YOUR Benefits

BOOKLET

MEDAVIE BLUE CROSS™

GROUP INSURANCE PLAN

aqtis

alliance québécoise
des techniciens et techniciennes
de l'image et du son

Group No. 96999

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The present Insurance Plan is intended for members of the

ALLIANCE QUÉBÉCOISE DES TECHNICIENS ET TECHNICIENNES DE L'IMAGE ET DU SON

as well as their permittee members

Group No. 96999

We are pleased to have you as one of our clients.

The AQTIS, through Medavie Inc. and Blue Cross Life Insurance Company of Canada, offers you a group insurance plan that provides you with medical and financial security.

This booklet and your insurance certificate contain important information.

Keep both documents in a safe place.

Revised: November 2017

Note

For ease of reading, the masculine is used throughout the text to designate both men and women.

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GENERAL PROVISIONS

DEFINITIONS

Participant

Any member, member with dual membership or permittee member who is eligible for and has subscribed to the insurance plan.

Able to work

The ability of a member or permittee member to perform all the normal duties related to his job as a technician for an entire workday.

Insured

The Participant or one of his dependents insured under the contract.

Member

AQTIS member

A technician, an assistant director or a TV production coordinator who, pursuant to the statutes and regulations of the AQTIS, has been duly admitted as a member and has not been suspended or excluded from the AQTIS.

An **active member** is a member who subscribes to the insurance plan through an employment contract related to his job as a technician with a producer who has a collective agreement with the AQTIS.

A **non-active member** is a member who does not have an employment contract with a producer who has a collective agreement with the AQTIS and who, as a result, does not subscribe to the insurance plan.

A **member with dual membership** is a member of the AQTIS and one or several other organizations with whom the AQTIS has an inter-union reciprocal agreement for group insurance, according to their respective status, who is eliglbe under each of the insurance plans of these organizations, and who has chosen to participate in the AQTIS' plan or who was attributed this choice by default.

Permittee member

Any technician to whom the AQTIS has issued a work permit, except for terminating members.

An **active permittee member** of the AQTIS is a permittee member who subscribes to the insurance plan through an employment contract related to his job as a technician with a producer who has a collective agreement with the AQTIS.

A **non-active permittee member** of the AQTIS is a permittee member who does not have an employment contract with a producer who has a collective agreement with the AQTIS and who, as a result, does not subscribe to the insurance plan.

Dependents

. The person who became your **spouse** following a legally contracted marriage or the person with whom you have been living maritally on a permanent basis for at least **one year** and who you have designated as such on your application form; the aforementioned period does not apply if a child is born of the union.

. Your unmarried **children** who are dependent on you for financial support and who are:

- under the age of 21, or
- under the age of 26 and full-time students, or
- if applicable, your children, regardless of their age, who live with you and became totally disabled while they were your dependents under the current definition and who continue to be disabled to date.

For Life Insurance, coverage of dependent children begins 24 hours after birth.

Hospital

A hospital centre providing short-term care as established under the Act respecting health services and social services *(Loi sur les services de santé et les services sociaux),* with the exception of any part of such centre intended for long-term care.

The term “hospital” does not include psychiatric hospitals, long-term care hospitals, hospitals providing antituberculotic care, sanatoriums, reception centres, nursing homes, retirement homes, spas, dispensaries, nor any other facility or part thereof intended to provide custodial care.

Member, member with dual membership or permittee member income

The income earned by a member or permittee member from his job as a technician with a producer who has a collective agreement with the AQTIS, less qualified expenses allowed by the Ministère du revenu (Department of Revenue) but before deduction of personal exemptions, expressed as an average of the last 24 months ending 3 months before the assessment date.

The income earned by a member with dual membership also includes all income from his job as a technician with producers belonging to an organization having an inter-union reciprocal agreement with the AQTIS for group insurance, providing that the contributions corresponding to all this income have been paid to the AQTIS.

For long-term disability insurance benefit, the Insurer may request all documents required to validate and review, if applicable, the amount of benefits payable (for example, T4 slips, income tax returns, business expenses, financial statements).

Average income during a maternity / parental leave

- The Participant's coverage is not re-evaluated during a maternity / parental leave; authorized period is established at 12 months (not including the period for the portion of the « preventive withdrawal », if applicable).
- The amount used to determine the average yearly income is calculated at the evaluation date before the beginning of the maternity / parental leave; this level giving rise to a coverage that is re-evaluated on the evaluation date following the end of the maternity / parental leave.

PARTICIPATION

Participation is **mandatory**, which means the member/permittee member must subscribe to all benefits to which he is eligible based on his average income, subject to the following paragraphs.

The member with dual membership is not eligible for this plan, for the period during which he has chosen to participate in the plan of another organization which has a reciprocal agreement with the AQTIS for group insurance, or who was attributed this choice by default.

CALCULATION OF AVERAGE INCOME

The total income of a member or permittee member during the period considered for the purpose of assessment (last 24 months ending 3 months before the assessment date), divided by the number of months in this period (24), and then multiplied by 12.

During any period of total disability (including the waiting period), the amount considered in the calculation of average annual income is the insured income on the date disability begins (meaning the income at the last assessment).

DETERMINATION OF BENEFITS ELIGIBILITY

The Participant's coverage is established on the assessment date, either on April 1st or October 1st of each year.

The income considered is the income earned (as a member or permittee member) during the 24-month period ending 3 months before the assessment date.

NOTE

A permittee member who becomes a member of the AQTIS is immediately eligible for the coverage offered to members based on average income, as established on the last assessment date.

COVERAGE GRANTED BASED ON AVERAGE INCOME

1. For members

Average income	Coverage
$0	No coverage
$1 to $4,999	Life Insurance for the Participant and his dependents
$5,000 to $15,499	Drug Insurance, Life Insurance for the Participant and his dependents, Critical Conditions Insurance and Accidental Death and Dismemberment Insurance
$15,500 to $20,499	Drug Insurance, Life Insurance for the Participant and his dependents, Accidental Death and Dismemberment Insurance, Critical Conditions Insurance, Short-term Disability Insurance, Health Insurance (hospitalization, basic professional treatment and medical expenses) and Travel Insurance
$20,500 to $40,999	Drug Insurance, Life Insurance for the Participant and his dependents, Accidental Death and Dismemberment Insurance, Critical Conditions Insurance, Short-term Disability Insurance, Long-term Disability Insurance, Health Insurance (hospitalization, basic professional treatment and medical expenses), Travel Insurance and Basic Dental Care Insurance (Plan A)
$41,000 and over	Drug Insurance, Life Insurance for the Participant and his dependents, Accidental Death and Dismemberment Insurance, Critical Conditions Insurance, Short-term Disability Insurance, Long-term Disability Insurance, Health Insurance (hospitalization, adjunctive professional treatment and medical expenses), Travel Insurance and Enhanced Dental Care Insurance (Plan B).

Notice regarding Participants who have not worked for an AQTIS production in the last six months ending three months before the assessment date.

It is agreed that this group insurance plan for the Participant is a supplemental plan (second payer) in relation with any other group insurance plan subscribed by a union, a producer or an association to which the member or employee is entitled to.

To respect the following provision, the Participant must, at each assessment date:

- Declare in writing that he is not eligible for any other group insurance plan as a member or employee of a member, or
- Identify in writing the other group insurance plan he is eligible for as a member or employee of a member.

The Participant who does not fill out his written declaration will not receive benefits to which he would have been otherwise entitled to under the Health Insurance Benefit and the Dental Care Insurance Benefit under this contract, until he produces his written declaration.

Furthermore, when the Participant is eligible for a group insurance plan other than the above mentioned plan, his participation in that other group insurance plan is mandatory, for insurance purposes under this contract, failing which, the insurer may terminate his coverage.

2. For permittee members

Average income	Coverage
$10,000 to $20,499	Life Insurance for the Participant and his dependents
$20,500 and over	Drug Insurance, Life Insurance for the Participant and his dependents, Critical Conditions Insurance and Accidental Death and Dismemberment Insurance

REQUIRED PREMIUMS

Active AQTIS members, members with dual membership or permittee members

The monthly contribution for any active member, member with dual membership or permittee member is established at a percentage of income and is subject to an annual maximum.

Members and permittee members without an employment contract are not required to pay premiums and retain all benefits during the inactive period, up to the next assessment date.

ELIGIBILITY DATE

Participant

Any person who becomes a permittee member in good standing of the AQTIS becomes eligible for insurance on the next assessment date.

Dependent

Any dependent of a Participant becomes eligible for insurance on the later of the following dates:

a) Date Participant becomes eligible;

b) Date the individual meets the definition of a dependent under the present contract;

c) Day following release from the hospital if the dependent is hospitalized on the date he would normally become eligible.

EFFECTIVE DATE OF INSURANCE

ALL BENEFITS

Member, member with dual membership or permittee member

Insurance coverage for a member, member with dual membership or permittee member takes effect on the date of eligibility, provided he is able to work on that date; otherwise, on the date he becomes able to work.

Dependents

Insurance coverage for any dependents takes effect on the later of the following dates:

1. Date of eligibility, if the insurance application is received by the Insurer on this date or within 31 days of the eligibility date; or

2. Date of acceptance by the Insurer of proof of insurability if the insurance application is received by the Insurer more than 31 days after the eligibility date, or more than 31 days after the end of the coverage granting an exemption.

PROOF OF INSURABILITY: applies to dependents only

1. Proof of insurability must be provided to the Insurer:

   when the Participant's insurance application for a dependent is received by the Insurer more than 31 days after the date the dependent became eligible, subject to paragraph 2 below.

2. No proof of insurability is required for DRUG INSURANCE BENEFIT.

3. For DENTAL CARE INSURANCE BENEFIT for any dependent whose coverage comes into effect more than 31 days after the insurance eligibility date, proof of insurability is replaced by a Limitation of Benefits, as described in the Dental Care Insurance chapter in this booklet.

TERMINATION OF INSURANCE

Subject to any other stipulation, insurance benefit will end at the occurrence of the first of the following events:

. Age specified in the text for each type of benefit, where applicable;

. Date on which the Participant ceases to be an AQTIS member or permittee member, or is suspended or excluded from the AQTIS except for Life Insurance benefit, which is then extended for 30 days;

. With regards to a given benefit, the date on which the Participant ceases to be eligible due to a drop in income, pursuant to the sub-section COVERAGE GRANTED BASED ON AVERAGE INCOME described in this section;

. Cancellation date of the group insurance contract;

. For dependents: the day the individual ceases to meet the definition of a dependent specified in this booklet;

. For benefits subject to extended term insurance in cases of disability: the date on which such a Participant reaches age 60;

. where applicable, the day an insured commits a fraudulent act against the Insurer.

EXTENDED COVERAGE IN CASE OF DISABILITY

If a Participant becomes **totally disabled** while his insurance is in effect and before his 60th birthday, he retains all his benefits. However, the extension ends on the first of the following events:

- End of total disability;
- Attainment of age 60;
- Cancellation of the group insurance contract, except for Life Insurance and Long-term Disability Insurance, which remain in effect for the disabled Participant.

The Participant's coverage cannot be revised during his total disability. Coverage is re-evaluated on the assessment date following the date of the end of disability.

COORDINATION OF BENEFITS

The total amount of benefits from all sources may never exceed the amount of expenses actually incurred.

If you or your dependents are entitled under any other insurance plan to compensation for expenses reimbursable under this insurance plan, the amount of compensation payable under such other insurance will be deducted from the reimbursable expenses under this insurance plan.

Benefits payable under any other insurance plan include benefits to which the insured would have been entitled if he had duly submitted a claim.

Applicable rule

. Expenses incurred by the spouse covered under another plan as an employee are reimbursed first by the spouse's plan, then by this plan for the remainder, if any.

. Expenses incurred by children covered as dependents of both parents are reimbursed first by the plan of the parent whose date of birth occurs first in the year.

LIMITATION OF BENEFITS

All insureds are deemed covered under the hospital and health insurance acts of Quebec or any other province, and under no circumstances shall the amount paid by the Insurer exceed those payable to insureds covered under the government plan.

GENERAL EXCLUSIONS

- No coverage applies to an insured while performing duties as an active member of the Armed Forces of any country, unless otherwise required by *the* Act respecting Prescription Drug Insurance (*Loi sur l'assurance-médicaments*.)

- An insured residing outside of Canada for a period exceeding six months ceases to be eligible for insurance, unless the Insurer has granted prior approval.

LIFE INSURANCE BENEFIT FOR THE PARTICIPANT AND DEPENDENTS

PURPOSE OF BENEFIT

In the event of your death or the death of one of your dependents while insurance is in effect, the Insurer shall pay the amount of life insurance specified in the Summary of Benefits to your beneficiary or to yourself, as the case may be.

BENEFICIARY

The beneficiary is the person named by the Participant in his application form. Subject to the provisions of the act, the Participant may change the beneficiary by submitting a signed written request to the Participant to the Insurer or AQTIS.

If there is no designated beneficiary, the death benefit is payable to the Participant's estate.

CONVERSION PRIVILEGE

You may, before age 65, convert your group insurance to an individual insurance plan offered by the Insurer within 31 days following the end of your insurance benefit due to termination of your membership to the AQTIS, without having to submit proof of insurability. This privilege also applies to your dependents.

Note

The converted insurance is subject to limitations, which are listed in the group insurance contract submitted to the AQTIS.

REDUCTION OF BENEFIT

The insurance reduction schedule for the Participant is indicated in the Summary of Benefits.

TERMINATION OF BENEFIT

The termination of benefit for the Participant and his dependents, is indicated in the Summary of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Your Accidental Death and Dismemberment Insurance covers you in the event of accidental death, of the loss or loss of use of a limb or loss of sight, speech or hearing. The amount payable is a percentage of the amount of insurance indicated in the Benefit Summary, according to the Table of loss that follows:

	Percentage of the amount of insurance
Loss of	
Life	100%
Both hands or both feet	100%
Speech and hearing in both ears	100%
Sight of both eyes	100%
Sight of one eye and one hand	100%
Sight of one eye and one foot	100%
One hand and one foot	100%
One arm or one leg	75%
One hand or one foot	66⅔%
Sight of one eye	66⅔%
Speech or hearing in both ears	66⅔%
Thumb and index finger of any one hand	33⅓%
At least four fingers of one hand	33⅓%
Hearing in one ear	16⅔%
All toes of one foot	12½%
Paralysis	
Quadriplegia	200%
Hemiplegia	200%
Paraplegia	200%
Loss of use	
Both arms	100%
Both hands	100%
One arm or one leg	75%
One hand or one foot	66⅔%

ADDITIONAL COVERAGE

Exposure - Should you be unavoidably exposed to the elements and suffer a loss, your loss will be covered, subject to the provisions of this benefit.

Disappearance - Should you disappear following the accidental wrecking, sinking or disappearance of a conveyance in which you were riding and your body is not found within 365 days following that event, it will be presumed that you have suffered a loss of life as a result of an accident.

Coma Benefit - Should you be in a state of complete and total unconsciousness in the 31 days following an accidental injury and for an uninterrupted 31 days, 1% of the amount of insurance will be payable monthly, until the amount has been paid in full or until death, whichever occurs first.

Repatriation - Should you suffer a loss of life due to an accident while you were at least 150 kilometres from your place of residence, a maximum reimbursement of $7,500 will be paid for burial or cremation. The cost of the coffin is excluded.

Rehabilitation - Should you suffer a loss such as described in the preceding Table of loss, a $5,000 maximum reimbursement will be provided for your special training. The expenses covered are those incurred within three years of the accident.

Occupational training for your spouse - Should your spouse require formal training to gain active employment following your accidental loss of life, a $5,000 maximum reimbursement will be provided for a formal training program. The expenses covered are those incurred within three years of the accident.

Education Benefit - Should you suffer an accidental loss of life, a benefit equal to the lesser of 5% of your amount of insurance, or $5,000 will be paid for each year your dependent child continues his education on a full-time basis in a school for post-secondary learning, for a maximum of five years or until the age of 25 inclusive.

Family Travel - Should you suffer an illness or injury as described in the preceding Table of loss, a $1,500 maximum reimbursement will be provided for family members traveling to the hospital where you are confined, if such confinement occurs more than 150 kilometres from your residence.

PAYMENT OF BENEFITS

In the case of accidental death, the Insurer pays the amount of insurance directly to your named beneficiary for life insurance. In the case of dismemberment, the amount is paid to you.

The Insurer reserves the right to request a medical examination, or in the event of death, an autopsy.

EXCLUSIONS

1. No benefit is payable if the disability, illness, injury or accident occurs while you are participating or engaging in any criminal activity, regardless of whether charges are laid or a conviction is obtained.

2. No benefits are payable if the loss sustained results, directly or indirectly, from one of the following causes:

    - Suicide, attempted suicide, voluntary or self-inflicted injury, whatever your state of mind at the time of the incident.
    - Insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or a civil commotion.
    - Voluntary ingestion of poison or drugs, or voluntary inhalation of fumes.
    - Illness or disease of any kind, or medical or surgical treatment thereof, other than septic infection caused through a wound accidentally sustained.
    - Injuries sustained while flying or attempting to fly an airplane or other type of aircraft if you are a member of the crew or perform any other flight duties.

3. Any accident or injury occurring while operating a motor vehicle with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.)

4. If you sustain more than one loss per accident, the Insurer will pay for one loss only, namely the one allowing the highest amount.

TERMINATION OF COVERAGE

Benefit ends at retirement or on your 70th birthday, whichever occurs first.

CRITICAL CONDITIONS INSURANCE OF THE PARTICIPANT

Although medical care is covered under the public plan, certain conditions exist resulting in additional expenses, which are at times quite costly, because a person is affected by a severe disease or handicap resulting from illness.

The Critical Conditions Insurance helps you cope with the burden of additional expenses caused by such conditions and becomes payable if you become afflicted and survive the elimination period specified in the Benefit Summary.

The benefit amount is payable towards the **first diagnosed critical condition**. The maximum lifetime benefit is specified in the Benefit Summary.

ADDITIONAL DEFINITIONS

Pre-existing condition: A pre-existing condition means any condition for which the Participant has, during the **24 months** immediately preceding the effective date of his coverage under this benefit, consulted a physician, received medical treatment, or medical care or services including diagnostic services, for any symptom or medical problem leading to the diagnosis or treatment of a critical condition as defined below.

Elimination period: The elimination period is the continuous period of time which must elapse between the date the definition of a covered critical condition is met and the date the benefit is payable, provided the Participant is still alive. The elimination period for the Critical Conditions Insurance Benefit is specified in the Benefit Summary.

COVERED CRITICAL CONDITIONS

All conditions with the exception of burns, must be the result of illness or disease.

1) Aorta Surgery: The undergoing of surgery for disease of the aorta, requiring excision and replacement of such diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. Traumatic damage and repair is not covered.

2) Benign Brain Tumour: A benign brain tumour that requires craniotomy or gamma knife surgery for removal.

3) Blindness: A definite diagnosis made by a certified ophthalmologist, of the permanent loss of sight in both eyes such that: visual acuity cannot be corrected beyond 20/200 in both eyes, or the field of vision must be less than 20 degrees in both eyes.

4) Major Burns: A diagnosis by a plastic surgeon of third degree burns (requires skin grafting) and covering at least 20% of the surface area of the body.

5) Cancer (Life threatening): Diagnosis by a physician of a malignancy, characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

   The following cancers are excluded from coverage:

   (a) carcinoma in situ
   (b) stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
   (c) any non-melanoma skin cancer that has not become metastatic (spread to distant organs)
   (d) stage A (T1a or T1b) prostate cancer
   (e) any tumour in the presence of any HIV (Human Immunodeficiency Virus).

   There is no coverage for cancer if the Participant is diagnosed with cancer and such diagnosis was made, or any symptom or medical problem is determined, which initiated the investigation leading to a diagnosis of cancer, within 90 days following the effective date of the Participant's Critical Conditions insurance coverage.

6) Coma: A state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four or less, continuously during the four days. Excluded are medically induced comas and comas which result directly from alcohol or drug use.

7) Coronary Artery Bypass Surgery: The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excludes non-surgical techniques, such as balloon angioplasty, laser embolectomy or other non-bypass techniques. The surgery must have been recommended by a cardiologist practicing in Canada.

8) Deafness: Definite diagnosis made by a certified otolaryngologist, of the permanent loss of hearing in both ears. The loss of hearing in each ear must be such that sounds of 90 decibels or less cannot be distinguished.

9) Heart Attack: Diagnosis by a physician of the death of a portion of heart muscle resulting from blockage of one or more coronary arteries due to atherosclerotic heart disease. The diagnosis must be based on all of the following criteria occurring at the same time:

   (a) new electrocardiographic (ECG) changes indicative of an acute myocardial infarction,
   (b) new episodes of typical chest pain or equivalent symptoms, and
   (c) biochemical evidence of myocardial necrosis (heart muscle death) including serial elevation of cardiac enzymes and/or troponin.

   Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are excluded.

10) Kidney Failure: End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

11) Loss of Speech: Total and irreversible loss of speech for a continuous period of 180 days as a result of physical disease as diagnosed by a medical specialist. Psychiatric conditions are excluded.

12) Major Organ Failure Requiring Transplant: The irreversible failure of the heart, liver, bone marrow or both lungs requiring a transplant of that organ, resulting in the Participant being accepted into a recognized transplant program in Canada or the United States. The Participant must survive at least 30 days following the date of enrolment into the transplant program.

13) Motor Neuron Disease: The definite diagnosis of Motor Neuron Disease resulting in weakness and wasting of muscles and made by a certified neurologist. Motor Neuron Disease includes ALS/Lou Gehrig's Disease, progressive muscular atrophy, progressive bulbar palsy, spinal muscular atrophy and primary lateral sclerosis.

14) Multiple Sclerosis: A diagnosis by a neurologist of definite Multiple Sclerosis, characterized by well defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis.

15) Paralysis: The complete and permanent loss of use of two or more limbs resulting from a neurological deficit caused by illness or disease with measurable objective impairment that lasts for a continuous period of 180 days, as diagnosed by a medically appropriate specialist.

16) Parkinson's Disease: Definite diagnosis by a neurologist of primary idiopathic Parkinson's Disease characterized by the clinical manifestations of two or more of the following:
    (a) rigidity
    (b) tremor
    (c) bradykinesis.

    Excluded are all other types of Parkinsonism.

17) Senile Dementia: Diagnosis by a certified neurologist of the loss of intellectual capacity involving impairment of memory and judgment, which results in significant reduction in mental and social functioning requiring supervision for daily living. This includes dementia caused by Alzheimer's disease and its variants such as, vascular disease dementia, Lewy body dementia and Pick's disease. Excluded are all other dementing organic brain disorders and psychiatric illnesses.

18) Severe stroke: Cerebrovascular event producing neurological sequelae lasting more than 30 days, caused by intracranial thrombosis, hemorrhage, or embolism from an extra-cranial source. For the stroke to be considered a covered condition, the diagnosis must be corroborated by measurable and objective evidence of neurological deficit. Transient ischemic attacks are specifically excluded.

EXCLUSIONS AND LIMITATIONS

1) No benefit is payable if a critical condition occurs while participating in or engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.
2) Also, Critical Conditions Insurance Benefit is not payable for any condition due to or resulting, directly or indirectly, from any of the following:
   a) an accident, except for major burns, as defined in item 4 of **Covered critical conditions**,
   b) self-inflicted injury or sickness contracted voluntarily, while sane or insane,
   c) insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion, or
   d) any accident or injury occurring while operating a motor vehicle with a blood alcohol level in excess of the legal limit in the jurisdiction where the accident occurred. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes, but is not restricted to, an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.)
3) No benefit is payable as a result of any pre-existing condition unless the covered condition as defined above occurs after 24 consecutive months of coverage.

TERMINATION OF BENEFIT

Coverage for Critical Conditions Insurance terminates when your employment terminates, upon your retirement or when you reach age 65, whichever occurs first.

Short-term Disability Insurance is subscribed as a supplemental unemployment benefit plan.

The disabled Participant must first contact the Employment Insurance Commission to obtain the benefits to which he is entitled. The Insurer then pays a supplementary benefit to the Participant so that he receives total compensation equivalent to **75% of the weekly income established based on average income**, as assessed at the beginning of his disability (subject to the maximum indicated in the Summary of Benefits).

However, the Insurer shall pay the total compensation established if the Participant does not qualify for employment insurance benefits.

APPLICATION OF THE SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN IS SUBJECT TO THE PROVISIONS OF THE SHORT-TERM DISABILITY INSURANCE BENEFIT DESCRIBED IN THE FOLLOWING CHAPTER.

SHORT-TERM DISABILITY INSURANCE BENEFIT

Not applicable to permittee members

PURPOSE OF BENEFIT

If you become **totally disabled** following an illness or accident while your insurance is in effect, the Insurer will pay you the weekly benefits specified in the Summary of Benefits, provided you are under the care of a physician. The elimination period and maximum duration of benefit payments are also specified in the Summary of Benefits.

DEFINITION OF TOTAL DISABILITY

Any state of incapacity resulting from an accident or illness requiring continuous medical care from the beginning of the disability and wholly preventing you from performing any and all of the main duties related to your job as a technician.

Total disability beginning more than 15 days after an accident is considered to be an illness.

EXCLUSIONS AND REDUCTION OF BENEFIT

Reduction of benefits

The weekly benefits payable under this benefit are reduced by an amount equal to the benefits payable:

i) by the Commission de la santé et de la sécurité du travail (hereinafter CSST) (Quebec Occupational Health and Safety Board);

ii) by the Société de l'assurance automobile du Québec (hereinafter SAAQ) (Quebec Motor Vehicle Bureau);

iii) pursuant to the *Employment Insurance Act* of Canada;

iv) pursuant to any other federal or provincial legislation;

v) pursuant to any other benefit plan established by the employer.

Weekly benefits shall be reduced even if the Participant, whose responsibility it is to submit the required application, fails or refuses to exercise his rights pursuant to the legislation and plans listed in this paragraph.

Exclusions

a) No benefits are payable during the following periods:

1. Period during which you are on vacation paid by your employer or period during which you receive or are entitled to receive any remuneration from your employer.

2. Periods related to pregnancy:

. period during which you receive maternity benefits under any provincial or federal law; or

. period during which maternity leave is taken in accordance with any provincial or federal law or an agreement between you and your employer.

b) No weekly benefits are payable for a disability that is a result of one of the following causes:

intentionally self-inflicted injury, active participation in a civil confrontation, riot or insurrection (except during the performance of your duties), injury sustained in war, and an occupational accident sustained by a Participant not covered by the CSST.

c) This benefit does not apply if you are injured while committing or attempting to commit any criminal act.

TERMINATION OF BENEFIT

Benefit ends at retirement or on your 70th birthday, whichever occurs first.

LONG-TERM DISABILITY INSURANCE BENEFIT

Not applicable to permittee members

PURPOSE OF BENEFIT

If you become **totally disabled** following an illness or accident while your insurance is in effect, the Insurer will pay you the monthly benefits specified in the Summary of Benefits, provided you are under the care of a physician. The elimination period and maximum duration of benefit payments are also specified in the Summary of Benefits.

DEFINITION OF TOTAL DISABILITY

Any state of incapacity that started while the Participant was insured under this insurance benefit resulting from an accident or illness requiring medical care and that completely and continuously prevents the Participant from:

i) performing all the duties inherent to his job as a technician for 36 months following the start of the disability, and

ii) engaging, subsequently, in gainful employment compatible with his training, education and experience.

EXCLUSIONS AND REDUCTION OF BENEFIT

1) <u>Reduction of benefits</u>

Your monthly benefits shall be reduced, where applicable, by the amount payable under the Régime de rentes du Québec (Quebec Pension Plan) or the Canada Pension Plan, the Occupational Health and Safety Act (Loi sur la santé et la sécurité du travail), any government automobile insurance plan, the Employment Insurance Act or any other provincial or federal law.

However, benefits are not reduced by the amounts to which the Participant is entitled for his dependent children. Furthermore, the amount of any increase in disability benefits payable under the above mentioned legislation and plans, granted as a cost-of-living adjustment, are not subject to deductions.

2) Coordination of benefits

If the sum of monthly benefits payable under this insurance benefit and any other disability income exceeds **85%** of gross monthly income, if benefits are taxable (or of net monthly income if they are not taxable), the monthly benefits payable under this insurance benefit shall be reduced so that the above mentioned percentage is not exceeded.

3) Rehabilitation program

If, following a period of total disability resulting in eligibility for benefits hereunder, you participate in a rehabilitation program, for the duration of this rehabilitation program **but for no more than 24 months**, the Insurer will pay you a monthly allowance equal to the full amount of your monthly disability benefits, reduced by half of the amount of your rehabilitation pay, provided your total income from all sources does not exceed 100% of your gross monthly basic income if benefits are taxable (or of your net monthly income if they are not taxable).

4) Alcoholism and drug addiction

If disability is a direct result of alcoholism or drug addiction, benefits are paid only if the Participant is undergoing an in-house detoxification treatment and is under medical supervision.

5) Exclusions

a) Pre-existing conditions

Unless you were insured under similar coverage during the 31 days preceding the effective date of the insurance hereunder, no benefits are payable if the disability occurs during the first twelve months of insurance coverage and if such disability results from an accident or illness for which you received treatment within the three months immediately preceding the effective date of your insurance coverage.

b) Periods related to pregnancy

No benefits are payable during the following periods:

. period during which you receive maternity benefits under any provincial or federal law; or

. period during which maternity leave is taken in accordance with any provincial or federal law or an agreement between you and your employer.

c) No monthly benefits are payable for any disability resulting from one of the following causes:

intentionally self-inflicted injury, injury sustained during active participation in a civil confrontation, riot or insurrection (except during the performance of your duties) or injury sustained in war, flying or attempting to fly aboard any form of aircraft, if the Participant is a member of the crew or performs any type of flight duty or if he is a parachutist, or occupational accident only in the case of a Participant not covered by the CSST.

d) This benefit does not apply if you are injured while committing or attempting to commit any criminal act.

TERMINATION OF BENEFIT

Benefit ends at retirement or on your 60th birthday, whichever occurs first.

DRUG INSURANCE BENEFIT

PURPOSE OF BENEFIT

This insurance covers the cost of **ELIGIBLE PRESCRIPTION DRUGS** required as the result of an illness, pregnancy or accident, subject to the deductible and percentage of reimbursement specified below.

Eligible expenses are deemed to have been incurred on the day services are provided or products are supplied.

TERMS OF SETTLEMENT

a) **Deductible:** none

b) **Percentage of reimbursement:** See SUMMARY OF BENEFITS

ELIGIBLE EXPENSES

Eligible expenses are the expenses for prescription drugs and products registered on the list provided by the Régie de l'assurance-maladie du Québec (hereinafter RAMQ) and dispensed by a pharmacist on prescription from a physician or dentist. Some of the prescription drugs on the RAMQ list are covered only in the cases, under the conditions and for the therapeutic indications specified by regulation, namely in cases of exception drugs.

The Insurer will manage the eligible expenses as follows:

- Application of a pre-authorized procedure for exception drug management;
- Step therapy management, to make sure that the insured is provided with a good quality treatment at the right time.

EXCLUSIONS

The following charges or services are not covered:

- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance plan, if applicable.
- Services, treatments or products received free of charge by the Participant.

PROVISIONS APPLICABLE TO QUEBEC RESIDENTS

When they reach the **age of 65**, the Participant or his Spouse have a decision to make regarding their drug coverage.

Decision to join the RAMQ plan at age 65
The Participant or his Spouse who reaches the age of 65 may choose to be insured under the basic prescription drug insurance plan provided by the Act respecting prescription drug insurance (RAMQ's plan) rather than to maintain his drug coverage under the group insurance plan. Such choice is then irrevocable.

If, at age 65, the Participant chooses to be insured under the RAMQ's plan, he and his dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan.

If, at age 65, the spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan.

However, the Participant and his dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below:

- the deductible and the coinsurance paid by the Participant under the RAMQ's plan.

Decision to cancel registration with the RAMQ at Age 65
When a Quebec resident reaches the age of 65, he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. The Participant **must therefore cancel their automatic registration** with the RAMQ plan.

The Participant, who continues his coverage with Blue Cross at age 65, must, however, pay an extra premium (the amount of such extra premium varies depending on whether the coverage is on an individual or on a family basis.)

TERMINATION OF BENEFIT

Benefit ends, for you and your dependents, on the date that you retire.

SURVIVOR BENEFIT

After your death, your dependents will continue to be covered at no cost until the first of the following dates:

- 24 months after your death;
- Date on which they cease to be eligible dependents;
- Effective date of similar insurance from another insurer;
- Date the contract is terminated.

HEALTH INSURANCE BENEFIT

Not applicable to permittee members

PURPOSE OF BENEFIT

If you or one of your insured dependents incurs expenses as the result of an illness, pregnancy or accident while your insurance is in effect, you are entitled to reimbursement of the following eligible expenses, **provided expenses are incurred in your province of residence**.

General information

Any health care professional and any specialist listed in this booklet must be duly authorized to practice his profession and be a member in good standing of the corresponding association or professional order.

For the purpose of claims settlement, all expenses described in this insurance benefit must be deemed to be reasonable and normal and must be incurred on recommendation of a physician, unless otherwise indicated.

Each insured in a family is eligible for the maximum amounts specified in this insurance benefit.

TERMS OF SETTLEMENT

- **Deductible:** none

- **Percentage of reimbursement:** see SUMMARY OF BENEFITS for each category of eligible expenses described below.

A. HOSPITALIZATION EXPENSES

. Hospitalization for **active treatment** in a general hospital: semi-private room.

. **Convalescent** and physical rehabilitation hospital: semi-private room, total maximum of 90 days per calendar year.

B. BASIC AND ADJUNCTIVE PROFESSIONAL TREATMENT

Basic professional treatment (50%)
Psychologist/psychotherapist: Eligible maximum per visit: $80
Other specialists: Eligible maximum per visit: $60
Maximum number of visits per calendar year: 20*
(20 x $40 for the psychologist or the psychotherapist)
(20 x $30 for all other specialists)

Adjunctive professional treatment (70%)
Psychologist/psychotherapist: Eligible maximum per visit: $80
Other specialists: Eligible maximum per visit: $60
Maximum number of visits per calendar year: 20*
(20 x $56 for the psychologist or the psychotherapist)
(20 x $42 for all other specialists)

*Combined maximum of 20 visits per calendar year for the psychologist and the psychotherapist.

The following **paramedical services**, without medical recommendation (except for massage therapist):

chiropractor, audiologist, physiotherapist (may be replaced by physical rehabilitation therapist), speech therapist, osteopath, homeopath, orthotherapist, occupational therapist, naturopath, clinical psychologist, psychotherapist, massage therapist, acupuncturist, dietician and podiatrist.

C. MEDICAL EXPENSES

- Stay in a specialized **alcohol and drug addiction detoxification** clinic under the care of a licensed physician and under the supervision of a registered nurse, up to a $2,500 lifetime maximum reimbursement. This paragraph does not apply to the member's dependents.

- The services of a **registered nurse** (or a nursing assistant if a registered nurse is not available) for services rendered at your home, subject to a total maximum of $5,000 per calendar year. The nurse must not be a member of your family nor reside in your home.

- **Ambulance** transportation, including by air or rail, when, for reasons the Insurer deems justified, an insured must be transported to or from the nearest hospital able to provide the necessary emergency care.

- Purchase of **orthopaedic shoes** (i.e. depth shoes and custom-made shoes) and podiatric ortheses for the insured, up to a total maximum reimbursement of $400 per calendar year. Purchases must be made from a recognized orthopaedic supplier.

- Purchase of **medical support hose**, subject to a maximum reimbursement of $100 per calendar year.

- Expenses for **artificial limbs**, including artificial eye.

- Purchase of a **capillary prosthesis** when required following chemotherapy, subject to a lifetime maximum reimbursement of $250.

- Purchase of **mammary prostheses** (including brassieres) when required following a mastectomy, subject to a total maximum reimbursement of $100 per calendar year.

- Purchase of **hearing aids**, subject to a maximum reimbursement of $300 per 36-month period.

- Purchase of an **intrauterine device** (I.U.D.), subject to a maximum reimbursement of $75 per 24-month period.

- Purchase of a **reflectometer**, subject to a maximum reimbursement of $250 per 60-month period.

- **Scleropathy injections** for medical purposes, subject to a maximum reimbursement of $15 per visit. (Only the cost of the medication is eligible).

- Expenses incurred for **an eye examination** by an ophthalmologist or optometrist, subject to a maximum reimbursement of $100 per period of 24 consecutive months. **These expenses do not require medical recommendation.**

- <u>Diagnostic testing</u>
  When deemed necessary for the treatment of an illness or following an accident:

  Laboratory analyses charges, subject to a maximum reimbursement of $200 per calendar year;

  X-ray charges, subject to a maximum reimbursement of $200 per calendar year;

  Charges for CT scans, subject to a maximum reimbursement of $200 per calendar year;

Charges for ultrasounds performed in a private office, subject to a maximum reimbursement of $200 per calendar year;

MRI expenses, subject to a maximum reimbursement of $500 per calendar year;

- **Dental surgeon** fees when sound natural teeth that have never been treated are damaged following an accidental blow to the mouth, subject to a maximum reimbursement of $2,500 per accident.

  Treatment must begin within 90 days of the accident and the Insurer will pay solely for treatment provided within two years of the accident.

- With prior approval from the Insurer, expenses related to a trained seeing-eye dog for an insured who has become blind while coverage is in effect, subject to a maximum lifetime reimbursement of $10,000. No benefits are payable if blindness results from an illness or accident for which the insured consulted a physician, received treatment or a drug prescription during the six months immediately preceding the start of his coverage.

- Purchase of casts, trusses and orthopaedic supports and devices, as well as the purchase or rental of crutches, canes and walkers.

- Purchase or rental of a wheelchair (up to the usual cost of a standard manual wheelchair) and standard manual hospital-type bed for a bedridden-patient. The insured must obtain prior approval from the Insurer before any purchase or rental; failure to comply may result in the refusal of the claim.

- **Oxygen** and rental of devices for its administration.

- Purchase of supplies related to a colostomy, ileostomy and ureterostomy, as well as the purchase of syringes, needles and reagent strips for the control of diabetes.

- Purchase of a continuous positive airway pressure unit (CPAP), (including the following pertaining items: humidifiers and ventilators), subject to a maximum of one purchase per 5 calendar years.

EXCLUSIONS

No benefits are paid to insureds in the following cases:

. Hospitalization expenses and medical care covered under any federal or provincial government legislation;

. Services, care or products that the insured receives free of charge;

. Charges that would not have been required in the absence of insurance coverage;

. Services, treatments or products administered for experimental purposes;

. Expenses for any care, services or products other than those declared necessary by the appropriate authorities for the treatment of an injury or illness;

. Prostheses or treatments for cosmetic purposes;

. Preventive treatments;

. Services of a home care nurse when acting as a midwife or psychotherapist, or when services other than nursing care are provided;

. All family planning interventions (with the exception of an I.U.D.), including artificial insemination and laboratory and other charges incurred in any type of fertility treatment, regardless of whether the infertility is considered an illness or not;

. Charges for dental care services, with the exception of treatment following an accident;

. Expenses incurred due to an illness or accident covered by the CSST or SAAQ, or any other similar legislation or plan;

. Eligible expenses directly or indirectly resulting from:

- bodily injuries intentionally self-inflicted by the insured, whether sane or insane;

- war, declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

. All charges, services, items or products that are not mentioned as eligible in this booklet;

. All expenses incurred outside the insured's province of residence;

. No benefit is payable under this insurance contract if the insured is injured while committing or attempting to commit any criminal act;

. Reimbursable expenses under DRUG INSURANCE or TRAVEL INSURANCE BENEFITS described in this booklet.

CONVERSION PRIVILEGE

The Participant may, within 31 days of the end of his coverage, convert his health insurance to an individual insurance contract offered by the Insurer in such cases. This privilege also applies to dependents.

TERMINATION OF BENEFIT

Benefit ends, for you and your dependents, on the date that you retire.

SURVIVOR BENEFIT

After your death, your dependents will continue to be covered at no cost until the first of the following dates:

- 24 months after your death;
- Date on which they cease to be eligible dependents;
- Effective date of similar insurance from another insurer;
- Date the contract is terminated.

TRAVEL INSURANCE BENEFIT

Not applicable to permittee members

This insurance covers unexpected expenses incurred by you or your dependents while travelling outside of your province of residence. Travel Insurance consists of three components:

A. Hospital and Medical Insurance
B. Trip Cancellation and Interruption Insurance
C. Baggage Insurance

To be reimbursed, eligible expenses incurred must first be authorized by Canassistance.

Payment of eligible expenses is limited to amounts that are in excess of coverage provided by any other plan. Where a court determines that the policy and any other plan(s) provide primary coverage, this benefit will be coordinated with the other plan.

Specific definition

In this benefit **Emergency or Emergency situation** means an illness or injury that requires immediate medical treatment due or related to:

- an injury resulting from an accident;
- a new medical condition which begins during the trip
- a medical condition that existed prior to the trip provided that it is **stable**.

Stable means the Participant, in the 90 days before the departure date (or 90 days before the booking date for Trip Cancellation and Interruption Insurance), has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- been prescribed a new treatment or change in treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established treatment plan);
- been admitted to or treated in a hospital for the condition; or
- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

HOSPITAL AND MEDICAL TRAVEL INSURANCE

ELIGIBLE EXPENSES

The plan reimburses normal and reasonable expenses incurred following an **emergency**, up to a lifetime maximum of $5,000,000 per insured.

Eligible treatments are those declared necessary to stabilize the medical condition and the benefits granted are in addition to those provided by government plans.

Hospitalization, medical and paramedical treatment

- Hospitalization expenses that exceed the amount refundable under the health insurance program of your province of residence;
- Incidental expenses (telephone, television, parking, etc.), up to a maximum of $100 per hospitalization;
- The difference between the physician's fees and the benefits provided under the health insurance program in your province of residence;
- The purchase or rental of crutches, canes or splints and the rental of standard manual wheelchairs, orthopaedic devices or other medical devices when prescribed by the attending physician;
- Fees for the services of a licensed nurse (other than a relative) during hospitalization when prescribed by the attending physician;
- Charges for laboratory analyses and X-rays when prescribed by the attending physician;
- The cost of drugs prescribed by a physician when required for emergency treatment;
- Dental care required to repair or replace sound natural teeth damaged as the result of an accidental blow, up to a maximum of $2,000 per accident per insured. Treatment must be completed within six months of the accident;
- Dentist's fees for any other emergency treatment to relieve pain, up to a maximum of $200 per insured.

Transportation

The following services must be approved and arranged by Canassistance:

- The cost of transportation in a ground or air ambulance to the nearest qualified medical facility, including inter-hospital transfer when the attending physician and Canassistance determine that existing facilities are inadequate to treat or stabilize the patient's condition;
- The cost of repatriating the insured to receive immediate medical attention, following authorization from the attending physician and Canassistance;
- The cost of simultaneously repatriating a travelling companion or any member of the immediate family of the insured also covered under this insurance benefit, if they are unable to return to the point of departure by the means of transportation initially planned;
- Economy class, round-trip airfare for transportation of a family member going to:
  - the hospital where the insured has been confined for at least 7 days, or
  - to identify the deceased, if necessary, prior to disposal of the body;
- Upon presentation of a medical certificate from the attending physician stating that the insured is incapable of operating a vehicle, the cost of returning the insured's vehicle, either private or rental, through a commercial agency, up to a maximum of $1,000;
- In case of death, the cost of preparing and transporting the mortal remains (excluding the cost of a coffin), or the cost of cremation or burial at the place of death, up to a maximum of $7,500.

Living expenses

The cost of accommodations and meals in a commercial establishment when your return must be delayed due to personal illness or injury or for an accompanying member of your immediate family or a travelling companion, up to a maximum of $3,000 ($150 per day for a maximum of 20 days).

Travel assistance

The Canassistance Inc. hotline is available 24 hours a day, 7 days a week. The Canassistance hotline will take the necessary measures to provide you with the required services when you need to consult a physician or be hospitalized following an accident or sudden illness by:

- directing you to an appropriate clinic or hospital;
- advancing funds to the hospital, if necessary;
- confirming medical insurance coverage so that you do not have to make a monetary deposit, which can sometimes be substantial;
- ensuring medical supervision and contacting the family physician;

- coordinating repatriation, if applicable;
- coordinating the return home of dependent children, if a parent is hospitalized;
- making the necessary arrangements for transporting a family member to your side if you are hospitalized for at least seven days and if prescribed by the attending physician;
- coordinating the return of your vehicle if you are unable to bring it back due to illness or an accident.

You also have access to the following services:

- Toll-free telephone assistance 24 hours a day, 7 days a week;
- Delivery of urgent messages;
- Coordination of claims;
- Services of an interpreter for emergency calls;
- Referral to legal counsel in the event of a serious accident;
- Completion of paperwork in the event of death;
- Assistance in the event of loss or theft of identity documents;
- Information on embassies and consulates.

Canassistance can also provide pre-departure information regarding visas and vaccinations.

SPECIFIC RESTRICTIONS

If you are an insured 65 years of age or older, all expenses described in the Hospital and Medical Travel coverage are eligible if they are incurred following an **emergency** which occurs during the first **31 days** of a trip outside the insured's province of residence, provided he is covered under the hospital and health government programs of his province of residence when emergency occurs.

TRIP CANCELLATION AND INTERRUPTION INSURANCE

Trip Cancellation and Interruption Insurance is limited to the reimbursement of expenses that are not reimbursed at the time of the event causing the cancellation, up to a maximum of $5,000 per insured per incident.

EXPENSES COVERED - CAUSES OF TRIP CANCELLATION OR INTERRUPTION

Coverage applies when you must either cancel your trip prior to departure or interrupt or extend your trip after it has begun for any of the following reasons:

- Illness, hospitalization, personal injury or death of yourself or a family member, a travelling companion or a member of your travelling companion's family;
- Illness, hospitalization, personal injury or death of a business associate or key employee;
- Diagnosis of pregnancy after the trip has been purchased (or the date of initial non-refundable deposit) if the departure or return date falls within eight weeks preceding or following the expected date of delivery;
- Summons for jury duty, quarantine or hijacking;
- Disaster that renders your primary residence inhabitable;
- A transfer requested by your employer and requiring that you relocate your primary residence;
- Call to service in the case of police officers, volunteer firefighters, reservists and members of the Armed Forces (excluding military service during a war, declared or not, or participation in peacekeeping efforts);
- Delay due to mechanical failure of your vehicle, bad weather, a traffic accident or a roadblock set up by the police which results in the insured missing a connection or preventing him from continuing the trip as planned,
- provided the vehicle was due to arrive at the connection point at least two hours before the scheduled departure time;
- Death or hospitalization of your host at the destination prior to departure;
- Subpoena to appear as a witness in a trial to be heard during the trip, excluding law enforcement officers;
- Involuntary loss of employment held for more than one year;
- An event in the destination country that leads the Government of Canada to issue a travel advisory to its citizens to avoid travel in that country. Travel arrangements must have been made before the advisory was issued;
- Cancellation of a business meeting due to illness, hospitalization or personal injury of the person with whom arrangements were made;
- Refusal of your visa application for the country to be visited, provided that you were eligible for the visa and that the refusal is not due to late submittal of the application or subsequent to a previous refusal.

ELIGIBLE EXPENSES

In the event of trip cancellation, the plan reimburses the following expenses:

- The pre-paid, non-refundable portion of travel expenses;
- Additional expenses incurred if you decide to continue with your trip when your travelling companion must cancel his trip for one of the cancellation causes covered, up to a maximum of the cancellation penalty applicable at the time your travelling companion must cancel;
- The additional cost of the most economical return airfare to the point of departure and the unused, non-refundable portion of pre-paid travel expenses, upon the occurrence of a covered risk.

The plan also reimburses the following expenses:

- The unused, non-refundable and pre-paid portion of travel costs, if weather conditions prevent you from making the connection from one carrier to another, for at least 30% of the total duration of the trip and if you decide not to continue your trip;
- The additional cost of the most economical fare (by airline, bus or train) to the destination point when you miss a connection for one of the following reasons:
    - Delay of the connecting carrier;
    - A traffic accident involving your private or rental vehicle or the taxi in which you are travelling.
- The additional cost of the most economical method of transportation to join an excursion or group if, after departure, you miss part of the trip due to the occurrence of one of the covered risks;
- The additional cost of the most economical airfare (one way) to the point of departure when you must delay your return due to illness or injury sustained by yourself or a member of your immediate family accompanying you, or a travelling companion.

BAGGAGE COVERAGE

The Baggage benefit covers the loss or damage to the baggage owned by the participant during a trip outside his province of residence, subject to a maximum of $500 per trip, per participant.

In the event the checked baggage is delayed by the carrier for 12 hours or more while en route and before returning to the point of departure, the Insurer will reimburse a maximum of $250, for the purchase of necessary toiletries and clothing. Proof of delay of checked baggage from the carrier along with receipts of purchases must accompany the claim upon presentation to the Insurer when returning from the trip.

This insurance covers expenses to replace passport, driver's license, birth certificate or travel visa in case these documents are lost or stolen, up to a maximum of $50.

Specific conditions

- Where loss is due to theft, burglary, vandalism or disappearance, the participant must notify the police upon discovery of the loss. Failure to report the said loss to the authorities invalidates any claim under this insurance for such loss.
- In the event of loss, the participant must notify the Insurer as promptly as possible and take all reasonable precautions to protect, safeguard or recover his property and must also promptly notify the police and obtain from them written confirmation regarding such loss. The participant must obtain written confirmation from the hotel manager, tour guide or transportation authorities. He must furnish proof of loss or damage and value with a sworn statement within 90 days of the date of loss. Failure to comply with these conditions invalidates claims under this benefit.
- If the covered property is checked with a public carrier and delivery is delayed until after expiry of the coverage, coverage will continue until such property is delivered by the public carrier.
- The Insurer is not liable beyond the actual cash value of the property at the time any loss or damage occurs and may elect to repair or replace any damaged or lost property with other of like quality or value.
- This insurance may not profit, directly or indirectly, any carrier or guarantor.

EXCLUSIONS

a) Applicable to sections A and B

No benefits are paid to the insured in the following cases:

- Failure to contact Canassistance in the event of medical consultation, hospitalization or an event giving rise to a claim;
- Expenses incurred after you have been repatriated for medical reasons;
- Expenses incurred due to pregnancy and related complications arising within the eight-week period preceding the expected date of delivery;
- An accident that occurs during the insured's participation in a sport for remuneration or any other dangerous activity;
- Abuse of medication or drug use, or driving a motor vehicle, aircraft or boat with an alcohol level of more than 80 milligrams to 100 millilitres of blood;
- Expenses for any treatments other than those declared to be medically necessary;

- Nurses' fees for supportive care or services rendered mainly for the patient's comfort;
- Travel in any country for which the Government of Canada has issued a travel advisory to Canadians, when such advisory was issued before the insured arrived in the country;
- Expenses for cosmetic treatment;
- Expenses incurred outside the province of residence when such expenses could have been incurred in the province of residence without endangering the life or health of the insured;
- Expenses incurred when travelling primarily or incidentally to seek medical advice or treatment, even if such a trip has been recommended by a physician;
- Medical or hospital expenses that are not eligible under the government health insurance program in the insured's province of residence;
- Eligible expenses arising from the following situations:
  - Suicide, attempted suicide or intentionally self-inflicted injury, whether the insured is sane or insane;
  - War (declared or not), invasion, incursion, foreign enemy attacks or actions, hostile acts or conflicts between nations, civil war, guerrilla warfare, military campaign or operation, revolt, rebellion, insurrection, riot, civil commotion or uprising, public disturbance, mutiny, piracy, coup d'état, terrorism, threat of terrorism, attacks of any kind, and violence for the furtherment of political goals;
  - Injury sustained while committing or attempting to commit a criminal act;
- The costs reimbursed by the government health insurance program in your province of residence;
- For Trip Cancellation and Interruption Insurance, expenses for a trip undertaken to visit or care for a sick or injured person, when this person's medical condition or death is the cause of cancellation, early return or delayed return;
- For Trip Cancellation and Interruption Insurance, the inability to obtain the desired accommodation, financial difficulties or fear of travel and flying.

b) Applicable to section C

The benefits are reduced or not payable in the event of or with regard to:

- loss of or damage to automobiles or automobile equipment, motorcycles, bicycles (unless registered with the carrier), boats, motors or other conveyances or their accessories, household furnishings or accessories, dentures, artificial limbs, glasses, contact lenses, cash notes, securities, tickets and documents, professional equipment or property, goods brought with the intent of trading them, antiques and collectors items, perishable articles, cosmetics, personal effects, animals or any item that is not part of the usual baggage;

- breakage of fragile or brittle articles unless caused by fire or theft;
- loss or damage due to confiscation or damage by order of any government or public authority, or to illegal transportation or trade, war, demonstration or insurrection or hostilities between nations (whether or not war is declared);
- loss or damage caused by wear and tear, gradual deterioration, moths or vermin or while the article is actually being worked upon or processed;
- theft from an unattended automobile, trailer or other vehicle, unless such vehicle was securely locked or was equipped with a closed compartment which was securely locked and the theft occurred as a result of forcible entry (of which there must be visible marks);
- the maximum amount payable for loss or damage for each item comprising the participant's baggage is $125;
- for the purpose of calculating the maximum, the following items are grouped in categories, and each category is considered, pursuant to the contract, as a single article:

    - jewelry: jewelry, watches, silver, gold or platinum items;
    - furs: fur or fur-trimmed articles;
    - photography equipment: cameras and photography equipment, video cameras and video or audio equipment.

    In addition, the maximum amount payable for loss or damage of the total of the three categories mentioned above is $250;
- in the event of the loss of an article which is part of a set, the measure of loss will be in reasonable and fair proportion to the total value of the set, giving consideration to the importance of such article and with the understanding that such loss cannot be construed to mean total loss of the set;
- loss or damage caused by any imprudent action or omission by the participant. When an article or personal property in question cannot be located and the circumstances of its disappearance cannot be explained or do not lend themselves to a reasonable conclusion that a theft occurred;
- loss or damage to articles specifically insured under any other insurance contract at the time this benefit is in effect.

TERMINATION OF BENEFIT

Benefit ends, for you and your dependents, at retirement or on the date that you reach age 85, whichever occurs first.

Coverage also ends for any insured on the day he is no longer covered under the government health insurance program in his province of residence.

CANASSISTANCE HOTLINE

In the event of a medical EMERGENCY outside the province of residence, the insured or his representative must call CANASSISTANCE as soon as possible at one of the following numbers:

From Canada or the United States: 1-886-491-7726
From anywhere else: 514 286-7726 (collect)

To facilitate communication, the person must identify himself, provide the telephone number from which he is calling as well as the group and certificate numbers.

If calling collect is not possible, BLUE CROSS will reimburse the cost of the call.

SURVIVOR BENEFIT

After your death, your dependents will continue to be covered at no cost until the first of the following dates:

- 24 months after your death;
- Date on which they cease to be eligible dependents;
- Effective date of similar insurance from another insurer;
- Date the contract is terminated.

DENTAL CARE INSURANCE BENEFIT

Not applicable to permittee members

PURPOSE OF BENEFIT

If you or one of your insured dependents incur expenses for recognized dental care provided by a dental surgeon or under his supervision, or by a denturist for removable prostheses, you are entitled to reimbursement of these expenses according to the terms of settlement mentioned in the Summary of Benefits for Plans A and B.

TERMS OF SETTLEMENT

Deductible: the deductible is the portion of eligible expenses that must be paid by the Participant and by his spouse (including children) before the Insurer will make any payment under this contract. It only applies once per calendar year and is specified in the Summary of Benefits for Plans A and B.

Reimbursement

After applying the deductible, if any, the Insurer will reimburse eligible expenses for each of the plans based on the percentages specified in the Summary of Benefits, and up to the amounts indicated in the suggested fee guide for dental services approved by the Association des chirurgiens dentistes (Association of Dental Surgeons) or in the fee guide for denturist of the insured's province of residence (**current year editions**).

The reimbursement per insured, per calendar year, also appears in the Summary of Benefits under Plans A and B.

PRE-DETERMINATION OF BENEFITS

For treatments **exceeding $500**, have your dentist complete the "Pre-determination" section of the claim form to be submitted to the Insurer. You will thus know in advance the exact amount of reimbursement.

PREVENTIVE TREATMENTS

(Plans A and B)

Exams and diagnoses

- complete oral exam (once every 2 years)
- follow-up exam
  Plan A: once per 12-month period
  Plan B: twice per 12-month period
- emergency oral exam
- specific exam

X-rays

- intraoral - periapical
- intraoral - occlusal
- intraoral – bitewings
- extraoral
- sialography
- panoramic film (once every 2 years)
- radiopaque dyes

Laboratory tests and exams

- microbiological culture
- biopsy of soft oral tissue
- biopsy of hard oral tissue
- cytological exam

Preventive treatment

- polishing of coronal portion of teeth
  Plan A: once per 12-month period
  Plan B: twice per 12-month period
- topical application of fluoride
  Plan A: once per 12-month period
- **Plan B:** twice per 12-month period
- oral hygiene instruction (lifetime maximum of 2 instructions)
- pit and fissure sealants (for insureds under 18 years of age)
- tooth positioners (for insureds under 18 years of age)

BASIC TREATMENT

(Plans A and B)

Restorations

- amalgam, acrylic, silicate or composite restoration
- retention pins
- prefabricated stainless-steel or polycarbonate crowns

Endodontics

- pulp capping
- pulpotomy
- emergency pulpotomy
- endodontic traumatism
- root canal treatment
- endodontic surgery
- bleaching (devitalized teeth only)
- apexification

Periodontics

- periodontal surgery
- provisional splinting
- scaling
  Plan A: once per 12-month period
  Plan B: twice per 12-month period
- treatment of acute infections
- desensitization (maximum of 3 teeth per 12-month period)
- other adjunctive periodontal services
- curettage, including root planing:
  code 42000 (first tooth): once per 12-month period
  code 42001: maximum of 7 teeth per 12-month period

Adjustment of removable prostheses

- minor adjustments
- rebasing and relining
- cleaning and polishing of prosthesis

Oral surgery

- removal of erupted teeth (without complication)
- surgical removal (complex)
- surgical excision of cysts and tumours

General adjunctive services

- anaesthesia (related to surgery)

Temporary dressing for emergency pain relief

Finishing of fillings

MAJOR RESTORATIVE TREATMENT

(Plan B only)

Restorations

- Gold foil (if no other material can be used)
- Inlays
- Porcelain inlays (if no other material can be used)

Other restorative services

- Cast post
- Prefabricated metal post
- Re-cementation of inlay or crown
- Removal of inlay or crown

- Crowns (single restorations only), other than prefabricated stainless-steel or polycarbonate crowns and replacement of an existing crown if such crown is at least four years old.
- Fixed bridgework and partial or complete permanent removable prostheses, other than prostheses with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - If the prosthesis was necessary due to the extraction of at least one natural tooth while insurance is in effect, or
  - if the existing prosthesis is at least five years old, or
  - if the temporary prosthesis is replaced by a permanent prosthesis within 12 months of the installation of the temporary one.
- Prosthesis repairs (twice per 12-month period)

ORTHODONTIC CARE

(Plan B only)

The reasonable expenses incurred for orthodontic treatment provided by an orthodontist to correct dental irregularities in a dependent child at least 6 years of age but less than 18 years of age when treatment begins.

Monitoring and adjustment

- oral exam
- unmounted diagnostic models
- removable appliances to reposition teeth
- fixed or cemented appliances
- oral habit control appliances
- retainers
- major comprehensive treatment

EXCLUSIONS AND REDUCTION OF BENEFIT

No benefits are paid to insureds in the following cases:

- Any treatment or appliance related to full-mouth reconstruction to correct vertical dimension or temporo-mandibular joint dysfunction;

- Services provided by a dental hygienist while not under the immediate supervision of a dentist;

- Dental services eligible under Health Insurance Benefit;

- Services and supplies relating to any appliance worn in the practice of a sport;

- Expenses payable or covered under a private or government insurance plan or that would normally be paid or reimbursed under such plans if a claim had been submitted;

- All expenses incurred due to an illness or accident covered by the CSST or SAAQ;

- Attempted suicide or intentionally self-inflicted injury, whether sane or insane;

- Injury or illness resulting from civil unrest, insurrection or war (declared or not) or participation in a riot;

- Services that are not medically required and that are provided for cosmetic purposes or that exceed services normally given in accordance with current therapeutic practice;

- Care or services rendered free of charge or that would have been if there were no insurance coverage, or those not charged to the insured;

- Care or services for implants (except fixed bridgework and partial or complete permanent removable prostheses and crowns related to implants);

- Splinting for periodontal reasons when crowns or inlays are used for this purpose, with or without onlays;

- All charges, services, items or products that are not mentioned as eligible in this booklet.

Limitation of Benefit

For a dependent whose insurance becomes effective more than 31days after his date of eligibility, the maximum amount reimbursed under this insurance benefit for all covered services is limited to $100 during the first twelve months of insurance for services other than orthodontic treatment, while the reimbursement for orthodontic-related expenses is limited to $100 per dependent child insured during the first 36 months of insurance.

TERMINATION OF BENEFIT

Coverage ends, for you and your dependents, on the date that you retire.

SURVIVOR BENEFIT

After your death, your dependents will continue to be covered at no cost until the first of the following dates:

- 24 months after your death;
- Date on which they cease to be eligible dependents;
- Effective date of similar insurance from another insurer;
- Date the contract is terminated.

HOW TO FILE A CLAIM

1) Hospitalization

At short-term hospitals in the province of Quebec, simply present your insurance certificate.

2) Drug Insurance Benefit

The claim procedure includes direct payments through the BLUE CROSS card. Show your BLUE CROSS card to your pharmacist and you will then have to pay only the deductible, if any, as well as your coinsurance.

You will have no claim to submit to your insurer.

3) Health Insurance and Dental Care Insurance Benefits

Obtain detailed receipts and **attach the originals** to the *Claim Forms* obtained from your Association or from AQTIS.

The completed claim form must be received by the Insurer no later than 12 months after the date expenses are incurred.

TO OBTAIN MORE INFORMATION ON YOUR INSURANCE PLAN, PLEASE SEND ALL INQUIRIES TO BLUE CROSS CUSTOMER SERVICE AT THE ADDRESS AND NUMBERS BELOW:

Blue Cross
Group Insurance
P.O. Box 3300, Station B
Montreal (Quebec) H3B 4Y5
1-800-263-2538
514-286-8430

4) Travel Insurance Benefit

The Participant must obtain detailed invoices for hospital, medical and other services and provide the Insurer with an attending physician's certificate confirming that all services for which a claim is being submitted were provided. The Insurer will claim from all government plans the portion of expenses reimbursable thereunder.

If needed, employees may obtain claim forms from the Insurer at the following address:

Blue Cross
Claims/Travel Insurance
P.O. Box 910, Station B
Montreal (Quebec) H3B 3K8
Tel: 514-286-6690

The completed claim form must be received by the Insurer no later than 6 months after the date expenses are incurred.

5) Disability Insurance Benefits

You must notify AQTIS as soon as your total disability begins and you must be under the care and supervision of a physician at the frequency required by your disability.

AQTIS
1001, boul. De Maisonneuve Est
Bureau 900
Montréal (Québec) H2L 4P9

info@aqtis.qc.ca
Tel.: 514-844-2113
Fax: 514-844-3540

SUMMARY OF BENEFITS FOR MEMBERS

LIFE INSURANCE BENEFIT FOR THE PARTICIPANT

Amount of insurance: 1 times the average income, minimum of $5,000
Reduction of 50% at age 70:

- Minimum $5,000
- Maximum $50,000

Reduction to a fixed amount of $5,000 at age 75

Maximum with or without proof of insurability

$100,000

Termination of benefit: retirement

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Applicable to members whose average income is $5,000 or more.

Amount of insurance: 2 times the average income,
minimum of $5,000 (AQTIS income)

Maximum with or without proof of insurability

$200,000

Termination of benefit: age 70 (or retirement, if earlier)

LIFE INSURANCE BENEFIT FOR DEPENDENTS

- Spouse: $10,000
- Child: $5,000

Termination of benefit: retirement of the Participant

CRITICAL CONDITIONS OF THE PARTICIPANT

Applicable to members whose average income is $5,000 or more.

Waiting period:	30 days
Maximum lifetime benefit:	$10,000
Termination of benefit:	age 65 (or retirement, if earlier)
18 critical conditions covered	see description of the benefit

SHORT-TERM DISABILITY INSURANCE BENEFIT

Applicable to members whose average income is $15,500 or more.

Amount of insurance: 75% of the weekly income calculated, based on average income

Maximum with or without proof of insurability

$1,400

Elimination period

hospitalization:	14 days
accident:	14 days
illness:	14 days

Maximum duration: 17 weeks

Benefits are taxable.

- The disabled Participant must contact the Employment Insurance Commission to obtain the benefits to which he is entitled and the Insurer then pays a supplementary benefit to make up the difference, up to 75% (subject to the weekly maximum).

Termination of benefit: age 70 (or retirement, if earlier)

LONG-TERM DISABILITY INSURANCE BENEFIT

Applicable to members whose average income is $20,500 or more.

Amount of insurance:

Members:

60 % of the first $5,000 of the monthly income calculated, based on average income, plus 40% on the excess (benefits are non-taxable)

Members with **dual membership** whose income is partly coming from a production for which the employer pays full contribution:

70 % of the monthly income calculated, based on average income (benefits are taxable)

Maximum with or without proof of insurability :

$10,000

Elimination period:

hospitalization:	17 weeks
accident:	17 weeks
illness:	17 weeks

Maximum duration: age 60

Termination of benefit: age 60 (or retirement, if earlier)

DRUG INSURANCE BENEFIT

Applicable to members whose average income is $5,000 or more.

Deductible: none

Percentage of reimbursement: 70% *

Termination of benefit: retirement

However, when you have paid an amount equivalent to the maximum contribution established by the Régie de l'assurance maladie du Québec (RAMQ), (in coinsurance) in any calendar year, whether for yourself or for your dependents, the amounts subsequently paid during that same calendar year for eligible drugs are reimbursed **100%** by the Insurer.

RAMQ drug list

Direct prescription drug card

*Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

The insured may request a higher cost drug. However, they will be responsible for paying the difference in cost.

Regardless of whether the insured's Physician indicates the prescribed drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

For insureds with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

HEALTH INSURANCE BENEFIT
(in the province of residence)

HOSPITALIZATION EXPENSES:
Applicable to members whose average income is $15,500 or more.

Up to a semi-private room
100%, no deductible

BASIC PROFESSIONAL TREATMENT
Applicable to members whose average income is between $15,500 and $40,999.

Deductible:	none
Percentage of reimbursement:	50%

ADJUNCTIVE PROFESSIONAL TREATMENT
Applicable to members whose average income is $41,000 or more.

Deductible:	none
Percentage of reimbursement:	70%

MEDICAL EXPENSES:
Applicable to members whose average income is $15,500 or more.

Deductible:	none
Percentage of reimbursement:	70%
Termination of benefit:	retirement

TRAVEL INSURANCE BENEFIT

Applicable to members whose average income is $15,500 or more.

Hospital and Medical Travel Insurance

Deductible:	none
Percentage of reimbursement	100%
Lifetime maximum per insured	$5,000,000
Restrictions	Only the first 183 days of a trip are covered. If the Participant or his spouse is 65 years of age and over, only the first 31 days of a trip are covered.*

Note: If the duration of your trip is to exceed the maximum number of days covered under this benefit, we strongly recommend that you take out an individual Travel insurance policy prior to your departure for the number of days that will not be covered under this benefit.

Trip Cancellation and Interruption Insurance	$5,000 per claim, per insured
Baggage Inssurance	$500 per trip, per insured
Termination of benefit	age 85, or retirement, if earlier (age of the Participant)

DENTAL CARE INSURANCE BENEFIT

PLAN A: basic coverage
Applicable to members whose average income is $20,500 to $40,999.

Deductible:	none
Percentage of reimbursement:	
PREVENTIVE TREATMENT:	80%
BASIC TREATMENT:	80%
Total maximum per insured, per calendar year:	$1,500
Fee guide:	current year
Termination of benefit:	retirement

PLAN B: enhanced coverage
Applicable to members whose average income is $41,000 or more.

Deductible:	none
Percentage of reimbursement:	
PREVENTIVE TREATMENT:	80%
BASIC TREATMENT:	80%
MAJOR TREATMENT:	50%
ORTHODONTICS:	50%
Maximum	
• Orthodontics	$2,000 lifetime maximum per child under the age of 18
• Other treatments: Total maximum per insured, per calendar year:	$2,000
Fee guide:	current year
Termination of benefit:	retirement

SUMMARY OF BENEFITS FOR PERMITTEE MEMBERS

LIFE INSURANCE BENEFIT FOR THE PARTICIPANT
Applicable if average income is $10,000 and more.

Amount of insurance: 1 times the average income
Reduction of 50% at age 70:

- Minimum $5,000
- Maximum $50,000

Reduction to a fixed amount of $5,000 at age 75

Maximum with or without proof of insurability

$100,000

Termination of benefit: retirement

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Applicable if average income is $20,500 and more.

Amount of insurance: 1 times the average income, minimum of $20,000 (AQTIS income)

Maximum with or without proof of insurability

$100,000

Termination of benefit: age 70 (or retirement, if earlier)

LIFE INSURANCE BENEFIT FOR DEPENDENTS
Applicable if average income is $10,000 and more.

- Spouse: $10,000

- Child: $5,000

Termination of benefit: retirement of the Participant

CRITICAL CONDITIONS OF THE PARTICIPANT
Applicable if average income is $20,500 and more.

Waiting period: 30 days

Maximum lifetime benefit: $10,000

Termination of benefit: age 65 (or retirement, if earlier)
18 critical conditions covered see description of the benefit

DRUG INSURANCE BENEFIT

Applicable if average income is $20,500 or more.

Deductible: none

Percentage of reimbursement: 70% *

> However, when you have paid an amount equivalent to the maximum contribution established by the Régie de l'assurance maladie du Québec (RAMQ), (in coinsurance) in any calendar year, whether for yourself or for your dependents, the amounts subsequently paid during that same calendar year for eligible drugs are reimbursed **100%** by the Insurer.

RAMQ drug list.

Direct prescription drug card

*Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

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For insureds with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

IMPORTANT NOTICE

Personal information transmitted to us will be kept in your insurance file at **Medavie Inc. and Blue Cross Life Insurance Company of Canada**.

This information will be used solely in the processing of your claims.

Only duly authorized employees or representatives of the Insurer will have access to your information in the course of the company's routine business practices.

Upon thirty (30)-day written notice, you are entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the provincial or federal Act (depending on which applies in your province of residence) regarding the protection of personal information. Please forward your inquiries to:

Access to Information Officer
Medavie Inc. and
the Blue Cross Life Insurance Company of Canada
550, Sherbrooke Street West
Montreal (Quebec) H3A 6T6

medavie.bluecross.ca

medaviesmallsteps.com

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Medavie Blue Cross

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