# GROUP INSURANCE PLAN

Insured by

# SCFP 3939 - EMPLOYÉS OCCASIONNELS SYNDIQUÉS CASINO DE MONTRÉAL & LAC-LEAMY

Contract 102890

Class 2 - Out of Quebec Employees

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La Capitale Civil Service Insurer Inc.
Insurer and Financial Services Firm

**IMPORTANT**

This booklet contains general information about your group insurance contract.

**Please refer to the Schedule of Insurance for your contract's specific coverage and related options and details.**

This document does not include all contractual clauses regarding definitions, eligibility, enrolment, termination of insurance and other specifications. You may access this information by consulting the contract available from your employer or group policyholder.

# TABLE OF CONTENTS


| | | PAGE |
|---|---|---|
| **SCHEDULE OF INSURANCE** | | **I** |
| **GENERAL INFORMATION** | | **1** |
| 1. | Definitions | 1 |
| 2. | Eligibility | 5 |
| 3. | Participation | 6 |
| 4. | Right of exemption | 7 |
| 5. | Continuation of insurance in the event of work interruption | 7 |
| 6. | Conversion privilege | 9 |
| 7. | Extension of dependents' coverage | 10 |
| 8. | Waiver of premiums | 11 |
| 9. | Beneficiary | 11 |
| 10. | Termination of insurance | 11 |
| **LIFE INSURANCE COVERAGE** | | **15** |
| 1. | Participant's Basic Life Insurance | 15 |
| 2. | Participant's Legal Access Insurance - For Quebec's residents only | 15 |
| 3. | Dependents' Basic Life Insurance | 16 |
| 4. | Spouse's Legal Access Insurance – For Quebec's residents only | 16 |
| 5. | Basic Accidental Death and Dismemberment Insurance | 16 |
| 6. | Optional Accidental Death and Dismemberment Insurance | 20 |
| 7. | Optional Life Insurance | 21 |
| 8. | Accelerated benefit payment in the event of terminal illness | 22 |
| **CRITICAL ILLNESS INSURANCE COVERAGE** | | **23** |
| 1. | Coverage for the participant and the insured spouse | 23 |
| 2. | Coverage for insured dependent children | 26 |
| 3. | Exclusions and reduction – Critical Illness Insurance | 27 |
| 4. | Pre-existing conditions | 27 |
| 5. | Evidence and examinations | 27 |
| 6. | Payment of insurance benefits | 27 |
| **HEALTH INSURANCE COVERAGE** | | **28** |
| 1. | Terms of reimbursement | 28 |
| 2. | Expenses exempt from deductible and reimbursed at 100% | 28 |
| 3. | Prescription drugs | 32 |
| 4. | Other eligible expenses | 35 |

5. Exclusions and reduction – Health Insurance 40

**DENTAL CARE INSURANCE COVERAGE 42**

1. Terms of reimbursement 42
2. Eligible expenses 42
3. Exclusions and reduction – Dental Care Insurance 49

**SHORT TERM DISABILITY INSURANCE COVERAGE 51**

1. Elimination period 51
2. Benefit period 51
3. Benefit amount 51
4. Exclusions and reduction – Short Term Disability Insurance 54
5. Pregnancy-related Supplemental Employment Benefits or Quebec Parental Insurance Plan Benefits 55

**LONG TERM DISABILITY INSURANCE COVERAGE 56**

1. Elimination period 56
2. Benefit period 56
3. Benefit amount 56
4. Rehabilitation 58
5. Cost-of-living adjustment 58
6. Exclusions and reduction – Long Term Disability Insurance 58
7. Pregnancy-related Supplemental Employment Benefits or Quebec Parental Insurance Plan Benefits 59
8. Pre-existing conditions 59

**CLAIMS 61**

**TRAVEL INSURANCE 63**

**TRIP CANCELLATION INSURANCE 68**

**LA CAPITALE ANSWERS YOUR QUESTIONS 72**

# SCHEDULE OF INSURANCE

***This summary table provides a brief description of your group insurance plan based on the class of eligible individuals you belong to. A full description of each benefit is provided in the following pages.***

| Description of eligible individuals | |
|---|---|
| **Class 2** | **Out of Quebec Employees** |
| **General information** | |
| **Maximum age for dependent children** | **Up to age 21, if not a full-time student. Up to age 26, if a full-time student.** |
| **Total disability – Own occupation definition** | **24 months** |
| **Disability period** | Any uninterrupted period of total disability, or a series of successive periods of total disability due to the same cause or to connected causes separated by a period of full-time work of less than:<br>- 15 days during the first 26 weeks, or 15 days during the Long Term Disability Insurance elimination period if the participant is covered under this benefit.<br>- 90 days thereafter. |
| **Definition 'Salary' including dividends** | **Not covered** |
| **Eligibility waiting period** | **Please consult your employer** |
| **Minimum number of hours worked** | **None** |
| **Continuation of insurance in the event of work interruption** | |
| **. Maternity, paternity, parental or adoption leave** | **24 months** |
| **. Authorized unpaid leave of absence** | **12 months** |
| **. Temporary lay-off** | **Insurance coverage under all benefits is suspended** |

| Participant's Basic Life Insurance<br>Coverage included | |
|---|---|
| **Protection** | $40,000 |
| **Amount rounded up to** | None |
| **Minimum amount of protection** | None |
| **Reduction of benefit** | $20,000 at age 65, $10,000 at age 70 |
| **Maximum without evidence** | $40,000 |
| **Maximum with evidence** | $40,000 |
| **Legal Access Insurance** | None |
| **Waiver of premiums** | Long Term Disability Insurance benefit elimination period |
| **Termination of insurance** | Date of participant's retirement |

| Dependent's Basic Life Insurance<br>Coverage not included |
|---|

| Participant's Accidental Death and Dismemberment Insurance<br>Coverage included | |
|---|---|
| **Protection - Participant (1 time the Participant's Basic Life Insurance)** | Yes |
| **Protection - Spouse (1 time the Spouse's Basic Life Insurance)** | None |
| **Waiver of premiums** | Same as Participant's Basic Life Insurance |
| **Termination of insurance** | Age 70 or the date of the participant's retirement if earlier |

| Optional Life Insurance<br>Coverage not included |
|---|

| | |
|---|---|
| **Accelerated benefit payment in the event of terminal illness (for Participant's Basic and Optional Life Insurance)** | Not covered |

| Critical Illness Insurance<br>Coverage not included |
|---|

| Health Insurance<br>Coverage included | |
|---|---|
| **Automated payment service** | Direct |
| **Annual deductible** | |
| **Prescription drugs** | $25 ind / $50 fam |
| **Other eligible expenses** | $25 ind / $50 fam |
| **Combined deductibles (Prescription drugs and Other eligible expenses)** | Yes |
| **Deductible carryover** | None |
| **Expenses exempt from deductibles and reimbursed at 100%** | |
| **Hospitalization** | Room with 2 beds |
| **Long-term care centre** | Not covered |
| **Travel Insurance and Assistance** | Insured under age 65: 180 consecutive days, maximum per insured: $5,000,000 lifetime<br>Insured age 65 to 69: 180 consecutive days, maximum per insured: $5,000,000 lifetime<br>Insured age 70 to 74: Not covered |
| **Trip Cancellation Insurance** | Not covered |
| **CAP Medical Assistance** | Yes |
| **Employee Assistance Program** | Not covered |

| Prescription drugs | |
|---|---|
| **User charge** | None |
| **Pharmacy dispensing fees cap** | None |
| **Coinsurance - Drugs** | 80% |
| **Coinsurance – Generic drugs** | 100%<br>up to the first $3,550 of eligible expenses and 100% of the excess |
| **Clause** | Standard |
| **Smoking cessation products** | Not covered |
| **Deductible and coinsurance not reimbursable by the public prescription drugs insurance plan** | None |
| **Substitution** | Mandatory |
| **Provisions applicable to insured of age 65 or over** | Not applicable |

| Other eligible expenses | |
|---|---|
| **Coinsurance** | 80%<br>**The maximums indicated below are reimbursement amounts, unless indicated otherwise.** |
| **Alterations to the insured's home or vehicule** | Not covered |
| **Ambulance** | Reasonable and customary expenses |
| **Artificial limb or eye, supports, plaster casts, corsets, trusses, crutches or other orthopedic equipment** | Reasonable and customary expenses |
| **Blood glucose monitor or dextrometer if the insured person is insulin-dependent** | $250 per period of 60 consecutive months, per insured |
| **Capillary prosthesis following chemotherapy treatments** | Not covered |

| | |
|---|---|
| **Corrective footwear (deep shoes)** | $100 per calendar year, per insured |
| **Cosmetic surgery required following an accident** | Not covered |
| **CT scans** | Not covered |
| **Dentist required following an accident** | Reasonable and customary expenses<br>Treatment must be provided within 12 months following the date of the accident. |
| **Electrocardiogram** | Not covered |
| **External breast prosthesis following a radical mastectomy** | Not covered |
| **Eye examination** | $200 per period of 24 consecutive months, per insured. No deductible applies. Expenses reimbursed at 100%. |
| **Eyeglasses or contact lenses following a cataract operation** | Not covered |
| **Foot orthoses** | Reasonable and customary expenses |
| **Hearing aid** | Reasonable and customary expenses |
| **Homeopathic medication** | Not covered |
| **Insulin pump** | Not covered |
| **Intra-uterine device** | $64 per calendar year, per insured |
| **Magnetic resonance imaging (MRI)** | $500 per calendar year, per insured |
| **Medication for sclerosing injections** | Reasonable and customary expenses |
| **Multiservices** | Not covered |
| **Nursing fees** | $10,000 per calendar year, per insured |

| | |
|---|---|
| **Orthopedic shoes** | Maximum combined with corrective footwear (deep shoes) |
| **Oxygen, blood, blood plasma, transfusion, X-rays, ultrasound examinations, laboratory analyses** | Reasonable and customary expenses |
| **Preventive vaccines** | Reasonable and customary expenses |
| **Private clinic for alcoholism or drug addiction** | Not covered |
| **Rehabilitation centre** | $20 per day, maximum 45 days per calendar year, per insured |
| **Special treatments not available in the insured's province of residence** | Not covered |
| **Support stockings** | Reasonable and customary expenses |
| **Surgical brassieres required following a radical mastectomy** | Not covered |
| **Transcutaneous electrical nerve stimulator** | $700 per calendar year, per insured |
| **Treatment of infertility: laboratory analyses and other expenses related to treatment of infertility (excluding drugs or substances)** | Not covered |
| **Treatment of infertility: Drugs or substances used for treatment of infertility (excluding laboratory analyses and other expenses)** | Not covered |
| **Wheelchair, hospital bed or other therapeutical appliances** | Reasonable and customary expenses |

| Vision Care | Coverage included |
|---|---|
| **. Deductible and coinsurance** | No deductible applies. Expenses reimbursed at 100%. |
| **. Glasses or contact lenses (including laser eye surgery)** | **Participant and Spouse:** $200 per period of 24 consecutive months, per insured<br>**Dependent child:** $200 per period of 24 consecutive months, per insured |
| **. Contact lenses for specific conditions** | $250 per period of 24 consecutive months, per insured |
| **Healthcare professionals** | |
| **Coinsurance** | 80%<br>**The maximums indicated below are reimbursement amounts, unless indicated otherwise.** |
| **Acupuncturist** | $500 per calendar year, per insured |
| **Audiologist** | $500 per calendar year, per insured |
| **Chiropodist** | Not covered |
| **Chiropractor** | $500 per calendar year, per insured |
| **Chiropractor X-rays** | $35 per calendar year, per insured. Included in the maximum for chiropractor |
| **Dietitian** | $500 per calendar year, per insured |
| **Homeopath** | Not covered |
| **Kinesitherapist** | Not covered |
| **Massage therapist** | $500 per calendar year, per insured / Physician's referral required |

| | |
|---|---|
| **Naturopath** | $500 per calendar year, per insured, including $35 for X-Rays |
| **Occupational therapist** | Not covered |
| **Orthotherapist** | Not covered |
| **Osteopath** | $500 per calendar year, per insured, including $35 for X-Rays |
| **Physiotherapist and physical rehabilitation therapist (maximum for all of these healthcare professionals)** | $500 per calendar year, per insured |
| **Podiatrist** | $500 per calendar year, per insured, including $35 for X-Rays |
| **Psychologist, psychiatrist and psychoanalyst in an outpatient clinic (maximum for all of these healthcare professionals)** | $500 per calendar year, per insured |
| **Social worker** | Not covered |
| **Speech therapist** | $500 per calendar year, per insured |
| **Waiver of premiums** | None |
| **Extension of coverage for dependents of a deceased participant** | 24 months immediately following the participant's death |
| **Conversion privilege** | 60 days |
| **Termination of insurance** | Date of participant's retirement. Travel Insurance: Participant's 70th birthday or date of participant's retirement if earlier |

| Dental Care Insurance<br>Coverage included | |
|---|---|
| **Automated payment service** | Included |
| **Annual deductible** | None |
| **Deductible carryover** | None |
| **Late application - Maximum reimbursement** | $250 per insured during the first 12 months of insurance |
| **Reimbursement based on dental fee guide** | For current year |
| **Module A: Preventive services** | 80% |
| **Frequency of examinations** | 1 examination per period of 9 consecutive months, per insured |
| **Module B: Basic restorative services** | 80% |
| **Module C: Major restorative services** | 80% |
| **Module D: Complex restorative services** | 50% |
| **Maximum annual reimbursement** | $1,500 per insured, applies to modules A, B, C and D |
| **Module E: Orthodontics** | Not covered |
| **Waiver of premiums** | None |
| **Extention of coverage for dependents of a deceased participants** | 24 months immediately following the participant's death |
| **Conversion privilege** | None |
| **Termination of insurance** | Age 70 or the date of the participant's retirement if earlier |

**Short Term Disability Insurance**
**Coverage not included**

| Long Term Disability Insurance<br>Coverage included | |
|---|---|
| **Elimination period** | 16 weeks |
| **Maximum period of benefits** | Up to age 65 |
| **Benefit amount as a percentage of monthly salary** | 66.67% |
| **Maximum without evidence** | $7,150 |
| **Maximum with evidence** | $13,000 |
| **Taxation status** | Non-taxable |
| **Income from all sources** | 80% of net salary |
| **Cost-of-living adjustment** | None |
| **Waiver of premiums** | Long Term Disability Insurance benefit elimination period |
| **Termination of insurance** | Age 65 or the date of the participant's retirement if earlier |

# GENERAL INFORMATION

## 1. Definitions

**Accident**
Any bodily injury confirmed by a physician and directly resulting from a sudden and unforeseeable action of an external cause, and independent of any other cause. Any bodily injury sustained following an attempted suicide is not considered to be an accident.

**Active employee**
Means an employee who performs his or her work as provided in the contract of employment binding that person to the employer.

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

**Assistor**
The Travel Assistance Provider designated by the Insurer.

**Business partner (applies to the Trip Cancellation Insurance benefit)**
A person with whom the insured is associated for business purposes as part of a company with four shareholders or fewer, or a profit-making corporation with four partners or fewer.

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

**Commercial activity (applies to the Trip Cancellation Insurance benefit)**
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.

**Date of retirement**
The date on which an employee's retirement begins in accordance with the participant's retirement plan, in accordance with the labour convention in force with the employer, or in accordance with the employer's current practice. Participants who become disabled before age 65 will be considered to be retired as soon as they reach age 65. Participants who become disabled at age 65 or over will be considered to be retired following expiry of the Long Term Disability Insurance elimination period, if Long Term Disability Insurance coverage is included in the **Schedule of Insurance**, or following expiry of a period of 6 months from the disability start date, if Long Term Disability Insurance coverage is not included in the **Schedule of Insurance**.

**Deductible**
That portion of eligible expenses for which the insured is not entitled to any refund on the part of the Insurer.

**Dentist**
Any person who is a member of a professional dental association recognized by the legislative authority where the dentist practices.

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

Spouse

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

i) is married or joined by a civil union to the participant; or,
ii) has been living in a conjugal relationship with the participant for at least one year, or for less than one year if that person is the parent of the participant's child ("common law union"); or,
iii) has been living in a conjugal relationship with the participant and had already lived in a conjugal relationship with this participant for an entire period of at least one year ("common law union").

The status of spouse is lost on the occurrence of one of the following events, as the case may be: dissolution by a judgment of divorce between the participant and the spouse in the case of a marriage; separation for at least 90 days in the case of a common law union; dissolution of the union by a notarized act or by a court decision in the case of a civil union.

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

Dependent child

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

i) be under the age indicated in the **Schedule of Insurance** if the child is not a full-time student; or
ii) be under the age indicated in the **Schedule of Insurance** if the child is attending a recognized educational establishment full time. In such a case, the participant must provide the Insurer with evidence that the child is registered in such an establishment at the beginning of each school year; or
iii) have reached the age of majority and be afflicted with a total disability or functional impairment recognized by the competent authorities in the participant's province of residence. The disability or impairment must have begun while the child was meeting one of the above criteria and must have persisted since that date. In addition, the child must reside with the participant, or the participant's spouse, who would exercise parental authority over the child or be his or her legal guardian if the child were a minor. The Insurer may request evidence of the disability or impairment at any time.

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

**Elimination period**
A period which starts at the beginning of a period of total disability and during which no disability benefit is payable.

If the one-day surgery option is retained in the **Schedule of Insurance**, the waiting period in the event of hospitalization also applies in the case of a patient admitted to a one-day surgical or treatment unit for whatever the duration of admission. Nonetheless, it does not apply in the case of a patient registered at the outpatient clinic or emergency ward.

**Employee**
A person who resides in Canada and works for the employer on an active full-time basis as set out in the **Schedule of Insurance**.

**Employer**
The Policyholder of this contract or any employer whose employees or one category of employees are represented by the Policyholder.

**Hospital Centre**
Hospital within the meaning of the *Act respecting health services and social services*, excluding self-financed private health facilities within the meaning of said Act. In the event of hospitalization outside Quebec, this definition also applies to any institution recognized and accredited as a hospital by the appropriate authorities under which the institution operates, except for convalescent homes, thermal resorts and other similar institutions.

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

**Host at destination (applies to the Trip Cancellation Insurance benefit)**
The person at whose principal residence the insured is planning to stay by prior agreement.

**Illness**
An organic or functional alteration considered in its evolution and as a definable entity that is diagnosed by a physician, including any complication resulting from pregnancy.

**Insured**
A participant (or one of his or her dependents) insured under this contract.

**Long term care centre**
A facility licensed to provide convalescent care and treatment for sick or injured patients on an inpatient basis. Nursing and medical care must be available 24 hours a day. Care homes, rest homes, homes for the aged or chronically ill, sanatoriums and establishments that provide treatment for abuse of alcohol or drugs are not included.

**Net salary**
The employee's salary following the deduction of federal provincial income tax and any public pension, employment insurance and parental insurance plan contributions, if applicable.

**Non-smoker (applies to the Optional Life Insurance benefit)**
A person who satisfies the conditions for non-smoker status set by the Insurer that are applicable at the time of signing the non-smoker declaration.

**Participant**
An eligible employee who is insured under this contract.

**Physician**
A physician duly licensed to practise medicine in the place where the services are provided.

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

**Province**
Any province or territory that is part of Canada.

**Rehabilitation centre**
A rehabilitation centre or convalescent home designated as such that is legally authorized to provide care and treatment to individuals who are hospitalized, and which is required to ensure nursing and medical care can be provided at all times. Care homes, homes for the aged or chronically or mentally ill, rest homes and establishments that provide treatment for abuse of alcohol or drugs are not included.

**Salary**
Gross regular pay excluding sums received from the employer which are not part of the participant's regular pay, such as bonuses, overtime pay, fees, allowances for meals and lodging, isolation pay, any lump-sum payments or other sums payable from time to time.

For a participant whose salary comes in whole or in part from commissions or bonuses, salary means the usual average pay of the employee paid by the employer, including commissions and bonuses reported on the employee's tax slips for the previous two calendar years. If the participant has not completed two continuous years of service with the same employer, but has completed at least one year, the average income shall be determined based on the length of service. If however the employee has less than one year of service, then salary shall mean the employee's usual pay, as declared by the employer.

**Salary including dividends**
If this option is retained in the Schedule of Insurance, the following description is added to the definition of "Salary".

For a participant whose remuneration is based in whole or in part on dividends, the term “salary” means:

a) the participant’s usual average remuneration paid by the employer, as reported on T4 income tax slips for the 2 calendar years ending on the previous December 31; plus

b) the average dividend income from the employer that appears on the “relevé 3” slips as the actual amount of dividends received, or on any other provincial income tax document, for the 2 calendar years ending on the previous December 31.

However, the annual salary for such participants is limited to the maximum specified to the **Schedule of Insurance**.

**Total disability or totally disabled**
During the period specified in the **Schedule of Insurance**: A state of incapacity resulting from an illness or an accident which prevents the participant from carrying out the essential duties of his or her regular employment and requires continuous medical care.

Thereafter: A state of incapacity resulting from an illness or an accident which prevents the participant from carrying out any gainful employment for which he or she is reasonably qualified by education, training or experience.

Total disability is determined regardless of the existence or availability of such employment.

Participants who are required to hold a government permit or licence to perform the tasks of their regular employment are not considered totally disabled solely because such permit or licence has been revoked or has not been renewed.

Total disability beginning more than 31 days following an accident is deemed to be resulting from illness.

**Travel companion (applies to Trip Cancellation Insurance benefit)**
The person with whom the insured shares accommodation at the travel destination or whose transportation expenses were paid with those of the insured.

**Trip**
A trip for the purpose of tourism or leisure, or a trip for the purposes of business or attendance at a commercial activity entailing the insured's absence from his or her province of residence.

For the purposes of Trip Cancellation insurance, a trip represents a tourism or leisure trip or a trip for the purposes of business, or a commercial activity that includes a stay of at least one (1) night at destination, either in or outside the insured's province of residence.

## 2. Eligibility

Employees are eligible after having completed the eligibility waiting period specified in the **Schedule of Insurance**, provided that the employee is actively at work full time on that date for the minimum number of hours specified in the **Schedule of Insurance** and that no evidence of insurability is required.

Any dependents of an employee are eligible for insurance either on the same date as the participant if they are already dependents, or on the date when they subsequently become dependents.

## 3. Participation

**Please refer to the Schedule of Insurance for the coverage that applies.**

**Participation of employees:** Participation in the plan is mandatory for any employee who satisfies the eligibility conditions. Participation must be signified in writing to the Insurer within a period of 31 days following the date on which the employee satisfies the eligibility conditions.

Any employee who submits an application for insurance after this deadline will be subject to evidence of insurability deemed satisfactory by the Insurer for all benefits, with the exception of:

- Health Insurance if participation in this benefit is required by an applicable legislation in the employee's province of residence; and
- Dental Care Insurance.

**Participation of dependents:** Participation of dependents in Life and Health Insurance coverage is mandatory when the participant holds a coverage status other than Individual for Health Insurance. Participants with one or more dependents must opt for the coverage status corresponding to their family situation depending on the coverage status options available. They can also choose to insure their dependents under other coverage.

If Single-Parent coverage status is available, employees may opt for that type of coverage if they do not have a spouse as previously defined.

In all situations, participants must submit their application to the Insurer within 31 days following the date the dependent becomes eligible. This 31-day limit applies also to any request to change coverage status made by participants after one of the following events: the participant's marriage or civil union; the birth or adoption of a first child; or the termination of insurance for an exempted dependent.

If the application or request for change is submitted after expiry of the 31-day period, participants must provide evidence of insurability for their dependents that is deemed satisfactory by the Insurer, at their own expense, for all benefits, with the exception of:

- Health Insurance, if participation in this benefit is required by an applicable legislation in the insured's province of residence; and
- Dental Care Insurance.

The Insurer reserves the right to exclude one or more members of the family from coverage after examining the evidence of insurability.

## 4. Right of exemption

**Please refer to the Schedule of Insurance for the coverage that applies.**

**Health Insurance and Dental Care Insurance** - Employees or their dependents may waive or terminate coverage under these benefits by providing written notice to the employer along with proof deemed satisfactory by the Insurer that they are covered under another group insurance plan offering similar benefits.

Employees who waived or terminated participation in insurance must or can, depending if participation is optional or mandatory, apply for or resume participation in insurance, without evidence of insurability, by demonstrating to the Insurer's satisfaction that:

a) they were previously insured under this contract as a dependent or under any other group insurance plan offering similar benefits;
b) they can no longer be insured under the other plan; and
c) they have submitted an application form to the Insurer within 31 days following termination of their insurance.

## 5. Continuation of insurance in the event of work interruption

**Maternity, paternity, parental or adoption leave**
Participants who cease to be actively at work full time due to maternity, paternity, parental or adoption leave must maintain participation in the Health Insurance benefit if participation in such benefit is required by an applicable legislation in the insured's province of residence. Participants can also maintain all other benefits in force by sending a written request to the Insurer for all benefit they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the employer's share, which remains payable by the employer. However, insurance may not be maintained in force for a period exceeding the period specified in the **Schedule of Insurance**. In certain situations, governing legislation may take precedence over this clause, requiring the employer to pay its share of the premium and providing for an extension of the above-mentioned period.

If Disability Insurance coverage is maintained in force, the elimination period, for a disability that begins during a period in which the participant is not receiving pregnancy-related Employment Insurance benefits, shall begin on the planned date of return to work, and payment of disability benefits, if applicable, shall only begin upon expiry of the elimination period. In the event that Disability Insurance coverage is not maintained in force by the participant, such coverage is reinstated once the participant returns to active full-time work.

**Unpaid authorized leave of absence**
Participants who cease to be actively at work full time due to an unpaid authorized leave of absence must maintain participation in the Health Insurance benefit if participation in such benefit is required by an applicable legislation in the insured's province of residence. Participants can also maintain all other benefits in force by sending a written request to the Insurer for all benefit they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the employer's share, which remains payable by

the employer. However, insurance coverage may not be maintained in force beyond the maximum period specified in the **Schedule of Insurance**. In certain situations, governing legislation may take precedence over this clause, requiring the employer to pay its share of the premium and providing for an extension of the above-mentioned period.

If Disability Insurance coverage is maintained in force, the elimination period ,for a disability that begins during the above-mentioned period shall begin as of the planned date of return to work, and payment of disability benefits, if applicable, shall begin only upon expiry of the elimination period. If the Disability Insurance coverage are not maintained in force, they shall be automatically reactivated when the participant returns to active, full-time employment.

**Temporary layoff**
Participants who cease to be actively at work full time due to a temporary layoff must maintain participation in the Health Insurance benefit if participation in such benefit is required by an applicable legislation in the insured's province of residence. Participants can also maintain all other benefits in force, except for Disability Insurance, by sending a written request to the Insurer for all benefit they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the employer's share, which remains payable by the employer. However, insurance may not be maintained in force for a period exceeding the period specified in the **Schedule of Insurance**.
Disability Insurance coverage is reinstated once the participant returns to active full-time work.

Temporary layoff is defined as an absence of a fixed length, during which the participant is still considered an employee by the employer.

**Dismissal or suspension**
When a participant is dismissed or suspended and contests the dismissal or suspension by means of a grievance or arbitration under governing legislation, the participant is considered to have remained insured without interruption during the period in question if the decision rendered in arbitration or by the competent court reinstates the participant's rights and obligations as an employee. Any unpaid premiums are then payable within 31 days following the date of the final decision of the arbitrator or court.

**Strike or lockout**
In the case of a strike or a lockout, Health Insurance coverage is kept in force, with payment of premiums, for a period of 30 days. Thereafter, Health Insurance coverage may be kept in force by means of paying the required premiums. Furthermore, all other coverages are kept in force by means of paying the required premiums insofar as the Health Insurance coverage is kept in force.

If Disability Insurance coverage is kept in force by the Policyholder, any total disability that begins during the strike or lockout is considered to have begun on the date on which the participant returns to work following the end of the strike or lockout and no disability benefits are payable during this period.

If the event that Disability Insurance coverage is not maintained in force by the Policyholder, such coverage is automatically reinstated once the participant returns to active full-time work.

## 6. Conversion privilege

The Insurer offers a Conversion privilege according to the following terms:

**Participant's Basic Life Insurance, Dependents' Basic Life Insurance and Optional Life Insurance**

**Please refer to the Schedule of Insurance for the coverage that applies.**

Termination of membership in the group

Participants whose membership in the group of insured persons terminates before age 65 are entitled to convert their life insurance in whole or in part or, if applicable, the life insurance for their dependents, to an individual life insurance policy without having to provide evidence of insurability for themselves or their dependents.

The minimal amount of insurance on the participant's life that may be converted is $10,000. Furthermore, the amount that may be converted must not exceed the lesser of the following amounts:

- all amounts of life insurance protection held by the participant under the contract on the conversion date, or
- $400,000 for participants residing in Quebec; $200,000 for participants residing outside Quebec.

In addition, dependents having at least $5,000 of life insurance protection under this contract may convert their life insurance. Furthermore, the amount that may be converted must not exceed the lesser of the following amounts:

- all amounts of life insurance protections on each dependent’s life under the contract on the conversion date, or
- $400,000 for insureds residing in Quebec; $200,000 for insureds residing outside Quebec.

To exercise this conversion option, participants must apply in writing to the Insurer within 31 days following the date on which their membership in the group of insured persons terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, until termination of the above-mentioned 31-day period. Any reduction in the amount of insurance due to age or a change in category of insured persons does not give entitlement to the conversion privilege.

Expiry of the contract

Participants who have been insured for a minimum of five years and who have at least $10,000 of life insurance coverage are entitled to convert their life insurance coverage, in whole or in part, to an individual life insurance policy within 31 days following the expiry of this contract if the contract is not replaced or the replacement contract provides for a lesser amount of insurance.

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

To exercise this conversion option, participants are not required to provide evidence of insurability but must apply in writing to the Insurer within 31 days following the expiry date of this contract. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

Coverage available upon conversion

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

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

**Health Insurance**
If this option is included in the **Schedule of Insurance**: insureds who are no longer eligible for coverage under this benefit may apply, without evidence of insurability, for an individual Health Insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within the deadline indicated in the **Schedule of Insurance**. Evidence of insurability will be required for applications submitted after this deadline. For insureds who exercise their conversion privilege within the specified deadline, their individual Health Insurance policy will be effective as of the date of termination of their collective Health Insurance plan. If evidence of insurabililty is required, insurance will become effective as of the date the Insurer accepts such evidence.

**Dental Care Insurance**
If this option is included in the **Schedule of Insurance**: insureds who are no longer eligible for coverage under this benefit may apply, without evidence of insurability, for an individual dental care insurance policy of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within the deadline indicated in the **Schedule of Insurance**. Evidence of insurability will be required for applications submitted after this deadline. For insureds who exercise their conversion privilege within the specified deadline, the individual dental care insurance policy will be effective as of the date of termination of the group Dental Care Insurance plan. If evidence of insurabililty is required, insurance will become effective as of the date the Insurer accepts such evidence.

## 7. Extension of dependents' coverage

**Please refer to the Schedule of Insurance for the coverage that applies.**

Following the death of a participant, Life, Health and Dental Care Insurance coverage for the participant's dependents will be extended without payment of premiums until the earliest of the following dates:

- The last day of the period indicated in the **Schedule of Insurance**.
- The date on which the dependents' insurance would have ended if the participant had been alive.

- The date on which this benefit or contract is terminated.

## 8. Waiver of premiums

**The waiver of premiums applies to coverage when this clause is included in the Schedule of Insurance.**

**Participant's Basic Life Insurance, Dependents' Basic Life Insurance, Optional Life Insurance and Long Term Disability Insurance**
If before reaching age 65, a participant is afflicted with a total disability while this coverage is in force, the Insurer will waive premiums payable with regard to the participant that fall due after the expiry of the period specified in the **Schedule of Insurance**, for as long as total disability lasts. The waiver of premiums ends on the earliest of the following dates: the date on which total disability ends; the date of the participant's 65th birthday; or the date of the participant's retirement.

**Accidental Death and Dismemberment Insurance, Critical Illnesses Insurance, Health Insurance, Dental Care Insurance and Short Term Disability Insurance**
If before reaching age 65, a participant is afflicted with a total disability while this coverage is in force, the Insurer will waive premiums payable with regard to the participant that fall due after the expiry of the period specified in the **Schedule of Insurance**, for as long as total disability lasts. The waiver of premiums ends on the earliest of the following dates: the date on which total disability ends, the date of the participant's 65th birthday, the date of the participant's retirement; or the date on which this benefit or contract terminates.

## 9. Beneficiary

Subject to the provisions of applicable legislation, participants may designate a beneficiary or change an existing beneficiary designation by means of a written statement filed at the Head Office of the Insurer. The Insurer shall not be liable for the validity of any change of beneficiary. The rights of any beneficiary who dies before 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. In the case of a change in insurer, the beneficiary designation made under the terminated contract is automatically transferred under the new contract, unless the participant changes this designation at the time of application to the new contract.

## 10. Termination of insurance

**Please refer to the Schedule of Insurance for the provisions that apply to your contract.**

Insurance for any participant terminates on the earliest of the following dates:

**Life Insurance**
- The date on which this contract terminates, subject to the provisions of the "Waiver of premiums in the event of total disability" section.
- The date on which the participant's employment terminates, subject to the provisions of the "Conversion privilege" section.

- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" and "Conversion privilege" sections, and subject to any legislated grace period in the applicable provincial jurisdiction.
- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance** for the benefit in question.
- The date on which the Insurer receives written notice from the participant to terminate coverage under the Optional Life Insurance benefit.
- The date of the participant's retirement.
- For a participant who becomes disabled before age 65: the date of the participant's 65th birthday.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the expiry of the Long Term Disability Insurance elimination period, if Long Term Disability Insurance coverage is included.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the end of a 6-month period from the onset of disability, if Long Term Disability Insurance coverage is not included.

**Critical Illness Insurance**
- The date on which this benefit or contract terminates.
- The date on which the participant's employment terminates.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section, if applicable.
- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance**.
- The date on which the participation has received 100% of the amount of insurance.
- The date of the participant's retirement.

**Health Insurance**
- The date on which this contract terminates, subject to the provisions of the "Conversion privilege" section.
- The date on which the participant's employment terminates, subject to the provisions of the "Conversion privilege" section.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" and "Conversion privilege" sections, if applicable, 30 days following the date on which written notice of termination is sent by the Insurer to the Policyholder's last known address.
- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance**, subject to provisions applicable to insureds of age 65 or over.
- The date of the participant's retirement.
- For a participant who becomes disabled before age 65: the date of the participant's 65th birthday.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the expiry of the Long Term Disability Insurance elimination period, if Long Term Disability Insurance coverage is included.

- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the end of a 6-month period from the onset of disability, if Long Term Disability Insurance coverage is not included.

**Dental Care Insurance**

- The date on which this contract terminates, subject to the provisions of the "Conversion privilege" section, if applicable.
- The date on which the participant's employment terminates, subject to the provisions of the "Conversion privilege" section, if applicable.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" and the "Conversion privilege" sections, if applicable.
- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance**.
- The date of the participant's retirement.
- For a participant who becomes disabled before age 65: the date of the participant's 65th birthday.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the expiry of the Long Term Disability Insurance elimination period, if Long Term Disability Insurance coverage is included.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the end of a 6-month period from the onset of disability, if Long Term Disability Insurance coverage is not included.

**Short Term Disability Insurance**

- The date the contract or benefit terminates, subject to the provisions of any applicable legislation.
- The date on which the participant's employment terminates.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section.
- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance**.
- The date of the participant's retirement.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the expiry of the Long Term Disability Insurance elimination period, if Long Term Disability Insurance coverage is included.
- For a participant who becomes disabled at age 65 or over and has not returned to active full-time work: the date corresponding to the end of a 6-month period from the onset of disability, if Long Term Disability Insurance coverage is not included.

**Long Term Disability Insurance**

- The date the contract or benefit terminates, subject to the provisions of any applicable legislation.
- The date on which the participant's employment terminates.
- The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section.

- The date on which the participant reaches the age for termination of insurance specified in the **Schedule of Insurance**.
- The date of the participant's retirement.

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

**Life Insurance**
- The date on which the participant's insurance terminates, subject to the provisions "Extension of coverage for dependents of a deceased participant" and "Conversion privilege" sections, if applicable.
- The date on which the person ceases to be considered a dependent.
- The date on which the Insurer receives written notice from the participant to terminate coverage for the spouse or dependent children under the Optional Life Insurance and the Optional Accidental Death and Dismemberment Insurance benefits, if applicable.
- The date specified in the **Schedule of Insurance**.

**Critical Illness Insurance**
- The date on which the participant's insurance terminates.
- The date on which the person ceases to be considered a dependent.
- The date on which the participation has received 100% of the amount of insurance payable for a dependent.
- The date on which the participant converts his or her coverage status so that one or all of his or her dependents are no longer insured.

**Health Insurance and Dental Care Insurance**
- The date on which the participant's insurance terminates, subject to the provisions of the "Extension of coverage for dependents of a deceased participant" section, if applicable.
- The date on which the person ceases to be considered a dependent.
- The date on which the participant converts his or her coverage status so that one or all of his or her dependents are no longer insured.

# LIFE INSURANCE COVERAGE

## 1. Participant's Basic Life Insurance

Upon the death of a participant, the Insurer will pay to the beneficiary a benefit equal to the amount specified in the **Schedule of Insurance**. The amount of benefit payable is also subject to any reduction and maximums provided for in the **Schedule of Insurance**.

## 2. Participant's Legal Access Insurance - For Quebec's residents only

If this coverage is included in the **Schedule of Insurance**, the following benefits are granted to the participant:

La Capitale General Insurance Inc. provide this coverage and will reimburse legal fees and expenses related to the consultations or proceedings specified hereinafter, if undertaken in Quebec with a legal advisor, notary member of the *Chambre des notaires du Québec* or lawyer member of the *Barreau du Québec*, up to a maximum of $1,000 for the term of the contract.

If the participant has dependents, the $1,000 maximum will apply to all of the insured persons.

In order for legal fees and expenses to be eligible, the Legal Access Department at La Capitale General Insurance Inc. must be notified prior to undertaking any consultation or legal proceedings.

Scope of legal services covered

. Liquidation of the participant's succession (estate): legal consultations related to the settlement and distribution of the properties of the participant's succession
. Probate of the participant's will: legal proceedings undertaken to probate the participant's will (holograph will or in presence of witnesses) before a court of law
. Mandate of incapacity (power of attorney)* for the participant: legal proceedings leading to an application for court approval of a mandate of incapacity (power of attorney)* for the participant in anticipation of the participant's incapacity to care for him or herself or administer his or her own property
. Protective supervision of persons of full age (adult guardianship) for the participant: legal proceedings leading to the appointment of an advisor, a tutor or a curator for the participant

This coverage shall not apply when:

. The consultation or proceedings involve or result in a legal dispute
. Succession is waived or disputed
. The Legal Access Department at La Capitale General Insurance Inc. was not notified prior to consulting or engaging in the legal proceedings

Benefits payable under this coverage are paid, according to the case, to the liquidator of the succession, to the legal heirs or to the person who has undertaken the legal proceedings or required the legal services described above.

**The Legal Access Department at La Capitale General Insurance Inc.** can be contacted at: 418 266-9555 or 1 800 363-7648.

*Power of attorney must be provided in anticipation of possible incapacity.

### 3. Dependents' Basic Life Insurance

If this coverage is included in the **Schedule of Insurance**, the amount payable upon the death of an insured dependent is equal to the amount set out in the **Schedule of Insurance**.

### 4. Spouse's Legal Access Insurance - <u>For Quebec's residents only</u>

If this coverage is included in the **Schedule of Insurance**, the following benefits are granted to the insured spouse:

If the participant is covered by Legal Access Insurance and the participant's spouse is insured under Dependents' Basic Life Insurance, the spouse is automatically covered by Legal Access Insurance subject to the same conditions as those that apply to the participant, as described in item 2 above.

### 5. Basic Accidental Death and Dismemberment Insurance

If this coverage is included in the **Schedule of Insurance** and a participant, or any of the participant's insured dependents, suffers an accident while this coverage is in force and sustains any of the losses specified in the table below within 365 days following the date of such accident, the Insurer will pay a benefit equal to a percentage of the amount of the Participant's Basic Life Insurance or Dependents' Basic Life Insurance, if applicable, which corresponds to the loss suffered, as specified in the table below.

The maximum amount payable under this benefit for all losses related to the same accident or multiple accidents occurring within the same 365-day period may not exceed 100% of the amount payable under this benefit. However, in the case of paraplegia, quadriplegia and hemiplegia, the maximum amount payable is limited to 200% of the amount of Life Insurance.

| | Loss | Percentage |
|---|---|---|
| - | Paraplegia, quadriplegia or hemiplegia | 200% |
| - | Of life | 100% |
| - | Of vision in both eyes | 100% |
| - | Of both hands or both feet | 100% |
| - | Of a hand or a foot and of sight in one eye | 100% |
| - | Of a hand and a foot | 100% |
| - | Of a hand or a foot | 50% |
| - | Of speech or hearing or vision in one eye | 50% |
| - | Of the thumb and index finger of the same hand | 25% |

The loss of a hand or foot means either the total and final loss of use, or complete separation from the wrist or ankle joint or above.

The loss of vision in an eye or the loss of speech or hearing means the total and irrecoverable loss of the sight in that eye, of speech or of hearing such that no surgical operation may provide a remedy.

The loss of the thumb and index finger of the same hand means complete separation at the joint between the finger and the hand.

By quadriplegia, we mean complete and irreparable paralysis of the 2 upper and 2 lower limbs, certified by a physician, which paralysis must persist for a continuous period of at least 365 days before the insured amount becomes payable.

By paraplegia, we mean complete and irreparable paralysis of the 2 lower limbs, certified by a physician, which paralysis must persist for a continuous period of at least 365 days before the insured amount becomes payable.

By hemiplegia, we mean the complete and irreparable paralysis of an upper and a lower limb on the same side of the body, certified by a physician, which paralysis must persist for a continuous period of at least 365 days before the insured amount becomes payable.

An indemnity in the event of accidental death or dismemberment is granted on a 24-hour a day basis whether or not the insured person is at work.

Prior to granting said benefits, the Insurer is entitled to have the insured person or the body examined and request, if such be the case, that an autopsy be performed, unless prohibited by law.

**Additional benefits**
The following benefits may be payable, in addition to the amount of insurance paid for one of the losses listed in the table of losses.

**1) Rehabilitation**

If the participant suffers a loss for which an amount is payable under this benefit, the participant may be entitled to rehabilitation benefits which are limited to a maximum reimbursement of $10,000 per accident. The participant must submit a request in writing to the Insurer to obtain the reimbursement of expenses related to a rehabilitation program approved by the Insurer. Benefits are payable provided:

a) the loss suffered renders the participant unable to perform the main functions related to his or her regular occupation;
b) the loss requires the participant to undertake training to be able to pursue an occupation other that his or her regular occupation;
c) expenses are incurred within 3 years following the date of the accident and deemed necessary and reasonable by the Insurer.

**2) Spouse's occupational training**

In the event of the participant's death following an accident for which an amount is payable under this benefit, the spouse may be entitled to additional benefits to undertake occupational training. Benefits are limited to a maximum reimbursement of $10,000. The spouse must submit a request in writing to the Insurer to cover expenses incurred for an

occupational training program that must be recognized by the competent government authorities and approved by the Insurer. This program must allow the spouse to pursue an occupation that he or she could not have otherwise pursued.
Expenses must be incurred within 3 years following the date of death and must be deemed necessary and reasonable by the Insurer.

**3) Education for spouse and children**

In the event of the participant's death following an accident for which an amount is payable under this benefit, the insured spouse and children may be entitled to benefits for education. Benefits are limited to a maximum reimbursement of $5,000 per school year for all expenses incurred by the spouse and children. Benefits are payable for maximum of 4 consecutive years.

The spouse must submit a request in writing to the Insurer to obtain reimbursement of annual tuition fees and school books allowing the spouse and children to pursue full-time studies in a post-secondary educational institution. Benefits are payable provided:

a) the insured person is enrolled as a full-time student in a post-secondary educational institution at the time of the participant's death. If not already enrolled, the insured person must enroll as a full-time student in a post-secondary educational institution within 365 days following the date of the participant's death.
b) the insured person submits proof of full-time student status to the Insurer at the beginning of each school year.

**4) Transportation and accommodation of family members during the participant's hospitalization**

If the participant is hospitalized following a loss for which an amount is payable under this benefit, the participant may be entitled to benefits to cover transportation and accomodation expenses for family members. Benefits are limited to a maximum reimbursement of $10,000 for all the participant's family members. Request for reimbursement of transportation and accomodation expenses incurred by the participant's family members must be submitted in writing to the Insurer. Benefits are payable if the following conditions are met:

a) transportation must be provided by the most direct route to the hospital;
b) the hospital must be at least 150 kilometres from the participant's place of residence;
c) the participant must be under the care of a physician;
d) expenses must be deemed necessary and reasonable by the Insurer.

**5) Repatriation of a deceased participant**

In the event of the participant's death following an accident for which an amount is payable under this benefit and that the death occurs more than 50 kilometres from the participant's place of residence, the individuals who incurred the following expenses may be entitled to a reimbursement by submitting a written request to the Insurer. Benefits are limited to a

maximum reimbursement of $10,000 and must be deemed necessary and reasonable by the Insurer.

a) expenses for the preparation of the participant's body before transportation;
b) expenses for transportation of the participant's body to the burial or cremation place, including a funeral home, close the participant's place of residence.

**6) Alterations to the participant's home or motor vehicle**

If the participant must permanently use a wheelchair following an accident for which an amount is payable under this benefit, the participant may be entitled to benefits for alterations to his or her home and motor vehicle. Benefits are limited to a maximum reimbursement of $10,000. The participant must submit a request in writing to the Insurer to obtain reimbursement of the following expenses:

a) cost of alterations to the main residence to make it accessible and inhabitable in a wheelchair;
b) cost of alterations to the participant's motor vehicle to make it wheelchair accessible and allow the participant to drive it himself or herself.

Expenses must be incurred within 365 days following the date of the accident and deemed necessary and reasonable by the Insurer.

Alterations to the home or the motor vehicle must be carried out by individuals or companies who are specialized in this field. These individuals or companies must have been recommended in writing by a recognized organization providing assistance to wheelchair users. Furthermore, alterations to the motor vehicle must be approved by the proper provincial authorities.

**7) Accident involving a motor vehicle**

If the participant suffers a loss following an accident for which an amount is payable under this benefit and which occurred while the participant was driving or was a passenger in a motor vehicle, the participant may be entitled additional benefits equal to 10% of the amount of insurance provided for in the table of losses of this benefit. Benefits are payable provided:

a) the driver was driving carefully at the time of the accident;
b) the participant's seatbelt was properly buckled at the time of the accident;
c) the driver's licence of the driver of the motor vehicle was valid at the time of the accident.

**8) Day care centre**

In the event of the participant's death following an accident for which an amount is payable under this benefit and that the participant's children are in a day care centre or school day care service, or if they are enrolled within 365 days following the date of the participant's death, the individual who incurs the child care expenses may be entitled to additional benefits. A written request must be submitted to the Insurer, along with the receipts for

child care expenses. Furthermore, expenses must be deemed necessary and reasonable by the Insurer.

Benefits are limited to a maximum reimbursement of $5,000 per child per calendar year. Benefits are payable for a maximum of 4 consecutive years and for children under age 13 only. Reimbursement of expenses is based on the amounts specified on the receipts for child care expenses.

**Exclusions and reduction of coverage**

This coverage does not apply and no benefits shall be payable to the insured if the loss sustained occurs in the following cases:

- While carrying out any of the duties of an airplane crew or any duty whatsoever related to a flight.
- Due to war, whether declared or undeclared, or participation in an insurrection, whether real or foreseeable.
- Due to attempted suicide or suicide of the insured, or voluntary self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.
- During the insured's participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit at the time of the accident.
- Due to a condition occurring while the insured is on active duty with the armed forces of any country.
- While a participant's life insurance is extended without premium payments following total disability if waiver of premiums in the event of total disability for this coverage is not retained in the **Schedule of Insurance.**
- Due to an illness which appears at the time of an accident but which is not due to such accident.
- Following medical or dental treatment, a surgical operation or anesthesia.
- While driving a vehicle, boat or aircraft while under the influence of drugs or medication not taken in compliance with the physician’s prescription or manufacturer’s recommended dosage.

## 6. Optional Accidental Death and Dismemberment Insurance

If this coverage is included in the **Schedule of Insurance**, insureds benefit from a supplemental amount equal to the amount of insurance provided for under the Optional Life Insurance benefit that is payable according to the provisions specified above for the Accidental Death and Dismemberment Insurance benefit. This insurance is not available for insureds who are not covered under the Optional Life Insurance benefit.

Also, in no case may the total amount for all losses suffered by the insured payable under Accidental Death and Dismemberment Insurance and Optional Accidental Death and Dismemberment Insurance coverage exceed $1,000,000.

**Evidence of insurability**

Coverage under this benefit is subject to evidence of insurability deemed satisfactory by the Insurer, which must be provided by the applicant at the time of enrolment and each time a new unit of Optional Accidental Death and Dismemberment Insurance is added for the insured. Any

misrepresentation or non-disclosure on the part of a participant or insured at the time of enrolment may nullify the original coverage. Any misrepresentation or non-disclosure on the part of a participant or insured at the time of any requested increase for coverage may nullify that additional coverage.

## 7. Optional Life Insurance

If this coverage is included in the **Schedule of Insurance:**

**Participant:** The amount of insurance payable following the death of a participant who has chosen this option is determined in accordance with the amount selected by the participant. The amount of Optional Life Insurance the participant may obtain is specified in the **Schedule of Insurance**.

**Spouse:** The amount of insurance payable following the death of the spouse of a participant who has chosen this option is determined in accordance with the amount selected by the participant. The amount of Optional Life Insurance the participant may obtain for the spouse is specified in the **Schedule of Insurance**. Participants may not exercise this option if their spouse is not insured under the Dependents' Basic Life Insurance benefit. This option is also unavailable for participants afflicted with a total disability. In such a case, participants may exercise this option for their spouse upon returning to active employment.

**Dependent child:** The amount of insurance payable following the death of a dependent child of a participant who has chosen this option is determined in accordance with the amount selected by the participant. The amount of Optional Life Insurance the participant may obtain for dependent children is specified in the **Schedule of Insurance**. Participants may not exercise this option if their dependent children are not insured under the Dependents' Basic Life Insurance benefit. This option is also unavailable for participants afflicted with a total disability. In such a case, participants may exercise this option for their dependent children upon returning to active employment.

In no case may the total amount payable under Basic and Optional Life Insurance exceed $1,500,000.

### Evidence of insurability

Coverage under this benefit is subject to evidence of insurability deemed satisfactory by the Insurer, which must be provided by the applicant at the time of enrolment and each time a new unit of Optional Life Insurance is added for the insured. Any misrepresentation or non-disclosure on the part of a participant or insured at the time of enrolment may nullify the original coverage. Any misrepresentation or non-disclosure on the part of a participant or insured at the time of any requested increase for coverage may nullify that additional coverage.

### Exclusions and reduction of coverage

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

## 8. Accelerated benefit payment in the event of terminal illness

If this coverage is included in the **Schedule of Insurance**, a disabled participant under age 63 whose life expectancy is 12 months at the most and who benefits from a "Waiver of premiums in the event of total disability" clause may obtain the payment of an accelerate benefit payment by submitting an application in writing to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent, if designated irrevocable.

The amount paid in accordance with this section is limited to the percentage indicated in the **Schedule of Insurance** of the Participant's Life Insurance amount (Basic and Optional), without exceeding the maximum amount indicated in the **Schedule of Insurance**.

The amount of life insurance used to calculate the accelerated benefit excludes any amount or fraction of an amount expiring in accordance with the provisions of the contract during the 24 months following the date of the application and which is not replaceable with another benefit.

At the participant's death, the insured amount payable by the Insurer is reduced by the amount paid as an accelerated benefit plus interest. The interest rate used to compute the final payment for a given year corresponds to the yield of Government of Canada 5- to 10-year bonds as posted in the monthly review of the Bank of Canada (V121757 series) as at the preceding December 31 rounded up by ¼ of 1%.

The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid.

Furthermore, the accelerated benefit payment provided under this section cease upon termination of the contract, even for participants who have been granted a waiver of premiums.

## CRITICAL ILLNESS INSURANCE COVERAGE

If this coverage is included in the **Schedule of Insurance**, the Insurer will pay the percentage of the amount of insurance indicated in the **Schedule of Insurance**, as specified hereinafter and in accordance with the following conditions.

### 1. Coverage for the participant and the insured spouse

The Insurer will pay the percentage of the amount of insurance, as indicated below and in accordance with the conditions specified, in the event that a surgical procedure covered under this insurance benefit is performed by a physician or a diagnosis of a critical illness included in this coverage is made by a physician for the first time in conformity with the description provided hereafter.

The amounts payable are limited to a lifetime maximum per insured of 100% of the amount of insurance for all specified surgical procedures and illnesses of an insured.

The benefit amount is only payable if the insured survives for a period of 30 days immediately following the date of surgical procedure or the date of diagnosis of the covered illness, insofar as the diagnosis remains unchanged throughout this entire period.

In addition, insurance must be in force on the date of diagnosis or surgical procedure, as applicable, in order for benefits to be payable. However, in the event that the critical illness or surgical procedure results directly from an accident, insurance must be in force on the date of the accident.

- **Amount of insurance**

  The amount of insurance payable is specified in the **Schedule of Insurance**.

- **Surgical procedures and illnesses covered**

**100% payment of the amount of insurance**

a) MULTIPLE SCLEROSIS: designates an unequivocal diagnosis made by a neurologist of at least two episodes of clearly defined neurological abnormalities confirmed by modern imaging techniques, one of which has persisted at least six consecutive months.

b) MUSCULAR DYSTROPHY: designates an unequivocal and final diagnosis made by a duly qualified physician of a sufficiently serious attack to prevent the insured from carrying out the ordinary activities of a person of the same age for a period of at least six months. The diagnosis must be confirmed by electromyography and muscular biopsy.

c) PARALYSIS: designates a diagnosis of total and permanent loss of use of two or more limbs following physical paralysis that has persisted for an uninterrupted period of 180 days or more.

d) ALZHEIMER'S DISEASE: designates the diagnosis of a progressive neurodegenerative illness made by a neurologist or geriatric specialist. The insured must show signs of diminished intellectual faculties, especially pertaining to memory and judgment, that reduce the mental

ability and capacity to function in society to the extent that the person requires constant supervision. Other organic mental disorders and psychiatric disorders are explicitly excluded.

e) PARKINSON'S DISEASE: designates the diagnosis of idiopathic and degenerative Parkinson's disease made by a neurologist and presenting several of the following characteristics: rigidity, shaking and akinesia. All other types of Parkinsonism are specifically excluded.

f) MOTOR NEURONE DISEASES: designates the unequivocal diagnosis of one of the following diseases: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal amyotrophy, progressive bulbar paralysis or pseudobulbar paralysis.

g) BLINDNESS: designates the total and irreversible loss of sight in both eyes confirmed 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) ACCIDENTAL OCCUPATIONAL HIV INFECTION: designates infection by the human immunodeficiency virus (HIV) occurring after the effective date of coverage under this benefit, arising from an accident or injury that happens in Canada during the course of the ordinary duties of the insured's occupation, exposing the insured to blood or other body fluids contaminated by the HIV virus.

Any accident or injury that may cause an HIV infection must be reported to the Insurer within 14 days following the event. Blood samples obtained within 14 days following the event must confirm that the insured is HIV-negative. Between three and six months after the event, blood tests must confirm that the insured is then HIV-positive.

The Insurer must have access to an independent test of all blood samples drawn and remains entitled to require any other blood sampling it deems necessary.

The accident must be reported, investigated and documented in accordance with the established procedures for the occupation in question.

Exclusions from coverage:

Any HIV infection resulting from or transmitted by any other cause including, but not limited to, sexual activity or the use of drugs, is specifically excluded from coverage under this benefit.

In addition, no benefit will be payable in the event that the insured refused any vaccine affording protection against the HIV virus that was available prior to the accident or injury.

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

**50% payment of the amount of insurance**

a) CEREBROVASCULAR ACCIDENT (STROKE): designates any cerebrovascular trauma causing neurological after-effects considered to be permanent and resulting in paralysis or other measurable neurological deficits that persist for at least 30 days following the trauma. Ischemic accidents and vertebrobasilar insufficiencies are excluded.

b) KIDNEY FAILURE: designates the diagnosis of a permanent and irreversible failure of both kidneys requiring regular treatment through hemodialysis or peritoneal dialysis.

c) SERIOUS BURNS: designates a diagnosis of third-degree burns covering at least 20% of the body, made by a physician who is a qualified plastic surgeon.

d) VITAL ORGAN TRANSPLANT: designates receipt by the insured of one of the following vital organs by surgical transplant, following an irreversible alteration of function, removed from the body of a suitable donor in accordance with generally recognized medical practice: heart, liver, bone marrow (excluding autografts), both lungs, both kidney or pancreas.

**35% payment of the amount of insurance**

a) MYOCARDIAL INFARCTION: designates the death of a portion of the heart muscle, resulting from the blockage of one or more coronary arteries. The diagnosis must be based on a specific attack presenting elevated cardiac enzymes and new electrocardiographic (ECG) changes confirming diagnosis of an acute myocardial infarction.

b) CANCER: designates the diagnosis of a malignant tumor, characterized by the uncontrolled development and propagation of malignant cells invading the tissue.

This benefit does not cover the following types of cancer:

- Any type of cancer classified as TX, TO or Tis (in situ) according to the TNM classification; for prostate cancer, the T1N0M0 classification is also excluded.
- Pre-cancerous lesions, benign tumors or polyps.
- Any type of skin cancer, except for malignant melanoma invading the dermis or deeper.
- Any tumor in the presence of the human immunodeficiency virus (HIV).
- Any diagnosis of cancer made within the first 90 days following the effective date of insurance for the insured, or related signs, symptoms or problems that occur during this period.

c) COMA: designates the diagnosis, confirmed by a neurologist, of a deep state of unconsciousness from which the insured cannot emerge, which persists continuously for at least 96 hours, and for which any external stimulus only provokes primitive avoidance reflex responses.

d) CORONARY BYPASS: designates surgery recommended by an internist or cardiologist and performed by a surgeon in order to correct the narrowing or obstruction of one or more coronary arteries by means of anastomosis or bypass grafting. This benefit does not cover non-surgical techniques such as angioplasty with a balloon-tip catheter, relief of an obstruction by laser or any other technique not involving a bypass or anastomosis.

**25% payment of the amount of insurance**

a) DEAFNESS: designates the diagnosis of total and irreversible loss of hearing in both ears, with an auditory threshold exceeding 90 decibels, confirmed by an ear, nose and throat specialist.

b) LOSS OF SPEECH: designates the diagnosis of total, permanent and irreversible loss of speech due to bodily injury or physical illness. Medical evidence attesting that there has been a loss of

speech for 365 consecutive days must be provided at the time of the diagnosis in order for benefits to be payable.

**2. Coverage for insured dependent children**

The Insurer will pay 100% of the benefit amount for dependent children, in accordance with the conditions specified under this contract, in the event that a diagnosis consistent with the description hereinafter of one of the following critical illnesses is made by a duly qualified physician for the first time.

The amounts payable under this benefit are limited to a lifetime maximum per insured of 100% of the amount of insurance for all specified surgical procedures and illnesses.

The benefit amount is payable only if the insured survives for a period of 30 days immediately following the date of surgical procedure or the date of diagnosis of the covered illness, insofar as the diagnosis remains unchanged throughout this entire period.

- **Amount of insurance**
  The amount of insurance per insured dependent child is specified in the **Schedule of Insurance**.

- **Critical illnesses covered**

a) DOWN SYNDROME (TRISOMY 21): designates the diagnosis of a congenital condition associated with physical, mental and chromosomic abnormalities.

b) SEVERE CEREBRAL ATTACK: designates the diagnosis of a dysfunction of the central nervous system following anoxia (cerebral palsy), craniocephalic trauma, infection, a cerebrovascular accident or a degenerative illness.

   Neurological signs (paralysis, involuntary and uncoordinated movements, difficulty speaking and/or behavioural difficulties) must cause permanent functional difficulties and require constant supervision.

c) SEVERE MENTAL DEFICIENCY confirmed by an IQ score of less than 50.

d) SEVERE HEART MALFORMATION: designates the diagnosis of a cardiac malformation requiring surgery.

e) CYSTIC FIBROSIS.

f) SPINA BIFIDA: designates the diagnosis of vertebral malformation causing significant and permanent neurological problems.

g) SERIOUS BURNS: designates a diagnosis of third-degree burns covering at least 20% of the body, made by a physician who is a qualified plastic surgeon.

h) BLINDNESS: designates the total and irreversible loss of sight in both eyes confirmed by an ophthalmologist. Corrected eyesight must be weaker than 20/200, or the visual fields must be less than 20 degrees in both eyes.

i) DEAFNESS: designates the diagnosis of total and irreversible loss of hearing in both ears, with an auditory threshold exceeding 90 decibels, confirmed by an ear, nose and throat specialist.

### 3. Exclusions and reduction – Critical Illness Insurance

The following situations are excluded from coverage under Critical Illness Insurance and are not eligible for any payment of benefits:

- Diagnosis of cancer made within the first 90 days following the effective date of insurance for the insured.
- Injuries that the insured has voluntarily inflicted upon him or herself or resulting from attempted suicide, whether or not the insured is of sound mind.
- Injury suffered or illness contracted during participation in a criminal act.
- Injury suffered or illness contracted while the insured is driving or piloting an automobile, a boat or an airplane and is under the influence of alcohol, drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.
- Any condition resulting directly or indirectly from abuse of alcohol, drug use or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.
- Any injury or illness due to war, whether declared or undeclared, or participation in a riot, attack or insurrection, whether real or foreseeable.
- Any condition for which the insured refuses or neglects to undergo the appropriate treatments.
- Any condition occurring while the insured is on active duty with the armed forces of any country.
- If the insured dies within 30 days following the date of the diagnosis or insured surgical procedure.

### 4. Pre-existing conditions

No benefit is payable for surgical procedure or the diagnosis of a critical illness resulting directly or indirectly from a condition for which the insured has received treatments or consulted a physician during the two years prior to the effective date of insurance. This exclusion applies for a period of two years following the effective date of insurance.

### 5. Evidence and examinations

The requisite evidence must be presented to the satisfaction of the Insurer within 90 days of the date on which the surgical procedure or the illness meets the conditions stipulated under this coverage, failing which no benefit shall be payable. An insured who submits a claim for benefits may, at any time, be obligated to attend an examination by a physician of the Insurer's choice.

### 6. Payment of insurance benefits

Any benefits payable are based on the amount of insurance in force at the time of the diagnosis or surgical procedure for the insured in question. Benefits are payable to the participant.

## HEALTH INSURANCE COVERAGE

Only expenses indicated in the **Schedule of Insurance** are eligible for a reimbursement under Health Insurance coverage, according to the terms described in this schedule.

In order to be eligible, the expenses must be reasonable, in accordance with the fee schedule in force in the region in which the expenses were incurred and justified by the seriousness of the case as well as by current medical practice.

### 1. Terms of reimbursement

**Automated payment service**
If the direct or deferred Automated Payment Service option is included in the **Schedule of Insurance**, participants may use their service card for prescription drug purchases. (See: Procedure for filing claims)

**Annual deductible**
The deductible may apply in different ways to the following expenses. Please refer to the **Schedule of Insurance** for the option included in your contract.

For the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless there is an agreement to the contrary between the Policyholder and the Insurer.

**Deductible carryover**
If this option is included in the **Schedule of Insurance**, when eligible expenses incurred during the last three months of the calendar year are insufficient to reach the deductible, the expenses are carried over to reduce the deductible for the following year.

### 2. Expenses exempt from deductible and reimbursed at 100%

**Hospitalization**
The Insurer will reimburse hospitalization expenses that are incurred in Canada in excess of amounts payable under any public health and hospitalization insurance plan, up to the cost specified in the **Schedule of Insurance**, without any limit as to the number of days, provided that hospitalization begins while insurance is in force.

**Accommodation expenses in a residential and long-term care centre**
Expenses for occupying a room in a residential and long-term care centre, recognized as such by the competent authorities in the province where the establishment is located or in a hospital if the insured is receiving long-term care, in excess of the expenses payable under any public health insurance plan, up to the cost specified in the **Schedule of Insurance**, provided that occupancy begins while insurance is in force. However, these expenses are limited to the number of days specified in the **Schedule of Insurance**.

**CAP Medical Assistance**

If this coverage is included in the **Schedule of Insurance**, subject to the following terms, the Insurer provides a medical assistance service that allows participants faced with a serious illness or injury to obtain a second medical opinion. Participants may take advantage of this medical assistance service when diagnosed by their physician with one of the following diseases or ailments:

AIDS
Alzheimer's disease
Benign brain tumor
Blindness
Cancer
Cardiovascular conditions
Cerebrovascular accident (stroke)
Coma
Deafness
Degenerative neurological disease
Kidney failure
Locomotive system disorder
Loss of speech
Major bone or lung disease
Motor neurone diseases
Multiple sclerosis
Paralysis
Parkinson's disease
Serious trauma
Severe burns
Vital organ transplant

Services offered

When diagnosed with an eligible illness or disorder, insureds may contact the Insurer directly to benefit from one of the following services:

- A second medical opinion upon review of their file by one or more general practitioners or medical specialists selected by the Insurer, in order to confirm or reverse an existing diagnosis;
- An appointment with a general practitioner or medical specialist, when the Insurer deems such an appointment appropriate, in order to obtain medical recommendations for the condition diagnosed.

The Insurer reserves the right to terminate the CAP Medical Assistance service at any time.

For more information about this service: 1 888 227-1112

**Employee Assistance Program**

If this coverage is included in the **Schedule of Insurance**, in collaboration with a firm specialized in health and wellness, the Insurer offers face-to-face, telephone or online counselling services to help participants and their dependents who are experiencing a difficult situation that could impact balance, psychological health or functioning.

***Eligible services***

1. Psychosocial counselling

   Participants and their dependents can take advantage of psychosocial counselling in situations such as:

   a) Family and marital difficulties: conflicts, communication, violence

b) Work-related issues: difficulties adjusting to a change in duties, stress, interpersonal problems with co-workers or supervisors, loss of interest in work, burnout

c) Personal problems: fatigue, sleep disturbance, general anxiety, loss of motivation, loss of self-esteem, stress, overwork, depression, isolation, bereavement

d) Dependency problems: abuse of alcohol, drugs or medication, compulsive gambling, Internet addiction

Psychosocial counselling services are available, up to a maximum of 12 hours per calendar year, for participants and their dependents.

2. Coaching to improve lifestyle habits

Participants and their dependents can take advantage of coaching to change lifestyle habits such as smoking cessation, physical activity, nutrition, stress management and sleep.

Coaching to improve lifestyle habits is available, up to a maximum of three hours per calendar year, for participants and their dependents.

3. Support with childcare issues

Participants and their spouses can take advantage of support services for their dependent children in situations such as:

a) Learning or behavioural difficulties either at school or at home

b) Difficulties organizing and managing homework

c) Locating childcare services and identifying available resources.

Support with childcare issues is available, up to a maximum of three hours per calendar year, for participants and their dependents.

4. Resources for seniors and caregivers

This service helps insureds find resources for seniors and provides homecare support for caregivers.

Services for finding resources for seniors and caregivers are available, up to a maximum of three hours per calendar year, for participants and their dependents.

5. Legal assistance or financial advice

Participants and their dependents can take advantage of legal assistance services or financial advice in situations such as:

a) Legal issues: family law, separation, divorce, child support, custody

b) Financial difficulties: credit and debt management, bankruptcy, budget planning, financial aspects of divorce.

Legal assistance services and financial advice are available, up to a maximum of one hour per calendar year, for participants and their dependents.

***Total maximum hours for all services of the employee's assistance program***

The services covered under the employee assistance program are available, up to a total maximum of 12 hours per calendar year, for participants and their dependents.

***Extension of the employee's assistance program in the event of termination***

If the employee assistance program terminates, counselling services are maintained for insureds who are already receiving such services. They receive a maximum of two hours per certificate, without however exceeding the total maximum number of hours covered, for services received up to 30 days following the termination date of the employee's assistance program.

***Extension of the employee's assistance program for dependents of a deceased participant***

In the event of the participant's death while the employee assistance program is in force, dependents may continue to use the counselling services for three months following the date of the participant's death, without however exceeding the total maximum number of hours covered.

***Exclusions and reductions of the employee's assistance program***

The exclusions and reductions applicable to health insurance also apply to the employee assistance program.

In addition, any counselling services not specifically covered by the employee's assistance program are excluded, even if the service is recommended by an employee assistance program advisor.

**Travel Insurance**
If this protection is included in the **Schedule of Insurance**, you will find a complete description at the end of this brochure.

**Trip Cancellation Insurance**
If this protection is included in the **Schedule of Insurance**, you will find a complete description at the end of this brochure.

## 3. Prescription drugs

### a) Definitions

The following definitions, in addition to those provided in the General Information section, are specifically applicable to prescription drug insurance:

- **Brand name or innovation drugs:** Brand name or innovation drugs are drugs for which a generic equivalent exists.
- **Deductible and coinsurance not reimbursed under the public prescription drug insurance plan:** The deductible and coinsurance not reimbursed under the public prescription drug insurance plan of the insured's province of residence represent the insured's contribution to the payment for prescription drugs and pharmaceutical services, which is required of individuals covered under the public plan, whether the contribution is in the form of a deductible, coinsurance or a user charge. These expenses are eligible under this contract when the "Deductible and coinsurance not reimbursed under the public prescription drug insurance plan" option is selected in the **Schedule of Insurance**.
- **Generic drugs:** Generic drugs are equivalent to brand name drugs.
- **Prior authorization drug list:** This list, which the Insurer has established and may review at any time, applies to prescription drugs for which the insured must obtain authorization before they can be eligible for reimbursement under this contract.
- **Pharmacy dispensing fee cap**: Dispensing fees for prescription represent professional fees charged by the pharmacy for medication preparation costs. If an amount is indicated in the **Schedule of Insurance** for pharmacy dispensing fees, this amount represents the maximum amount payable by the Insurer. The overage charges are payable by the insured.
- **Single source drugs:** Single source drugs are drugs for which no generic equivalent exists.
- **User charge:** The user charge represents the portion of eligible expenses that the insured must pay for each prescription drug or pharmaceutical services for which expenses have been incurred. Please refer to the **Schedule of Insurance** to find out if a user charge applies**.**

### b) Eligibility criteria for prescription drugs

The Insurer reimburses expenses incurred for the prescription drugs provided they meet the following conditions:

- They bear a valid Drug Identification Number (DIN), issued by Health Canada, and they are available in the insured's province of residence.
- They are obtained from a pharmacy only and dispensed by a legally authorized healthcare professional.

- They are medically required and necessary for the insured's treatment.
- They must be prescribed by a legally authorized healthcare professional in accordance with the manufacturer's directions for use or, if no such directions exist, in accordance with instructions issued by the appropriate government authorities.
- The Insurer must approve and recognize them for their effectiveness and therapeutic value.
- Drugs on the prior authorization drug list must meet the criteria determined by the Insurer. In this regard, the required form must be completed by a healthcare professional at the insured's expense. This form may be obtained from the Insurer.

For the purposes of this prescription drug insurance, it is understood that the Insurer considers any product that meets the above conditions as a prescription drug.

**c) Available clauses**

Three options are available: the Provincial clause, the Standard clause and the Extended clause. Please refer to the **Schedule of Insurance** to know which option is applicable.

**Provincial clause**: The Insurer reimburses prescription drugs and pharmaceutical services that are covered under the public prescription drugs insurance plan of the insured's province of residence.

**Standard clause:** The Insurer reimburses prescription drugs and pharmaceutical services that can be obtained only by prescription from a healthcare professional.

Moreover, Quebec residents also receive reimbursement of expenses for prescription drugs and pharmaceutical services that are covered under the public prescription drug insurance plan.

**Extended clause:** The Insurer reimburses prescription drugs and pharmaceutical services that are prescribed by a healthcare professional.

**d) Substitution**

**- Substitution:**
When the **Schedule of Insurance** indicates that a substitution has been selected, only expenses for the least expensive drug equivalent to the drug prescribed are eligible. However, if the healthcare professional who prescribed the drug has indicated on the prescription that no substitutions are to be made, the amount payable will be based on the eligible drug prescribed.

**- Mandatory substitution:**
When the **Schedule of Insurance** indicates that a mandatory substitution has been selected, only expenses for the least expensive drug equivalent to the drug prescribed are eligible, even if the healthcare professional has indicated on the prescription that no substitutions are to be made.

Insureds wishing to obtain reimbursement of a brand name drug must have the required form completed by a healthcare professional at their expense. This form may be obtained from the Insurer. The insured must then submit this form to the Insurer for analysis.

### e) Provisions applicable to insureds of age 65 or over

If the public prescription drug insurance plan of the insured's province of residence provides for the reimbursement of drugs for any insured aged 65 or over, this public plan then acts as the first payer for reimbursement of eligible drugs.

If the public prescription drug insurance plan offers to any insured aged 65 or over the option to remain covered for drugs under the present health insurance, participants may submit their drug claims to the Insurer for this purpose. To do so, participants must submit a request to this effect to the Insurer within 31 days following the date the participant or the spouse reaches age 65, according to the provisions of the insurance proposal/au sommaire des garanties and pay any extra premium established by the Insurer. Furthermore, the insureds must cancel their registration with the public prescription drug insurance plan.

Finally, an individual who agrees to become insured under the public prescription drug insurance plan may not subsequently choose to become insured under the present benefit for drugs eligible under this public plan

**Extra premium**
In accordance with the option in the **Schedule of Insurance**, an extra premium may be applicable.

### f) Exclusions and reductions - Prescription drug expenses

Subject to any legislation applicable in the insured's province of residence, the following prescription drugs and products are not eligible, with the exception of those that are specifically indicated as being eligible in the insurance proposal/au sommaire des garanties.

These exclusions and reductions are not, in any case, intended to cause this benefit to be less generous than the legal obligations provided under any public prescription drug insurance plan with regard to a private plan.

- Aesthetic, cosmetic and personal hygiene products
- Dietary supplements, food products and substances
- Drugs, hormones, products and injections used for the treatment of obesity
- Preparations for infants
- Growth hormones; however, upon presentation of a complete medical report to the Insurer, growth hormones may be eligible for reimbursement under this contract
- Vitamins, natural and homeopathic products
- Items related to the use of injectable drugs, such as rubbing alcohol, cotton swabs, automatic injectors or other similar equipment
- Sunscreens

- Drugs administered primarily for preventive purposes; for the purposes of this exclusion, a drug used to stabilize or regulate a pathological condition diagnosed by a healthcare professional is not considered to be used for preventive purposes
- Smoking cessation products
- Drugs or substances used for the treatment of erectile dysfunction or any other sexual dysfunction
- Drugs used for the treatment of infertility, as well as any product or substance used for artificial insemination or in vitro fertilization or for assisted procreation purposes
- Contraceptive jellies, foams and devices
- Drugs administered in a hospital centre, whether or not the insured has been admitted
- Drugs and products of an experimental nature, administered within the context of a research project or obtained under a federal program providing special access to medical products
- Drugs which the Insurer considers to be intended for administration in a hospital centre because of their route of administration and the condition for which the drug is being used

When indicated in the **Schedule of Insurance**, limitations may apply to certain eligible expenses.

In addition, pharmaceutical services are subject to maximums applicable under the prescription drug insurance plan of the insured's province of residence.

Lastly, subject to any legislation applicable in the insured's province of residence, the Insurer reserves the right to adopt measures which exclude, limit or terminate the reimbursement of drug expenses or change the eligibility criteria. In addition, the Insurer reserves the right to exclude a drug, if the cost of which could significantly affect the risk insured under this benefit or the right to modify the rates applicable to that drug.

**4. Other eligible expenses**

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

**The following expenses are reimbursed in accordance with the percentage of coinsurance, the deductible and the maximum specified in the Schedule of Insurance.**

- Expenses incurred for **alterations to the home or vehicle** of the insured person, made necessary when, following an event that occurs while this insurance is in force, the insured person is required to use a wheel chair permanently.

- Expenses for transportation by **ambulance** to the nearest hospital able to provide the care required, including emergency air transportation or by train.

- Expenses for the purchase of an **artificial limb or eye,** or the rental or purchase of **supports, plaster casts, corsets, trusses, crutches or other orthopedic equipment.**

- Expenses for the purchase of an appliance used to manage diabetes (**blood glucose monitor, dextrometer or any other appliance of a similar nature**) as well as the travel case for

transporting it, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent.

- Expenses for the purchase of **capillary prosthesis (wigs)** required following chemotherapy treatments.
- The purchase of **corrective footwear (deep shoes).** These shoes must be sold by a specialized laboratory or establishment licensed and authorized under all applicable legislation in the insured's province of residence.
- Expenses for **cosmetic surgery** required to repair an esthetic condition resulting from an accident that occurred while insurance was in force, provided services are rendered within 12 months of the accident.
- Expenses for **CT scans** carried out outside a hospital for purposes of diagnosis.
- Professional fees of a **dentist** for treatment of a fractured jaw or damage to healthy, natural and vital teeth caused by an accident occurring while insurance is in force. However, 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 incurred outside a hospital for an **electrocardiogram** carried out for prevention or diagnostic purposes.
- Expenses for the purchase of an **external breast prosthesis** following a radical mastectomy.
- Professional fees for an **eye examination** carried out by an ophthalmologist or optometrist.
- Expenses for the purchase **eyeglasses or contact lenses** following a cataract operation.
- Expenses for the purchase of **foot orthoses** added to ordinary shoes, made by a specialized orthopedic laboratory licensed under applicable provincial legislation.
- Expenses for the purchase of a **hearing aid.**
- Expenses for the purchase of **homeopathic medicine** supplied by a homeopath or a licensed pharmacist on prescription by a homeopath.
- Expenses for the purchase of an **insulin pump** for controlling diabetes, if the insured’s condition requires the use of such an appliance.
- Expenses for the purchase of an **intra-uterine device.**
- Expenses for **magnetic resonance imaging (MRI**) tests carried out outside a hospital centre for purposes of diagnosis.
- **Medication expenses for sclerosing injections** that are medically necessary and administered by a physician.

- **Multiservices** Protection – Home Care and Service

  Expenses for the services described hereinafter, when recommended by a physician and deemed necessary following hospitalization or one-day surgery, are eligible for reimbursement, up to the amount indicated in the **Schedule of Insurance,** for all of these expenses, provided the expenses are incurred 30 days following the hospitalization or discharge from the outpatient surgery of day medicine unit and the services cannot be provided by a person who resides with the insured.

  a) Fees for home assistance services, invoiced by a specialized agency, for purposes of washing, feeding, dressing and looking after the insured's basic hygienic needs.
  b) Expenses incurred for a stay in a convalescent hospital specialized in post-hospitalization care.
  c) Basic expenses for general home maintenance services (meal preparation, housekeeping, laundry, dishwashing, lawn mowing and snow removal) performed by someone other than a close relative of the insured.
  d) Expenses for childcare services provided for minor children by a person other than a close relative of the insured.
  e) Public transportation expenses incurred to attend medical appointments at a physician's office or hospital, including expenses for accompaniment, if necessary, by someone other than a close relative of the insured.

  In order to obtain the services described in points a) and b), we recommend that you communicate with our Customer Service Department at the numbers indicated at the end of this booklet. Also, following hospitalization or outpatient surgery, we offer a telephone service providing information about different resources available in the area where the insured resides (CLSCs, pharmacies, laboratories, hospitals, etc.).

- The initial or replacement cost of **orthopedic shoes** that are custom made for the insured. These shoes must be sold by a specialized laboratory or establishment licensed and authorized under all applicable legislation in the insured's province of residence.

- Expenses for **oxygen, blood, blood plasma and transfusion**, as well as expenses for **X-rays, ultrasound examinations and laboratory analyses**, for purposes of prevention or diagnosis performed outside a hospital, except expenses for the preservation or freezing of blood or plasma.

- Expenses incurred for **preventive vaccines** available only on medical prescription and injected by a physician or a registered nurse.

- Expenses incurred for a stay in a **private clinic**, specialized in treatment for alcoholism or drug addiction and recognized as such, excluding however addiction to smoking.

- Professional fees for medical care provided in the participant's home by a **registered nurse or nursing assistant** who is a member in good standing of a professional order recognized by appropriate legislative authorities, excluding any person who usually resides in the participant's home or is a member of the participant's family.

- Expenses for occupying a room, including meals, for at least 12 consecutive hours in a **rehabilitation centre**, provided that the insured is admitted to the centre within 14 days following hospitalization and that hospitalization begins while insurance is in force.

- In the event that an insured under age 65 must receive **special treatments not available in the province of residence,** the Insurer will reimburse medical and hospital expenses in accordance with the following conditions:

  . The treatments must be recommended by a physician and approved by the public health insurance plan of the insured's province of residence and the Insurer. Treatments of an experimental nature are excluded.
  We mean by "treatment" a series of acts performed by one and the same practitioner within a period of 24 consecutive months.
  . The treatments are not offered in the province of residence, i.e. the request is not the result of a lack of temporary availability of such treatments.
  . The treatments provided outside Canada are eligible only if such treatments are not offered either in the insured's province of residence or elsewhere in Canada.

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

- Expenses for the purchase of **surgical brassieres**, sold by a specialized laboratory, required following a radical mastectomy.

- Expenses for the purchase a **transcutaneous electrical nerve stimulator**.

- Expenses for the **treatment of infertility** (laboratory analyses and other expenses related to treatment of infertility), excluding drugs and substances used for the treatment of infertility.

- Expenses for the **treatment of infertility** (drugs or substances used for treatment of infertility), excluding laboratory analyses and other expenses related to treatment of infertility.

- Expenses for the rental or purchase of a basic model, if this option is deemed more economical by the Insurer, of a **wheelchair, hospital bed or other therapeutic appliances.**

**Vision Care**

**The following expenses are reimbursed in accordance with the percentage of coinsurance, the deductible and the maximum specified in the Schedule of Insurance.**

10.1 Expenses for the purchase of **glasses or contact lenses** on recommendation of a physician or optometrist, as well as expenses for **laser eye surgery** performed by a duly qualified ophthalmologist, in order to correct myopia, hypermetropia, astigmatism or presbyopia.

10.2 Expenses for the purchase of **contact lenses for specific conditions**.

Expenses for the purchase of contact lenses are also eligible, provided that visual acuity is sufficiently corrected to reach 20/40 vision, a level that would have been unobtainable with regular glasses.

**Healthcare professionals**

**The following expenses are reimbursed in accordance with the percentage of coinsurance, the deductible and the maximum specified in the Schedule of Insurance for "Other eligible expenses".**

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

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

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

- Professional fees of an **acupuncturist.**
- Professional fees of an **audiologist.**
- Professional fees of a **chiropodist.**
- Professional fees of a **chiropractor** *and **X-rays** taken by chiropractors.
- Professional fees of a **dietitian.**
- Professional fees of an **homeopath.**
- Professional fees of a **kinesitherapist.**
- Professional fees of a **massage therapist.**
- Professional fees of a **naturopath.**
- Professional fees of an **occupational therapist.**
- Professional fees of an **orthotherapist.**
- Professional fees of an **osteopath.**
- Professional fees of a **physiotherapist and a physical rehabilitation therapist** working under supervision of a physiotherapist or a physiatrist.
- Professional fees of a **podiatrist.**
- Professional fees of a **psychiatrist, a psychoanalyst in an outpatient clinic and a psychologist. *** The only services of psychiatrists considered eligible for reimbursement are those rendered as psychoanalytic treatments, insofar as these professionals are members of the Canadian Psychoanalytic Society.
- Professional fees of a **social worker.**

- Professional fees of a **speech therapist.**

## 5. Exclusions and reduction – Health Insurance

These products and services described are excluded hereunder and no reimbursement is made by the Insurer for expenses incurred at the time of the following events, subject to the provisions of the respecting laws in the participant's province of residence:

The following exclusions apply unless the coverage is included in the **Schedule of Insurance.**

- Preventive vaccines.
- Dentures, except for an initial purchase if required following an accident.
- Eyeglasses, contact lenses and laser surgery.
- Hearing aids or adjustment of hearing aids.
- Sclerosing injections.
- Injections provided as part of a weight reduction program.
- Treatments or prosthesis provided for aesthetic purposes, except following an accident.
- Surgery for aesthetic purposes, except following an accident.
- Care or treatment provided primarily for aesthetic purposes, protective glasses or sunglasses and care or treatment provided free of charge.
- Any product or service that is not medically required.
- Capillary prosthesis (wigs), except following chemotherapy treatments.
- Hearing examinations, except if carried out by an audiologist, when expenses for this healthcare professional are covered under this contract.
- Eye examinations.
- Intentional self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.
- Treatment or services provided by a member of the insured's family or by a person who resides with the insured.
- Periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or health trips.
- Any condition occurring while the insured is on active duty with the armed forces of any country.
- War, whether declared or undeclared, or active participation in an insurrection, whether real or foreseeable.
- Any condition occurring due to participation in a criminal act or an act deemed to be criminal.
- Any expenses related to insemination.
- Any expenses related to infertility treatment.
- Any treatment, services or products of an experimental nature.
- Any user charge, deductible or coinsurance required by any public prescription drugs insurance plan for products and services eligible for reimbursement under this benefit.

With regard to healthcare professionals, no benefits shall be payable for expenses incurred while the insured is entitled to similar benefits under the public health insurance plan of the insured's province of residence, regardless of whether such plan covers such expenses in whole or in part. Once any benefits provided for under a public health insurance plan have been exhausted, this limitation shall no longer apply.

Also excluded are any expenses payable under any other individual or group plan and expenses for which the insured is entitled to an indemnity under any federal, provincial or foreign law.

Also excluded are any expenses for care, services or supplies that the insured is not required to pay, that the insured would not be required to pay if insured under the provisions of a public insurance plan, or that the insured would not have had to pay in the absence of this coverage.

# DENTAL CARE INSURANCE COVERAGE

## 1. Terms of reimbursement

When this coverage is included in the **Schedule of Insurance**, the Insurer pays eligible expenses to the insured according to the percentage of coinsurance and up to the maximums specified in the **Schedule of Insurance**.

Also, for the first year of insurance, the maximums are proportional to the number of months between the effective date and the end of the calendar year in the case of a group not insured for this coverage under the previous contract.

If there is more than one treatment for the dental condition of the insured person, the Insurer refunds the least expensive normal and appropriate treatment.

**Automated Payment Service**
If the Automated Payment Service option is included in the **Schedule of Insurance**, participants may use the service card for electronic payment of dental care treatment.

**Annual deductible**
The deductible may apply in different ways to the following expenses. Please refer to the **Schedule of Insurance** for the option included in your contract.

For the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless there is an agreement to the contrary between the Policyholder and the Insurer.

**Deductible carryover**
If this option is included in the **Schedule of Insurance**, any deductible or partial deductible that has been applied to expenses incurred during the last quarter of a calendar year will be subtracted from the applicable deductible for the following year.

**Late application – Maximum reimbursement**
When the insured's application form is sent to the Insurer after the expiry of a 31-day period following the date the insured became eligible, reimbursement of all dental care is limited to the amount indicated in the **Schedule of Insurance**.

## 2. Eligible expenses

Please refer to the **Schedule of Insurance** to find out which modules are included in your insurance coverage and which expenses are eligible for reimbursement.

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 and Description of Dental Treatment Services for general practitioners approved by the provincial dental association of the insured's province of residence, in force at the time the treatment is administered and for the year specified in the **Schedule of Insurance**.

When a dental fee and description of dental treatment services guide is not published for a given year, "dental fee guide" means the adjusted fee guide established by the Insurer.

## Module A) Preventive services

### DIAGNOSIS

Clinical oral examination:
- Complete examination, up to one examination per period specified in the **Schedule of Insurance**
- Recall or periodic examination, up to one examination per period specified in the **Schedule of Insurance**
- Dental examination for dependent children under age 10, if not covered under the public health insurance plan of the insured's province of residence, up to one examination per period of 12 consecutive months
- Emergency examination (examination and diagnosis due to acute pain and/or an infection)
- Specific oral examination
- Complete periodontal examination, up to one examination per period of 36 consecutive months

Limitation: Only one recall, periodic or complete oral examination in accordance with the frequency specified in the **Schedule of Insurance** is covered.

Intraoral radiographs:
- Radiograph, periapical
- Occlusal film
- Bitewing film
- Radiograph of soft tissue

Extraoral radiographs:
- Radiograph, extraoral film
- Radiograph, sinus
- Radiograph, sialography
- Radiopaque dyes
- Radiograph, TMJ
- Panoramic film
- Tomography

Limitation: One series of radiographs is eligible for reimbursement per period specified in the **Schedule of Insurance**, except in the case of 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.

### PREVENTIVE SERVICES

- Prophylaxis (polishing of coronal portion of teeth or implants), up to one treatment per period specified in the **Schedule of Insurance**

- Fluoride, treatment (topical application of fluoride for dependents age 16 and under), up to one treatment per period specified in the **Schedule of Insurance**
- Finishing restorations
- Removal of surplus subgingival filling material, when local anesthetic is required, without flap, per tooth
- Pit and fissure sealants for dependent age 14 and under
- Interproximal disking of teeth (per tooth)
- Enameloplasty, per tooth
- Periodontal scaling, up to one treatment per period specified in the **Schedule of Insurance**

**Module B) Basic restorative services**

**RESTORATION**

Primary teeth:
- Amalgam, non-bonded, anteriors or posterior:
- Amalgam, bonded, anteriors or posteriors
- Composite, primary anteriors
- Composite, primary posteriors

Permanent teeth:
- Amalgam, non-bonded, anteriors and bicuspids
- Amalgam, non-bonded, molars
- Amalgam, bonded, anteriors and bicuspids
- Amalgam, bonded, permanent molars
- Composite anteriors
- Veneer applications (anteriors and bicuspids)
- Composite, bicuspids, up to the amount payable for amalgam, bonded bicuspids
- Composite, molars, up to the amount payable for amalgam, bonded molars
- Retentive pins (amalgam or composite)

Other restorative services:
- Supplement for restoration of a tooth under an appliance or supporting an existing removable partial denture, per restoration

**ORAL SURGERY**

- Removal of erupted teeth (uncomplicated)
- Removal of erupted teeth (complex)
- Removal of impacted tooth
- Residual roots
- Tooth fragment, removal
- Surgical exposure of teeth
- Surgical movement of teeth
- Enucleation
- Alveolectomy
- Alveoloplasty

- Stomatoplasty
- Osteoplasty
- Tuberoplasty
- Removal of hyperplasic tissue
- Removal of excess mucosa
- Alveolar ridge reconstruction with alloplastic material
- Extension of mucous folds with secondary epithelization (including vestibuloplasty)
- Extension of mucous folds with mucous or skin graft
- Surgical excision (tumour)
- Removal and curettage of intra-osseous cyst or granuloma
- Surgical incision and drainage
- Foreign body, removal
- Frenectomy
- Hemorrhage, control

**GENERAL SERVICES**

- Local anesthesia for diagnostic purposes
- Conscious sedation by inhalation or intravenous route
- Professional visit
- Oral or percutaneous conscious sedation requiring monitored care

## Module C) Major restorative services

**ENDODONTICS**

Caries/trauma/pain control:
- Sedative filling
- Recontouring and polishing of traumatized tooth
- Bonding/cementation of broken tooth chip
- Supplement for endodontic treatment through a metal and/or porcelain crown
- Unsuccessful attempt to complete root canal treatment due to its complexity

Endodontic emergency:
- Pulpotomy
- Open and drain (separate emergency procedure from root canal treatment)
- Pulpectomy (emergency procedure separate from root canal treatment)
- Occlusal traumatism
- Reimplantation of avulsed tooth
- Repositioning of traumatically displaced tooth

General endodontic treatments:
- Preparation of tooth for treatment

Root canal therapy:
- Root canal treatment
- Apexification
- Perforation repair

Periapical endodontic surgery:
- Apicoectomy
- Apicoectomy and root canal treatment performed jointly, with or without retrofilling
- Apicoectomy and root canal retreatment performed jointly, with or without retrofilling
- Apicoectomy and retrofilling
- Root amputation
- Intentional reimplantation
- Hemisection

Bleaching:
- Non-vital tooth, performed in office by dentist, up to an overall maximum of 10 visits per calendar year, per insured
- Vital tooth, performed in office by dentist, up to an overall maximum of one visit per calendar year per insured for all teeth

**PERIODONTICS**

Periodontal emergencies:
- Treatment of acute infection or inflammation
- Desensitization, up to an overall maximum of 10 applications per civil year, per insured, for all teeth

Surgical periodontal services:
- Root planing
- Excision of gingival tissue in preparation for a restoration (including hemostasis and/or tissue retraction)
- Gingivoplasty and/or gingivectomy
- Fibrotomy
- Autogenous grafts, soft tissue
- Gingival graft using allograft or xenograft material
- Periodontal surgery, flap approach
- Grafts, osseous tissue
- Periodontal surgery, miscellaneous procedures

Adjunctive periodontal procedures:
- Splint or ligation
- Cast metal splint, acid etch bonded
- Removal or recementation of splint
- Occlusal equilibration
- Intraoral appliance (to control parafunction)
- Deprogrammer
- Intraoral appliance for temporomandibular joint (occlusal guard)
- Periodontal irrigation, subgingival
- Intra-sulcular application of slow release antimicrobial and/or chemotherapeutic agents

### REMOVABLE PROSTHODONTICS

Dentures, complementary services:
- Minor adjustments
- Remount and equilibration of complete or partial dentures
- Repairs without impression
- Repairs with impression
- Structural additions to the partial denture
- Replacement of teeth in prosthesis
- Vertical dimension recuperation by addition of acrylic to existing prosthesis
- Relining of complete or partial denture
- Rebase of complete or partial dentures
- Therapeutic tissue conditioning

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.

## Module D) Complex restorative services

### DIAGNOSTIC CASTS

- Unmounted, maxillary
- Unmounted, mandibular
- Mounted

### RESTORATION

- Gold foil
- Metal inlays and onlays
- Porcelain, resin or ceramic inlays and onlays
- Retentive pins for inlays or onlays
- Full preformed crowns

### FIXED PROSTHODONTICS

Individual crowns:
- Acrylic processed
- Temporary, acrylic (transitional)
- Porcelain, acrylic, ceramic, resin or metal
- Complementary services
- Cast posts
- Removal of cemented post or cast metal post

Other restorative services:
- Crown or veneer repair
- Recementation and/or removal

- Removal of inlay, onlay, non-prefabricated crown or veneer (in addition to preparation of a new restoration), first unit of time and each additional unit
- Prefabricated post with build-up
- Reconstruction of tooth in preparation for crown

**REMOVABLE PROSTHODONTICS**

- Complete dentures, standard or equilibrated
- Immediate or transitional complete dentures
- Dentures, complete, overdenture, standard or equilibrated
- Partial denture, immediate or transitional, with or without clasp
- Partial denture, transitional, acrylic tray type with teeth, maxillary and mandibular
- Partial permanent denture
- Cast partial dentures, chrome-cobalt alloy with cast and/or wrought rests and clasps
- Complete dentures with partial dentures (opposing arch), chrome-cobalt, with or without free end base
- Removable cast partial dentures with precision attachments
- Semi-precision cast partial dentures
- Hybrid partial dentures, cast
- Remake, partial dentures (using existing framework)

**FIXED BRIDGES**

- Pontics
- Butterfly bridge (Rochette) or Maryland
- Monarch bridge

**FIXED BRIDGES, COMPLEMENTARY SERVICES**

- Sectioning of an abutment or a pontic plus polishing of remaining portion
- Removal, fixed bridge
- Removal of fixed bridge not to be recemented (in addition to the preparation of a new abutment), first unit of time and each additional unit
- Recementation, fixed bridge
- Repairs, fixed bridge
- Abutments
- Abutments, inlays or onlays
- Semi-precision or precision attachment; however, not eligible for reimbursement more than once per five consecutive years

**RESTRICTIONS CONCERNING REMOVABLE AND FIXED PROSTHODONTICS AND FIXED BRIDGES**

- Any purchase of a prosthesis or fixed bridge is only eligible for reimbursement if the extraction that makes the purchase necessary takes place while the insured is covered under this benefit.
- Any replacement of a prosthesis or fixed bridge or the addition of teeth to a removable prosthesis or a fixed bridge is only eligible for reimbursement if satisfactory proof is provided that:

. the replacement or addition of teeth is necessary following the removal of teeth after the initial insertion of the prosthesis or fixed bridge; or
. the prosthesis or fixed bridge cannot be repaired and, if the prosthesis or fixed bridge was inserted while this Dental Care Insurance coverage was in force, that at least five years have elapsed prior to the replacement.

- Any replacement of a prosthesis or fixed bridge is eligible for reimbursement up to the maximum reimbursement amount provided for an equivalent model to the prosthesis or fixed bridge that the person had prior to the first replacement for which expenses were reimbursed.
- When fixed prosthesis are used as retainers for a fixed bridge, the fixed prosthesis are eligible for reimbursement under the same conditions as fixed bridges.
- Dentures on implants are eligible for payment according to the amount for a standard equivalent denture, in accordance with the provisions of this contract. However, implants and surgery related to implants are not eligible.

**Module E) Orthodontics**

- Specific orthodontic examination and diagnosis
- Radiograph, cephalometric
- Radiograph, hand and wrist (as diagnostic aid for dental treatment)
- Complete orthodontic oral examination
- Adjustments, alterations or recementation (fixed or removable appliance)
- Correction of oral habits
- Space maintainers
- Removable appliances
- Orthopedic devices
- Fixed appliances - Retention appliances
- Major orthodontics
- Orthodontic emergencies

**3. Exclusions and reduction – Dental Care Insurance**

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

- 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 benefit.
- Dental treatments for which the insured is entitled to compensation under any act respecting industrial accidents and occupational diseases, any government automobile plan, or any other Canadian or foreign law with similar provisions; and any dental treatments payable under any health insurance benefit in which the insured participates.
- 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.

- Dental treatments administered primarily for aesthetic purposes, including the transformation, extraction or replacement of healthy teeth in order to modify their appearance.
- Dental treatments required due to intentional 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 foreseeable.
- 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.
- 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.
- Fees charged for diet assessments, recommendations for initial oral hygiene instruction or re-instruction, plaque control programs or any type of mouth guard.
- Dental implants and surgery related to implants.
- Expenses incurred while insurance under this benefit was not in force.

## SHORT TERM DISABILITY INSURANCE COVERAGE

When this coverage is included in the **Schedule of Insurance**, upon receipt and approval by the Insurer of medical evidence establishing that a participant has become totally disabled as defined under the contract, and following expiry of the elimination period, the Insurer will pay a weekly benefit, as defined below.

### 1. Elimination period

The elimination period is a period that begins at the start of total disability, during which no disability benefit is payable. This period is specified in the **Schedule of Insurance**.

If outpatient surgery is included in the **Schedule of Insurance,** cases in which a patient is admitted to an outpatient surgery or day medicine unit, regardless of the duration of admission, are considered hospitalization.

### 2. Benefit period

The first payment falls due starting on the 7th day following the expiration of the waiting period and payments are made weekly thereafter.

Furthermore, benefits cease to be payable on the earliest of the following events:

- The expiration of the maximum period of benefits specified in the **Schedule of Insurance**. If the **Schedule of Insurance** specifies that benefits are integrated with Employment Insurance, the maximum benefit period includes the number of weeks during which benefits are payable under the *Employment Insurance Act*. However, if the participant is eligible for supplemental employment benefits, this period ends on the date on which payment of benefits under the Employment Insurance Act ends.
- The date of the participant's retirement.
- The date on which total disability ends.
- Death of the participant.

Notwithstanding the above, if this benefit is part of a plan registered with Employment Insurance, the payment of short-term disability insurance benefits may continue past the insurance termination age for a participant whose disability persists.

### 3. Benefit amount

The benefit amount corresponds to the percentage indicated in the **Schedule of Insurance** of the participant's weekly salary at the onset of disability. This benefit is subject to the maximums provided in the said **Schedule** and reduced by the sum of the following amounts:

a) Any disability income benefits the participant is entitled to receive under any pension plan applicable in his or her province of residence, before any apportionment or deductions of any sort, or which the participant would be entitled to receive if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

A disabled participant who is entitled to disability income benefits under any pension plan applicable in his or her province of residence and who has applied for retirement income from such pension plan shall be presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that the participant would continue to receive if an application for retirement income benefits had not been submitted.

In the event that a participant whose remuneration is based in whole or in part on dividends becomes disabled, the integration with any pension plan applicable in his or her province of residence, as provided for above, shall be calculated based on the amount of the benefit that the participant would have received under this pension plan if such remuneration had been an eligible salary.

b) Any disability-related benefits paid or payable under any government automobile insurance plan, provided that any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the automobile insurance plan and that applicable legislation does not prohibit any such deductions. The benefits in question include any benefits that are paid or that would be paid to the participant if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

   After the first 17 weeks of total disability, when the maximum benefit period specified is longer than 17 weeks, disability benefits will also be reduced by the amount of benefits, indemnities and income received by the participant from any government plan, government agency or legislation, for the same or a subsequent disability, including all amounts payable to a participant on behalf of a dependent, but excluding Employment Insurance benefits and automatic cost-of-living increases that occur after benefit payments begin.

c) All benefits, indemnities and income received by the participant from the employer, including dividend payments or from a retirement plan of the employer.

d) If the "Supplemental Employment Benefits" option is included in the **Schedule of Insurance**, Employment Insurance benefits in case of accident or illness that the participant is entitled to receive, or which the participant would be entitled to receive if an application were submitted and approved, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

In all cases involving a reduction of the benefit amount as stated in sections a) and b), it is the participant's responsibility to submit an application for disability benefits to the relevant authorities when required by the Insurer, and if the participant fails to do so, the benefit will be reduced as described in these sections.

No increase in any amount referred to in items a), b), or c) that is due to a cost-of-living adjustment shall reduce the benefit amount payable under this insurance coverage.

The amount of benefit in the event of disability is divided, if applicable, at a rate of 1/5 of the amount provided for a complete week per working day during a normal work week or at a rate of 1/7 for each day of absence during a week in accordance with the option retained in the Insurance Proposal.

For any participant working on an irregular schedule, the following apply:

For the first week of payable benefits regarding a disability due to illness or accident, the benefit will be proportional to the loss of salary sustained during this same week, established in pro rata to the number of working hours lost, taking into account the waiting period.

For the week of benefits which coincides with the return-to-work day, the benefit to be paid will be in pro rata to the number of working hours effectively lost.

In addition, the sum of disability insurance benefits described above and income coming from other sources may not exceed the percentage of the participant's salary at the beginning of his or her disability, provided in the **Schedule of Insurance** at the "Income from all sources" item.

The following is considered income from other sources:

- Disability benefits payable under:
    - The provisions of any government automobile plan or any legislation with similar provisions, when such legislation does not take into account benefits payable under the *Employment Insurance Act* when calculating disability benefits.
    - Any pension plan applicable in the participant’s province of residence (initial benefit amount only).
    - Any other social legislation excluding Employment Insurance benefits.
    - Any other group insurance plan, including any supplemental income plan to which the employer contributes.
- Any other remuneration received from the employer (with the exception of amounts received for a rehabilitation program).

In addition, for the purposes of calculating income from other sources, a disabled participant who is entitled to disability income benefits under any pension plan applicable in his or her province of residence and who has applied for retirement income from such pension plan shall be presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that the participant would continue to receive if an application for retirement income benefits had not been submitted.

However, if this benefit is part of a plan registered with Employment Insurance, the direct and indirect reductions of benefits payable during the benefit period of this government program are applied in such a way that this benefit is as generous as the Employment Insurance program would have been.

## 4. Exclusions and reduction – Short Term Disability Insurance

No benefit shall be payable under this insurance coverage:

a) If total disability occurs due to any of the following causes:

- War, whether declared or undeclared, or active participation in an insurrection, whether real or foreseeable.
- Self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician's prescription or the manufacturer's recommended dosage.
- Surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.
- Any condition occurring while the participant is on active duty with the armed forces of any country.
- Alcoholism or drug addiction, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care as a part of a detoxification treatment or rehabilitation in an establishment, agency or institution specialized for such purposes.

b) For a period of total disability corresponding to one of the following periods:

- A period of maternity leave taken in compliance with a provincial or federal statute or maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.
- A period during which the participant is receiving maternity benefits provided under the *Employment Insurance Act* or the *Parental Insurance Act.*

c) For any period during which the participant engages in any gainful occupation, except within a rehabilitation program.

d) For any period during which the participant refuses to take part in a rehabilitation program or perform rehabilitative work considered appropriate by the Insurer.

e) During a period when the participant, covered under any act respecting industrial accidents and occupational diseases, is eligible for an indemnity under the said act.

f) If integration with Employment Insurance is specified in the **Schedule of Insurance**, the payment of benefits is suspended as long as the participant is entitled to benefits under the *Employment Insurance Act*.

g) For any period during which the participant fails to provide proof of continuing disability deemed satisfactory by the Insurer.

h) For any period during which the participant refuses to undergo a medical examination as required by the Insurer.

i) For any period during which the participant ceases to be under regular and ongoing care and treatment by a physician deemed satisfactory by the Insurer.

j) When the participant is absent from Canada for a period longer than four weeks. However, the payment of benefits continues during such a period if the Insurer previously accepts to do so or if the participant needs to stay outside Canada in order to receive treatments at a facility recognized and accredited as a medical institution by competent authorities when such treatments are not readily available in the participant's area of residence.

k) For any period during which the participant is incarcerated in a prison, correctional facility or forensic psychiatric hospital by order of a criminal court.

**5. Pregnancy-related Supplemental Employment Benefits or Quebec Parental Insurance Plan Benefits**

When a participant who is otherwise eligible for benefits is subject to exclusion b) of this benefit and is receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, the Insurer will pay a supplement calculated to cover the difference between the amount of Employment Insurance benefits or Quebec Parental Insurance Plan benefits payable and the amount to which the participant would have been entitled if exclusion b) were not applicable.

# LONG TERM DISABILITY INSURANCE COVERAGE

When this coverage is included in the **Schedule of Insurance**, upon receipt and approval by the Insurer of medical evidence establishing that a participant has become totally disabled as defined under the contract, and following expiry of the elimination period, the Insurer will pay a monthly benefit, as defined below.

## 1. Elimination period

The elimination period is a period that begins at the start of total disability, during which no disability benefit is payable. This period is specified in the **Schedule of Insurance**.

## 2. Benefit period

The first benefit payment is made as of the 31st day following expiry of the elimination period and subsequent payments are made every month. Furthermore, benefits cease to be payable on the earliest of the following events:

- The last day of the week in which the participant reaches the maximum benefit period specified in the **Schedule of Insurance.**
- The date of the participant's retirement.
- The date on which total disability ends.
- Failure to provide proof of continuing disability deemed satisfactory by the Insurer.
- Refusal to undergo a medical examination as required by the Insurer.
- Incarceration in a prison, correctional facility or forensic psychiatric hospital by order of a criminal court.
- If the participant is absent from Canada for longer than 4 weeks due to any reason, unless the Insurer agrees in writing in advance to pay benefits during any such period.
- Death of the participant.

## 3. Benefit amount

The benefit amount corresponds to the percentage indicated in the **Schedule of Insurance** of the participant's monthly salary at the onset of disability. This benefit is subject to the maximums specified in the said **Schedule** and reduced by the sum of the following amounts:

a) Any disability income benefits the participant is entitled to receive under any pension plan applicable in his or her province of residence, before any apportionment or deductions of any sort, or which the participant would have been entitled to receive 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.

   A disabled participant who is entitled to disability income benefits under any pension plan applicable in his or her province of residence and who has applied for retirement income from such pension plan shall be presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that the participant would continue to receive if an application for retirement income benefits had not been submitted.

In the event that a participant whose remuneration is based in whole or in part on dividends becomes disabled, the integration with any pension plan applicable in his or her province of residence, as provided for above, shall be calculated based on the amount of the benefit that the participant would have received under this pension plan if such remuneration had been an eligible salary.

b) Any disability income benefits the participant is entitled to receive under any applicable industrial accidents and occupational diseases legislation or any provincial automobile insurance legislation, or which the participant would have been entitled to receive 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.

c) All benefits, indemnities and income received by the participant from the employer, , including dividend payments or from a retirement plan of the current employer or any previous employer, with the exception of any amounts that the participant was receiving from a retirement plan before the onset of the disability.

In all cases involving a reduction of the benefit amount as stated in sections a) and b), it is the participant's responsibility to submit an application for disability benefits to the relevant authorities when required by the Insurer, and if the participant fails to do so, the benefit will be reduced as described in these sections.

No increase in any amount referred to in sections a), b) and c) that is due to a cost-of-living adjustment shall reduce the benefit amount payable under this insurance coverage.

If any amount referred to in sections a) or b) is paid as a lump sum, the participant will be deemed to have received the monthly equivalent of the lump sum amount, and as such the Insurer may recover any overpayment of benefits, or cease or reduce benefits payable under this contract as if the income from other sources were paid in monthly instalments.

For the week of benefits which coincides with the return-to-work day, the benefit to be paid will be in pro rata to the number of working hours lost.

In addition, the total disability insurance benefits specified above and initial income from other sources may not exceed the percentage of the participant’s salary at the onset of disability, which percentage is indicated in the "Income from all sources" section in the **Schedule of Insurance.**

The following is considered income from other sources:

- Disability benefits payable under:
    . Any act respecting industrial accidents and occupational diseases or any other similar legislation.
    . Any automobile insurance act or any other similar legislation.
    . Any pension plan applicable in the participant’s province of residence (initial benefit amount only).
    . The *Crime Victims Compensation Act*.

. Any other social legislation and any other public or private group insurance plan, including any supplemental income plan to which the current employer contributes or to which any previous employer has contributed.
. Any other remuneration received from the current or previous employer, including dividend payments (with the exception of amounts received for a rehabilitation program).

For the purposes of calculating income from other sources, a disabled participant who is entitled to disability income benefits under any pension plan applicable in his or her province of residence and who has applied for retirement income from such pension plan shall be presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that he or she would continue to receive if an application for retirement income benefits had not been submitted.

**4. Rehabilitation**

Any participant who participates in a rehabilitation program sponsored by the Insurer is entitled to monthly benefits equal to the amount of the participant's monthly benefit prior to registration in the rehabilitation program, reduced by an amount of 50% of the remuneration for work carried out under this program. If the participant's income from rehabilitation benefits and remuneration for work carried out under the program exceeds 100% of the net basic monthly salary received from the participant's employer at the beginning of the elimination period if benefits are non-taxable or gross basic monthly salary if benefits are taxable, monthly rehabilitation benefits are reduced by the excess amount. The benefits end after the expiry of a 24-month period following the beginning of the program, the interruption of the program, or the withdrawal of the Insurer's approval of the rehabilitation program.

**5. Cost-of-living adjustment**

If this option is included in the **Schedule of Insurance**, during the period of disability and for as long as the participant is disabled, the benefit amount is adjusted on January 1 each year, in accordance with the provisions specified in the **Schedule of Insurance**.

**6. Exclusions and reduction – Long Term Disability Insurance**

No benefit shall be payable under this insurance coverage:

a) If total disability occurs due to any of the following causes:

- War, whether declared or undeclared, or active participation in an insurrection, whether real or foreseeable.
- Self-inflicted injury or self-mutilation, whether or not the insured is of sound mind.
- Participation in a criminal act or an act deemed to be criminal, including the act of driving a vehicle, boat or aircraft while having a blood alcohol level in excess of the prescribed legal limit where the accident occurs or while under the influence of drugs or medication not taken in compliance with the physician’s prescription or the manufacturer’s recommended dosage.
- Any condition occurring while the participant is on active duty with the armed forces of any country.

- Alcoholism, drug addiction or compulsive gambling, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care as a part of a detoxification treatment or rehabilitation in an establishment, agency or institution specialized for such purposes.
- Surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.

b) For a period of total disability corresponding to one of the following periods:

- A maternity leave taken in compliance with a provincial or federal statute or a maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.
- A period during which the participant is receiving maternity benefits provided for under the *Employment Insurance Act* or the *Parental Insurance Act.*

c) For any disability period during which the participant is not under the care of a physician. In the event of a disability due to a mental illness, the disabled participant must be under the care of a specialist in psychiatry.

d) For any period during which the participant engages in any gainful occupation, except within a rehabilitation program.

e) If the participant is dismissed for reasons not related to the disability and the said disability does not prevent the participant from engaging in any gainful activity for which he or she is reasonably qualified due to education, training or experience.

f) For any period during which the participant refuses to take part in a rehabilitation program or perform rehabilitative work considered appropriate by the Insurer.

g) After the planned end date of employment, for contractual employees.

**7. Pregnancy-related Supplemental Employment Benefits or Quebec Parental Insurance Plan Benefits**

When a participant who is otherwise eligible for benefits is subject to exclusion b) of this benefit and is receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, the Insurer will pay a supplement calculated to cover the difference between the amount of Employment Insurance benefits or Quebec Parental Insurance Plan benefits payable and the amount to which the participant would have been entitled if exclusion b) were not applicable.

**8. Pre-existing conditions**

If the participant's disability results from a pre-existing condition, the participant is not entitled to disability insurance benefits or waiver of premiums under this coverage.

A pre-existing condition is defined as an accident suffered or an illness that began before the effective date of the participant's disability insurance and for which, during the 3-month period immediately preceding this date:

- the participant consulted a healthcare professional; or

- the participant received treatments or medical care; or
- the participant was prescribed drugs that can only be obtained on prescription by a healthcare professional legally authorized to do so.

This provision applies to any participant who is a new employee of the Policyholder and who was not covered under a disability insurance benefit that ended within the 30 days immediately preceding the date of the first day of work for his or her new employer.

However, this provision no longer applies when the participant has been effectively and continuously at work, according to his or her regular schedule, for a 12-month period following the effective date of the participant's insurance under this disability benefit.

## CLAIMS

***All forms are available from your employer's group plan administrator or the group policyholder. You can also download forms from our website at***

**https://www.lacapitale.com/en/individuals/insurances/group-insurance/forms**

### Health Insurance

### Prescription Drugs – Direct Automated Payment Service

When making prescription drug purchases, if this option is included in the **Schedule of Insurance**, insureds present their service card to the pharmacist. La Capitale will automatically issue payment for the insured portion of prescription drug expenses. There's no need to fill out a claim form, and insureds pay only the uninsured portion of prescription drug expenses including any applicable deductible.

### Prescription Drugs – Deferred Automated Payment Service

When making prescription drug purchases, if this option is included in the **Schedule of Insurance**, insureds present their service card to the pharmacist. The insured must pay the full cost of the prescription drugs, but the claim is automatically filed with the Insurer. La Capitale will issue payment to the participant once $75 of expenses have been claimed or after a period of 14 days has elapsed, whichever occurs first.

### Other expenses

Insureds must submit a duly completed, signed and dated claim form to the Insurer. It is important to follow the directions on the form and enclose original receipts and paid invoices for the expenses incurred. Insureds should keep copies for their own records as the originals will not be returned. In the event of hospitalization, insureds show their service card at the time of admission, and the hospital will then bill the Insurer directly for any expenses payable under the contract. All claims must be submitted to the Insurer no later than 12 months following the date expenses are incurred and may be sent by regular mail or through mobile application. Also applies to prescription drug expenses if the automated payment service option is no included in the **Schedule of Insurance**.

### Dental Care Insurance

If this option is included in the **Schedule of Insurance**: There are two parts to the claim form: one to be filled out by the dentist and the other by the insured. When both parts have been completed, the insured submits the form to the Insurer. We also accept dentists' standard electronic forms. All claims must be submitted to the Insurer no later than 12 months following the date expenses are incurred.

### Dental Care Insurance – Automated Payment Service

If this option is included in the **Schedule of Insurance**: Insureds present their service card in the dentist's office. The system validates the card and confirms whether the dental treatment is covered as well as the percentage of reimbursement applicable. There's no need to fill out a claim form since the insured portion of treatment expenses is claimed directly by the dentist from the Insurer. Insureds pay only the uninsured portion of dental expenses including any applicable

deductible. If the dentist does not offer this service, insureds must pay the treatment expenses in full and submit a claim to the Insurer.

**Direct Deposit of benefits - Health and Dental Care benefits (if applicable)**
It's easy to take advantage of this handy service. Fill in the information requested in the Application for direct deposit of benefits section when filing a claim. Upon approval of the claim, benefits are deposited directly in the participant's account. The Insurer then issues a statement confirming the date the claim was processed and the amount paid.

You can also download an Application for Direct Deposit of Benefits form our website, fill in the information requested and return it to us.

**Life Insurance**
The beneficiary must contact the Insurer to obtain all required claim forms and submit a claim for the insured amount.

**Disability Insurance**
Benefits are payable to the participant after expiry of the elimination period. The claim form must be completed by the participant, the employer and the attending physician, then forwarded to the Insurer as soon as possible.

# TRAVEL INSURANCE

**IMPORTANT NOTICE**

In the case of travel outside your province of residence, you must contact the Assistor at the following numbers: 1 800 363-9050 or 514 985-2281 ONLY if you suffer from a known illness or condition and you are unsure about your health condition or you are awaiting diagnosis (please refer to the "Exclusion and reduction of coverage" section below).

If this coverage is retained in the **Schedule of Insurance**, the following benefits are granted to the insured.

La Capitale will reimburse the customary and reasonable expenses described hereafter, 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.

To be considered as temporarily outside the province of residence, the insured's stay must not exceed the period specified in the **Schedule of Insurance**; the stay may however be extended beyond that period if the extension is due to an illness or accident that occurs during the period specified in the **Schedule of Insurance** and a return to the province of residence is impossible due to justifiable medical reasons.

Benefits are granted over and above and not in replacement of any benefits provided under government programs. The maximum lifetime reimbursement is limited to the amount specified in the **Schedule of Insurance**.

**EXCLUSION AND REDUCTION OF COVERAGE**

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

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

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

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

**Eligible expenses**

**a) Hospitalization, medical and paramedical expenses**

- Expenses for hospitalization in a semi-private or private room, in excess of the amounts reimbursed or eligible for reimbursement under the public health and hospitalization insurance plans of the insured's province of residence.
- Incidental expenses (telephone, television, parking, etc.) related to hospitalization, upon presentation of supporting documents, up to a maximum of $100 per hospitalization.
- Professional fees of a physician for medical, surgical or 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.
- The cost of drugs prescribed by a physician in an emergency treatment situation.
- Professional fees of a registered nurse, who is a member in good standing of a recognized professional order, for private nursing care dispensed exclusively in a hospital, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $3,000; the nurse must not be related to the insured nor be a travel companion.
- Rental of therapeutic devices and purchase of trusses, corsets, crutches, splints, casts and other orthopedic devices, when prescribed by the attending physician.
- Professional fees of a dentist for treatment of accidental injury to healthy, natural and vital teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident; to be covered, expenses must be incurred within 12 months following the accident.

**b) Transportation expenses**

- Expenses for transportation of the insured by air or surface ambulance to the nearest medical centre where adequate medical care is available. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing the patient's condition.
- Repatriation expenses for the insured to return to the place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as the insured's health condition so allows and insofar as the means of transport initially planned for the return cannot be used. If required by the insured's health condition, the Assistor will send a medical escort on site to accompany the insured on the return trip. Repatriation must be approved and planned by the Assistor.
- When the insured is repatriated or transported, the Assistor organizes and pays expenses for the insured's spouse and dependent children or the insured's travel companion, as applicable, to return to the insured's province of residence, up to the cost of a regularly scheduled airline flight, train or bus ticket, if the means of transport initially planned for the return cannot be used.
- When the insured's health condition does not allow medical repatriation and hospitalization outside the province must extend beyond 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.
- The Assistor will make necessary arrangements to return home any children under age 18 accompanying the insured if, following the insured's accident or illness, the insured or another accompanying adult is unable to do so personally.
- If the insured is unable to drive the automobile used for a trip following an illness or accident that occurs during the trip and no other accompanying person is able to drive the vehicle, the Assistor will pay the expenses incurred for a commercial agency to return the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency, subject to a maximum reimbursement of $1,000.
- In the event of the insured's death, when necessary, the Assistor will organize and pay expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, providing that no close relative age 18 years or over accompanied the insured on the trip. The maximum reimbursement is $1,500.
- In the event of the insured's death, the Assistor will pay for the cost of preparing and returning the remains of the insured (excluding the cost of the coffin or casket) to the place of burial in the province of residence, subject to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

**c) Living expenses**

- Expenses for accommodation and meals in a commercial establishment 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, up to a maximum reimbursement of $150 per day for a maximum of eight days.

**d) Travel Assistance Service**

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

- Cash advances for expenses covered under the travel insurance. Thereafter, the Assistor files a claim for the reimbursement of expenses incurred with the public health and hospitalization insurance plans of the insured's province of residence and with the Insurer.
- In the event of illness or accident abroad, the Assistor will provide straightforward medical advice and information as to the location of a medical centre. If necessary, the Assistor will help coordinate the insured's admission to an appropriate clinic or hospital.
- Subject to the provisions herein, once notified of an illness or accident suffered 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.
- The Assistor will take charge of transmitting any urgent messages when the insured is personally unable to do so.

- The Assistor will ensure, insofar as possible, the dispatch of any drugs that are indispensable for the ongoing treatment of the insured in the event that it is impossible to obtain such drugs or equivalent drugs on site. In all cases, drugs must be paid for by the insured and then, if eligible, reimbursed by the Insurer.
- Upon presentation of supporting documents, the Assistor will reimburse the insured for any telephone and other communication expenses incurred by an insured in distress abroad in order to gain access to covered services.
- Upon request by the insured, the Assistor will provide any information required in the event of major problems occurring during the trip following the loss of the insured's passport, visa, credit card, etc.
- The Assistor will provide insureds in distress abroad with telephone access to a multilingual interpretation service.
- In the event that an insured is involved in legal proceedings following a traffic accident, highway traffic 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.

**e) Obligations of the insured person**

- NOTIFICATION: The insured person has the obligation to notify the Assistor as soon as possible of the occurrence of the incident, accident or illness.
- RESTRICTION: The insured person, as soon as he or she is capable of so doing, must obtain the previous consent of the Assistor before taking any initiative or incurring any expense. If the insured person fails in this obligation, the Assistor will be relieved of its obligations to the insured person.
- UNUSED TICKETS: When an insured person has profited from transportation for medical purposes under the terms of travel insurance coverage, the Assistor reserves the right to claim from the insured person, the ticket he or she holds and has not used due to services rendered by the Assistor.
- SUBROGATION: For purposes of this coverage and for any moneys advanced or refunded by the Assistor, the insured person assigns and subrogates the Assistor in all of his or her rights and recourses to any refund from which he or she benefits or claims to benefit according to any public or private plan of insured person services similar to those for which the advances or expenses have been incurred by the Assistor. The insured persons agree to sign any document and execute any deed required by the Assistor in order to give full and complete effect to the present assignment and subrogation and especially mandate the Assistor for this purpose as attorney and representative for submitting any claim and collecting any refund.

**f) Exclusions and reduction of coverage**

In addition to the exclusions and reduction of reduction 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:

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

- When the insured refuses without any valid medical reason to comply with the Assistor's recommendations with regard to repatriation or the choice of hospital or required care; by required care is meant the treatment needed to stabilize the insured's medical condition.
- If the insured fails to contact the Assistor in the event of a medical consultation or hospitalization following an accident or sudden illness.
- When expenses are incurred due to pregnancy, and any related complications, within eight weeks preceding the expected date of delivery.
- 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 inferior quality to that available outside the province does not constitute a danger to the insured's life or health.
- When expenses are incurred for insureds in hospitals for the chronically ill, services for the chronically ill in public hospitals, extended care homes or thermal resorts.
- For elective or non-urgent surgery or treatment, or if the trip was taken for the purpose of obtaining medical treatment or hospital services, whether or not the trip was taken on the recommendation of a physician.
- For an accident occurring during the insured's participation in a sport for remuneration, in any kind of motor vehicle's competition or any kind of speed contest, in flying a glider or deltaplane, mountain climbing, parachuting whether or not in free fall, bungee jumping or any other dangerous activity.
- If the insured has consumed toxic quantities of alcohol, drugs or medication.
- For repatriation or travel assistance services, when the loss occurs in a country that is at war, whether declared or undeclared, under a travel advisory or during a riot, an uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving an Act of God making any intervention by the Assistor physically impossible.

**g) Coordination**

This insurance is an insurance called "second payer". The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of the benefits paid under any public or private, individual or collective plan. It is understood that the rules of coordination of benefits of different insurance plans are in accordance with the guidelines of the Canadian Life and Health Insurance Association.

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

## TRIP CANCELLATION INSURANCE

If this coverage is retained in the **Schedule of Insurance**, the following benefits are granted to the insured.

The Insurer will pay, in accordance with the terms and conditions specified hereunder, the expenses incurred by the insured following the cancellation or interruption of a trip, insofar as the expenses incurred are related to prepaid travel expenses by the insured while this benefit is in force and, 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. Expenses are subject to a maximum reimbursement per insured indicated in the **Schedule of Insurance**.

### 1. Causes of cancellation or interruption

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

- An illness or accident preventing the insured, the insured's travel companion, a close relative of either, or a business partner of the insured from performing his or her usual activities, which is sufficiently serious to justify the cancellation or interruption of the trip.
- Death of the insured, the insured's spouse, the insured's child or spouse's child, or the insured's travel companion or business partner.
- Death of a close relative of the insured, other than the insured's spouse or child, or a close relative of the travel companion if the funeral is scheduled to take place during the trip or the preceding 14 days.
- Death or emergency hospitalization of the host at destination.
- The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the planned trip, provided the person involved is not a party to the litigation and has taken all necessary measures to have the hearing postponed.
- Quarantine of the insured or travel companion, except if quarantine ends seven days or more before the scheduled date of departure.
- Hijacking of the airplane on which the insured is travelling.
- Damage rendering the principal residence of the insured, of the travel companion or of the host at destination uninhabitable, provided the residence remains uninhabitable seven days or fewer prior to the scheduled date of departure, or the damage occurs during the time of the trip.
- Transfer of the insured or travel companion, by the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required within the 30 days preceding the scheduled date of departure.
- Terrorism or any other situation in the country to which the insured is travelling, provided the Government of Canada issues a warning that Canadians should not travel in that country during the time of the planned trip and that the warning was issued after travel expenses were incurred.
- Missed departure due to a delay in the means of transportation used to reach the point of departure, provided that the means of transportation used provides for scheduled arrival at the point of departure at least 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.

- 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 from making a scheduled connection with another carrier, provided the scheduled connection after departure is delayed for at least 30% (minimum 48 hours) of the planned duration of the trip.
- Damage occurring to a commercial establishment or location where a commercial activity is scheduled to be held, preventing the activity from taking place, provided that a written cancellation notice is issued by the organization officially responsible for the activity.
- Involuntary loss of the insured's or the insured's spouse's permanent employment provided the person in question has occupied a permanent position with the same employer for at least one year.

## 2. Expenses covered

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

- In the event of cancellation prior to departure:
  a) The non-refundable portion of prepaid travel expenses.
  b) Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the eligible reasons for cancellation provided hereunder and the insured decides to proceed with the trip as initially planned; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.
  c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to atmospheric conditions and the insured decides not to proceed with the trip.
- In the event of missed departure, at the beginning of or during the trip, due to one of the reasons provided hereunder, the additional cost charged by a scheduled public carrier for economy class travel, via the most direct route, to the initially planned trip destination.
- If the return is earlier or later than planned:
  a) The additional cost of a one-way economy class ticket, by the most direct route to the point of departure, by the means of transportation initially planned, or if the initially-planned means of transportation cannot be used, the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure; these expenses must be pre-approved by the Insurer.
  However, if the 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.
  b) The unused and non-refundable portion of the ground portion of prepaid travel expenses.

## 3. Exclusions applicable to Trip Cancellation Insurance

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

- Any trip taken for the purpose of obtaining medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.
- Any trip taken to visit a person who is ill or has suffered an accident, insofar as the cancellation or interruption of the trip is due to a change in the medical condition or the death of such person.
- War, whether declared or undeclared, or active participation in an insurrection, whether real or foreseeable.
- Active participation of the insured or travel companion in a criminal act or an act deemed to be criminal.
- Pregnancy, and any related complications, within eight weeks preceding the expected date of delivery.
- Suicide or attempted suicide by the insured or travel companion, or intentional self-inflicted injury or self-mutilation, whether or not the person is of sound mind.
- If the insured has consumed toxic quantities of alcohol, drugs or medication.
- Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity.
- A medical condition for which the insured or travel companion has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date on which travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the person in question was stable at the time expenses are incurred. Any change in medication, including use and dosage, is considered to be a medical treatment.
- Any loss related to a known condition of the insured or travel companion that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.

## 4. Deadline for cancelling

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

## 5. Coordination

This insurance is an insurance called "second payer". The Insurer reimburses eligible expenses, subject to the exclusions and reductions of this contract, in excess of the benefits paid under any public or private, individual or collective plan. It is understood that the rules of coordination of benefits of different insurance plans are in accordance with the guidelines of the Canadian Life and Health Insurance Association. Also excluded from coverage are any expenses incurred that an insured would not have had to pay if not covered under this benefit.

## 6. Trip Cancellation Insurance claims

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 the 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 to cancel, delay or interrupt the trip.
- An official police report, if the means of transportation used by the insured 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 was cancelled and the specific reasons why.
- Any other report required by the Insurer in support of the insured's claim.

## LA CAPITALE ANSWERS YOUR QUESTIONS

- **When and how can you contact La Capitale?**

  Call 1 800 463-4856 or 418 644-4200 Monday to Friday, from 8:30 a.m. to 5:00 p.m.

  Be sure to have your service card handy when you call. It shows your contract and identification numbers and having this information on hand helps us to serve you efficiently.

- **Moving?**

  Please contact us and tell us your new address as soon as possible. This is the best way to avoid any mailing delays.

- **Do you have dependent children between age 17 and 20*?**

  Remember that every semester you must provide us with confirmation of full-time student status by completing and returning the section at the bottom of your claim form. (*depending on the age specified in your contract.). Confirmation can be made by regular mail, by fax or through the mobile application.

- **Need a claim form?**

  Please visit our website at **https://www.lacapitale.com/en/individuals/insurances/group-insurance/forms** to download and print required form. All claim forms are available from your employer's group plan administrator or the group policyholder. Health insurance benefit claims can be sent by regular mail, by fax or through the mobile application.

- **Help us to help you**

  In all correspondence, please indicate your full name, contract number, employer number as well as the identification number shown on your service card.

- **Claiming expenses for services provided by healthcare professionals?**

  All healthcare professionals covered under this contract must stamp or seal the receipt. The professional's signature, association and licence number must also be provided, along with the dates of treatments and the name of the patient.

  The Insurer accepts personalized and computerized receipts from healthcare professionals, provided they contain the information specified above.

- **Have any questions about your reimbursement cheque?**

  If you've received a lower reimbursement amount than you expected, remember that at the beginning of the year, you may have a deductible to cover or coinsurance to pay. You can see the breakdown of your reimbursement on your cheque stub or deposit confirmation.

  Please be reminded that uncashed cheques expire after six months.

**NOTE:**

**NOTE:**

**NOTE:**

***CONTACT LA CAPITALE***

**Quebec City**
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P.O. Box 1500
Quebec QC  G1K 8X9
**418 644-4200**

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

**Toll free: 1 800 463-4856**
**Mobile application La Capitale**

**The Policyholder may at any time, upon agreement with the Insurer, make modifications to the insurance benefits with regard to the individuals eligible for insurance, the scope of coverage and the sharing of costs between classes of insureds. Any such modifications shall apply to all insureds, whether they are active, disabled or retired.**

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