatment, consultation or X-ray, up to a maximum reimbursement of $1,200 per calendar year for all of these professionals
Acupuncturist, dietitian, occupational therapist, osteopath, physiotherapist, podiatrist, sports therapist and physical rehabilitation therapist	Not covered		
Kinesitherapist, massage therapist* and orthotherapist	Not covered	Not covered	
Audiologist, special education teacher and speech-language pathologist	Not covered	Eligible expenses of $100 per consultation, up to a maximum reimbursement of $900 per calendar year for all of these professionals	Eligible expenses of $100 per consultation, up to a maximum reimbursement of $1,800 per calendar year for all of these professionals

	Basic coverage (Module A)	Standard coverage (Module B)	Enriched coverage (Module C)
4. **Healthcare professionals**			
Career counsellor in private practice, psychoanalyst, psychiatrist, psychoeducator, psychologist, psychotherapist and social worker	Not covered	Eligible expenses of $100 per consultation, up to a maximum reimbursement of $900 per calendar year for all of these professionals	Eligible expenses of $100 per consultation, up to a maximum reimbursement of $1,800 per calendar year for all of these professionals
Assessment by a psychologist, neuropsychologist, special education teacher or speech-language pathologist	Not covered	Eligible maximum of $1,250 per calendar year	Eligible maximum of $1,250 per calendar year

4.2 Eligible Health Insurance expenses

4.2.1 Hospitalization

Expenses are reimbursed according to the terms and conditions indicated in the *Schedule of Insurance*, based on the module selected by the participant.

a) When an insured, on recommendation of a physician, is admitted to a hospital in Canada after the effective date of his or her insurance, the Insurer pays the fees for a private or semi-private room on behalf of the insured as long as the insured is eligible for insured hospital care for inpatients, but only up to the amount the hospital is authorized to directly charge the patient for a semi-private room.

b) When an insured, on recommendation of a physician and after the effective date of his or her insurance, is admitted for extended care of a chronic condition to a tuberculosis hospital, a sanatorium, a home for the mentally ill, a nursing home, a retirement home or a treatment centre after the effective date of his or her insurance and the establishment is authorized by the Quebec *Ministre de la Santé et des Services Sociaux* to register with the hospital insurance plan introduced under the *Health Insurance Act* of this province, the Insurer pays the fees set by this establishment on behalf of the insured, up to the amount the hospital is authorized to directly charge the patient for a semi-private room.

4.2.2 Prescription drugs

Expenses are reimbursed according to the terms and conditions indicated in the *Schedule of Insurance*, based on the module selected by the participant.

a) RAMQ list:

The Insurer reimburses participants for expenses incurred for themselves or their insured dependents for the purchase of prescription drugs that can be obtained only by prescription from a healthcare professional legally authorized to prescribe such drugs. Prescription drugs means any products included in the most recent drug formulary of the *Régie de l'assurance maladie du Québec* (RAMQ).

b) Standard list:

The Insurer reimburses participants for expenses incurred for themselves or their insured dependents for the purchase of prescription drugs that can be obtained only by prescription from a healthcare professional legally authorized to prescribe such drugs. Prescription drugs means any products included in the most recent drug formulary of the *Régie de l'assurance maladie du Québec* (RAMQ) or in the drug formulary of the *Association québécoise des pharmaciens propriétaires* (AQPP), with the exception of drugs coded "V" or "Z".

However, pharmaceutical services and prescription drugs that are covered under the Public Prescription Drug Insurance Plan (PPDIP) as established under the Act respecting prescription drug insurance are not covered for participants age 65 or over and their dependents unless the participant has requested otherwise in accordance with the provisions specified in the section on participation. If the participant chooses to insure prescription drugs with the RAMQ, only the portion not eligible for reimbursement (deductible and coinsurance) is eligible under this contract.

The Insurer also reimburses drugs obtained by medical prescription and whose therapeutic indication is directly related to treatment of the following medical conditions:

- Cardiac disorders
- Pulmonary disorders
- Diabetes
- Arthritis
- Parkinson's disease
- Epilepsy
- Cystic fibrosis
- Glaucoma

Upon receipt and approval by the Insurer of the prior authorization form duly completed by the participant's attending physician, the Insurer also reimburses prescription drug costs incurred for the treatment of erectile dysfunction related to certain medical conditions resulting from prostate cancer treatment or surgery.

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

- To limit reimbursement according to the criteria stipulated by the regulation regarding the *Act respecting prescription drug insurance*, if it is registered as an exception drug on the list in accordance with article 60 of the act;

- To exclude it or establish reimbursement criteria, if this drug is not included on the list.

Notwithstanding any of the definitions or exclusions of this contract, expenses for all prescription drugs that must be covered under the group insurance contract in accordance with the *Act respecting prescription drug insurance* are considered to be eligible expenses.

If there are medical contraindications preventing the insured from purchasing a generic drug, the brand name drug can be reimbursed in accordance with the percentage indicated for a patented drug. The insured must submit to the Insurer a document specifying the contraindications signed by the physician who prescribed the drug. If the Insurer accepts the request, no other medical document will be required for the renewal of the approved prescription drug.

4.2.3 Other eligible expenses

Expenses are reimbursed according to the terms and conditions indicated in the *Schedule of Insurance*, based on the module selected by the participant.

a) Expenses for transportation by ambulance, including round-trip air or train transportation, in the case of an emergency.

b) Expenses for the purchase of an artificial limb and prosthetic devices (excluding dental prostheses) for a loss occurring while insurance is in force. Expenses for the repair of such devices are also covered if the cost is less expensive.

c) Expenses for the purchase of ''back up'' batteries for sleep apnea support (CPAP) devices aimed at providing required electricity during a power outage, or when no source of electricity is available.

d) Expenses for the purchase of an external breast prosthesis following a mastectomy, in excess of the amount paid by the *Régie de l'assurance-maladie du Québec*.

e) Expenses for the purchase of a continuous glucose monitoring device and accessories required exclusively for using a continuous glucose monitoring device.

f) Corrective footwear purchased from a specialized establishment.

g) The professional services of a dental surgeon to repair accidental damage to natural teeth occurring after the effective date of insurance, provided that treatment takes place within one year after the date of the accident.

h) Professional fees for an eye examination carried out by an ophthalmologist or an optometrist, for insureds age 18 to 64.

i) The cost of purchasing foot orthoses, casts and orthopedic devices, except for orthopedic shoes. Expenses for the repair of such devices are also covered if the cost is less expensive.

j) Expenses for the gender affirmation surgery:

   i) Eligible expenses include expenses incurred while undergoing surgery performed by a physician to modify the insured person's sexual characteristics in order to harmonize them to those associated with their self-identified gender. Expenses for hair removal through electrolysis or laser treatment are also eligible. Only the portion of expenses not covered by the public health insurance plan will be eligible for reimbursement.

ii) Expenses are eligible if all of the following conditions are met:

- the insured person must have received a gender dysphoria diagnosis from a physician;
- the surgery or hair removal must be performed in Canada;
- the surgery or hair removal must not be covered under the public health insurance plan of the insured person's province of residence.

k) Expenses for the purchase of a glucometer, dextrometer or any other device of a similar nature as well as the travel case for transporting it, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of this device.

l) The purchase of a hair prosthesis (wig) required following chemotherapy treatment.

m) Expenses for the purchase or repair of a hearing aid.

n) Expenses for the purchase of an insulin pump used to manage diabetes, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent and that his or her condition requires the use of this device.

o) Expenses for the purchase of supplies and accessories required exclusively for using an insulin pump.

p) Expenses for medical cannabis.

Expenses are eligible if all of the following conditions are met:

i) The cannabis is obtained from a producer authorized by competent government authorities.

ii) The Insurer receives the following two documents duly completed by a healthcare professional legally authorized to do so:

- The medical form authorizing the insured's use of medical cannabis; and
- The Insurer's authorization form.

iii) The cannabis must be consumed in order to relieve one or more symptoms associated with medical conditions eligible for such treatment, as defined by the Insurer.

Limitation: Subject to any other related terms and conditions indicated in the *Schedule of Insurance* or any other related legal changes, reimbursement of expenses is limited to three grams of cannabis, per day, per insured.

q) Expenses for medical reports.

r) Expenses for the purchase of orthopedic shoes (from a mould).

s) Oxygen therapy services administered under the supervision of or prescribed by a physician. The professionals who provide such services must be registered with the organization governing their profession.

t) Expenses incurred within Canada or outside of Canada for a program in a recognized private clinic specializing in the treatment of alcoholism, drug addiction (excluding addiction to smoking) or compulsive gambling.

u) The professional services of a registered nurse (R.N.) or licensed practical nurse, excluding services provided by a person who usually resides in the insured's home or is a member of the insured's family.

v) Expenses for occupying a room, including meals, for at least 12 consecutive hours in a rehabilitation centre or convalescent home as defined by the *Act respecting health services and social services*, in excess of the expenses payable under any government insurance plan, provided that the insured is admitted to the centre or home immediately following hospitalization and that the hospitalization lasted for at least three days and began while the insurance was in force.

w) Expenses for serums and fluids injected for curative purposes, including injections for artificial insemination.

x) Expenses for the purchase of support stockings.

y) Expenses incurred by insureds who must travel outside of their area of residence in order to consult a specialist or receive specialized treatment not available in their area of residence. The following expenses are eligible:

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

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

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

Eligible expenses must be incurred by and for the participant if he or she has Individual coverage. If participants have Family or Single-Parent coverage, eligible expenses must be incurred by and for the participants or their dependents. This benefit also covers expenses for a person accompanying the insured, when required.

z) Expenses for vaccines, including preventive vaccines, which are administered by a physician or nurse.

aa) Expenses for the rental, or purchase if this option is deemed more economical, of a wheelchair, iron lung and any therapeutic equipment, including the purchase of diapers for incontinence, probes, catheters and other similar hygienic items required following a total and irrecoverable loss of bladder or intestinal function.

4.2.4 Healthcare professionals

Expenses incurred for treatments or consultations with the following healthcare professionals are reimbursed according to the terms indicated in the *Schedule of Insurance*, based on the module selected by the participant.

The healthcare professionals must be members in good standing of a professional association recognized by the competent authorities or, failing the existence of such association, of a professional association recognized by the Insurer.

Insureds may not receive more than one treatment or one consultation per day from the same healthcare professional, regardless of the number of specialties the professional practises.

a) Acupuncturist

b) Audiologist

c) Chiropractor, including X-rays

d) Career counsellor in private practice

e) Dietitian

f) Occupational therapist

g) Kinesitherapist

h) Massage therapist

i) Special education teacher. Expenses for an assessment by a special education teacher are also covered.

j) Speech-language pathologist. Expenses for an assessment by a speech-language pathologist are also covered.

k) Orthotherapist

l) Osteopath

m) Physiotherapist, sports therapist, and physical rehabilitation therapist

n) Podiatrist

o) Psychoanalyst in an outpatient clinic. Fees for marital therapy for both spouses are also covered.

p) Psychiatrist. Fees for marital therapy for both spouses are also covered. For expenses to be eligible, the psychiatrist must be a member of the Canadian Psychoanalytic Society.

q) Psychoeducator

r) Psychologist. Fees for marital therapy for both spouses are also covered, as well as expenses for an assessment by a psychologist or a neuropsychologist.

s) Psychotherapist

t) Social worker

4.3 Travel insurance

The customary and reasonable expenses and services described below are eligible for reimbursement, if incurred following an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the public health and hospitalization insurance plans of the province of residence.

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

The maximum reimbursement per insured is indicated in the *Schedule of Insurance*.

LIMITATION

If an insured travels to a destination covered under a Canadian government travel advisory to avoid all non-essential travel in force on the day of departure, the travel insurance coverage period is limited to 30 days.

EXCLUSION AND REDUCTION OF COVERAGE

To be covered under this benefit, insureds who have a known illness or condition must ensure before departure that their health condition is stable and under control, that they can carry out usual daily activities and that they are experiencing no symptoms that may reasonably suggest that complications may arise or that medical care may be required during the planned stay outside the province of residence.

An illness or condition is considered to be stable in the absence of any:

- deterioration;
- relapse;
- diagnosis of terminal phase;
- chronicity likely to lead to deterioration or complications during the planned trip outside the province of residence.

Insureds with a known illness or condition who are uncertain about their state of health, or who are awaiting diagnosis, must contact the Assistor at least 15 days before departure to obtain confirmation of insurance coverage under this benefit.

4.3.1 Eligible hospitalization, medical and paramedical expenses

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

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

c) Professional fees of a physician for medical, surgical or anesthetic care other than fees for dental care; expenses incurred are payable only for the portion of expenses in excess of the benefits payable under the public health and hospitalization insurance plans of the insured's province of residence.

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

e) Professional fees of a registered nurse, who is a member in good standing of a professional association recognized by a legislative authority, for private nursing care dispensed exclusively in a hospital, when medically required and prescribed by the attending physician, up to a maximum reimbursement of $3,000 per hospitalization. The nurse must not be related to the insured nor be a travel companion.

f) Rental of therapeutic equipment and purchase of trusses, corsets, crutches, splints, casts and other orthopedic devices, when prescribed by the attending physician.

g) Professional fees of a dental surgeon for accidental injury to sound, natural, vital teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident. Expenses must be incurred within 12 months following the accident.

4.3.2 Eligible transportation expenses

a) Expenses for transportation of the insured by air or surface ambulance to the nearest adequate medical centre. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing his or her condition.

b) Repatriation expenses for the insured to return to his or her place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as his or her state of health so allows and insofar as the means of transport initially planned for the return cannot be used. If required by the insured's state of health, the Assistor will send a medical escort on site to accompany the insured on the return trip. Repatriation must be approved and planned by the Assistor.

c) When the insured is repatriated or transported, the Assistor organizes and pays expenses for the insured's spouse and dependent children or the insured's travel companion, as applicable, to return to the insured's province of residence, up to the cost of a regularly scheduled airline flight, train or bus ticket, if the means of transport initially planned for the return cannot be used.

d) When the insured's health condition does not allow medical repatriation, and hospitalization outside the province must extend beyond seven days, the Assistor will organize and pay round-trip transportation expenses to enable a close relative of the insured, residing in the insured's province of residence, to be at the bedside of the insured. The maximum reimbursement is $1,500.

However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative age 18 or over, if the necessity of a visit is not confirmed by the attending physician, or if the visit is not approved in advance and planned by the Assistor.

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

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

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

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

4.3.3 Eligible living expenses

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

4.3.4 Travel assistance services

On request, the Assistor will provide insureds with worldwide travel assistance service 24 hours a day, 365 days a year, excluding countries at war or under a travel advisory, making any intervention by the Assistor materially impossible.

a) The Assistor provides advances for expenses covered under the Travel Insurance benefit. The Assistor then files a claim for reimbursement of expenses covered under the public health and hospitalization insurance plans of the insured's province of residence and with the Insurer.

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

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

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

e) The Assistor will ensure, insofar as possible, the dispatch of any drugs that are indispensable for the ongoing treatment of the insured in the event that it is impossible to obtain such drugs or equivalent drugs on site. In all cases, drugs must be paid for by the insured and then, if eligible, reimbursed by the Insurer.

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

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

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

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

4.3.5 Obligations of insureds

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

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

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

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

4.3.6 Exclusions and reduction of Travel Insurance coverage

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

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

b) For any other trip than that defined in the first paragraph of article 1.43, which involves the insured's absence from the province of residence. This includes any trip during which teaching professional accompanies students as part of their duties, unless otherwise agreed by the Policyholder and the Insurer.

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

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

e) When expenses are incurred due to pregnancy and any related complications within eight weeks preceding the expected date of delivery.

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

g) When expenses are incurred for insureds in hospitals for the chronically ill, departments for the chronically ill in public hospitals, or for patients in extended care homes or thermal spas.

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

i) For an accident occurring while the insured is practising any sporting activity involving remuneration, motor vehicle competition or any speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity. Activities offered to the public at tourist resorts, other than the above-mentioned activities, are not considered dangerous activities.

j) Voluntary abusive consumption of medication, drugs or alcohol and the resulting condition.

k) For repatriation or travel assistance services, when the loss occurs in a country at war, whether declared or undeclared, under a travel advisory, during a riot, uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving force majeur making any intervention by the Assistor materially impossible.

l) When expenses are incurred by the insured after the date a Canadian government travel advisory is issued or the risk level of an existing advisory is upgraded, recommending that travellers avoid:

- any trip to a location where the insured is or will be travelling; or
- any trip on a cruise ship, whether the insured is already on board or not.

Furthermore, if an advisory is issued or if the risk level of an existing advisory is modified, while the insured is visiting the location in question or during the insured's cruise, the insured must comply with the advisory within 14 days following the date it is issued or the risk level is modified. If the insured is unable to demonstrate that the necessary arrangements were made, no expenses incurred by the insured will be eligible for reimbursement.

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

4.3.7 Coordination of benefits

This insurance is deemed “second payor” insurance. The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of benefits paid under any public or private, individual or group plan. It is understood that the rules governing the coordination of benefits under various plans are in compliance with the directives of the Canadian Life and Health Insurance Association.

4.4 Trip Cancellation Insurance

In accordance with the following conditions and the percentage indicated in the *Schedule of Insurance*, the Insurer will reimburse any expenses incurred by the insured following the cancellation or interruption of a trip, insofar as the expenses incurred are related to prepaid travel expenses while this benefit is in force and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip.

Only the portion of prepaid travel expenses that has not been the subject of any form of credit, compensation or indemnity (with or without restriction as to use) offered by the travel services provider or any organization is eligible.

Moreover, any prepaid travel expenses paid to a travel services provider must be unused, unusable, non-refundable and non-transferable.

Notwithstanding the above, when the insured demonstrates that he or she will be unable to use a travel credit prior to its expiry due to health conditions not existing at the time the trip was purchased or the occurrence of one of the causes of cancellation recognized under this benefit, the insured can send the claim to the Assistor for a refund.

4.4.1 Causes for cancellation or interruption

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

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

b) Death of the insured, the insured’s spouse, the insured’s child or spouse’s child, or the insured’s travel companion or business partner.

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

d) Death or emergency hospitalization of the host at destination.

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

f) Quarantine of the insured or travel companion, unless quarantine ends more than seven days prior to the scheduled trip departure date.

g) Hijacking of the airplane on which the insured is travelling.

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

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

j) If a travel advisory is issued by the Canadian government or the risk level of a travel advisory is upgraded, recommending that travellers avoid:

   i) any trip or any non-essential trip to a location where the insured is or will be travelling; or

   ii) any trip on a cruise ship, whether the insured is already on board or not.

   Trip cancellation expenses are eligible if the following conditions are met:

   - The advisory was issued or the risk level of an advisory was modified after travel expenses were incurred.
   - The advisory or the modified risk level of an advisory is still in force on the departure date of the insured's trip.

   Trip interruption expenses are eligible if the following conditions are met:

   - The advisory was issued or the risk level of an existing advisory was modified after the departure date of the insured's trip.
   - The advisory or the modified risk level of an advisory is still in force for the scheduled period of the insured's trip.
   - The insured took the necessary measures to comply with this advisory within 14 days following the date it was issued or the risk level was modified.

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

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

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

n) Permanent involuntary loss of employment or involuntary interruption of an employment contract of the insured or the spouse, provided the person in question has been working for the same employer for at least one year.

o) Default by the travel services provider.

4.4.2 Expenses covered

The following expenses are covered, provided they are incurred by the insured.

a) In the event of cancellation prior to departure:

- The non-refundable portion of prepaid travel expenses.
- Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the eligible reasons for cancellation provided hereunder and the insured decides to proceed with the trip as initially planned; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.
- The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's departure is delayed due to atmospheric conditions and the insured decides not to proceed with the trip.

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

c) If the return is earlier or later than planned:

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

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

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

d) If the return is earlier or later than planned due to the issuance of a Canadian government travel advisory or if the risk level of an existing advisory is upgraded, as indicated in the eligible cancellation or interruption causes section under this benefit:

The cost of accommodation and meals in a commercial establishment incurred by the insured, as well as essential telephone communication and additional travel expenses, subject to a daily maximum allowance of $300, per insured and an overall maximum of $3,000 per insured for the duration of the stay:

i) During transit to the destination when the insured must change travel plans, or;

ii) During transit to return to the point of departure when the insured is unable to return by the initially planned means of transportation, or;

iii) In the event of a trip extension.

e) In the event of default by a travel services provider:

Subject to the following provisions and subrogation in favour of the Insurer for any amount reimbursed, the Insurer will cover the financial loss incurred due to default by the service provider up to the amount eligible for reimbursement under this benefit:

- If the default occurs before departure, the Insurer will reimburse the non-refundable portion of prepaid travel expenses.
- If the default occurs after departure, the Insurer will reimburse the unused and non-refundable portion of prepaid travel expenses.

For the purposes of this contract, the Insurer's liability is limited to $500,000 for all claims due to the same travel services provider's default, and to an overall maximum of $1,000,000 per calendar year for all claims submitted with regard to defaults by travel services providers.

4.4.3 Exclusions from Trip Cancellation Insurance coverage

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

a) An illness or condition that was not stable at the time the insured finalized travel arrangements. Criteria used to define a stable illness or condition are specified in article 4.3.

b) For any other trip than that defined in the first paragraph of article 1.43, which involves the insured's absence from the province of residence. This includes any trip during which teaching professional accompanies students as part of their duties, unless otherwise agreed by the Policyholder and the Insurer.

c) Any trip taken for the purpose of obtaining medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.

d) Any trip for purposes of visiting a person who is ill or has had an accident, and the trip cancellation or interruption is due to the person's death or deteriorated medical condition.

e) War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.

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

g) Pregnancy, and any related complications, within eight weeks preceding the expected date of delivery.

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

i) Voluntary abusive consumption of medication, drugs or alcohol and the resulting condition.

j) Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity. Activities offered to the public at tourist resorts, other than the above-mentioned activities, are not considered dangerous activities.

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

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

m) When expenses are incurred by the insured after the date a Canadian government travel advisory is issued or the risk level of an existing advisory is upgraded, recommending that travellers avoid:

- any trip to a location where the insured is or will be travelling; or
- any trip on a cruise ship, whether the insured is already on board or not.

Furthermore, if an advisory is issued or if the risk level of an existing advisory is modified, while the insured is visiting the location in question or during the insured's cruise, the insured must comply with the advisory within 14 days following the date it is issued or the risk level is modified. If the insured is unable to demonstrate that the necessary arrangements were made, no expenses incurred by the insured will be eligible for reimbursement.

n) For fees related to eligible causes for trip cancellation, benefits are not payable if the insured made travel arrangements while a Canadian government travel advisory was in effect, recommending that travellers avoid trips to a location where the insured will be travelling or on a cruise ship, and the risk level of the advisory remains in effect when the cause for cancellation provided for under this contract occurs.

Furthermore, benefits are not payable for any fees related to causes for trip interruption if the insured leaves on a trip while a Canadian government travel advisory is in effect, recommending that travellers avoid trips to a location where the insured will be travelling or on a cruise ship, and the risk level of the advisory remains in effect when the cause for interruption provided for under this contract occurs. However, if the risk level of an advisory is modified to a recommendation to avoid all trips to the location that the insured is visiting or during the insured's cruise, the insured must take all the necessary measures to comply with this advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible, regardless of the cause.

4.4.4 Deadline for requesting cancellation

In the event of trip cancellation prior to departure, the trip must be cancelled within a maximum period of 48 hours from the time the cause for cancellation is known or on the next business day, if a statutory holiday. The Insurer must be notified at the same time. The Insurer's liability is limited to cancellation expenses set out in the travel contract for the 48 hours following the time the event justifying the trip cancellation occurred, or the next business day if this period coincides with a statutory holiday.

If a Canadian government travel advisory is in force or the risk level of an existing advisory is modified, the insured must contact the Assistor 72 hours before the date of payment of the deposit required for prepaid travel expenses or 72 hours before the departure date of the insured's trip, depending on the case.

4.4.5 Coordination of benefits

This insurance is deemed "second payor" insurance. The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of benefits paid under any public or private, individual or group plan. It is understood that the rules governing the coordination of benefits under various plans are in compliance with the directives of the Canadian Life and Health Insurance Association.

4.4.6 Trip Cancellation Insurance benefit claim

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

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

4.5 Exclusions and reduction of Health Insurance coverage

Without further limitation to care, supplies and services described under eligible health insurance expenses, and subject to the provisions of the *Act respecting prescription drug insurance*, the Insurer will not reimburse the following expenses:

a) For eye and hearing examinations, except if required following an accident. However, this exclusion does not apply for eye examinations covered under Standard (Module B) or Enriched (Module C) coverage.

b) For dentures, eyeglasses or contact lenses, except if required following an accident.

c) Those that the insured would not be required to pay if he or she had invoked the provisions of any public plan for which the insured was eligible.

d) For treatments, surgery or prostheses provided for aesthetic purposes, except following an accident.

e) Treatment or services provided by a close relative of the insured or by a person who resides with the insured.

f) For periodic medical examinations for the purposes of employment or insurance.

g) Any condition occurring while the insured is on active duty with armed ground, sea or air forces.

h) As a result of any war, whether declared or undeclared, or active participation in an insurrection.

i) As a result of active participation in a criminal act.

j) For dietetic substances or foods.

k) Following the termination of this contract, subject to article 4.10 Extension of Coverage.

l) For drugs or substances used for the treatment of impotence, with the exception of prescription drugs for the treatment of erectile dysfunction eligible under this contract.

m) For any user charge, deductible or coinsurance required by any public plan for products and services eligible for reimbursement under this benefit, with the exception of the deductible and coinsurance required by the RAMQ.

Exclusions and reductions in coverage listed in the Travel Insurance benefit apply in addition to those listed in this article.

For the Trip Cancellation Insurance benefit, only exclusions and reductions set out in article 4.4.3 apply.

4.6 Pre-existing conditions

Benefits related to causes that existed before the effective date of this contract are not excluded solely for this reason.

4.7 Claims

The Insurer is liable under this benefit only if claims are submitted within the 12 months following the date eligible expenses were incurred. Expenses are considered as being incurred on the date the services were rendered or the supplies were provided.

If the participant demonstrates that it was impossible to submit the claim within this deadline and the claim was submitted as soon as the participant was able to do so, the claim will then be eligible under this benefit.

4.8 Information

The Insurer may require any information, details, files and case histories regarding the diagnosis, treatment or services provided to each insured, either before or after the effective date of insurance for the insured. The insured agrees, as a condition of the Insurer's liability under this contract, to disclose or have disclosed to it all required information, details and files and authorizes any hospital or person providing or having provided such services to disclose such information directly to the Insurer. All this information is considered strictly confidential by the Insurer.

4.9 Waiver of premiums

Insurance for participants (and any dependents) who become disabled before the effective date of retirement is maintained in force without payment of premiums for as long as the disability lasts, provided the contract remains in force and the disabled participant has not reached age 65.

Waiver of premiums applies after expiry of a 52-week period following the start of disability.

4.10 Extension of coverage

Upon termination of a participant’s insurance and for the three-month period immediately following the termination date, the Insurer reimburses, for a disabled participant or an insured dependent who is hospitalized when insurance terminates, eligible expenses incurred for the illness or the accident that caused the disability or hospitalization, provided that:

a) The participant incurred eligible expenses for the illness or accident that caused the participant’s disability or the insured dependent’s hospitalization before the termination date of the insurance.

b) Disability or hospitalization continues without interruption.

4.11 Conversion privilege

Insureds who are no longer eligible for coverage under this benefit for a reason other than retirement may apply, without evidence of insurability, for an individual health insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within 60 days following the termination date of insurance. Evidence of insurability is required for applications submitted after this deadline. The individual health insurance contracts of insureds who exercise their conversion privilege within the required time frame take effect on the date their group insurance contract terminates. If evidence of insurability is required, insurance becomes effective as of the date the Insurer approves such evidence.

4.12 Termination of insurance

4.12.1 Participant

Subject to the provisions of articles 4.9 Waiver of Premiums and 4.10 Extension of Coverage, a participant's insurance terminates on the first of the following dates:

a) The date this contract terminates.

b) The date a participant ceases to be employed, except in the event of disability. However, the transfer of a participant to a college where the insurance contract is administered by the committee is not considered a termination of employment.

   For non-permanent employees, coverage is maintained until the first day of the following session, without exceeding two months from their contract termination date.

c) The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65.

d) In the event of non-payment of premium, 30 days following the date written notice to that effect is sent by the Insurer to the participant's last known address.

4.12.2 Dependents

Subject to the provisions of articles 4.9 Waiver of Premiums and 4.10 Extension of Coverage, dependents' insurance terminates on the earliest of the following dates:

a) The insurance termination date of the participant associated with the dependent.

b) The date the person ceases to meet the definition of dependent under this contract.

SECTION 5 – **DENTAL CARE INSURANCE**

5.1 Eligible expenses

Eligible expenses are expenses that are reasonably incurred, recommended by a dentist and justified by current dental practice, for the treatments specified below, up to the amount of the fees specified in the fee guide approved by the *Association des chirurgiens dentistes du Québec* at the time services are rendered.

Expenses payable under any other individual or group insurance plan and expenses for which the insured is entitled to an indemnity under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, or under any other similar federal or foreign legislation are excluded.

The codes used in the description of eligible expenses are drawn from the document entitled “Fee Guide and Description of Dental Treatment Services, 2014”, approved by the *Association des chirurgiens dentistes du Québec*. For subsequent years, these codes will be replaced by their equivalents from later documents approved by the Association. All new dental procedure code numbers related to the following expenses, added while the contract is in force, are considered an integral part of the description of eligible expenses under this contract.

If more than one type of treatment exists for the insured's dental condition, the Insurer reimburses expenses based on the least expensive normal and appropriate treatment.

Expenses are reimbursed according to the terms and conditions indicated in the *Schedule of Insurance*, based on the module selected by the participant.

5.2 Schedule of Insurance

The minimum participation period for both these options is 36 months, subject to the provisions of article 2.5 Change in Coverage – Health and Dental Care Insurance.

The maximums indicated are per insured.

	Basic coverage (Option 1)	Enriched coverage (Option 2)
Preventive services	80% One examination per period of 9 consecutive months.	80% One examination per period of 9 consecutive months.
Basic restorative services	80%	80%
Endodontics, periodontics, denture adjustment and repair costs	Not covered	80%
Maximum reimbursement	$1,000 per calendar year	$1,000 per calendar year
Annual deductible	None	None
Reimbursement based on	Fee guide for the current year	Fee guide for the current year

5.3 Description of preventive services

5.3.1 Diagnosis:

- Clinical oral examinations:

  a) Complete examination: one examination per period of nine consecutive months (01110, 01120, 01130);

  b) Recall or periodic examination: one examination per period of nine consecutive months (01200);

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

  d) Emergency examination (01300);

  e) Specific oral examination: one examination per period of nine consecutive months (01400);

f) Complete periodontal examination: one examination per period of 24 consecutive months (01500)

Limitation: only one recall, periodic, complete or specific oral examination is covered per period of nine consecutive months.

– Radiographs:

a) Intraoral radiographs:

i) Radiograph, periapical (02111 to 02116);

ii) Occlusal film (02131, 02132);

iii) Bitewing film (02141 to 02144);

b) Extraoral radiographs:

i) Extraoral film (02201, 02202);

ii) Radiograph, sinus (02304);

iii) Radiograph, sialography (02400);

iv) Radiopaque dyes (02430);

v) Radiograph, temporomandibular joint (02504);

c) Tomography (02920, 02929).

Limitation: Only one series of radiographs is eligible for reimbursement per period of nine consecutive months, except for a series of radiographs taken during an emergency examination. Furthermore, a complete series of periapical and bitewing films is only eligible for reimbursement once per period of 36 consecutive months.

5.3.2 Preventive services:

– Polishing of coronal portion of teeth (prophylaxis): one treatment per period of nine consecutive months (11100, 11200, 11300)

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

– Topical application of fluoride for dependents age 16 and under: one treatment per period of nine consecutive months (12400);

– Finishing restorations (13300);

- Removal of subgingival filling material, when local anesthetic is required, without flap, per tooth (13301);
- Pit and fissure sealants for dependents age 14 and under (13401, 13404);
- Teeth recontouring:
  a) Interproximal discing of teeth (13700);
  b) Enameloplasty, per tooth (13715).

5.4 Description of basic restorative services

5.4.1 Restoration:

- Primary teeth:
  a) Amalgam, non-bonded anteriors or posteriors (21101 to 21105);
  b) Amalgam, bonded anteriors or posteriors (21121 to 21125);
  c) Composite, bonded anteriors (23311 to 23315);
  d) Composite, bonded posteriors (23411 to 23415);
- Permanent teeth:
  a) Amalgam, non-bonded anteriors and bicuspids (21211 to 21215);
  b) Amalgam, non-bonded molars (21221 to 21225);
  c) Amalgam, bonded anteriors and bicuspids (21231 to 21235);
  d) Amalgam, bonded molars (21241 to 21245);
  e) Composite, bonded anteriors (23111 to 23115, 23118);
  f) Veneer applications (anteriors and bicuspids) (23122);
  g) Composite, bonded bicuspids: up to the amount payable for amalgam, bonded bicuspids (23211 to 23215);

h) Composite, bonded molars: up to the amount payable for amalgam, bonded molars (23221 to 23225);

– Retentive pins (amalgam or composite) (21301 to 21304);

– Supplement for restoration (amalgam or composite) under an appliance or supporting an existing removable partial denture (21601).

5.4.2 Oral surgery:

– Removal of erupted teeth (uncomplicated) (71101, 71111);

– Surgical excision:

a) Erupted teeth (complex) (72100, 72110);

b) Impacted teeth (72210, 72220, 72230, 72240);

c) Residual roots (72300, 72310, 72320);

d) Removal of fragment(s) of a fractured tooth (72350)

e) Surgical exposure of teeth (72410 to 72412);

f) Surgical movement of teeth (72430, 72440);

g) Enucleation of teeth (72450);

– Remodelling and recontouring of oral tissues:

a) Alveolectomy (73020);

b) Alveoloplasty (73100, 73110);

c) Stomatoplasty (73123);

d) Osteoplasty (73133 to 73135, 73140);

e) Tuberoplasty (73150, 73151);

f) Removal of hyperplasic tissue (by radiosurgery or dissection) (73171 to 73176);

g) Removal of excess mucosa (by radiosurgery or dissection) (73181 to 73186);

h) Alveolar ridge reconstruction with alloplastic material (73360, 73361);

i) Extension of mucous folds with secondary epithelization (including vestibuloplasty) (73381 to 73384);

j) Extension of mucous folds with mucous or skin graft (73401 to 73404);

- Surgical excision (cyst and tumor):

a) Removal of tumor (74108, 74109);

b) Removal and curettage of intra-osseous cyst or granuloma (74408 to 74410);

- Surgical incision and drainage (75100, 75101, 75110);
- Removal of foreign body from the bone or soft tissue (75301, 75361);
- Frenectomy (77801 to 77803);
- Hemorrhage control (79400, 79401).

5.4.3 Additional general services:

- Local anesthesia (92110, 92120);
- Conscious sedation by inhalation (92311);
- Professional visits (94100, 94200, 94400).

5.5 Description of endodontics, periodontics, denture adjustment and repair costs

5.5.1 Endodontics:

- Caries/trauma/pain control:

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

b) Recontouring and polishing of traumatized tooth (20131);

c) Recementation of broken tooth chip (20161);

- Endodontic emergency;
  a) Pulpotomy (32201, 32202, 32210);
  b) Open and drain (separate emergency procedure from root canal treatment):
     i) Open through natural teeth (39201, 39202);
     ii) Open through metal or porcelain crown (32101);
  c) Pulpectomy (separate emergency procedure from root canal treatment) (39901 to 39904);
  d) Relieving traumatic occlusion (39970);
  e) Reimplantation of avulsed tooth (39981);
  f) Repositioning of traumatically displaced tooth (39985);
- Preparation of tooth for treatment (39100, 39110, 39120);
- Root canal therapy:
  a) Root canal treatment:
     i) One canal (33100 to 33102, 33110 to 33112);
     ii) Two canals (33200 to 33202, 33210 to 33212);
     iii) Three canals (33300 to 33302, 33310 to 33312);
     iv) Four canals (33400 to 33402, 33410 to 33412);
     v) Additional canal (33475);
  b) Apexification:
     i) One canal (33521, 33531, 33541);
     ii) Two canals (33522, 33532, 33542);
     iii) Three canals (33523, 33533, 33543);

- Periapical endodontic surgery:

  a) Apicoectomy (as a separate procedure from the root canal treatment) (34101 to 34104);

  b) Apicoectomy and root canal performed jointly, with or without retrofilling (34111, 34112, 34114, 34115);

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

  d) Root amputation (34401, 34402);

  e) Intentional reimplantation (34451 to 34453);

  f) Hemisection (39230);

- Bleaching of endodontically treated tooth, carried out in office by the dentist: up to an overall maximum of 10 sessions per calendar year, per insured (39410).

- Bleaching of vital teeth, carried out in office by the dentist: up to a maximum of one session per calendar year, per insured, for all teeth (97101, 97102).

5.5.2 Periodontics:

- Management or treatment of acute infections, inflammations or other conditions (41200);

- Desensitization: up to an overall maximum of 10 applications per year, per insured, for all teeth (41300);

- Periodontal surgery:

  a) Gingival curettage and root planing (42000, 42001);

  b) Gingivoplasty and/or gingivectomy (42003, 42010);

  c) Fibrotomy (42330, 42331);

  d) Flap approach with osteoplasty and/or ostoectomy (42100);

  e) Grafts:

     i) Soft tissue (42200, 42300, 42560, 42561);

     ii) Osseous tissue (42611, 42700, 42711);

     iii) Gingival using allograft or xenograft material (42570, 42575);

f) Interproximal wedge (mesial or distal) (42400);

g) Exploratory surgery, flap approach (42441);

h) Flap approach, with osteoplasty/ostoectomy for crown lengthening (42451);

i) Postoperative visit for dressing change (42720);

– Periodontal procedures, adjunctive:

a) Temporary splints or ligations (43200, 43211, 43212, 43260);

b) Permanent splints (43290, 43295);

c) Occlusal equilibration (43300, 43310);

d) Periodontal appliances (to control bruxism) (43611, 43612, 43622, 43631);

e) Intraoral appliance for temporomandibular joint (occlusal guard) (43711, 43712, 43732, 43741);

f) Periodontal irrigation, subgingival (49211);

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

5.5.3 Denture adjustments:

– Minor adjustments, provided that adjustments are made more than six months after the initial insertion of the denture (54250, 54251);

– Remount and equilibration of complete or partial dentures (54300 to 54302).

5.5.4 Complete or partial denture repairs:

– Complete denture repairs without impression (55101 to 55104);

– Complete denture repairs with impression (55201 to 55204);

– Structure additions to the partial denture (55520, 55530);

– Resetting of teeth of denture (56602);

– Vertical dimension recuperation by addition of acrylic to existing prosthesis (56631).

5.5.5 Rebase and reline:

- Reline complete or partial dentures (56200, 56201, 56210, 56211, 56220 to 56222, 56230 to 56232);
- Rebase (jump) (56260 to 56263, 56280, 56290);
- Therapeutic tissue conditioning (56270 to 56273).

5.5.6 Restriction regarding article 5.5.5

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

However, these services are not eligible for reimbursement if performed on a transitional denture.

5.6 Exclusions and reduction of coverage

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

5.6.1 Dental care that is free of charge or expenses for dental care that the insured is not required to pay or those that the insured would not be required to pay if he or she had invoked the provisions of any public, private, individual or group plan for which the insured may be eligible, for coverage or those the insured would not be required to pay if not covered under this contract.

5.6.2 Dental care for which the insured is entitled to reimbursement under the *Act respecting industrial accidents and occupational diseases*, the Quebec *Automobile Insurance Act*, or any other federal or foreign law with similar provisions; and any dental treatments payable under any health insurance benefit in which the insured participates.

5.6.3 Dental treatments and supplies which, in accordance with the accepted standards of the dental profession, are not required from a dental viewpoint or which do not meet the accepted standards of the dental profession.

5.6.4 Dental treatments administered primarily for aesthetic purposes, including altering, extracting or replacing healthy teeth in order to modify appearance.

5.6.5 Dental treatments required due to voluntary self-inflicted injury, whether or not the insured is of sound mind, or due to war, or active participation in an insurrection, whether real or apprehended.

5.6.6 Fees charged for unkept appointments, filling out claim forms required by the Insurer, or for additional information required by the Insurer; also for travel time, transportation expenses and counselling provided by any means of telecommunication.

5.6.7 Fees charged for treatment plans, be it for extra time spent for explanation due to the complexity of the treatment, or when the insured requires extra time for explanation, or when the diagnostic material comes from another source, as well as any related fees charged for consultation with the insured or another dentist.

5.6.8 Fees charged in relation to diet assessments, recommendations for initial instruction or oral hygiene re-instruction, plaque control programs or any type of mouth guard.

5.6.9 Dental treatments related to implants.

5.6.10 Expenses incurred while insurance under this benefit is not in force.

5.6.11 Claims submitted by an insured with regard to procedures carried out under a treatment plan established prior to the effective date of this insurance benefit are not eligible under this insurance.

Furthermore, benefits for an insured with regard to procedures carried out under a treatment plan established prior to the effective date of this insurance benefit are not eligible under this insurance.

5.7 Claims

The Insurer is liable under this contract if claims are submitted within the 12 months following the date eligible expenses were incurred. Expenses are considered as being incurred on the date the services or supplies were provided.

The deadline set out above is mandatory. However, if the participant demonstrates to the satisfaction of the Insurer that it was impossible to submit the claim within this deadline and that it was submitted as soon as the participant was able to do so, the claim will then be eligible under this insurance benefit.

5.8 Coordination of benefits

The total amount of benefits paid to the same person under other insurance contracts or government plans may not exceed the actual amount of eligible expenses incurred.

If an insured under this contract is also insured under another plan, any initial reimbursement prior to applying any coordination of benefits is made under the plan in which the insured is not a dependent. Thereafter, any expenses not reimbursed fall under the plan under which the insured is considered to be a dependent.

In the case of dependent children, any initial reimbursement prior to applying coordination of benefits is made under the plan of the insured spouse whose birthday occurs earliest in the calendar year. Thereafter, any expenses not reimbursed fall under the plan of the other spouse.

5.9 Information

The Insurer may require any information, details, files and case histories regarding the diagnosis, treatment or services provided to each insured, either before or after the effective date of insurance for the insured. The insured hereby agrees, as a condition of the Insurer's liability under this contract, to disclose or have disclosed all required information, details and files and authorizes any person providing or having provided such services to disclose such information directly to the Insurer. All this information is considered strictly confidential by the Insurer.

5.10 Waiver of liability

The payment of benefits under this contract releases the Insurer from all liability for any act or omission of persons providing any of the services referred to in this contract.

5.11 Waiver of premiums

Insurance for participants, and any dependents, who become disabled before the effective date of retirement is maintained in force without payment of premiums for as long as the disability lasts, provided the contract remains in force and the disabled participant has not reached age 65.

Waiver of premiums applies after expiry of a 52-week period following the start of disability.

5.12 Termination of insurance

5.12.1 Subject to the provisions of article 5.11 Waiver of Premiums, a participant's insurance terminates on the first of the following dates:

5.12.1.1 The date this benefit or contract is terminated.

5.12.1.2 The date a participant ceases to be employed, except in case of disability. However, the transfer of a participant to a college where the insurance contract is administered by the committee is not considered a termination of employment.

For non-permanent employees, coverage is maintained until the first day of the following session, without exceeding two months from their contract termination date.

5.12.1.3 The due date of any unpaid premium.

5.12.1.4 The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums.

5.12.2 Subject to the provisions of article 5.11 Waiver of Premiums, a dependent's insurance terminates on the first of the following dates:

5.12.2.1 The insurance termination date of the participant associated with the dependent.

5.12.2.2 The date the person ceases to be considered a dependent according to definition 1.12 of section 1.

5.12.2.3 The date the participant changes Family or Single-Parent coverage to Individual coverage.

SECTION 6 – **SHORT-TERM DISABILITY INSURANCE**

Upon receipt and approval by the Insurer of proof establishing that a participant insured under this contract became disabled, as defined under article 1.13, and following expiry of the elimination period indicated in article 6.2, the Insurer will pay benefits to this participant according to the amount and frequency determined in accordance with articles 6.3, 6.5 and 6.8.

6.1 **Benefit period**

6.1.1 Participants who became disabled prior to January 1, 2020

The first benefit payment is payable as of the 31st day following expiry of the elimination period defined in article 6.2 and subsequent payments are made each month thereafter for as long as the participant remains disabled, up to a maximum period of 23 months. However, if the disability ends at the beginning of or during vacation, benefits will be paid until the end of the vacation unless a specific date is indicated.

6.1.2 Participants who became disabled on January 1, 2020 or after

The first benefit payment is payable as of the seventh day following expiry of the elimination period defined in article 6.2 and subsequent payments are made each week thereafter for as long as the participant remains disabled, up to a maximum period of 23 months. However, if the disability ends at the beginning of or during vacation, benefits will be paid until the end of the vacation unless a specific date is indicated.

Benefit payments end no later than the last week of the month in which the participant reaches age 65. However, if this insurance benefit is registered with the Employment Insurance premium reduction program, the maximum benefit period cannot be shorter than the benefit period payable under the *Employment Insurance Act.*

6.2 **Elimination period**

The elimination period is the 30-day period that begins at the start of disability and during which no disability benefits are payable.

However, specific provisions apply to any individuals or classes of individuals approved by the Policyholder and indicated in Schedules II, IV, VI, VII and VIII.

6.3 Benefit amount

For participants who became disabled before January 1, 2020, the initial amount of disability benefits payable is equal to 80% of the participant's net monthly salary, as defined in article 1.30, the net salary being the salary established when the sick leave reserve is depleted. However, benefits are limited to $5,000 per month.

For participants who became disabled between January 1, 2020 and December 31, 2024, the initial amount of disability benefits payable is equal to 80% of the participant's net weekly salary, as defined in article 1.30, the net salary being the salary established when the sick leave reserve is depleted. However, benefits are limited to $5,000 per month.

For participants who became disabled on January 1, 2025 or after, the initial amount of disability benefits payable is equal to 75% of the participant's net weekly salary, as defined in article 1.30, the net salary being the salary established when the sick leave reserve is depleted.

When necessary, the amount of disability benefits for the weeks or days following the last complete month of disability is calculated as follows:

- At a rate of 12/52 for a complete week of disability;
- At a rate of 1/5 of the amount for a complete week per business day during a regular work week.

6.4 Change in the benefit amount

If the participant's salary is modified, the change in the benefit amount becomes effective on the date the change in salary comes into force or, if later, the date an agreement to this effect is reached between the Policyholder and the Insurer, provided the participant is effectively at his or her regular employment or failing that, when the participant resumes his or her regular employment.

6.5 Cost-of-living adjustment

During the disability period and for as long as the participant is disabled, benefits are indexed annually on January 1 in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 3% for the purposes of this insurance benefit.

6.6 Waiver of premiums

Premiums are waived as of the first payment of disability benefits.

6.7 Scope of coverage

Coverage is in force 24 hours a day, 12 months a year.

6.8 Integration

If a disabled participant is entitled to other income during the disability period, the benefits are reduced by:

6.8.1 The initial amount of any basic disability benefits under the Quebec Pension Plan or the Canada Pension Plan, including pension benefits under the Quebec Pension Plan which the participant receives or is entitled to receive due to total disability, regardless of future increases in basic benefits resulting from cost-of-living adjustments.

With respect to the Quebec Pension Plan, the Insurer reserves the right to adjust, if necessary, the initial amount of disability benefit (including the disability pension benefits) after the initial amount has been revised by Retraite Quebec.

6.8.2 The initial amount of any basic disability benefits under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act* and any other public plan, regardless of future increases in basic benefits resulting from cost-of-living adjustments.

6.8.3 Parental benefits payable under any government plan. Benefits include maternity, paternity, adoption, parental or family leave benefits.

6.8.4 Any benefits payable under any salary continuance or sick leave policy.

6.8.5 50% of the gross amount of any pension benefits to which the participant is entitled. However, this source of integration is not applicable if the participant was receiving this pension benefit before the start of disability.

6.8.6 50% of the gross amount of the pension benefits paid to the participant under the Quebec Pension Plan or the Canada Pension Plan. However, this source of integration is not applicable if the participant was receiving this pension benefit before the start of disability.

6.9 Pre-existing conditions

Claims related to causes that existed before the effective date of this benefit are not excluded solely for this reason.

6.10 Rehabilitation services

Subject to an assessment by the Insurer, participants may receive rehabilitation services, the cost of which are assumed by the Insurer.

6.11 Vocational reorientation program

6.11.1 The Insurer must be informed of and pre-approve any participation in a vocational reorientation program.

6.11.2 A vocational reorientation program only applies to participants recognized as permanently disabled from their regular employment and who wish to undertake another gainful activity.

6.11.3 Participants enrolled in a vocational reorientation program continue to receive disability insurance benefits reduced by 50% of the net salary received by their new gainful activity under the vocational reorientation program.

6.11.4 If the participant's disability insurance benefits and remuneration from his or her new gainful activity under the vocational reorientation program exceed 100% of the basic net salary the participant would have received if actively at work, disability income benefits are reduced by the excess amount.

6.12 Gradual return to work

6.12.1 The Insurer must pre-approve any period of gradual return to work.

6.12.2 Participants making a gradual return to work continue to receive disability benefits from the Insurer as described in article 6.12.3. These benefits end when one of the following events occurs:

a) Expiry of a 12-month period following the start of the gradual return to work.

b) Interruption of the gradual return to work.

c) Withdrawal of the Insurer's approval of the gradual return to work.

6.12.3 Subject to article 6.12.2, during the gradual return to work period, disability insurance benefits will be reduced by the percentage of time the participant works each week or month in that period compared to the time the participant normally worked before becoming disabled.

6.12.4 Subject to the Insurer's approval, the participant who began a gradual return to work can benefit from a waiver of premiums if the gradual return to work began during the elimination period, as defined in article 6.2.

6.13 Extension of coverage

If on the termination date of the contract or this benefit, there are one or more disabled participants, each disabled participant is entitled to the benefits for which he or she would have been eligible had the contract or benefit remained in force.

6.14 Exclusions and reduction of coverage

No benefits are payable under this benefit for a disability that results, directly or indirectly, from one of the following causes:

6.14.1 War, whether declared or undeclared, or active participation in an insurrection.

6.14.2 Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.

6.14.3 Active participation in a criminal act.

6.14.4 Compulsive gambling, except for a disability period during which the participant is receiving treatment or uninterrupted medical care for the purposes of his or her recovery. However, this exclusion only applies if it does not prevent registration of this plan with Employment Insurance.

6.14.5 Any condition occurring while the insured is on active duty with armed ground, sea or air forces

6.15 Proof of disability

Within 30 days following the date of the accident or the start of disability, the participant must send written proof of disability and of the accident or illness to the Insurer's head office.

If the participant demonstrates that it was impossible to submit proof within this deadline and that such proof was submitted as soon as the participant was able to do so, the claim will then be admissible under this benefit.

However, if the participant fails to provide this proof to the Insurer within six months, the participant automatically forfeits the right to disability benefits, for the disability in question, retroactively to the date the Insurer initially made the request.

Thereafter, proof of continuing disability must be submitted each time the Insurer so requests. If the participant fails to provide any additional proof of disability or to undergo a medical examination within 31 days of the Insurer's written request, the participant forfeits the right, subject to the second paragraph of this article, to disability benefits for the disability in question, for the period extending from the end of this 31-day period up to the date the Insurer receives the additional proof required or the participant undergoes the required medical examination.

If the participant disagrees with any decision rendered by the Insurer regarding the non-recognition or termination of a disability, he or she must request a review within 30 business days of receiving such decision from the Insurer and submit any additional documentation, if applicable. The Insurer will render its decision within 20 business days of receiving the request to review.

6.16 Medical arbitration

This is a consensual process through which the Insurer and the Policyholder agree to settle between themselves any dispute related to the recognition of a participant's disability in order to specifically avoid court proceedings to settle such disputes.

If the participant disagrees with any decision rendered by the Insurer regarding the non-recognition or termination of a disability, he or she must request a review within 30 business days of receiving such decision from the Insurer and submit any additional documentation, if applicable. The Insurer shall render its decision within 20 business days of receiving the request for review. If the participant disagrees with the Insurer's revised decision, he or she may contest it within 90 business days of receiving the revised decision by submitting a request for medical arbitration to the Insurer and the Policyholder. The time limits set out in this paragraph apply unless otherwise agreed in writing between the Insurer and the Policyholder.

In such a case, a medical arbitration process will begin, based on the following provisions:

6.16.1 The Insurer informs the Policyholder and the employer of its decision and the fact that the participant is contesting it.

6.16.2 The Insurer, the Policyholder and the participant's attending physician shall collaborate in order to agree on the selection of a medical arbitrator and on the mandate to be assigned to the arbitrator. The Insurer shall propose three physician experts specializing in a field relevant to the condition related to the disability, favouring those who practice within an independent medical expertise firm. Failing agreement on one of these physician experts, the attending physician may suggest up to three other physician experts under the same terms. If the physician experts proposed by the participant's attending physician refuse the arbitration mandate or if the Insurer's medical advisor disagrees with the suggestions, a call between the participant's attending physician and the Insurer's medical advisor will take place in order to reach an agreement.

6.16.3 The Insurer and the Policyholder jointly send the mandate to the medical arbitrator with a copy of this article. A copy of the mandate is sent to the participant at the same time. The Insurer shall also transmit to the medical arbitrator all medical information in its possession.

6.16.4 The medical arbitrator meets with the participant and examines him or her, if deemed pertinent, in the official language selected by the participant, or if this is not possible, in the presence of a translator.

6.16.5 The participant must attend any appointment scheduled by the medical arbitrator to avoid forfeiting his or her right to benefits, unless the participant has a valid reason supported by proof.

6.16.6 The participant may bring any document he or she considers useful to the medical arbitrator to make an informed decision.

6.16.7 If the participant incurs travel expenses due to his or her assessment by the medical arbitrator, he or she may request reimbursement from the Insurer of certain reasonable expenses. Reimbursement will be made according to the Policyholder's scales in force at the time the expenses are incurred.

6.16.8 The medical arbitrator must render a written decision within 60 days of the participant's in-person assessment. The decision must include a list of all medical documents that were submitted.

6.16.9 The medical arbitrator's decision must be rendered in writing in the official language selected by the participant. In the event that the arbitral decision is not rendered in the language selected by the participant between the two official languages of Canada, the Insurer agrees to have the medical report translated.

6.16.10 The medical arbitrator must send a copy of the decision to the Insurer, the Policyholder and the participant, unless the arbitrator believes sending such decision is medically contraindicated, in which case the participant's copy will be sent to the attending physician.

6.16.11 Copies sent to the Insurer and the Policyholder are limited to the following:

a) The list of medical documents submitted;

b) Duration of the assessment;

c) Indication of the participant's collaboration or lack thereof;

d) Diagnosis;

e) Prognosis, if any;

f) Medical-administrative recommendations;

g) Answers to other questions included in the mandate do not explicitly include medical history, family history or any other information about a person other than the participant.

6.16.12 The medical arbitrator's decision is final and irrevocable, enforceable and binds the Insurer, the Policyholder and the participant. Therefore, it excludes any court proceedings unless the medical arbitrator raises an issue not related to his or her specialty and determines in writing, that a second medical arbitration is necessary to resolve the dispute related to the recognition or non-recognition of a participant's disability. In such case, a new medical arbitration will be requested regarding the new issue raised with an arbitrator from the relevant specialty.

6.16.13 Without prejudice to the Insurer's rights, during the medical arbitration process the participant is entitled to receive compensation equivalent to disability insurance benefits payable when the participant's disability is recognized by the Insurer, until the month following receipt of the arbitrator's decision regarding the non-recognition or termination of his or her disability, up to a maximum period of six months, whichever occurs first.

6.16.14 Expenses and fees of the medical arbitrator are not assumed by the participant. The Insurer will be billed for such expenses and fees.

6.16.15 If the medical arbitrator's decision entails the end of benefits during the vacation period of the participant's school calendar, benefits will be payable until the end of that vacation period.

6.16.16 If the medical arbitrator's decision recognizes the existence or continuation of the participant's disability, the Insurer will pay benefits retroactively to the date of refusal or cessation of payments, but subtract the monetary compensation paid in accordance with article 6.16.13.

6.17 Termination of insurance

Subject to the provisions of article 6.13 Extension of Coverage, a participant's insurance terminates on the first of the following dates:

6.17.1 The date the benefit or this contract is cancelled.

6.17.2 The date a participant ceases to be employed, except in case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is administered by the Policyholder is not considered a termination of employment.

Non-permanent employees as defined in the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding two months after their contract termination date, unless they cancel their coverage, in which case the insurance terminates with their contract.

6.17.3 The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65.

6.17.4 The day before the due date of any unpaid premium, subject to the provisions of article 6.6 Waiver of Premiums.

6.17.5 The expiry of the five-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

SECTION 7 – **LONG-TERM DISABILITY INSURANCE**

Upon receipt and approval by the Insurer of proof establishing that a participant insured under this contract became disabled, as defined under article 1.13, and following expiry of the elimination period indicated in article 7.2, the Insurer will pay monthly benefits to this participant according to the amount determined in accordance with articles 7.3, 7.5 and 7.8.

7.1 **Benefit period**

The first benefit payment is payable as of the 31st day following expiry of the elimination period defined in article 7.2 and subsequent payments are made each month thereafter for as long as the participant remains disabled. However, if the disability ends at the beginning of or during vacation, benefits will be paid until the end of the vacation unless a specific date is indicated.

Benefit payments end no later than the last week of the month in which the participant reaches age 65.

7.2 **Elimination period**

Monthly disability benefits are payable at the expiry of the elimination period, which end on the latest of the following dates:

7.2.1 The end of the 104-week period following the start of disability, in a single disability period, plus any unused credits in the participant's sick leave bank, if applicable;

7.2.2 The end of benefit payments as provided for in the collective agreement;

7.2.3 The end of benefit payments as provided for in another group insurance plan or another collective agreement to which the participant is eligible when taking unpaid leave to pursue another gainful employment.

7.3 **Benefit amount**

7.3.1 Participants who became disabled prior to July 1, 1996

The initial amount of monthly disability benefits payable is equal to 70% of the first $2,500 of the participant's monthly salary and 50% of any excess, the salary being the one the participant would have received at the expiry of the elimination period, as provided for in the collective agreement, had he or she not become disabled. However, benefits are limited to $5,000 per month.

7.3.2 Participants who became disabled between June 30, 1996 and December 31, 2024

The initial amount of monthly disability benefits payable is equal to 80% of the participant's net monthly salary as defined in article 1.30, the net salary being the one the participant would have received at the expiry of the elimination period, as provided for in the collective agreement, had he or she not become disabled. However, benefits are limited to $5,000 per month.

7.3.3 Participants who became disabled on January 1, 2025 or after

The initial amount of monthly disability benefits payable is equal to 75% of the participant's net monthly salary as defined in article 1.30, the net salary being the one the participant would have received at the expiry of the elimination period, as provided for in the collective agreement, had he or she not become disabled.

When necessary, the amount of disability benefits for the days following the last complete month of total disability is calculated at a rate of 1/30 of the monthly amount.

7.4 Change in the benefit amount

If the salary of a participant who is not receiving benefits under this benefit is modified, the change in the amount of disability benefits becomes effective on the date the change in salary comes into force or, if later, the date an agreement to this effect is reached between the Policyholder and the Insurer.

However, in the case of a temporary assignment, the amount of disability benefits is based on the salary the participant would have received in the absence of such assignment.

7.5 Cost-of-living adjustment

During the disability period and for as long as the participant is disabled, monthly benefits are indexed annually on January 1 in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 6% for participants whose disability start date is on or after January 1, 1981, and 4% for participants whose disability start date is prior to January 1, 1981, for the purposes of this insurance benefit.

When benefits are integrated in December, as described in article 7.8, indexation is based on the benefits paid during that month. The indexation thus calculated is added to the amount of monthly benefit for January.

7.6 Waiver of premiums

For participants who became disabled prior to January 1, 2025, waiver of premiums applies after the expiry of a 30-day period following the start of disability.

For participants who became disabled on January 1, 2025 or after, waiver of premiums applies after the expiry of a 52-week period following the start of disability.

However, specific provisions apply to senior lecturers at Laval University and are listed in Schedule IV attached to this contract.

7.7 Scope of coverage

Coverage is in force 24 hours a day, 12 months a year.

7.8 Integration

If a disabled participant is entitled to other income during the disability period, the benefits are reduced by:

7.8.1 The initial amount of any basic disability benefits under the Quebec Pension Plan or the Canada Pension Plan, including pension benefits under the Quebec Pension Plan which the participant receives or is entitled to receive due to total disability. This includes disability income benefits that are paid or would have been paid if an application had been submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined. Denial of benefits by the Quebec Pension Plan or the Canada Pension Plan in no way deprives the participant of his or her entitlement to benefits.

It is the participant's responsibility to submit an application for disability benefits and, if applicable, pension benefits due to disability to the appropriate authority if the Insurer so requires, and failure to do so will result in a reduction of benefits, as described in the previous paragraph.

Future increases to basic disability benefits resulting from indexation will not be taken into account.

With respect to the Quebec Pension Plan, the Insurer reserves the right to adjust, if necessary, the initial amount of disability benefit (including the disability pension benefits) after the initial amount has been revised by Retraite Quebec.

7.8.2 Any benefits payable under any salary continuance or sick leave policy.

7.8.3 50% of the gross amount of any pension benefits to which the participant is entitled. However, this source of integration is not applicable if the participant was receiving this pension benefit before the start of disability.

The Insurer may ask the disabled participant to submit a pension benefit application to the appropriate authority if the disabled participant meets the three following criteria:

a) Is eligible for pension benefits without actuarial reduction;

b) Has completed the elimination period for the disability pension plan;

c) Has received confirmation that the Insurer will no longer challenge the state of disability.

If the disabled participant refuses to submit such application or upon expiry of a six-month period, the pension benefits used to reduce the disability benefits will be estimated as follows:

a) Based on the pension plan participation status, which must be provided by the participant; otherwise

b) 70% of the participant's effective salary at the start of disability.

The estimated pension benefits can be corrected retroactively, for a maximum period of six months, if the disabled participant should decide to submit an application for pension benefits or provide the Insurer with his or her pension plan participation status.

7.8.4 The initial amount of any basic disability benefits under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act* and any other public plan, regardless of future increases in basic benefits resulting from cost-of-living adjustments.

7.8.5 50% of the gross amount of the pension benefits paid to the participant under the Quebec Pension Plan or the Canada Pension Plan. However, this source of integration is not applicable if the participant was receiving this pension benefit before the start of disability.

7.8.6 If the participant is entitled to other income during a disability period starting on or after January 1, 2008, the benefits are reduced by:

50% of the gross amount received for any gainful activity carried out by a disabled participant after the start of disability. To establish the gross amount used for purposes of integration, disabled participants must provide the Insurer with a copy of their income tax return and subsequent notices of assessment.

7.9 Pre-existing conditions

Claims related to causes that existed before the effective date of this benefit are not excluded solely for this reason.

7.10 Rehabilitation services

Subject to an assessment by the Insurer, participants may receive rehabilitation services, the cost of which are assumed by the Insurer.

7.11 Vocational reorientation program

7.11.1 The Insurer must be informed of and pre-approve any participation in a vocational reorientation program.

7.11.2 A vocational reorientation program only applies to participants recognized as permanently disabled from their regular employment and who wish to undertake another gainful activity.

7.11.3 Participants enrolled in a vocational reorientation program continue to receive disability insurance benefits reduced by 50% of the net salary received by their new gainful activity under the vocational reorientation program.

7.11.4 If the participant's disability insurance benefits and remuneration from his or her new gainful activity under the vocational reorientation program exceed 100% of the basic net monthly salary the participant would have received if actively at work, disability income benefits are reduced by the excess amount.

7.12 Gradual return to work

7.12.1 The Insurer must pre-approve any period of gradual return to work.

7.12.2 Participants making a gradual return to work continue to receive monthly disability benefits from the Insurer as described in article 7.12.3. These benefits end when one of the following events occurs:

a) Expiry of a 12-month period following the start of the gradual return to work.

   Any gradual return period during the elimination period under this benefit is included in the maximum 12-month period.

b) Interruption of the gradual return to work.

c) Withdrawal of the Insurer's approval of the gradual return to work.

7.12.3 Subject to article 7.12.2, during the gradual return to work period, monthly disability insurance benefits will be reduced by the percentage of time the participant works each month in that period compared to the time the participant normally worked each month before becoming disabled.

7.12.4 Subject to the Insurer's approval, the participant who began a gradual return to work can benefit from a waiver of premiums if the gradual return to work began during the elimination period, as defined in article 7.2.

7.13 Extension of coverage

If on the termination date of the contract, there are one or more disabled participants, each disabled participant is entitled to the benefits for which he or she would have been eligible had the contract remained in force.

7.14 Exclusions and reduction of coverage

No benefits are payable under this benefit for a disability that results, directly or indirectly, from one of the following causes:

7.14.1 Performing any of the duties of a crew member of a commercial aircraft, unless he or she is an employee of a flying school whose union is affiliated with the FNEEQ-CSN and as set out in the collective agreement or in his or her personal employment contract.

7.14.2 War, whether declared or undeclared, or active participation in an insurrection.

7.14.3 Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.

7.14.4 Active participation in a criminal act.

7.14.5 Alcoholism, drug addiction or compulsive gambling, except for a disability period during which the participant is receiving treatment or uninterrupted medical care for the purposes of his or her recovery.

7.14.6 Any condition occurring while the insured is on active duty with armed ground, sea or air forces

7.15 Proof of disability

Participants from the public sector must send, to the Insurer's head office, written proof of their accident or illness and of their disability after 18 months following the date of the accident or the start of disability, but without exceeding 21 months of that date. When evidence of persistence of disability has been submitted by participants of the private sector or a university under the Short-Term Disability Insurance benefit, such evidence is deemed satisfactory under this insurance benefit.

If the participant demonstrates that it was impossible to submit proof within this deadline and that such proof was submitted as soon as the participant was able to do so, the claim will then be admissible under this benefit.

However, if the participant fails to provide this proof to the Insurer within six months, the participant automatically forfeits the right to disability benefits for the disability in question, retroactively to the date the Insurer initially made the request.

Thereafter, proof of continuing disability must be submitted each time the Insurer so requests, with regard to any disabled participant. If the participant fails to provide any additional proof of disability or to undergo a medical examination within 31 days of the Insurer's written request, the participant forfeits the right, subject to the second paragraph of this article, to disability benefits for the disability in question, for the period extending from the end of this 31-day period up to the date the Insurer receives the additional proof required or the participant undergoes the required medical examination. Furthermore, if the Insurer does not receive such proof or the results of the requested medical examination within six months, the participant completely forfeits the right to benefits for the disability in question.

If the participant's and the Insurer's physicians do not agree on the participant's disability, the participant has 60 days, excluding any vacation period, to notify the Insurer of his or her intention of obtaining a medical assessment from a third physician. In this case, the participant's and the Insurer's physicians must then agree on the choice of the third physician whose decision will be final. The cost of the examination is assumed by the Insurer. In such cases, and in cases where the expert assessment of a third physician is required as stipulated in the pertinent provisions of the current collective agreement (5.5.26 of the FNEEQ-CSN 2000-2002 collective agreement), the participant receives benefits between the date the Insurer receives the notice from the participant's physician or from the employer's physician, as the case may be, and the date of the decision, without exceeding six months if no decision has been reached by the end of this period. If the decision is in favour of the Insurer, the participant is not required to reimburse the benefits paid during this period.

If the participant disagrees with any decision rendered by the Insurer regarding the non-recognition or termination of a disability, he or she must request a review within 30 business days of receiving such decision from the Insurer and submit any additional documentation, if applicable. The Insurer will render its decision within 20 business days of receiving the request to review.

Moreover, the employer must report to the Insurer, upon the Insurer's request, any disability that lasts more than six months with respect to disabled participants in the public sector.

7.16 Medical arbitration

This process is a consensual process through which the Insurer and the Policyholder agree to settle between themselves any dispute related to the recognition of a participant's disability in order to specifically avoid court proceedings to settle such disputes.

If the participant disagrees with any decision rendered by the Insurer regarding the non-recognition or termination of a disability, he or she must request a review within 30 business days of receiving such decision from the Insurer and submit any additional documentation, if applicable. The Insurer shall render its decision within 20 business days of receiving the request for review. If the participant disagrees with the Insurer's revised decision, he or she may contest it within 90 business days of receiving the revised decision by submitting a request for medical arbitration to the Insurer and the Policyholder. The time limits set out in this paragraph apply unless otherwise agreed in writing between the Insurer and the Policyholder.

In such a case, a medical arbitration process will begin, based on the following provisions:

7.16.1 The Insurer informs the Policyholder and the employer of its decision and the fact that the participant is contesting it.

7.16.2 The Insurer, the Policyholder and the participant's attending physician shall collaborate in order to agree on the selection of a medical arbitrator and on the mandate to be assigned to the arbitrator. The Insurer shall propose three physician experts specializing in a field relevant to the condition related to the disability, favouring those who practice within an independent medical expertise firm. Failing agreement on one of these physician experts, the attending physician may suggest up to three other physician experts, under the same terms. If the physician experts proposed by the participant's attending physician refuse the arbitration mandate or if the Insurer's medical advisor disagrees with the suggestions, a call between the participant's attending physician and the Insurer's medical advisor will take place in order to reach an agreement.

7.16.3 The Insurer and the Policyholder jointly send the mandate to the medical arbitrator, with a copy of this article. A copy of the mandate is sent to the participant at the same time. The Insurer shall also transmit to the medical arbitrator all medical information in its possession.

7.16.4 The medical arbitrator meets with the participant and examines him or her, if deemed pertinent, in the official language selected by the participant, or if this is not possible, in the presence of a translator.

7.16.5 The participant must attend any appointment scheduled by the medical arbitrator to avoid forfeiting his or her right to benefits, unless the participant has a valid reason supported by proof.

7.16.6 The participant may bring any document he or she believes is useful to the medical arbitrator to make an informed decision.

7.16.7 If the participant incurs travel expenses due to their assessment by the medical arbitrator, he or she may request reimbursement from the Insurer of certain reasonable expenses. Reimbursement will be made according to the Policyholder's scales in force at the time the expenses are incurred.

7.16.8 The medical arbitrator must render a written decision within 60 days of the participant's in-person assessment. The decision must include a list of all medical documents that were submitted.

7.16.9 The medical arbitrator's decision must be rendered in writing in the official language selected by the participant. In the event that the arbitral decision is not rendered in the language selected by the participant between the two official languages of Canada, the Insurer agrees to have the medical report translated.

7.16.10 The medical arbitrator must send a copy of the decision to the Insurer, the Policyholder and the participant, unless the arbitrator believes sending such decision is medically contraindicated, in which case the participant's copy will be sent to the attending physician.

7.16.11 Copies sent to the Insurer and the Policyholder are limited to the following:

a) The list of medical documents submitted;

b) Duration of the assessment;

c) Indication of the participant's collaboration or lack thereof;

d) Diagnosis;

e) Prognosis, if any;

f) Medical-administrative recommendations;

g) Answers to other questions included in the mandate do not explicitly include medical history, family history or any other information about a person other than the participant.

7.12.3 The medical arbitrator's decision is final and irrevocable, enforceable and binds the Insurer, the Policyholder and the participant. Therefore, it excludes any court proceedings unless the medical arbitrator raises an issue not related to his or her specialty and determines, in writing, that a second medical arbitration is necessary to resolve the dispute related to the recognition or non-recognition of a participant's disability. In such a case, a new medical arbitration will be requested regarding the new issue raised with an arbitrator from the relevant specialty.

7.16.13 Without prejudice to the Insurer's rights, during the medical arbitration process the participant is entitled to receive compensation equivalent to disability insurance benefits payable when the participant's disability is recognized by the Insurer, until the month following receipt of the adjudicator's decision regarding the non-recognition or termination of his or her disability, up to a maximum period of six months, whichever occurs first.

7.16.14 Expenses and fees of the medical arbitrator are not assumed by the participant. The Insurer will be billed for such expenses and fees.

7.16.15 If the medical arbitrator's decision entails the end of benefits during the vacation period of the participant's school calendar, benefits will be payable until the end of that vacation period.

7.16.16 If the medical arbitrator's decision recognizes the existence or continuation of the participant's disability, the Insurer will pay benefits retroactively to the date of refusal or cessation of payments, but subtracting the monetary compensation paid in accordance with article 7.16.13.

7.17 Termination of insurance

Subject to the provisions of article 7.13 Extension of Coverage, a participant's insurance terminates on the first of the following dates:

7.17.1 The date the benefit or this contract is cancelled.

7.17.2 The date a participant ceases to be employed, except in the case of disability. However, the transfer of a participant from one employer to another employer whose insurance contract is administered by the Policyholder is not considered a termination of employment.

Non-permanent employees as defined in the collective agreement are considered to have terminated employment on the first day of the session following the one indicated in their contract, without exceeding two months after their contract termination date, unless they cancel their coverage, in which case the insurance terminates with their contract.

7.17.3 The effective date of the participant's retirement. However, a disabled participant who applies for pension benefits before age 65 continues to benefit from waiver of premiums until age 65.

7.17.4 The day before the due date of any unpaid premium, subject to the provisions of article 7.6 Waiver of Premiums.

7.17.5 The date the Insurer receives written notice from the participant, or the termination date indicated in such notice, whichever is later, requesting termination of insurance, according to the terms and conditions applicable to right to waive coverage.

7.17.6 The expiry of the five-year period following the termination of the participant's disability for an employee eligible under article 2.1.7.

SECTION 8 - **PREMIUM PAYMENT – GRACE PERIOD – PREMIUM RATES**

8.1 Change in government policy

Should the adoption or amendment of any law, regulation or other item by the federal or provincial government influence the Insurer's rates, the Insurer reserves the right to adjust premium rates, upon an agreement with the Policyholder, for any affected insurance benefits and retention provisions at the time such law, regulation, item or amendment becomes effective.

8.2 Payment of premiums

The initial premium due under this contract is payable at the beginning of the invoicing period during which the contract becomes effective. Subsequent premiums are payable at the beginning of every invoicing period.

Premiums payable under this contract are forwarded by the employer to the Insurer at the beginning of every invoicing period. The premium amount is equal to the sum of premiums due per participant at the beginning of the invoicing period in question.

The premium is based on the premium rate applicable for the participant on the first day of the pay period.

No premium is payable for an invoicing period if the participant is not covered on the first day of that period. However, the full premium is payable for the invoicing period during which the participant ceased to be covered.

8.3 Grace period

The Insurer grants the employer a 60-day grace period following the date any premium becomes due, except for the first one. In the event that premiums are still unpaid after expiry of the grace period, interest will be added to the amount of premiums due. Interest is equal to the annual interest rate corresponding to the arithmetic mean of the average yield of Government of Canada three- to five-year bonds (V121756 series) at the end of each month of the contract year, rounded to the multiple of ¼ of 1% lower than or coinciding with this average.

8.4 Premium rates

Premium rates indicated in the premium tables can be modified by the Insurer on each renewal date of the contract, but no modification can be made without prior written notice of at least 150 days.

8.5 Premium table

Please refer to the *Schedule of coverage*.

SECTION 9 – **CANCELLATION OF THIS CONTRACT OR ONE OF ITS BENEFITS**

9.1 In the event of failure to pay premiums prior to expiry of the grace period as set out in article 8, the Insurer may notify the Policyholder to that effect and if such premiums are not paid within the five days following the date notice is received, the contract is automatically terminated as of the due date of the unpaid premiums.

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

9.3 The Insurer reserves the right to cancel the Life Insurance benefit at any time upon prior written notice of at least 90 days if the percentage of eligible employees who are insured under this benefit falls below 50% of those eligible on the effective date of this contract.

9.4 The Insurer reserves the right to cancel the Long-Term Disability Insurance benefit at any time upon prior written notice of at least 90 days if the percentage of eligible employees who are insured under this benefit falls below 50% of those eligible on the effective date of this contract.

9.5 All FNEEQ-CSN affiliated unions participating in plans available under this contract and in accordance with the provisions thereof must do so for a minimum period of 36 months. Following this period, the union may cease participation within 31 days prior to the renewal date of this contract.

SECTION 10 – **MODIFICATIONS TO THE CONTRACT**

The Policyholder may at any time, upon agreement with the Insurer, make modifications to the contract with respect to the persons eligible for insurance, the scope of coverage and the sharing of costs among classes of insureds. Such modifications then apply to all insureds, whether they are active, disabled or retired.

SECTION 11 – **MISCELLANEOUS PROVISIONS**

11.1 Any notice given by the Insurer to the Policyholder is deemed sufficient if the Insurer mails it (by registered mail for notices indicated in articles 8.1 and 9.1 to 9.4) to the Policyholder's address as recorded in the Insurer's files. Any notice given by the Policyholder is deemed sufficient if the Policyholder mails it (by registered mail for notices indicated in article 9.2) to the Insurer's head office in Quebec City, Quebec.

11.2 No legal action against the Insurer regarding a claim for benefits under this contract can be taken after the time limits provided for in the *Act respecting insurance*.

11.3 The Insurer must provide insurance certificates and the employer agrees to distribute them to the participants covered under this contract. Furthermore, upon specific request and in exchange for reasonable fees other than those listed in the retention formula, the Insurer will promptly provide any information or report deemed necessary by the Policyholder.

11.4 As a preliminary condition for the payment of benefits, the Insurer may require subrogation to all rights to compensation due to the insured by the person responsible for the accident or illness, up to the amount due to the insured by the Insurer under this contract.

11.5 Any errors or omissions affecting the amount of the premium are corrected as soon as they are discovered, and the required premium adjustments are made.

However, for any errors or omissions affecting the validity of insurance or the amount of insurance in force, the true facts are used to determine whether insurance is in force and the amount of insurance in force in accordance with the terms and conditions of this contract.

No error on the part of the Policyholder or the Insurer in the keeping of insurance records, nor any delay in the compilation of such records, invalidates insurance in force in accordance with the articles of this contract nor extends insurance terminated in accordance with the articles of this contract.

11.6 All premium payments under this contract are made to the Insurer's head office in the legal tender of Canada. All benefit payments under this contract are made in the legal tender of Canada.

11.7 An insured's rights under this contract may not be assigned or seized, and no assignment by an insured of entitlement to benefits or to payment of a benefit under this contract is binding on the Insurer.

11.8 Entitlement to benefits automatically ceases for any insured who attempts to fraudulently obtain, or who assists any person in fraudulently obtaining or attempting to fraudulently obtain any benefit under this contract. The Insurer will then be automatically released from any liability with regard to expenses that would otherwise be eligible that are incurred after the termination date of this entitlement.

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

11.10 The Policyholder allows the Insurer to examine its payroll records and other employee files relevant to the eligibility and enrolment of employees and eligible dependents under this contract.

11.11 Should a reduction in coverage under government plans entail the increase of the scope of coverage under this contract, provisions of the contract continue to apply as if coverage under the government plans had not been reduced until an agreement is reached between the parties to the contract to modify the premium rates accordingly.

SECTION 12 – **EFFECT OF THE CONTRACT**

This contract is the entire agreement and completely represents both parties' intentions. It is presumed to include the essential elements of the specifications, the proposal and any written agreements between the parties. These documents are not part of the contract and can only be used to clarify the scope of the contract in case of ambiguity. In the event of any discrepancies, the contract prevails.

Furthermore, this contract should be considered as a consolidated version and, from time to time, a reformulated version of endorsements, written agreements and previous versions of the 001008 or 001010 contracts. This contract does not confer any rights retroactively and the contract provisions applicable to any covered event remain the same as those in force on the date such event occurs.

Furthermore, December 31, 2025, is not considered the termination date of the contract, for all legal purposes, but a renewal date. However, February 28, 1999, is considered as the termination date of contract 001010 for the purposes of calculating experience credits.

Contract 001008-001010

SCHEDULE I CEGEP INSTRUCTOR TEACHING PROFESSIONALS

1. This schedule applies to teaching professionals who are instructors represented by a union that participates in this contract and whose participation in the plan was decided by majority vote at their general meeting. The union must inform the policyholders in writing. Insurance becomes effective on the first day of the month following the date written notice is received, if this notice is received before the 15th of the month. Otherwise, insurance becomes effective on the first day of the second month.

2. Instructor teaching professionals who have three years of seniority based on the official seniority list are eligible the calendar year following the school year in which their total workload established according to the following formula attains 1: CI / 80 + (number of teaching periods) / 450. To maintain eligibility, the instructor participant's total workload must attain 0.6 each school year, based on the same formula. If, for a given school year, the participant does not attain a total workload of 0.6 based on the same formula, the participant is not eligible for insurance the following calendar year. The instructor participant becomes eligible again the calendar year following the school year in which his or her total teaching load reaches 0.6 based on the same formula.

3. Participation in Basic Life Insurance and Dependents' Life Insurance benefits is optional.

4. Participation in the Health Insurance benefit is mandatory for all employees who meet the eligibility conditions and any dependents.

5. Participation in the Short-Term Disability and Long-Term Disability Insurance benefits is mandatory for all employees who meet the eligibility conditions.

   The instructor participant may waive or terminate coverage under the Short-Term Disability or the Long-Term Disability, upon written notice to the employer, if they certify that they are covered under another group insurance contract, or if they certify that they will not accept any course load for a period of 6 months during the insurable school year. In this case, the instructor participant must obtain a total course load of 1 during the school year to be eligible again.

6. Participation in the Optional Life Insurance benefit is optional for participants and their spouses.

7. Premiums and amounts of insurance are based on the salary scale applicable to full-time teaching professionals, -i.e.- the hourly rate of the teaching professional who is an instructor multiplied by 525 hours.

When the teaching professional who is an instructor is also eligible under article 2.1.1 of this contract with the same employer, the full-time annual salary established based on the above formula must be reduced by the percentage of the workload allowing for eligibility under article 2.1.1 using the following formula:

Instructor's hourly rate x 525 h – (instructor's hourly rate x 525 h x **percentage of the workload covered under article 2.1.1**).

Example of salary calculation to be used for a teaching professional who is an instructor with a 50% workload in a given position covered under article 2.1.1 at an hourly rate of $70.54 as an instructor:

$70.54 x 525 h – ($70.54 x 525 h x **0.5**)

8. Terms for the payment of premiums must be determined between the union and the employer. Premiums are then forwarded by the employer to the Insurer in the usual way.

9. The calculation of hours takes into account all hours that would have been worked had it not been for the absences provided for in the collective agreement.

10. All other provisions of the contract are applicable, except if otherwise indicated in this schedule.

CONTRACT 001008-001010

SCHEDULE II LASALLE COLLEGE TEACHING PROFESSIONALS AND INSTRUCTORS

1. This schedule applies to teaching professionals and instructors employed by LaSalle College who participate in this contract.

2. Eligibility and participation provisions of the contract apply to teaching professionals.

3. Instructors are eligible for all insurance benefits provided under this contract if their employment contract requires them to teach for a minimum of 15 hours per week.

   If they become eligible during the winter session, the insurance period extends from February 1 to August 31. However, if they become eligible for coverage during the fall session, the insurance period extends from September 1 to January 31.

4. Instructors are considered permanent employees, within the meaning of the contract, two years after the date they were hired, and eligibility and participation provisions of article 2 Conditions of Insurance will then apply.

5. For the purposes of this schedule, the terms “wage or salary” defined in the contract are not applicable and are defined as follows:

   “Wages or salary”: The wage or salary used is equal to the lesser of the following two amounts:

   a) The hourly rate in force at the beginning of the session multiplied by the number of teaching hours per week (up to a maximum of 24 hours), the result being multiplied by 42 weeks;

   b) $55,000.

   Bonuses, overtime pay, honoraria, accommodation and meal allowances, isolation pay and any lump-sum payments are not included when calculating wages or salary.

6. The Short-Term Disability Insurance benefit elimination period is 25 days for persons covered under this schedule. Furthermore, a specific rate applies to these persons.

CONTRACT 001008-001010

SCHEDULE III TUTORS OF THE TÉLÉ-UNIVERSITÉ-CSN

1. This schedule applies to tutors of the *Télé-université* component of the *Université du Québec à Montreal* who participate in this contract.

2. The expression “salaried employee” used in articles 3 to 10 below designates the tutors covered under this schedule.

3. Salaried employees are eligible for all benefits of this contract, in accordance with the provisions of the following articles. In the absence of specific provisions indicated in this schedule, terms and conditions of the 001008-001010 contract will apply to the benefits for which salaried employees are eligible.

4. For the purposes of this schedule, the reference year used to determine eligibility and to calculate the annual salary and insurable salary extends from September 1 to August 31 preceding January 1 of each year.

5. For the purposes of this schedule, the annual salary is that defined in the 001008-001010 contract and is determined on January 1 of each year, based on the salary actually earned during the reference year for tutoring, union leaves and participation in activities listed in articles 21.08 and 21.09 of the collective agreement.

6. Salaried employees must have earned an annual salary equal to 45% of the maximum pensionable earnings (MPE) during a reference year to be eligible for the benefits indicated in this schedule for the first time. The MPE used for calculating is that applicable on January 1 of the reference year. After becoming eligible for the first time, salaried employees must maintain an annual salary equal to 40% of the MPE during the reference years following the initial date of eligibility. Otherwise, insurance terminates and salaried employees become eligible for insurance again when the annual salary is equal to at least 45% of the MPE applicable for the reference year in question.

7. Eligibility of salaried employees is determined by the employer once a year, on January 1 of each year.

8. Enrolment in Long-Term Disability Insurance can be done without evidence of insurability within 30 days following the start date of each of the first three eligibility periods. Eligibility periods begin on January 1 of each year and salaried employees must submit their application forms before January 31 of each year to be eligible for Long-Term Disability Insurance without evidence of insurability.

   Salaried employees can also apply at any time during the first three eligibility periods following the date they were hired, upon presentation of evidence of insurability deemed satisfactory by the Insurer. If the Insurer declines the insurance application after analysis of the evidence of insurability, the salaried employee will not be entitled to submit a new application for insurance before the expiry of a three-year period of eligibility for insurance.

   Participation in this benefit becomes mandatory at the expiry of this three-year period and the salaried employee must apply for it, without evidence of insurability.

9. For the purposes of disability insurance benefits, calculation of benefits payable is based on the insurable salary that is established on January 1 preceding the start date of disability.

10. In case of temporary leaves from work set out in the collective agreement, salaried employees can maintain participation in benefits they held before the date the leave began, provided they continue to pay applicable premiums, including the employer's share, if applicable.

    For salaried employees who are partially or completely absent from work due to a maternity leave, a family leave, a paternity leave or disability during a reference year, the salary used for calculating the annual salary is that earned during the reference year preceding the date the leave began.

    For any other type of leave, the annual salary is calculated based on the provisions of article 5 of this schedule.

CONTRACT 001008-001010

SCHEDULE IV SENIOR LECTURERS AT LAVAL UNIVERSITY

1. This schedule applies to senior lecturers at Laval University who participate in this contract.

2. Senior lecturers are eligible for Health Insurance (Modules A, B and C), Dental Care Insurance (Option 2 only), Short-Term Disability Insurance and Long-Term Disability Insurance benefits.

3. Participation in the Health Insurance and Short-Term Disability Insurance benefits is mandatory as of the date the senior lecturer becomes eligible.

4. Participation in Option 2 of the Dental Care Insurance benefit is only possible for senior lecturers who selected Module C for Health Insurance. In addition, participation in Module C for Health Insurance automatically results in participation in Option 2 for Dental Care Insurance. Module C for Health Insurance and Option 2 of the Dental Care Insurance benefit cannot be dissociated.

5. Participation in Long-Term Disability Insurance is optional during the first three years. Senior lecturers can enrol in this benefit when enrolling in the Short-Term Disability Insurance benefit or at any time during the three years following this date. Upon expiry of the three-year period, senior lecturers who have not enrolled in the Long-Term Disability Insurance benefit must do so, if they are still eligible for insurance.

6. The elimination period for the Short-Term Disability Insurance benefit is 180 days for persons covered under this schedule. Furthermore, a specific rate applies to these persons.

7. The definition of “Disability period” set out in the contract does not apply and is replaced by the following:

1.30 “Disability period”:

During the first 180 days of disability:

Any uninterrupted disability period, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of fewer than 30 days of work unless the disability for a given period results from an illness or accident that is entirely independent of the illness or accident that caused the disability of the previous period, and the disability only starts upon the participant’s return to work.

Thereafter:

Any uninterrupted disability period, or successive periods of disability resulting from the same illness or the same accident, separated by a period of remission of fewer than 180 days of work unless the disability for a given period results from an illness or accident that is entirely independent of the illness or accident that caused the disability of the previous period, and the disability only starts upon the participant’s return to work.

8. Waiver of premiums for the Long-Term Disability Insurance benefit begins upon expiry of the 26-week period of Short-Term Disability Insurance benefits.

9. All insurance benefits indicated in this schedule terminate on the date of the senior lecturer’s retirement.

10. All other provisions of the contract are applicable, except if otherwise indicated in this schedule.

CONTRACT 001008-001010

SCHEDULE V INDIVIDUALS OR CLASSES OF INDIVIDUALS ACCEPTED BY THE POLICYHOLDER FOR THE PURPOSES OF INSURANCE

- Employees working for unions affiliated with the FNEEQ-CSN whose members are insured under this contract. For the purposes of this contract, these employees are considered as employees of the private sector.

- Employees covered by a bargaining certificate issued to a private college union affiliated with the FNEEQ-CSN.

- Elected FNEEQ members who have an employment relationship with an educational institution or one related to education for which a grouping of employees has formed a union affiliated with the FNEEQ-CSN and whose union activities have resulted in the loss of their insurance coverage with an insurer other than La Capitale Civil Service Insurer Inc.

- Managers of private teaching establishments who were participants before January 1, 2006, namely at *Collège Mont-Royal*, *Collège de Lévis* and at the *Centre d'intégration scolaire*. Payment of premiums by the participant or claims reimbursed by the Insurer to the participant are proof of coverage.

- Participants who become managers in their establishments after January 1, 2006 may maintain their participation, provided they have the right to return to their bargaining unit, as specified in the applicable collective agreement.

- Support worker employees of *Collège François-de-Laval* who are permanent and work at least 35 hours per week are eligible for all benefits under this contract.

CONTRACT 001008-001010

SCHEDULE VI FNEEQ-CSN UNIONIZED TEACHING AND OTHER PROFESSIONALS EMPLOYED BY COLLÈGE TRINITÉ

1. This schedule applies to FNEEQ-CSN unionized teaching and other professionals employed by *Collège Trinité* who participate in this contract.

2. The FNEEQ-CSN unionized teaching and other professionals employed by *Collège Trinité* are eligible for all benefits under this contract, in accordance with the provisions of the following articles. Unless otherwise indicated in this schedule, terms and conditions of the 001008-001010 contract will apply to the benefits for which these persons are eligible.

3. For the purposes of this schedule, the invoicing period corresponds to a pay period of 28 consecutive days.

4. FNEEQ-CSN unionized permanent professionals employed by *Collège Trinité*, whose employment status is based on 242 days per year, may maintain all their benefits during the 18-day interruption of work during the slower summer season, in accordance with the provisions of article 2.7.

5. For the purposes of the Short-Term Disability Insurance benefit, the elimination period is 14 calendar days for persons covered under this schedule. Furthermore, a specific rate applies to these persons.

CONTRACT 001008-001010

SCHEDULE VII PERMANENT TEACHING PROFESSIONALS OR TEACHING PROFESSIONALS WITH A TEACHING CONTRACT OF ONE YEAR OR MORE – INSTITUT DE TOURISME ET D'HÔTELLERIE DU QUÉBEC

1. This schedule applies to permanent teaching professionals or teaching professionals with a teaching contract of one year or more at the Institut de tourisme et d'hôtellerie du Québec who are now covered by joining this contract.

2. Permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible for all benefits of this contract, in accordance with the provisions of the following articles. In the absence of specific provisions indicated in this schedule, terms and conditions of the 001008-001010 contract will apply for the benefits to which permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible.

3. Permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible for all benefits of this contract following 21 days of continuous work.

4. Participation in the Short-Term Disability and Long-Term Disability Insurance benefits is mandatory for all permanent teaching professionals and teaching professionals with a teaching contract of one year or more who meet the eligibility conditions.

5. The Short-Term Disability Insurance benefit elimination period is 52 weeks of total disability plus the sick leave bank for individuals covered under this schedule. Furthermore, a specific rate applies to these individuals.

CONTRACT 001008-001010

SCHEDULE VIII PERMANENT TEACHING PROFESSIONALS OR TEACHING PROFESSIONALS WITH A TEACHING CONTRACT OF ONE YEAR OR MORE – INSTITUT DE TECHNOLOGIE AGROALIMENTAIRE DU QUÉBEC

1. This schedule applies to permanent teaching professionals or teaching professionals with a teaching contract of one year or more at the Institut de technologie agroalimentaire du Québec who are now covered by this contract.

2. Permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible for all benefits of this contract, in accordance with the provisions of the following articles. In the absence of specific provisions indicated in this schedule, terms and conditions of the 001008-001010 contract will apply for the benefits to which permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible.

3. Permanent teaching professionals and teaching professionals with a teaching contract of one year or more are eligible for all benefits of this contract following 21 days of continuous work.

4. Participation in the Short-Term Disability and Long-Term Disability Insurance benefits is mandatory for all permanent teaching professionals and teaching professionals with a teaching contract of one year or more who meet the eligibility conditions.

5. The Short-Term Disability Insurance benefit elimination period is 52 weeks of total disability plus the sick leave bank for individuals covered under this schedule. Furthermore, a specific rate applies to these individuals.

SCHEDULE IX TEACHING PROFESSIONALS – UNIVERSAL COLLEGE – GATINEAU CAMPUS

1. This schedule applies to teaching professionals employed by Universal College – Gatineau Campus who participate in this contract.

2. Teaching professionals at Universal College – Gatineau Campus are eligible for all benefits of this contract, in accordance with the provisions of the following articles. In the absence of specific provisions indicated in this schedule, terms and conditions of the 001008-001010 contract will apply to the benefits for which said persons are eligible.

3. For the purposes of this schedule, the invoicing period corresponds to a pay period of 14 consecutive days. The first full pay period is from November 12, 2023 to November 25, 2023.

4. For the purposes of the Short-Term Disability Insurance benefit, the elimination period is 14 calendar days for persons covered under this schedule. Furthermore, a specific rate applies to these persons.