GROUP INSURANCE CONTRACT

NO. **109995**

ENTERED INTO BY

LA CAPITALE CIVIL SERVICE INSURER INC.

(the Insurer)

AND

***L'ASSOCIATION DE PERSONNES RETRAITÉES DE LA FAE* (APRFAE)**

(the Policyholder)

In consideration of payment of the applicable premiums, the Insurer agrees to pay the insurance and benefit amounts in accordance with this contract.

Any modification made to the contract must be accepted by the Insurer and the Policyholder and signed by the authorized representatives of both parties.

Effective date of the insurance: This contract comes into force on March 1, 2019.

Renewal date: March 1, 2020. Renewals will take place on every subsequent January 1.

Time the insurance comes into effect, is changed or terminates: All insurance comes into effect, is changed or terminates at 12:01 a.m. in the insured's province of residence.

Beneva designates La Capitale Civil Service Insurer Inc. as insurer.

TABLE OF CONTENTS

DEFINITIONS

For the purposes of this contract, some of the terminology used in the description of the insurance terms and conditions and benefits, as well as that of the general provisions, is defined in this section. Additional definitions are also found in certain sections concerning the insurance benefits to which they specifically apply.

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

2. **Age**: The age of an insured, at his or her last birthday, at the time of calculation, or at the time an event provided for under the contract occurs.

3. **APRFAE**: *Association de personnes retraitées de la FAE*.

4. **Calendar year**: The period beginning January 1 of a given year and terminating on December 31 of the same year.

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

6. **Coinsurance**: The percentage of reimbursable expenses that the Insurer pays to the participant as healthcare benefits.

7. **Contract**: This contract, the application, the service card, any endorsements and any required evidence of insurability constitute the entire contract between the parties.

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

9. **Dentist**: A doctor of dentistry duly licensed to practice dentistry in the place where the services are provided.

10. **Dependent**: The participant's spouse or dependent child, as defined below.

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

    i) is married or civilly united to the participant or

    ii) has been cohabiting in a conjugal relationship with the participant for at least one year, or for less than one year if he or she is the father or mother of a child of the participant or

    iii) is cohabiting in a conjugal relationship with the participant and had previously cohabited with the participant for an entire period of at least one year.

Note that the status of spouse may be cancelled by any of the following events, as the case may be:

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

If the participant has a spouse meeting the definition under item i) above and another spouse meeting the definition under items ii) or iii) above, the Insurer will recognize as the spouse the person last designated by the participant as his or her spouse by written notice to the Insurer. The spouse must remain the same person for all benefits insured under the contract.

10.2 **Dependent child**: The term “dependent child” designates any of the following individuals:

i) A person under age 18 for whom the participant or spouse exercises parental authority.

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

Furthermore, a dependent child on sabbatical school leave may maintain the status of dependent child, provided that the participant meets the following requirements:

- A request must be submitted in writing to and approved by the Insurer before the start of the leave.
- The request must indicate the start date of the sabbatical leave.

Sabbatical leave may only be approved once per lifetime for each dependent child.

The sabbatical leave may not exceed 12 months, subject to eligibility for *Régie de l’assurance maladie du Québec* (RAMQ) coverage, and must end at the beginning of a school year or semester (September or January).

iii) A person who has reached the age of majority, who has no spouse and is living at the participant’s home, for whom the participant or spouse would exercise parental authority if a minor, and who is afflicted with a total disability or functional impairment, as defined in applicable legislation, that occurred while the person met any of the conditions indicated above, and has remained totally and continuously disabled since that date.

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

11. **FAE**: *Fédération autonome de l'enseignement*.

12. **Family coverage status**: Refers to the coverage status of a participant whose plan includes coverage for the spouse and dependent children or for the spouse only.

13. **Hospital centre**: A hospital centre within the meaning of A*n 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 centre by the appropriate authorities under which the institution operates, except for convalescent homes, thermal spas and other similar institutions.

14. **Hospitalization**: The act of occupying a room in a hospital centre 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.

15. **Illness**: An organic or functional alteration observed by a physician, including any complication resulting from pregnancy.

16. **Individual coverage status**: Refers to the coverage status of a participant whose plan provides coverage for the participant only, with no coverage for a spouse or dependent child.

17. **Insured**: A participant or a dependent covered under this contract.

18. **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, homes for the aged or chronically or mentally ill, rest homes and establishments that provide treatment for abuse of alcohol or drugs are not considered to be long-term care centres for the purposes of this contract.

19. **Participant**: A retiree who is eligible for insurance and is covered under this contract.

20. **Period of hospitalization**: Any continuous period of hospitalization in a hospital centre, or successive periods of hospitalization due to the same cause or to related causes, if separated by a period of fewer than 60 consecutive days during which the insured is not hospitalized.

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

22. **Previous contract**: The group insurance contract offered by the FAE, any other group insurance contract offering a health insurance benefit or the individual health insurance conversion product obtained following the end of a group insurance contract, under which retirees and any dependents were covered before the insurance under this contract took effect.

23. **Province**: Any province or territory of Canada.

24. **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 considered to be rehabilitation centres for the purposes of this contract.

25. **Resident**: The participant or dependent whose principal residence is located in Canada and who resides there a sufficient number of days during a calendar year to maintain eligibility for the public health insurance plan of the province of residence.

26. **Retiree**: A person who opted to retire while he or she was considered to be an employee under a group health insurance contract.

27. **Retirement date**: The date on which an employee begins retirement according to the pension plan in which the employee participates or the employer's existing labour agreement or the employer's usual practice.

28. **Single-Parent coverage status**: Refers to the coverage status of a participant without a spouse, as defined in this contract, and whose plan includes coverage for dependent children.

INSURANCE TERMS AND CONDITIONS

1. Participation

It is optional for retirees and any dependents to participate in the healthcare insurance benefit.

Retirees with one or more dependents may request Family or Single-Parent coverage status.

2. Eligibility Conditions

2.1 Retirees

Retirees are eligible for insurance benefits when they meet all of the following conditions:

a) The retiree must be a regular member of the APRFAE **and**

b) The retiree must be, or have been, insured under a group insurance contract offering a health insurance benefit or

c) The retiree must be insured under an individual health insurance conversion product obtained after ceasing to be eligible for a group insurance plan offering a health insurance benefit. However, it is understood that:

i) Insurance under this conversion product is still in force when the enrolment application for this contract is submitted **and**

ii) Insurance under this conversion product includes travel insurance for a minimum coverage period of 30 days.

d) The retiree must be a resident of Canada.

e) The retiree must be eligible for the public health insurance plan of the province of residence.

To maintain eligibility for insurance, the retiree must remain an APRFAE member.

2.2 Dependents

A retiree's dependents are eligible for insurance when they meet all of the following conditions:

a) The retiree must have met the eligibility conditions.

b) Dependents must meet the criteria set out in the definitions of spouse or dependent child, as applicable, under this contract.

c) Dependents must be a resident of Canada.

d) Dependents must be eligible for the public health insurance plan of their province of residence.

3. Enrolment

3.1 FAE-affiliated union members, FAE employees and FAE-affiliated union employees

On their retirement date, FAE-affiliated union members, FAE employees and FAE-affiliated union employees have a 90-day period, following the termination of their eligibility under the group insurance contract, in which to submit an enrolment application for this contract to the Insurer for themselves and any dependents.

Evidence of insurability is required if more than 90 days have elapsed between the termination of the person's eligibility under the group insurance contract and the date on which the Insurer receives the enrolment application for this contract.

3.2 Individual insurance contract participants

In accordance with the criteria stipulated in the section on eligibility conditions, individual insurance contract participants may submit an enrolment application for this contract to the Insurer at any time for themselves and any dependents.

However, evidence of insurability is required if more than 90 days have elapsed between the end of the person's participation in the individual insurance contract and the date on which the Insurer receives the enrolment application for this contract.

4. Effective date of the insurance

4.1 Retirees

Subject to receipt by the Insurer of the enrolment application within the required time frame, the retiree's coverage takes effect on the latest of the following dates:

a) The end date of the previous contract

b) The date on which the retiree meets the eligibility conditions

c) The date of the Insurer's acceptance of any required evidence of insurability.

However, for any retiree who participated in an individual insurance contract, an additional 30-day period, during which the person is a regular member of the APRFAE, applies following the above-mentioned effective date of insurance.

4.2 Dependents

Subject to receipt by the Insurer of the enrolment application within the required time frame, dependents' coverage takes effect on the latest of the following dates:

a) The same date as that of the participant, if they are already dependents

b) The date on which the dependents meet the eligibility conditions

c) The date of the Insurer's acceptance of any required evidence of insurability.

Under no circumstances can insurance for dependents take effect before that of the retiree.

5. Effective date of a coverage status change for inforce coverage if the family situation changes

The following changes to a family situation may give entitlement to a change in coverage status:

a) Birth or adoption of a child

b) Marriage, civil union or cohabitation, in accordance with the criteria set out in the definition of spouse under this contract

c) Divorce, marriage annulment, dissolution of the civil union or de facto separation, in accordance with the criteria set out in the definition of spouse under this contract

d) Termination of the dependent's eligibility, in accordance with the criteria set out in the definition of dependent under this contract.

To increase the coverage status, the participant must provide evidence of insurability. However, no evidence of insurability is required on the birth or the adoption of a child if the Insurer receives the change request within 90 days following the event.

Similarly, if the request for a change in coverage status is submitted in relation to a marriage, civil union or cohabitation, in accordance with the criteria set out in the definition of spouse under this contract, no evidence of insurability is required if the spouse is covered under a group insurance contract offering a health insurance benefit during the 90-day period preceding the request.

The participant may, moreover, decrease the coverage status at any time.

6. Provisions applicable to the modular healthcare insurance benefit

6.1 Options available under the modular plan

The following options are available under the modular plan:

a) Basic option
b) Intermediate option
c) Enhanced option.

6.2 Minimum participation period

A period that must elapse before the participant may select a different option.

The modular plan provides a minimum 36-month participation period for the intermediate and enhanced options. There is no minimum participation period required for the basic option.

6.3 Eligible option changes

Participants may only request an option offering a level of coverage immediately below or above their current option.

Participants may increase or decrease the option held, one level at a time, as follows:

- From the basic to the intermediate option
- From the intermediate to the basic or enhanced option
- From the enhanced to the intermediate option.

Any option change will trigger the start of a new minimum participation period.

6.4 Effective date of option changes

6.4.1 At the end of the minimum participation period

In the event the participant wishes to change options, the Insurer must receive a request to that effect specifying the choice of option within 90 days after the minimum participation period has ended. Insurance under the selected option takes effect as of the end date of the minimum participation period.

6.4.2 Due to a change in the family situation

Participants may change options before the end of the minimum participation period if one of the above-mentioned changes in the family situation occurs.

In such case, the Insurer must receive a request to that effect specifying the choice of option within 90 days following the date of the event. Insurance under the selected option takes effect as of the date of this change.

7. Termination of insurance

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

a) The date on which this contract terminates, subject to the provisions applicable to the conversion privilege on termination of eligibility

b) The date on which the participant or a dependent ceases to meet the eligibility conditions, subject to the provisions applicable to the conversion privilege on termination of eligibility

c) The date of the participant's death, subject to the provisions applicable to the conversion privilege for the spouse of a deceased participant

d) The due date of any premium that is not paid to the Insurer before expiry of the grace period provided for in this contract and after any required notice to such effect has been sent within the prescribed time frame

e) The last day of the month in which the Insurer receives written notice from a participant to terminate participation in this contract or the last day of the month of the date of termination indicated on such notice, whichever is later

f) The date on which a dependent ceases to be a dependent, subject to the provisions applicable to maintenance of the spouse's coverage in the event of separation or divorce

g) The last day of the month in which the Insurer receives written notice from a participant to terminate insurance for his or her dependents or the last day of the month of the date of termination indicated on such notice, whichever is later

h) The date on which the Insurer obtains evidence that the participant is attempting to fraudulently obtain, or is helping another person to fraudulently obtain, insurance or benefit amounts under this contract, regardless of any other recourse available to the Insurer.

Finally, a participant's decision to terminate their participation in this contract or to terminate the insurance coverage for their dependents is irrevocable, subject to the provisions relating to the conversion privilege for the spouse of a deceased participant or the provisions relating to the spouse's enrolment in insurance on divorce, annulment, dissolution of civil union or de facto separation. Such a person may not re-enroll in this contract thereafter.

8. Conversion privilege on termination of eligibility

An insured who is no longer eligible for coverage under this contract may obtain, without evidence of insurability, an individual health insurance, provided a written request is sent to the Insurer within 60 days following the date eligibility terminates. Evidence of insurability is required for applications submitted after this deadline.

The individual health insurance contract of insureds who exercise their conversion privilege within the required time frame takes effect on the date their eligibility under this contract terminates. If evidence of insurability is required, insurance becomes effective as of the date the Insurer approves such evidence.

Insureds who exercise their conversion privilege and enrol in an individual health insurance contract will not be able to subsequently re-enrol in this contract.

9. Conversion privilege for the spouse of a deceased participant

In the event of the death of a participant who had family coverage under this contract, the surviving spouse can exercise the conversion privilege to apply for insurance as a participant. The spouse must choose Individual or Single-Parent coverage.

To apply, the spouse must submit an application form to the Insurer within 90 days following the date of the participant's death. However, the spouse's participation in this contract is subject to his or her participation in the APRFAE as a member.

Similarly, maintenance of insurance is also subject to payment of the applicable premiums.

If the application form is not sent to the Insurer within the required time frame, the spouse's coverage is considered to have terminated on the date of the participant's death.

10. Spouse’s enrolment in insurance on divorce, annulment, dissolution of civil union or de facto separation

In the event of the divorce, annulment, dissolution of civil union or de facto separation of a participant who holds Family coverage status, the spouse may apply for insurance as a participant. The spouse must choose Individual or Single-Parent coverage.

To apply, the spouse must submit an application form to the Insurer within 90 days following the date of the event. However, the spouse’s participation in this contract is subject to his or her participation in the APRFAE as a member.

Similarly, maintenance of insurance is also subject to payment of the applicable premiums.

If the application form is not sent to the Insurer within the required time frame, the spouse's coverage is considered to have terminated on the date of the event.

11. Transfer provisions

The Insurer guarantees continuity between this contract and the previous contract for participants and their dependents who were covered under the previous contract.

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

HEALTHCARE INSURANCE BENEFIT

1. Purpose of the coverage

The eligible expenses described below are those reasonably incurred in the insured's province of residence and justified by the seriousness of the case, as well as by current medical practice and the customary and reasonable charges in force in the area where the products, services and supplies are obtained.

In addition, the expenses incurred for the products, services and supplies are covered, provided they are medically required, prescribed by a legally authorized healthcare professional and necessary for the treatment of the insured.

2. Reimbursement policy

The eligible expenses for products, services and supplies are covered according to the terms and conditions indicated in the ***Schedule of Insurance***, based on the option selected by the participant.

3. Schedule of insurance

ALL THE MAXIMUMS SPECIFIED IN THIS TABLE ARE MAXIMUM REIMBURSEMENT AMOUNTS PER INSURED

BENEFITS	BASIC OPTION	INTERMEDIATE OPTION	ENHANCED OPTION
TRAVEL, TRIP CANCELLATION AND HOSPITALIZATION INSURANCE EXPENSES			
Deductible	None	None	None
Coinsurance	100%	100%	100%
Travel insurance	$5,000,000/trip Maximum coverage period: 60 days	$5,000,000/trip Maximum coverage period: 90 days	$5,000,000/trip Maximum coverage period: Insured under age 80: 180 days Insured age 80 or over: 90 days
Trip cancellation insurance	$10,000/trip	$10,000/trip	$10,000/trip
Hospitalization	Semi-private room	Semi-private room	Semi-private room

BENEFITS	BASIC OPTION	INTERMEDIATE OPTION	ENHANCED OPTION
Residential and long-term care centre	Semi-private room, 180 days/calendar year	Semi-private room, 180 days/calendar year	Semi-private room, 180 days/calendar year
Rehabilitation centre	Semi-private room, 180 days/calendar year	Semi-private room, 180 days/calendar year	Semi-private room, 180 days/calendar year
OTHER ELIGIBLE EXPENSES			
Deductible	None	None	None
Coinsurance	70%	75%	80%
Prescription drugs			
Eligible prescription drugs	Prescription drugs not eligible under the prescription drug insurance plan of the province of residence		
Substitution	Mandatory generic substitution		
Maximum	$15,000/ calendar year	$20,000/calendar year	$25,000/calendar year
Preventive vaccines	$100/calendar year	$150/calendar year	$200/calendar year
Sclerosing injections	N/A	$20/session	$30/session
Automated payment service	Direct	Direct	Direct
Medical services			
Ambulance	Covered	Covered	Covered
Dentist following accident	$5,000/accident	$5,000/accident	$5,000/accident
Detoxification, including clinic for gambling addiction	N/A	N/A	$80/day, maximum of 30 days/calendar year
Home care and assistance	N/A	N/A	$500/calendar year
Nursing care	$3,000/calendar year	$5,000/calendar year	$5,000/calendar year

BENEFITS	BASIC OPTION	INTERMEDIATE OPTION	ENHANCED OPTION
Travel and accommodation expenses for treatment outside the area of residence	Travel of 200 km or more from area of residence	Travel of 200 km or more from area of residence	Travel of 200 km or more from area of residence
- Accommodation	$80/day	$80/day	$125/day
- Maximum reimbursement	$1,000/calendar year	$1,000/calendar year	$1,000/calendar year
Diagnostic services			
Computerized axial tomography (CAT scan)	N/A	$200/calendar year	$200/calendar year
Diagnostic and laboratory tests	$500/calendar year	$750/calendar year	$1,000/ calendar year
Magnetic resonance imaging (MRI)	$500/calendar year	$750/calendar year	$1,000/ calendar year
Polysomnography	$500/calendar year	$500/calendar year	$500/calendar year
Ultrasound examination	$80/calendar year	$80/calendar year	$80/calendar year
X-rays	Covered	Covered	Covered
Miscellaneous services			
Gender affirmation surgery	$10,000/ calendar year $20,000 lifetime	$10,000/ calendar year $20,000 lifetime	$10,000/ calendar year $20,000 lifetime
Other medical expenses			
Artificial limb or eye, supports, corsets, trusses, crutches or other orthopedic equipment	Covered	Covered	Covered
Compression stockings	3 pairs/period of 12 consecutive months	4 pairs/period of 12 consecutive months	6 pairs/period of 12 consecutive months

BENEFITS	BASIC OPTION	INTERMEDIATE OPTION	ENHANCED OPTION
Custom-made foot orthoses and orthopedic shoes	$250/calendar year for all of these expenses	$350/calendar year for all of these expenses	$500/calendar year for all of these expenses
Devices for diabetics (blood glucose monitor, dextrometer)	N/A	$200/period of 36 consecutive months	$250/period of 36 consecutive months
External breast prosthesis	N/A	$150/calendar year	$250/calendar year
Hearing aid	$250/period of 24 consecutive months	$500/period of 24 consecutive months	$1,000/period of 24 consecutive months
Insulin pump	N/A	$3,000/period of 36 consecutive months	$6,000/period of 60 consecutive months
IUDs	N/A	$75/period of 24 consecutive months	$75/period of 24 consecutive months
Other therapeutic devices	Covered	Covered	Covered
Post-surgical bra	N/A	1 bra/calendar year	2 bras/calendar year
Respirator and oxygen	Covered	Covered	Covered
Transcutaneous electrical nerve stimulation (TENS)	N/A	$750/period of 60 consecutive months	$1,000/period of 60 consecutive months
Wheelchair, hospital bed	Covered	Covered	Covered
Wig (capillary prosthesis)	$100 lifetime	$300 lifetime	$300 lifetime

BENEFITS	BASIC OPTION	INTERMEDIATE OPTION	ENHANCED OPTION
Healthcare professionals			
Acupuncturist	N/A	$50/visit, $600/calendar year	$50/visit, $700/calendar year
Audiologist Occupational therapist Naturopath Speech-language pathologist Osteopath Podiatrist	N/A	$70/visit, $600/calendar year for all of these professionals	$70/visit, $700/calendar year for all of these professionals
Chiropractor Chiropractor X-rays	N/A N/A	$50/visit, $600/calendar year $50/calendar year	$50/visit, $700/calendar year $50/calendar year
Dietitian	N/A	$60/visit, $600/calendar year	$60/visit, $700/calendar year
Homeopath Kinesitherapist Massage therapist Orthotherapist	N/A	N/A	$50/visit, $700/calendar year for all of these professionals
Physiotherapist, physical rehabilitation therapist and sports therapist	N/A	$60/visit, $600/calendar year	$60/visit, $700/calendar year
Psychologist, psychiatrist, psychoanalyst in an outpatient clinic and psychotherapist	N/A	$90/visit, $600/calendar year for all of these professionals	$90/visit, $700/calendar year for all of these professionals

4. Travel, trip cancellation and hospitalization insurance expenses

4.1 Travel insurance

A description of eligible expenses under this coverage is provided in the following section of this contract.

4.2 Trip cancellation insurance

A description of eligible expenses under this coverage is provided in the section following that of travel insurance.

4.3 Hospitalization

Hospitalization expenses incurred in Canada in excess of the expenses payable under any government insurance plan of the insured's province of residence, without any limit as to the number of days, provided that the hospitalization begins while insurance is in force.

4.4 Residential and long-term care centre

Expenses for occupying a room in a **residential and long-term care centre** recognized by an appropriate government agency or in a hospital centre if the insured is receiving long-term care, in excess of the expenses payable under any government insurance plan of the insured's province of residence, provided that occupancy begins while insurance is in force. However, expenses for assistance with activities of daily living are excluded.

4.5 Rehabilitation centre

Expenses for occupying a room, including meals, for at least 12 consecutive hours, in a **rehabilitation centre** recognized by an appropriate government agency, in excess of the expenses payable under any government insurance plan of the insured's province of residence, provided the insured is admitted to such centre less than 14 days following the end of hospitalization and that hospitalization begins while insurance is in force.

5. Other eligible expenses

5.1 Prescription drugs

The Insurer reimburses prescription drugs and pharmaceutical services prescribed by a healthcare professional that are not eligible under the prescription drug insurance plan of the province of residence and meet all the following conditions:

a) They must bear a valid Drug Identification Number (DIN) issued by Health Canada and be available in the insured's province of residence.

b) They must be obtained from a pharmacy only and dispensed by a legally authorized healthcare professional.

c) They must be prescribed in accordance with the manufacturer's directions for use, or in the absence of such directions, with the directions for use approved by the competent authorities in the insured's province of residence.

Limits may apply to certain prescription drugs, when permitted by law. These limits are indicated in the **Schedule of Insurance**.

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

5.1.1 Mandatory generic substitution

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 be reimbursed based on the cost of the brand name drug or another generic must obtain the appropriate form from the Insurer and have it completed by their healthcare professional, specifying the medical contraindications associated with the least costly generic. The insured must then submit this form to the Insurer for analysis. Prescription drug refills for the drug that has been accepted by the Insurer will then be approved through the Insurer's electronic transmission system. The medical form need not be completed again.

Generic drugs: Generic drugs are copies of patented drugs whose market exclusivity is no longer protected by the patent.

5.1.2 Expenses for **preventive vaccines** (substance only) administered by a physician or nurse to prevent or treat an illness.

5.1.3 Expenses for the substance used in **sclerosing injections** that are medically required and administered by a physician are also covered.

5.1.4 Automated payment service

The automated payment service allows insureds to use their service card for prescription drug purchases, based on the payment method indicated in the **Schedule of insurance**.

5.1.5 Exclusions and reduction – Prescription drug expenses

The following prescription drug, product and treatment expenses are excluded from this coverage and no reimbursement is made by the Insurer:

a) Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment

b) Dietetic substances or foods, anti-obesity and weight control products

c) Homeopathic medicines, vitamins or natural products

d) Drugs administered primarily for preventive purposes, except for preventive vaccines. 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

e) Products used to treat hair loss or wrinkles or any other treatment administered primarily for aesthetic purposes

f) Smoking cessation products with the exception of those covered under the public drug insurance plan of the insured's province of residence

g) Drugs or substances used for the treatment of infertility or erectile dysfunction with the exception of those covered under the government drug insurance plan of the insured's province of residence

h) Any substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams

i) Drugs provided during a period of hospitalization

j) Any treatments or drugs of an experimental nature

k) Items related to the use of injectable drugs, such as rubbing alcohol, cotton swabs, automatic jet injectors or other similar equipment

l) Drugs for which reimbursement is denied under recognized guidelines of the government prescription drug insurance plan of the insured's province of residence.

Furthermore, the Insurer may deny reimbursement of any drugs prescribed for a condition other than those listed in the manufacturer’s directions for use or not prescribed in accordance with current medical practice. The Insurer may, among other things, require a medical diagnosis and limit reimbursement to a reasonable maximum.

In the event that Health Canada approves a new drug that may substantially affect the cost of coverage under this benefit, the Insurer reserves the right to exclude such drug from coverage in compliance with any legislative provisions of the insured’s province of residence or modify the applicable premium as of the drug's date of approval.

5.2 Medical services

5.2.1 Ambulance

Emergency transportation by ground ambulance to the nearest hospital centre where the insured can receive the care required to treat his or her condition.

In cases where no other form of transportation is possible, expenses for emergency transportation by air ambulance are also eligible.

5.2.2 Dentist following accident

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. Treatment must be provided within 12 months following the date of the accident.

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.

5.2.3 Detoxification, including clinic for gambling addiction

Expenses incurred for a stay in a recognized private clinic specialized in rehabilitation treatment of alcoholism or drug addiction excluding tobacco use.

Expenses for a stay in a clinic specialized in rehabilitation treatment for gambling addiction are also eligible for reimbursement.

5.2.4 Home care and assistance

Expenses for the care and assistance described below, when recommended by a physician and deemed necessary following hospitalization or day surgery, are eligible for reimbursement, provided the expenses are incurred 30 days following the insured’s hospitalization or discharge from a day surgery unit and the services cannot be provided by a person who resides in the insured’s home or is a close relative.

a) Fees for home assistance services, invoiced by a home care service provider, for purposes of washing, feeding, dressing and looking after the insured's basic hygiene needs.

b) Expenses incurred for a staying in a facility specialized in post-hospitalization care.

c) Basic expenses for general home maintenance services (meal preparation, housekeeping, laundry and dishwashing, lawn mowing and snow removal).

d) Expenses for childcare services provided for minor children.

e) Public transportation expenses incurred to attend medical appointments at a physician's office or hospital, including transportation expenses for a person accompanying the insured, if necessary.

5.2.5 Nursing care

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

5.2.6 Travel and accommodation expenses for treatment outside the insured's area of residence

Expenses for transportation and accommodation incurred to obtain the services of a medical specialist not available in the insured's area of residence.

Expenses for travel by automobile or with a public carrier (bus, airplane, boat, train) and expenses for accommodation incurred in a commercial establishment, provided the consultation or treatment requires an overnight stay.

However, the following conditions apply:

- Eligible expenses must be incurred on medical prescription for a consultation with a medical specialist not available in the insured's area of residence. Also eligible are expenses incurred for treatment provided by a specialist that is not available in the insured's area of residence.
- Eligible expenses must be incurred for travel, based on the minimum distance (in km) indicated in the **Schedule of insurance**, from the insured's place of residence to the location of the consultation (one way only), which is the nearest possible location available to the insured's place of residence.
- When travelling by automobile, eligible expenses are equal to those that would have been incurred had the trip been made by bus.
- Eligible expenses are reimbursed on production of receipts or paid invoices, except if the means of transport used is an automobile.
- Eligible expenses include expenses incurred by an insured as well as a person accompanying the insured, if justified by the situation.

5.3 Diagnostic services

5.3.1 Computerized axial tomography (CAT scan)

Expenses for computerized axial tomography (CAT scan) performed outside a hospital centre for purposes of prevention or diagnosis.

5.3.2 Diagnostic and laboratory tests

Expenses for diagnostic and laboratory tests performed outside a hospital centre for purposes of prevention or diagnosis.

5.3.3 Magnetic resonance imaging (MRI)

Expenses for magnetic resonance imaging (MRI) performed outside a hospital centre for diagnostic purposes.

5.3.4 Polysomnography

Expenses for polysomnographies performed outside a hospital centre for purposes of prevention or diagnosis.

5.3.5 Ultrasound examination

Expenses for ultrasound examinations (other than fetal) performed outside a hospital centre.

5.3.6 X-rays

Expenses for X-rays performed outside a hospital centre for purposes of prevention or diagnosis.

5.4 Miscellaneous services

5.4.1 Gender affirmation surgery

The Insurer reimburses expenses incurred by the insured while undergoing gender affirming surgery performed by a physician to modify the insured's sexual characteristics so that they can correspond to those associated with their self-identified gender. Expenses for hair removal through electrolysis or laser treatment are also eligible.

Expenses are eligible if all the following conditions are met:

i) the insured must have received a gender dysphoria diagnosis from a physician;

ii) the surgery of hair removal must be performed in Canada;

iii) the surgery or hair removal must not be covered under the public health insurance plan of the insured's province of residence.

5.5 Other medical expenses

5.5.1 Artificial limb or eye, supports, corsets, trusses, crutches or other orthopedic equipment

Purchase or rental expenses, depending on the circumstances.

5.5.2 Compression stockings

Purchase expenses.

5.5.3 Custom-made foot orthoses and orthopedic shoes

Expenses for the purchase of corrective elements added to ordinary shoes, made by a specialized orthopedic laboratory; the initial or replacement cost of orthopedic shoes that are custom-made for the insured by a specialized orthopedic laboratory.

The specialized orthopedic laboratory must be licensed and authorized under all applicable legislation in the insured's province of residence.

5.5.4 Devices for diabetics (blood glucose monitor, dextrometer)

Expenses for the purchase of an appliance used to manage diabetes (glucometer, 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.

5.5.5 External breast prosthesis

Expenses for the purchase of an external breast prosthesis following a mastectomy, in excess of the amount paid under any government insurance plan of the insured’s province of residence.

5.5.6 Hearing aids

Purchase or repair expenses.

5.5.7 Insulin pump

Rental or purchase expenses. Expenses for continuous glucose monitoring systems are also eligible.

5.5.8 IUDs

Purchase expenses.

5.5.9 Other therapeutic devices

Expenses for the rental or purchase of a therapeutic device, if this option is deemed more economical. This benefit also covers expenses for adjustment, replacement and repair.

The following equipment or supplies are also considered to be therapeutic devices:

a) Aerosol therapy devices, namely devices required for treating, among other conditions, acute emphysema, chronic bronchitis and chronic asthma (e.g.: nebulizer or compressor)

b) Fracture consolidation stimulators (e.g.: bone stimulator)

c) Respiratory monitors in cases of respiratory arrhythmia (e.g.: apnea monitor)

d) Intermittent positive pressure respirators (e.g.: volumetric ventilator)

e) Burn treatment garments

f) Purchase of adult diapers for incontinence, probes, catheters and other similar hygienic items required following a total and irrecoverable loss of bladder or bowel function.

This benefit does not cover measuring devices such as stethoscopes, thermometers, etc.; nor does it cover domestic devices such as whirlpool baths, air purifiers, humidifiers and air conditioners or other devices of a similar nature.

5.5.10 **Post-surgical bra**

The purchase of a post-surgical bra required following a mastectomy that can only be obtained from a specialized laboratory.

5.5.11 **Respirator and oxygen**

Expenses for the rental or purchase of a respirator and oxygen, if this option is deemed more economical.

5.5.12 **Transcutaneous electrical nerve stimulation (TENS)**

Purchase, adjustment, replacement or repair expenses.

5.5.13 **Wheelchair, hospital bed**

Expenses for the rental or purchase of a basic wheelchair or hospital bed, if this option is deemed more economical by the Insurer.

5.5.14 **Wig (capillary prosthesis)**

Expenses for the purchase of a capillary prosthesis (wig) required following chemotherapy treatments.

5.6 Healthcare professionals

A healthcare professional who provides services must be authorized to do so under government legislation and must be a member in good standing of a professional order recognized by appropriate legislative authorities. Moreover, a single treatment or consultation per day, per insured, is eligible for benefits.

5.6.1 **Acupuncturist**

5.6.2 **Audiologist, naturopath, occupational therapist, osteopath, podiatrist and speech-language pathologist**

5.6.3 **Chiropractor** and **chiropractor X-rays**

5.6.4 **Dietitian**

5.6.5 **Homeopath, kinesitherapist, massage therapist** and **orthotherapist**

5.6.6 **Physiotherapist**, **physical rehabilitation therapist** and **sports therapist**

5.6.7 **Psychologist, psychiatrist**, **psychoanalyst in an outpatient clinic** and **psychotherapist**

The maximum for these professional fees will also apply in the case of marital therapy for both spouses. The only psychiatric services considered eligible for reimbursement are those rendered as psychoanalytic treatments, insofar as these professionals are members of the Canadian Psychoanalytic Society.

6. Exclusions and reduction of coverage

Any expenses incurred for the following products and services are excluded from coverage under this benefit and no reimbursement is made by the Insurer for any expenses incurred due to any of the following:

6.1 Dental prostheses, except if required following an accident.

6.2 Eyeglasses or contact lenses, except if required following an accident.

6.3 Laser eye surgery.

6.4 Injections provided as part of a weight loss program.

6.5 Surgery, treatments or prostheses provided for aesthetic purposes, except following an accident.

6.6 Treatment provided for aesthetic purposes.

6.7 Protective glasses or sunglasses.

6.8 Care or treatment provided free of charge.

6.9 Eye examination.

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

6.11 Treatment or services provided by a family member or close relative of the insured or by a person who resides with the insured.

6.12 Periodic medical examinations or medical examinations for the purposes of employment, admission to an educational institution, insurance or health trips.

6.13 Any condition occurring while the insured is on active duty with the armed forces of any country.

6.14 A condition occurring due to the insured's participation in a criminal act or an act deemed to be criminal, including operating a motor vehicle with a blood alcohol level in excess of the prescribed legal limit.

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

6.16 In the event of hospitalization for extended care, expenses for a stay in a reception centre or any other establishment, including hospital centres providing the same type of service (accommodation).

6.17 Expenses for products, 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 government insurance plan, or that the insured would not have had to pay if not covered under this benefit.

6.18 Expenses payable under any other individual or group plan and expenses for which the insured is entitled to an indemnity under any Canadian or foreign law.

6.19 Any product, care, services or supplies of an experimental nature.

6.20 Any product, care, services or supplies that are not medically required.

HEALTHCARE INSURANCE BENEFIT – TRAVEL INSURANCE

Telephone numbers for the Assistor:

In Canada and the United States: 1 800 363-9050

Elsewhere in the world (collect call): 514 985-2281

The Assistor can be reached 24/7.

IMPORTANT GUIDELINES

Before incurring any expenses for services, care, treatment or supplies following an emergency situation, the insured must first contact the Assistor to obtain its authorization for any expenses the insured is planning to incur. The insured must comply at all times with the Assistor's recommendations.

However, if an emergency situation prevents the insured from contacting the Assistor before incurring expenses, the Assistor must be contacted by the insured, or by another person on the insured's behalf, as soon as it is possible to do so to allow the Assistor to rapidly make arrangements with the supplier.

PRE-EXISTING HEALTH CONDITION

A pre-existing health condition may affect the insured's eligibility for travel insurance. An insured having such a condition must ensure before departure that this pre-existing health condition does not affect eligibility. Travel insurance eligibility conditions are set out in this section.

If in doubt, the insured must contact the Assistor, who can provide information on the insured's eligibility.

1. Definitions

In addition to the definitions in the Definitions section, the following apply specifically to travel insurance, where appropriate.

a) **High-risk activity**: A highly dangerous activity that involves speed, height, significant physical effort, highly specialized equipment or dramatic stunts. Activities such as off-trail skiing or snowboarding, ski jumping, parachute jumping, hang gliding, any gliding contests, bungee jumping, scuba diving, whitewater rafting, luge, skeleton, alpine climbing, rock climbing, kite surfing or participating in a rodeo are considered high-risk activities.

Notwithstanding the above, the following activities are not considered high-risk activities:

i) Scuba diving at depths not exceeding 30 metres, if the diver is appropriately certified

ii) Whitewater rafting, if practised in rapids graded 1 to 4 for rafts and 1 to 3 for canoes and kayaks

b) **Assistor**: The travel assistance service provider designated by the Insurer. The Insurer reserves the right to modify the travel assistance services available or replace the Assistor without notice.

c) **Travel companion**: The person who plans the trip with the insured, accompanies the insured on the trip and with whom the insured shares accommodation and transportation expenses.

d) **Diagnosis**: The identification by a physician of the nature and cause of an insured's medical condition.

e) **Emergency situation**: A situation in which the insured requires immediate attention or treatment as a result of an accident, a sudden and unexpected illness or a deterioration of the insured's medical condition after the trip departure date. The immediate attention or treatment must prevent or minimize a threat to the insured's life or health.

An emergency situation ceases to exist when no further attention or treatment is required during the insured's trip or can be provided, if required, when the insured has been transported to the province of residence in accordance with the provisions of this contract.

f) **Stable**: A medical condition, other than a minor condition, is considered stable if, in the 90 days preceding the insured's scheduled trip departure date, all of the following requirements are met:

i) There has been no new diagnosis.

ii) The insured has not been prescribed any new treatment.

iii) There have been no changes in the type, number and frequency of treatments or termination of treatment.

iv) There have been no changes in the type, dosage and frequency of medication, and no recommendations to begin new medication have been received.

v) The insured has not experienced any new symptoms or been hospitalized, and no tests have demonstrated a deterioration of the state of health.

vi) No medical treatment or consultation has been scheduled, recommended or planned by a physician.

vii) The insured is not waiting to undergo medical tests or receive the results of such tests.

However, the previously mentioned 90-day period is not applicable if it is proven to the satisfaction of the Assistor that the insured's medical condition was considered stable at the time of departure.

g) **Treatment**: A medical care protocol that is prescribed, performed or recommended by a physician for a medical condition, such as prescribing medication, performing investigative tests and surgeries.

h) **Public carrier**: Any carrier approved by competent authorities and operated under a transport permit for the transportation (air, sea or land) of passengers for remuneration.

i) **Trip**: Travel for the purposes of tourism, leisure, business or participating in a commercial activity requiring the insured's absence from the province of residence. For the purposes of this definition, it is understood that a trip begins on the insured's departure date and ends on the date the insured returns to the province of residence.

2. Purpose of the insurance

Through the Assistor, the Insurer reimburses expenses for services, care, treatment and supplies that must be incurred in an emergency situation if the insured sustains an accident, comes down with a sudden and unexpected illness or dies while travelling.

The Assistor provides insureds with travel assistance services upon request at any time and anywhere in the world.

Eligible expenses and travel assistance services are described in the sections below. Eligible expenses are reimbursed according to the terms and conditions indicated in the **Schedule of insurance**.

The insured is covered as of the trip departure date until the earlier of the following events:

a) The insured's return to the province of residence

b) The expiry of the maximum coverage period set out in the **Schedule of insurance**.

The above-mentioned maximum coverage period may be extended if an emergency situation continues to exist while the insured is receiving medical care. In this case, the coverage period continues for the duration of the insured's hospitalization and up to 24 hours after discharge from the hospital.

3. Insureds' eligibility conditions

Insureds who have a medical condition must ensure before trip departure that:

a) Their state of health is stable.

b) They are able to carry out the usual activities of daily living.

c) No medical consultations for their medical condition are needed during the period of the trip.

d) They are not travelling contrary to a physician's or the Assistor's recommendation against travel.

e) They have not been diagnosed with a terminal illness.

Insureds with a medical condition who are uncertain about their state of health, or who are awaiting diagnosis, must contact the Assistor as soon as possible before departure to obtain confirmation of eligibility for coverage under this insurance.

4. Eligible expenses

All eligible expenses described in this section must be authorized in advance by the Assistor. The insured must contact the Assistor before incurring any expenses or taking any initiatives.

4.1 Hospitalization and emergency medical care expenses

a) **Hospital**

Expenses for hospitalization in a semi-private room. If deemed medically necessary, expenses for care received in an intensive care or coronary care unit are also covered.

b) **Physician's fees**

Professional fees of a physician for medical, surgical or anesthetic care, excluding fees for dental care.

c) **Medical and orthopedic equipment**

Expenses for the purchase or rental of crutches, canes or splints; expenses for the rental of wheelchairs, orthopedic equipment or other medical equipment, when prescribed by the attending physician.

d) **Laboratory tests and diagnostic services**

Expenses for laboratory tests and diagnostic services, when prescribed by the attending physician.

e) **Incidental expenses**

Expenses related to the insured's hospitalization, such as telephone, television rental and parking costs. Reimbursement is limited to $100 per period of hospitalization, per insured, upon presentation of supporting documents.

f) **Nursing care**

Professional fees of a registered nurse for private care received in a hospital, when medically required and prescribed by the attending physician. The nurse must be a member in good standing of a professional association recognized by the competent authorities in the place where care is provided. Reimbursement is limited to $3,000 per trip, per insured.

g) **Prescription drugs**

Expenses for prescription drugs for treatment in an emergency situation, when prescribed by the attending physician. Over-the-counter drugs are not eligible.

h) **Dental care following an accident**

Professional fees of a dentist for treatment made necessary by an accident causing a fractured jaw or damage to healthy, natural teeth.

A tooth is considered to be healthy in the absence of pathological impairment, whether in the tooth itself or in adjacent structures. Furthermore, the tooth must not require additional restoration to remain intact or in place.

Care must begin while the insured is travelling and be completed within six months following the date of the accident. Reimbursement is limited to $1,000 per accident, per insured.

4.2 Transportation and living expenses and those related to the insured's death

Reimbursement of the transportation expenses described below is limited to rates charged by the most economical public carrier via the most direct route.

a) **Ambulance service**

Transportation expenses by air or surface ambulance for taking the insured to the nearest appropriate hospital. Expenses for transfers between hospitals are also covered when the attending physician and the Assistor deem that the establishment where the insured is hospitalized cannot adequately treat or stabilize the insured's condition.

b) **Transporting the insured home**

i) Expenses for transporting the insured home to receive emergency care or to a hospital for immediate hospitalization.

ii) Expenses for the insured's return to the province of residence when the means of transport initially planned for the return are not suitable due to the insured's state of health.

Transporting the insured home must be done by the carrier deemed the most appropriate by the Assistor. The insured's return to the province of residence must take place as soon as the insured's state of health so allows. A medical escort designated by the Assistor may accompany the insured when being transported home, if required due to the insured's state of health.

c) **Transporting dependents or the travel companion home**

If the insured is transported home or to a hospital, expenses for the purchase of a public carrier ticket to transport the insured's dependents or travel companion, as applicable, to their province of residence, if the means of transport initially planned cannot be used.

d) **Transportation of close relatives**

i) Round-trip transportation expenses for a close relative of the insured from the residence to the hospital where the insured is hospitalized. The insured must be hospitalized for at least seven consecutive days before these expenses become eligible. Furthermore, the necessity of the close relative's visit must be confirmed by the insured's attending physician. Reimbursement is limited to $1,500 per trip.

ii) Transportation expenses for transporting dependent children under age 18 to their province of residence if the insured or another adult on the trip is unable to supervise them due to an emergency situation.

iii) Round-trip transportation expenses for a close relative of the insured to identify the remains of an insured who dies during travel. Reimbursement is limited to $1,500 per trip.

e) **Accommodation and meals**

Accommodation and meal expenses incurred in a commercial establishment when an insured, a close relative accompanying the insured, or the insured's travel companion must postpone the return trip due to an accident or an illness. Reimbursement is limited to $200 per day, up to a maximum of eight days, per trip.

f) **Vehicle return**

Expenses incurred for a commercial agency to return the insured's vehicle to the residence, or to return a rental vehicle to the rental agency nearest to where the insured is staying. Expenses are eligible only if an accident or illness prevents the insured from driving the vehicle. Incapacity must be confirmed by the attending physician. The travel companion must also be unable to drive the vehicle. Reimbursement is limited to $2,000 per trip.

g) **Preparation and return of the insured's remains**

Expenses incurred for preparing and returning the insured's remains to the place of burial or cremation in the province of residence. Expenses incurred for the purchase of a coffin or urn are not covered. Reimbursement is limited to $5,000.

h) **Burial or cremation where the insured was staying**

Expenses incurred for the insured's burial or cremation where the insured was staying during the trip. Reimbursement is limited to $3,000.

5. Travel assistance services

a) **Assistance before the insured's departure**

The Assistor provides a telephone consultation service prior to the insured's trip departure date with information and useful advice from nurses and assistance coordinators. This information and advice may concern:

i) Vaccination requirements

ii) Sanitary precautions regarding water, food and the trip destination

iii) Recommended precautions for the insured's state of health

iv) Items to include in a first aid kit

v) Telephone numbers and country codes

vi) Exchange rates and foreign currency

vii) Passports, visas and other required documents

viii) Time zones and weather conditions

ix) Federal government travel advisories.

b) **Assistance during the insured's trip**

The Assistor provides the insured with medical and non-medical assistance during the trip.

Medical assistance:

i) Referral to physicians or hospitals

ii) Assistance in admission to a hospital

iii) Coordination of transportation for emergency care

iv) Follow-up of medical files by the Assistor's physicians and nurses

v) Organization of the transportation of a close relative if the insured is hospitalized

vi) Sending of medical aid and medications if the insured is too far from a hospital to be transported there

vii) Transporting the insured home or to a hospital as soon as the insured's state of health so allows

viii) Transporting dependents or the travel companion home

ix) Return of the insured's vehicle home or to the rental agency, as applicable

x) Assistance in the event of death (including attending to the official procedures with the appropriate authorities and returning the remains home).

Non-medical assistance:

i) Assistance in obtaining advances or increasing credit card limits

ii) Assistance in replacing tickets, passports, identity or official documents, in the event of loss or theft, required to continue the trip

iii) Assistance in the event of legal issues

iv) Sending of messages to close relatives in the event of emergency situations

v) Assistance in the event of language barriers

vi) Assistance in obtaining medical prescriptions in the region where the insured is staying

vii) Referral to competent authorities, legal resources, the embassy or consulate in the country where the insured is staying, in the event of difficulties.

6. Exclusions and reductions of coverage

The exclusions and reductions applicable to the healthcare insurance benefit also apply to travel insurance. In addition, insureds are not entitled to any reimbursement or service from the Assistor in the following circumstances:

a) The failure of the insured to follow the instructions set out in the box at the beginning of the travel insurance section.

b) Pregnancy, terminated pregnancy or miscarriage and any related complications, within eight weeks preceding the expected date of delivery.

c) Any services, care, treatment or supplies that the insured receives outside the province of residence when it would have been possible to obtain them in the province of residence with no threat to life or health.

d) Any services, care, treatment or supplies that are not medically required.

e) Any services, care, treatment or supplies that are not provided during an emergency situation including, but not limited to, those provided during aesthetic surgery, elective surgery, treatment for chronic illness, rehabilitation or convalescence and any consequences of elective medical procedures.

f) Any travel expenses that are not incurred during an emergency situation.

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

h) Any accident or injury resulting from the abuse of alcohol, drugs or toxic substances or from medication taken in a manner contrary to the medical prescription or the manufacturer's recommended dosage.

i) Any accident or injury caused while the insured is practising or engaging in a sport for remuneration as a professional athlete or for which an amount of money is awarded to winners, including any competitive motorized sporting events, speed contests or other motor vehicle races as well as any other high-risk activity.

j) Any paramedical treatment that is not explicitly covered by this contract.

k) Any expenses incurred by the insured, after the date the risk level of a Canadian government travel advisory is modified recommending that travellers avoid:

   i) any trip to the location where the insured is or will be travelling; or

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

   If the risk level of an advisory is modified while the insured is visiting the location in question or during the insured's cruise, the insured must comply with the advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible.

l) The Assistor is discharged of all liability with regard to delays or obstacles in providing the assistance services set out in this contract in the event of the following: a strike, civil war, foreign invasion or military intervention, insurrection, terrorist attack, coup d'état, riot or uprising, radioactive fallout or any other event beyond its control.

m) The lawyers, physicians and other healthcare professionals, as well as hospitals, clinics and other establishments to which the Assistor may refer the insured, are independent contractors. The Assistor and the Insurer do not assume any liability with regard to any errors or omissions committed by lawyers, physicians and other healthcare professionals, as well as hospitals, clinics and other establishments, including with regard to accessibility, quality or availability of the services.

HEALTHCARE INSURANCE BENEFIT – TRIP CANCELLATION INSURANCE

Telephone numbers for the Assistor:

In Canada and the United States: 1 800 363-9050

Elsewhere in the world (collect call): 514 985-2281

The Assistor can be reached 24/7.

IMPORTANT GUIDELINES

If an event justifying trip cancellation before departure occurs, the insured must notify the Assistor within 48 hours following the occurrence of the eligible event that results in trip cancellation. If the end of the 48-hour period coincides with a statutory holiday, notice may be submitted on the next business day.

The Insurer's liability is limited to cancellation costs incurred during the 48 hours following occurrence of the event justifying the trip cancellation, or the next business day if this period coincides with a statutory holiday.

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

PRE-EXISTING HEALTH CONDITION

A pre-existing health condition may affect the insured's eligibility for travel insurance. An insured having such a condition must ensure before incurring any travel expenses that this pre-existing health condition does not affect eligibility. Trip cancellation insurance eligibility conditions are set out in this section.

If in doubt, the insured must contact the Assistor, who can provide information on the insured's eligibility.

1. Definitions

In addition to the definitions in the Definitions section, the following apply specifically to trip cancellation insurance, where appropriate.

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

b) **High-risk activity**: A highly dangerous activity that involves speed, height, significant physical effort, highly specialized equipment or dramatic stunts. Activities such as off-trail skiing or snowboarding, ski jumping, parachute jumping, hang gliding, any gliding contests, bungee jumping, scuba diving, whitewater rafting, luge, skeleton, alpine climbing, rock climbing, kite surfing or participating in a rodeo are considered high-risk activities.

Notwithstanding the above, the following activities are not considered high-risk activities:

i) Scuba diving at depths not exceeding 30 metres, if the diver is appropriately certified

ii) Whitewater rafting, if practised in rapids graded 1 to 4 for rafts and 1 to 3 for canoes and kayaks

c) **Assistor**: The travel assistance service provider designated by the Insurer. The Insurer reserves the right to replace the Assistor without notice.

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

e) **Travel companion**: The person who plans the trip with the insured, accompanies the insured on the trip and with whom the insured shares accommodation and transportation expenses.

f) **Diagnosis**: The identification by a physician of the nature and cause of an insured's medical condition.

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

h) **Travel expenses**: The amount paid in advance by the insured for:

i) Purchasing a trip from a travel services provider, including tickets from a public carrier, rental of a motor vehicle and lodging

ii) Reserving ground travel arrangements usually included in a package trip, whether the reservations are made by the insured or by a travel service provider

iii) Registration fees for a commercial activity.

i) **Caregiver**: The person who is entrusted with the full-time care of the insured's dependent children and who supervises them on a daily basis.

j) **Host at destination**: The person in whose main residence the insured will stay for at least a portion of the trip, as agreed to in advance.

k) **Emergency situation**: A situation in which the insured requires immediate attention or treatment as a result of an accident, a sudden and unexpected illness or a deterioration of the insured's medical condition after the trip departure date. The immediate attention or treatment must prevent or minimize a threat to the insured's life or health.

An emergency situation ceases to exist when no further attention or treatment is required during the insured's trip or can be provided, if required, when the insured has been transported to the province of residence in accordance with the provisions of this contract.

l) **Stable**: A medical condition, other than a minor condition, is considered stable if, in the 90 days preceding the insured's scheduled trip departure date, all of the following requirements are met:

i) There has been no new diagnosis.

ii) The insured has not been prescribed any new treatment.

iii) There have been no changes in the type, number and frequency of treatments or termination of treatment.

iv) There have been no changes in the type, dosage and frequency of medication, and no recommendations to begin new medication have been received.

v) The insured has not experienced any new symptoms or been hospitalized, and no tests have demonstrated a deterioration of the state of health.

vi) No medical treatment or consultation has been scheduled, recommended or planned by a physician.

vii) The insured is not waiting to undergo medical tests or receive the results of such tests.

However, the previously mentioned 90-day period is not applicable if it is proven to the satisfaction of the Assistor that the insured's medical condition was considered stable at the time the travel expenses were incurred.

m) **Treatment**: A medical care protocol that is prescribed, performed or recommended by a physician for a medical condition, such as prescribing medication, performing investigative tests and surgeries.

n) **Public carrier**: Any carrier approved by competent authorities and operated under a transport permit for the transportation (air, sea or land) of passengers for remuneration.

o) **Trip**: Travel for the purposes of tourism, leisure, business or participating in a commercial activity that includes the insured's stay of at least one night at destination, either in or outside the insured's province of residence. For the purposes of this definition, it is understood that a trip begins on the insured's departure date and ends on the date the insured returns to the permanent residence.

2. Purpose of the insurance

Through the Assistor, the Insurer reimburses travel expenses incurred by the insured if an eligible event occurs resulting in trip cancellation or interruption, a delayed return trip or a missed departure at the beginning of or during the trip. The eligible event must occur while this insurance is in force and during an emergency situation or one which is beyond the insured's control.

The expenses are eligible, provided they were actually paid in advance by the insured while covered under this insurance or equivalent insurance that was in force immediately before the effective date of the healthcare insurance benefit of this contract.

Eligible expenses are described in the Eligible Expenses sections and are reimbursed according to the terms and conditions indicated in the **Schedule of insurance**.

3. Insureds' eligibility conditions

Insureds who have a medical condition must ensure before trip departure that:

a) Their state of health is stable.

b) They are able to carry out the usual activities of daily living.

c) No medical consultations for their medical condition are needed during the period of the trip.

d) They are not travelling contrary to a physician's or the Assistor's recommendation against travel.

e) They have not been diagnosed with a terminal illness.

Insureds with a medical condition who are uncertain about their state of health, or who are awaiting diagnosis, must contact the Assistor as soon as possible before incurring any travel expenses to obtain confirmation of eligibility for coverage under this insurance.

4. Trip Cancellation or Interruption and Delayed Return Trip Coverage

4.1 Eligible events

a) **Medical emergencies or death**

i) Any emergency situation affecting the insured, the travel companion or a close relative of either, the caregiver of the insured's dependent children, the business partner or the host at destination.

The emergency situation must be sufficiently serious to prevent the person in question from performing usual activities and justify the cancellation, interruption or delayed return.

ii) Death of the insured, the spouse, the insured's or the spouse's child, the travel companion, a person for whom the insured or the travel companion is the testamentary executor, the business partner or the host at destination.

iii) Death of a close relative of the insured, other than the spouse or child, a close relative of the travel companion or the caregiver of the insured's or travel companion's children. The funeral must take place during the 14 days preceding the scheduled date of departure or during the scheduled period of the trip for this event to be eligible under this insurance.

b) **Upgraded risk level of a Canadian government travel advisory**

If the risk level of government travel advisory is upgraded, recommending that travellers avoid:

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

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

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

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

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

- The risk level of an advisory was modified after the departure date of the insured's trip;
- The modified risk level of an advisory is still in effect during the scheduled period of the insured's trip;

- The insured complied with the advisory within 14 days following the date the risk level was modified.

c) **Jobs and occupations**

i) The insured's or the spouse's involuntary loss of permanent employment, provided that the person in question occupied this position with the same employer for one year or more.

ii) The move of the insured or the travel companion from the principal residence due to a job transfer required by the employer. The move must be more than 100 kilometres from the current residence of the person in question and take place during the 30 days preceding the scheduled date of trip departure.

iii) 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. However, the person in question must not be one of the parties involved in the case and must have taken all possible measures to have the case postponed. An insured's subpoena to act as a witness in the course of regular occupational duties is not an eligible event under this insurance.

iv) Cancellation of the commercial activity. Cancellation must be confirmed by a written notice issued by the official organization that is responsible for the activity.

d) **Delays and cancellations**

Weather conditions causing the departure of the public carrier used by the insured, at the planned point of trip departure, to be delayed or cancelled or preventing the insured after departure from making a scheduled connection with another carrier.

Expenses are eligible if the delay of the public carrier corresponds to at least 30% of the total trip duration (minimum of 48 hours).

e) **Other eligible events**

i) A loss rendering the principal residence of the insured, the travel companion or the host at destination uninhabitable, provided the residence remains uninhabitable seven days or less prior to the scheduled date of departure or the loss occurs during the trip.

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

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

4.2 Eligible expenses

All eligible expenses described in this section must be authorized in advance by the Assistor. The insured must contact the Assistor before incurring any expenses or taking any initiatives.

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

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

a) **In the event of trip cancellation prior to the insured's departure**

The non-reimbursable portion of travel expenses as of the date of the eligible event resulting in the cancellation of the insured's trip. However, if the insured's departure is delayed due to weather conditions, and the insured decides to cancel the trip, reimbursement is limited to 70% of the travel expenses.

b) **In the event of cancellation of the travel companion's trip**

Additional expenses incurred by an insured who decides to travel alone if the travel companion must cancel the trip due to any of the eligible events set out under this insurance. These expenses are eligible up to a maximum of the travel and cancellation expenses that would have been applicable had the insured cancelled the trip.

c) **In the event of trip interruption or delayed return**

i) Additional expenses incurred by the insured for the purchase of a return ticket for economy class travel by the most direct route to return to the insured's point of trip departure.

If the initially planned means of transport cannot be used, eligible expenses are those incurred for the purchase of a return ticket for economy class travel by the most direct route to return to the insured's point of trip departure.

ii) The non-reimbursable portion of unused travel expenses for ground travel arrangements as of the date of the eligible cause resulting in the insured's trip interruption or delayed return.

5. Missed departure coverage

5.1 Eligible events

A missed departure or connection due to a delay of the public carrier or the means of transportation used by the insured to arrive at the trip departure or connection point. The delay must be due to one of the following causes:

a) Mechanical problems affecting the public carrier or the means of transportation used by the insured, excluding a private automobile

b) Weather conditions

c) Traffic accident or emergency closure of a road used by the public carrier or the means of transportation used by the insured, including a private automobile.

Expenses are eligible if the insured must be at the trip departure or connection point at least three hours in advance.

5.2 Eligible expenses

All eligible expenses described in this section must be authorized in advance by the Assistor. The insured must contact the latter before incurring any expenses or taking any initiatives.

Additional expenses incurred by the insured for the purchase of a ticket from a public carrier for economy class travel by the most direct route to the scheduled destination.

6. Exclusions and reductions of coverage

The exclusions and reductions applicable to the healthcare insurance benefit also apply to trip cancellation insurance. In addition, insureds are not entitled to any reimbursement from the Assistor in the following circumstances:

a) The failure of the insured to follow the instructions set out in the box at the beginning of the trip cancellation insurance section.

b) Pregnancy, terminated pregnancy or miscarriage and any related complications, within eight weeks preceding the expected date of delivery.

c) Any trip for purposes of visiting a person who is ill or has had an accident, and the trip cancellation, trip interruption or delayed return results from the person's death or deteriorated medical condition.

d) Any event occurring before the purchase date or the date of the first non-reimbursable trip deposit that would have reasonably allowed a person to anticipate that the insured's trip would need to be cancelled or interrupted, the return would be delayed or departure would be missed at the beginning of or during the trip.

e) The insured's suicide or attempted suicide, regardless of the reasons, causes or circumstances of the event.

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

g) Any accident or injury resulting from the abuse of alcohol, drugs or toxic substances or from medication taken in a manner contrary to the medical prescription or the manufacturer's recommended dosage.

h) Any accident or injury caused while the insured is practising or engaging in a sport for remuneration as a professional athlete or for which an amount of money is awarded to winners, including any competitive motorized sporting events, speed contests or other motor vehicle races as well as any other high-risk activity.

i) Any expenses due to financial loss sustained by the insured due to a travel service provider's failure to honour its commitments and provide the travel services originally promised.

j) Any expenses incurred by the insured, after the date the risk level of a Canadian government travel advisory is modified recommending that travellers avoid:

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

If the risk level of an advisory is modified while the insured is visiting the location in question or during the insured's cruise, the insured must comply with the advisory within 14 days following the date the risk level is modified, failing which, the expenses incurred are not eligible.

CLAIMS

1. General provisions

All benefit amounts payable under the healthcare insurance benefit of this contract are paid to the participant.

Before paying a benefit amount, the Insurer reserves the right to have the insured examined. In addition, the Insurer may require submission of all medical information and files regarding the diagnosis, treatment or services received by an insured, before or after the effective date of insurance.

1.1 Recovery

The Insurer reserves the right to recover:

a) Any benefit amount paid in error to a participant or for a dependent.

b) Any benefit amount obtained by the participant or for a dependent to which the participant was not eligible under this contract, and that the Insurer would not have paid had it not been for an omission, non-disclosure or misrepresentation by the participant or a dependent.

c) Any amount paid to a third party who was not entitled to such amount due to an omission, non-disclosure or misrepresentation by the participant or a dependent.

d) Any overpayment made to the participant or for a dependent.

1.2 Right of set-off

If the overpayment cannot be recovered from the participant, the Insurer reserves the right to set off any amount of future benefits payable to the participant or for a dependent until the overpayment has been fully recovered.

1.3 Subrogation of the participant's rights to the Insurer

a) General provision

The Insurer is subrogated to all rights of the participant against a third party that is liable for an event giving rise to a claim under this contract, up to a maximum of the amount paid to the participant by the Insurer.

b) **Provision regarding travel insurance**

For any funds advanced or reimbursed by the Assistor, the insured assigns the Assistor all rights and recourses to any reimbursement from which the insured benefits or claims to benefit under any government insurance plan or any other insurance providing benefits similar to those for which the advances or expenses have been incurred by the Assistor. The insured agrees to sign any document and perform any acts required by the Assistor to give full and complete effect to this assignment. The insured acknowledges and agrees that the Insurer may then exercise the right of subrogation and specifically mandates the Assistor as a representative for submitting any claim and collecting any reimbursement.

1.4 Termination of this contract or cancellation of an insurance benefit

Subject to the transfer provisions, the termination of this contract or the cancellation of an insurance benefit covering an insured cannot be set up against any claim related to:

a) Death occurring while this contract was in force

b) Death due to a total disability occurring while this contract was in force

c) Death or dismemberment due to an accident occurring while this contract was in force

d) Total disability or illness occurring while this contract was in force.

The Insurer must continue paying disability insurance benefits in the event the participant's total disability, for which such benefits are being received under this contract, persists after the termination of this contract.

1.5 Legal action against the Insurer

No legal action can be taken against the Insurer regarding any claims submitted:

a) During the 60 days following the deadline for submitting a claim, subject to applicable statutory time limits.

b) During the 60 days following the deadline indicated by the Insurer when evidence of insurability or additional information is required, subject to applicable statutory time limits.

c) For Alberta, British Columbia and Manitoba residents: Legal action against the Insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time limits set out in the Insurance Act.

d) For Ontario residents: Legal action against the Insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time limits set out in the Limitations Act, 2002.

e) For residents of other provinces, legal action or proceedings cannot be taken against the Insurer after expiry of the time limits set out in any applicable provincial legislation.

1.6 Incontestability

Even if there was no intent to commit fraud, any error or omission in the evidence of insurability submitted by the insured may invalidate the insurance coverage or amount during the first two years following the effective date of insurance or the amount increase.

1.7 Non-assignability of insureds' rights

Insured's rights under this contract may not be assigned or seized, and no assignment by an insured of entitlement to benefits or to payment of a benefit under this contract is binding on the Insurer.

2. Healthcare insurance benefit

All claims must be submitted to the Insurer within 12 months following the date expenses are incurred. If the contract or the insurance benefit is terminated, claims must be submitted within 12 months following the termination date.

Official receipts or paid invoices must be enclosed with the claim. Expenses are considered as being incurred on the date the products, service or supplies were provided. For certain expenses, the insured is required to enclose the medical prescription with the claim.

2.1 Prescription drugs and healthcare

a) **Claims submitted by a healthcare professional**

In some cases, insureds may have their claims submitted by certain healthcare professionals who have been pre-approved by the Insurer, such as pharmacists. The Insurer pays the covered portion of eligible expenses to the healthcare professional at the time of the transaction. The insured must pay the portion of expenses for which the insured is responsible to the healthcare professional, according to the provisions of this contract.

b) **Claims submitted to the Insurer**

The insured may pay the total expenses incurred for the services of the healthcare professional. The insured may then use one of the following methods to forward the claim to the Insurer:

i) Mobile app

ii) Online from the secure site

iii) By mail, by sending the completed claim form.

c) **Coordination of benefits**

i) Extended insurance coverage supplementary to any government insurance plan

The payment of benefits under prescription drug and healthcare coverage supplement any government insurance plans. As a result, eligible benefits under this contract are reduced by the amount of any benefits payable under any government insurance plan, whether or not the insured submits a claim.

ii) Coordination of benefits with any other group or individual insurance contract providing similar insurance benefits

Benefits under prescription drug and healthcare coverage are payable for the portion of expenses over and above those covered by benefits paid under any other group or individual insurance contract to ensure that the total reimbursement does not exceed the expenses actually incurred by the insured.

In the event an insured is eligible to receive benefits under this contract and under another group insurance contract, coordination of benefits is done by the Insurer in accordance with the guidelines issued by the Canadian Life and Health Insurance Association.

2.2 Travel insurance and trip cancellation insurance

The insured pays the supplier for the total cost of products, services or supplies. The Assistor reimburses eligible expenses upon receipt of the required official and supporting documents.

In some cases, and subject to the Assistor's prior authorization, the Assistor may reimburse incurred expenses directly to the supplier.

When an insured is transported home in accordance with the provisions of travel insurance and trip cancellation insurance of this contract, the Assistor reserves the right to claim any unused transportation tickets.

a) **Important guidelines**

Before incurring any expenses for services, care, treatment or supplies following an emergency situation, the insured must always contact the Assistor first. However, if an emergency situation prevents the insured from contacting the Assistor before incurring expenses, the Assistor must be contacted by the insured, or by another person on the insured's behalf, as soon as it is possible to do so to allow the Assistor to rapidly make arrangements with the supplier.

Furthermore, if an event justifying trip cancellation before departure occurs, the insured must notify the Assistor within 48 hours following the occurrence of the eligible event that results in trip cancellation. The Insurer's liability is limited to cancellation costs incurred during the 48 hours following occurrence of the event justifying the trip cancellation, or the next business day if this period coincides with a statutory holiday.

b) **Coordination of benefits**

Travel insurance and trip cancellation insurance under this contract are deemed “second payor” insurance. The Insurer reimburses eligible expenses in excess of the benefits first paid under any government insurance plan or any other insurance providing similar insurance benefits.

Coordination of benefits is done by the Insurer in accordance with the guidelines issued by the Canadian Life and Health Insurance Association.