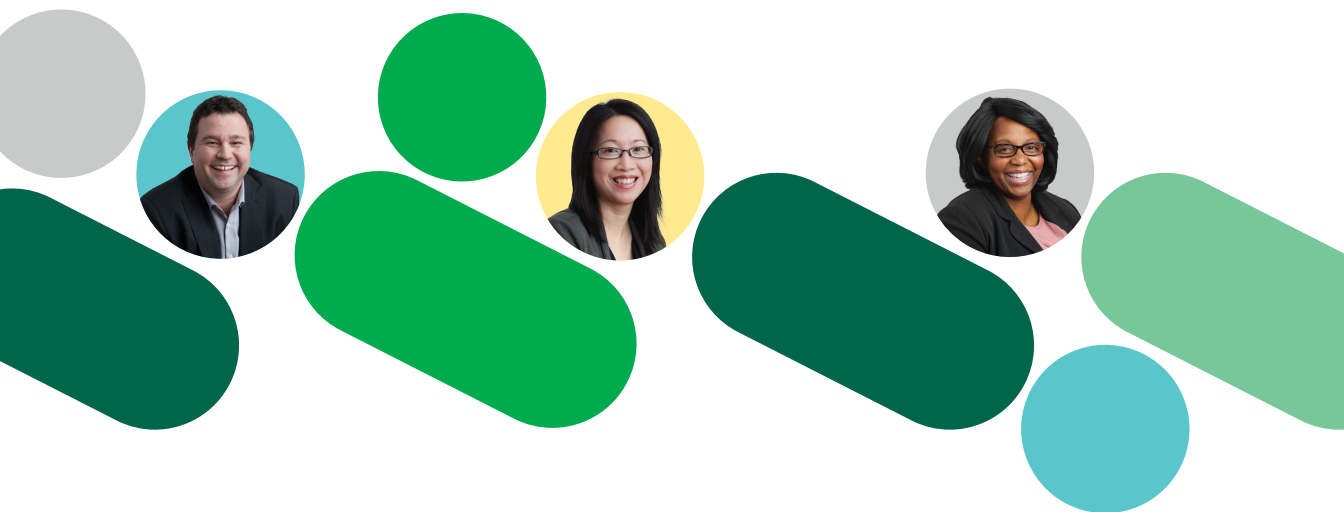




Your plan



ASSOCIATION DES
CHIRURGIENS DENTISTES
DU QUÉBEC

Sogedent  Assurances^{inc}

Cabinet de services financiers

Une filiale de l'Association des chirurgiens dentistes du Québec

Policy 14A00
L'ASSOCIATION DES CHIRURGIENS
DENTISTES DU QUÉBEC
January 1, 2026

SSQ, LIFE INSURANCE COMPANY INC.

ASSOCIATIVE INSURANCE PLAN

from

L'ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

This document shows the contractual provisions in force on January 1, 2026

Policy No.: 14A00

In this document, “SSQ Insurance (or SSQ)” refers to SSQ, Life Insurance Company Inc.

NOTICE REGARDING THE PROTECTION OF YOUR PERSONAL INFORMATION

Protecting your personal information is a priority for SSQ Insurance. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g.: pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g.: preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does SSQ Insurance collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does SSQ Insurance share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers

- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Chief Privacy Officer
625 rue Jacques-Parizeau
Quebec QC G1R 2G5
cpo@beneva.ca

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at:

<https://www.beneva.ca/en/legal-notes-confidentiality/personal-information-protection>

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but SSQ Insurance will not be able to continue providing you with its products or services.

AVAILABLE INFORMATION ON YOUR GROUP INSURANCE PLAN

If your contract has been modified since the production date of this booklet, there may be wording differences between the booklet and the policy. If so, the policy wording will prevail; hence, you are entitled to consult the policy at the policyholder's address and obtain a copy thereof.

The masculine gender is used throughout this document solely for readability purposes and applies to both men and women.

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GENERAL PROVISIONS

DEFINITIONS

Accident

Any bodily injury certified by a physician, resulting from a sudden and unforeseen external cause, directly and independently of any other cause.

Active member of ACDQ

An active member of ACDQ according to the ACDQ statutes.

ACDQ

The Association des chirurgiens dentistes du Québec.

Administrator

Any corporation designated by the policyholder (For the purpose of the present plan, SOGEDENT ASSURANCES INC. has been designated by the policyholder to act as the administrator).

After-Tax Net Income

The net income minus the following amounts:

- a) Quebec Pension Plan or Canada Pension Plan contributions, Employment Insurance contributions, if applicable, and any other universal contributions;
- b) tax payable to the provincial and federal governments.

For the purposes of this plan, the tax payable to the provincial and federal governments is determined by applying the appropriate tax calculation rules to the taxable income. The taxable income is equal to the net income minus the basic personal tax credits, those recognized as tax credits for the spouse and dependent children, as well as child support payments, tax credits for medical expenses, and any other similar required deductions.

The calculation of tax payable specifically excludes contributions to a registered retirement savings plan, a registered education savings plan, charitable donations, or any other optional deductions.

CDA

Canadian Dental Association.

Contract

Agreement between SSQ and the Policyholder regarding the policy whose number identifies the present document.

Day

A calendar day, unless otherwise specified in this policy.

Dental Surgeon

A legally qualified dentist authorized to practise dentistry in Quebec and a member in good standing of the Ordre des dentistes du Québec or another dental regulatory body in Canada or the United States.

Dental surgeon paid on commission or on a percentage basis

Dental surgeon who does not own the dental clinic in which the surgeon practices, in whole or in part, personally or through a company.

Dependent Child

An eligible person who:

- a) is under 21 years of age and over whom the participant or the participant's spouse exercises parental authority, or did exercise parental authority until he reached the age of majority;
- b) does not have a spouse, is 25 years of age or under and is a duly enrolled full-time student at an accredited educational institution and over whom the participant or the participant's spouse would exercise parental authority if he were a minor;
- c) is of full age, without a spouse, and who suffers from a functional deficiency under the Regulation respecting the application of the Drug Insurance Act adopted by the Quebec government, a deficiency that began while this person met one of the definitions provided in paragraph a) or b) above. For the person to be considered as suffering from a functional deficiency, the person must be living with a person who, in addition to being insured as a participant or the spouse of a participant, would exercise parental authority over the functionally deficient person if he were a minor.

Hospitalization

Admission to hospital for a minimum duration of 24 hours, or for day surgery.

Illness

Any deterioration in health or a bodily disorder certified by a physician. For the purposes of this plan, organ donation and its related complications are also considered to be illnesses, as well as complications related to cosmetic surgery.

Income

The professional fees and salary received from practising dentistry, wages earned as a teacher, researcher, administrator or manager related to his profession as a dental surgeon, and any other amount received for professional dentistry services.

In the case of a dental surgeon who is part of a joint stock company in accordance with the Regulation respecting the practice of the dental profession within the partnership of the Professional Code (R.S.Q., c. C-26, s. 93, paragraphs g) and h) and s. 94, paragraph p)), the net income before tax that comes from the company's professional activities is considered a remuneration under the present plan. If a company has more than one shareholder, the portion of the annual net income that comes from professional activities will be determined by taking into account the percentage of voting shares held in the company by the participant, as defined in the shareholders' agreement.

Dividends are not considered as income under the present plan.

Insured

The participant and, where applicable, the participant's spouse and dependent children.

Insurer

SSQ, Life Insurance Company Inc.

Net Income

The income minus the office overhead expenses determined in accordance with the income tax returns when calculating the business income or, when the income tax returns for a given period are not available for the entire period, in accordance with the financial statements.

In the case of a dental surgeon who is part of a joint stock company, the net income is equivalent to the income as defined in the present plan.

Participant

Any dental surgeon (or dentistry student when eligible to the benefit) insured under this contract.

Physician

A person legally licensed and authorized to practise medicine in the region where medical care is provided.

Policyholder

The Association des chirurgiens dentistes du Québec.

Previous Plan

Group insurance plan in force prior to January 1, 2012.

Specialized Resident

A dental surgeon duly enrolled in a graduate program at an academic institution or affiliated with an academic institution for specialization in Canada or the United States.

Spouse

An eligible person who, at the time of the event giving rise to the claim:

- a) is joined to the participant in marriage or in a civil union;
- b) has been living in a conjugal relationship with the participant for at least 12 months and has not been separated from the participant for 90 days or more due to a breakdown in their relationship;
- c) is living in a conjugal relationship with the participant and has a child with this person, and has not been separated from the participant for 90 days or more due to a breakdown in their relationship.

However, if two persons meet the definition of “spouse”, the insurer will recognize only one spouse for all benefits under the same plan. Priority will be granted in the following order:

- a) the eligible spouse whom the participant last designated as such in writing to the insurer, subject to approval of any evidence of insurability required under this policy;
- b) the spouse to whom the participant is legally married.

Subrogation

The substitution of one person or thing in the place of another with respect to a lawful claim. SSQ’s right of subrogation is described later in this “General Provisions” section.

NON-SMOKER STATUS

Participants who wish to receive the rate granted to non-smokers must submit a non-smoker declaration on the appropriate form.

Definition

To be recognized as a non-smoker, the participant must not have used tobacco products in any form (cigarette, cigar, pipe, etc.) during the 12 months prior to the date of his declaration.

Misstatement

Any participant who falsely declares himself to be a non-smoker on his application for insurance or in his last declaration is making a misstatement.

Should it be determined after the participant’s death that the latter made a misstatement, the sum insured payable by the insurer upon the participant’s death shall be calculated based on the premium paid by the participant and the premium rate in effect, upon the participant’s death, for participants in the same age group who are smokers.

Change of Status

A declaration of non-smoker status must be signed by the participant in the case of any changes that require evidence of insurability.

If the status is modified, the smoker rate will then be applicable on the complete sum insured and, if applicable, on the sum insured for the PARTICIPANT'S LIFE INSURANCE, DISABILITY INSURANCE - INCOME PROTECTION and DISABILITY INSURANCE - OFFICE OVERHEAD benefits and for the spouse, on the SPOUSE'S AND DEPENDENT CHILDREN'S LIFE INSURANCE AND ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE.

AMENDMENT TO COVERAGE UNDER GOVERNMENT PLANS

In the event that an amendment to the content or scope of the coverage provided under the government plans should modify the scope of the coverage provided under the DISABILITY INSURANCE – INCOME PROTECTION benefit, the DISABILITY INSURANCE – OFFICE OVERHEAD benefit and the HEALTH INSURANCE benefit, the policyholder and the insurer shall undertake to reach an agreement as quickly as possible to determine how to deal with the financial impact of such amendment.

TEMPORARY NON-ACTIVE STATUS

- a) Should the participant's license be rendered temporarily non-active, the participant residing or not residing in Quebec should keep all benefits in force for himself, his spouse and his dependent children, if applicable.
- b) In the event of disability that occurs during a non-active period, the disability will be deemed to have begun the day after the expected date of the participant's return to practice.

INFORMATION

The administrator shall provide the insurer with all information that it may reasonably require with respect to any matters pertaining to this plan.

The administrator must inform all eligible persons and insureds of their rights and obligations under this plan, and of any amendments thereto.

INCONTESTABILITY

When evidence of insurability is required to approve an eligible person for coverage under one of the benefits of this plan, all statements made in the aforementioned evidence, unless it refers to age or is fraudulent, shall be accepted as true and incontestable after the insurance or benefit of the eligible person has been in force for two years during his lifetime.

If the insurance is cancelled and subsequently reinstated, this two-year period starts again as of the reinstatement date.

For any person insured under the previous plan on December 31, 2012, or for any participant who transfers from the CDA Plan, the two-year period applies as of the date the required evidence of insurability is approved for any amount or partial amount of insurance under the previous plan or the CDA plan.

INSURANCE CERTIFICATE

The administrator issues an insurance certificate to each participant. If a certificate is issued to or in the possession of an individual who for any reason is not insured under this plan, such certificate shall be null and void.

CURRENCY

All payments provided under this plan shall be made in Canadian currency.

EXAMINATION

The insurer is entitled to have any person examined, at its own cost, when such person sustains an accident or becomes totally disabled, and a claim is submitted in his regard.

THIRD-PARTY LIABILITY AND SUBROGATION

You must notify SSQ of any notice served to, or legal action taken against a third party or any judgment, claim or settlement related to an event which may result in entitlement to benefit under the insurance plan.

If you are entitled to receive financial compensation from a third party with respect to which benefits are payable under the contract, you will be required to reimburse SSQ the amount of any benefits overpaid.

SSQ is subrogated to all rights of the insured against a third party liable for damage that results in an entitlement to payment of benefits under the terms of the contract, up to the amounts paid by SSQ. Should SSQ decide to exercise its right of subrogation, the insured may be required to sign a letter of subrogation drafted by SSQ.

BENEFICIARY

Subject to the provisions of the law, the participant may appoint or revoke one or more beneficiaries of his insurance at any time by sending a notice in writing to the administrator. The rights of a beneficiary who predeceased the participant shall return to the participant.

Under the terms of the DISABILITY INSURANCE - OFFICE OVERHEAD benefit, benefits are payable directly to the creditor, subject to the provisions provided under this benefit. For the purposes of this paragraph, "creditor" means the dental surgeon who owns the dental clinic or the dental clinic. If there is no valid beneficiary designation, the participant is the beneficiary.

The insurer and the administrator shall assume no liability as to the validity of any beneficiary appointment or revocation.

ASSIGNMENT AND TRANSFER

The insurance under this plan may not, at any time, be assigned or transferred.

CALCULATION OF PREMIUMS

The total premium payable on any due date is the sum of the various premiums for each benefit and for each participant. This premium is determined in accordance with the rates in effect on that date.

PAYMENT OF PARTICIPANTS' PREMIUMS

All premiums and premium adjustments, where applicable, are payable by the participant to the administrator.

A grace period of 31 days is granted to the participant for the payment of any premium. The benefit or benefits are maintained in force during this period, unless the participant has previously notified the administrator or the insurer in writing that such benefits should be terminated on the due date of the last premium owing.

Upon expiry of the grace period, the participant's benefit or benefits shall terminate automatically if the premium owing for the benefit or benefits in question has not been paid.

PARTICIPANT'S LIFE INSURANCE

ELIGIBILITY

Any dental surgeon who is less than 70 years of age and who performs his usual professional functions in Canada or the United States is eligible for this benefit, as well as any dental surgeon who is a new graduate and who is not disabled under the meaning of this plan.

Any dentistry student is also eligible for this benefit on the commencement of courses at the academic level corresponding to the year of study provided he is a duly enrolled student studying in Quebec and is not disabled under the meaning of this plan.

A student who does not pass his last study session and who wishes to maintain his status as a dentistry student for the purposes of this benefit must confirm in writing that he is retaking the session in question during the same year. He will then maintain this status until the earliest of the following dates:

- a) the date of completion of the retake session if he still does not pass;
- b) the actual date of graduation or, if earlier, the date that represents the end of the 12-month period from the date he would normally have graduated.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

Enrolment in this benefit is optional. Eligible persons who wish to enrol in this benefit must complete an application for insurance to this effect, and must also provide evidence of insurability deemed satisfactory by the insurer.

For a dentistry student who is not disabled under the meaning of this plan, no evidence of insurability is required for any sum insured of \$80,000 or less.

Subject to all other provisions of this benefit, any participant who wishes to amend his coverage must provide evidence of insurability deemed satisfactory by the insurer if the requested amendment is more advantageous than the coverage previously held.

EFFECTIVE DATE OF COVERAGE

- a) The insurance shall take effect on one of the following dates:
 - i) for all persons insured on December 31, 2011, under the participant's life insurance benefit of the previous plan, the insurance under this benefit shall take effect on January 1, 2012, unless the person is a participant who is totally disabled, in which case the insurance shall take effect at the end of the total disability period if he is eligible for the waiver of premium;

- ii) for an application that requires evidence of insurability, the insurance shall take effect on the date on which the evidence of insurability or the declaration of good health is approved, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer, and provided that the dental surgeon is insurable at the regular premium rate on the day the evidence of insurability or the declaration of good health is approved.

If the evidence of insurability or the declaration of good health is not provided within 60 days after the application for insurance was signed, said application shall become null and void;

- iii) for an application that does not require evidence of insurability, the insurance shall take effect on the date the application for insurance is received, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer;
 - iv) for a dental surgeon who is insurable at a premium rate other than the regular rate, his insurance shall take effect on the date the extra premium is received by the administrator or the insurer.
- b) If a dental surgeon should die or become totally disabled due to an accident that occurred within 60 days after completing his application for insurance, but before the last evidence of insurability has been sent to the insurer or before the insurer has approved or declined his application and the evidence of insurability provided, the coverage applied for is deemed to have taken effect at the time of death or total disability, subject to no other conditions.

SPECIALIZED RESIDENCY

- a) A participant who becomes a specialized resident as defined in the DEFINITIONS provision may interrupt or maintain the full amount or a reduced amount of coverage under this benefit for the scheduled specialized residency period, subject to the following provisions:
- i) The participant must inform the administrator or the insurer prior to the start of his specialized residency of the scheduled date of completion of said residency;
 - ii) The participant must continue to pay premiums to the administrator or the insurer for the entire duration of the specialized residency if he has chosen to maintain the full amount of coverage or reduce it, subject to the provisions of the WAIVER OF PREMIUM clause.
- b) If, during the specialized residency period, the participant interrupts his coverage or maintains a reduced amount of coverage, he may, upon completion of said period, become insured once again for the amount of coverage previously held under this benefit without having to prove his insurability, provided that he submits the request within 60 days immediately following the date of completion of the specialized residency period and provided that he did not become disabled during this period.

If the participant did become disabled during this period, he may become insured once again for the amount of coverage held prior to the residency period, as of the termination date of his disability if this date is later than the end of said period.

SUM INSURED

- a) The sum insured payable upon the death of a participant who is under age 65 is equal to the multiple of \$1,000 that he chose upon enrolment and for which the corresponding premium was paid, subject to the insurance minimums and maximums and any indexation set out in this provision. The sum insured is allocated as follows:
- Participant's Life Insurance
 - Partner's Life Insurance
- b) On the plan renewal date following the participant's 65th birthday, the sum insured stipulated for the participant on that date is reduced by 50% and may not exceed \$400,000.
- c) On the plan renewal date following the participant's 70th birthday, the sum insured stipulated for the participant on that date is once again reduced by 50% and may not exceed \$200,000.
- d) On the plan renewal date following the participant's 75th birthday, the sum insured stipulated for the participant on that date is once again reduced by 50% and may not exceed \$100,000.
- e) On the plan renewal date following the participant's 80th birthday, the sum insured stipulated for the participant on that date is once again reduced by 50%, without exceeding a maximum amount of \$50,000.
- f) The sum insured selected upon enrolment may not be less than \$20,000. However, the sum insured may become less than \$20,000 following the stipulated reductions in the sum insured on the participant's 65th, 70th, 75th and 80th birthdays.
- g) Any sum insured resulting from a reduction in the participant's initial sum insured due to his age is rounded off to the nearest multiple of \$1,000.
- h) As of January 1, 2026, the sum insured upon enrolment may not be greater than the following amounts, which are, however, indexed in accordance with the present provision:
- i) \$2,619,000 for a participant under age 65;
 - ii) \$400,000 for a participant between 65 and 69 years old.

The maximum amount applicable to dentistry students is limited to \$250,000.

- i) The sum insured for participants between the ages of 36 and 54 inclusively who perform the main tasks of their usual professional functions is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- j) The sum insured for participants who are 35 years of age or under and who perform the main tasks of their usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the higher of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

- k) No increase in the sum insured can be applied during a total or partial disability period. After the participant's return to work, any indexation of the sum insured that was not applied due to a disability that began in 1994 or later shall be applied on the date of return to work for any new disability period.
- l) The maximum sum insured set out in in subarticle i) of article h) of this provision is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- m) The results of the indexation of the sum insured specified in article l) and the maximum sum insured are rounded off to the nearest multiple of \$1,000.

PREPAYMENT

- a) A participant whose life expectancy is less than 24 months, as certified by his attending physician and subject to approval by the insurer, may obtain prepayment, upon request, of a portion of the sum insured set out in his regard under this benefit. The amount paid, however, is limited to 50% of said sum insured, up to a maximum of \$100,000.

Upon the death of the participant, the sum insured payable will be reduced by the amount of the prepayment and the interest accrued on said amount until the date of death.

- b) The interest rate used for the prepayment is the interest rate credited by the insurer upon payment of the death benefits.
- c) The participant is still responsible for paying the entire premium, unless premium payments are waived.
- d) In addition, the following conditions must be met:
 - i) This plan must be in force at the time of the prepayment request;
 - ii) The beneficiary appointed by the participant must be a revocable beneficiary. If the beneficiary is irrevocable, authorization from this beneficiary is required and must be attached to the prepayment request;
 - iii) The participant's state of health must not be due to a voluntarily self-inflicted injury.

EXCLUSION

If the participant should die during the first two years following the date of enrolment in insurance and his death is the result of a suicide, whether the participant is sane or insane, the sum insured for the participant will not be payable and the insurer's liability shall be limited to refunding the premium paid for said participant's life insurance.

This exclusion also applies to any portion of the sum insured that constitutes an increase other than an increase due to indexation. In this case, the two-year exclusion period begins on the effective date of the increase in the sum insured.

WAIVER OF PREMIUM

- a) Definition of total disability: a participant is totally disabled if, following an illness or accident, he is incapable of carrying out the main tasks of his usual professional functions and for which he is under medical supervision. In the case of a dentistry student or a specialized resident, the state of incapacity in question must prevent the participant from performing the main tasks of a dental surgeon's usual professional functions.

Definition of presumptive total disability: In the event of total and irrecoverable loss of speech, vision in one eye, hearing, the use of one hand or the use of both feet, the person who suffers the loss is deemed to be totally disabled, regardless of whether or not he holds another job and whether or not he is under the care of a physician, provided the loss is caused by an illness or accident.

- b) Definition of total disability period: for the purpose of applying the WAIVER OF PREMIUM provision, any continuous period of total disability or successive periods of total disability resulting from the same illness or the same accident and separated by a period of less than 12 consecutive months of regular work. If, during a given period, the total disability is the result of an illness or accident that is completely independent of the illness or accident that caused the previous total disability, it is considered to be a new total disability period. This definition applies to the waiver of premium only.
- c) A participant under age 65 who has been totally disabled for at least 6 consecutive months is entitled to a waiver of premium under this benefit. All premiums paid during the first 6 months of total disability are then reimbursed to the participant.

However, the waiver of premium applies only to the premium that corresponds to the sum insured for which this provision was selected.

Proof of the participant's total disability must be deemed satisfactory by the insurer.

- d) The waiver of premium shall terminate on the earliest of the following dates:
- i) the date on which the participant is no longer totally disabled;
 - ii) the date on which the participant is unable or unwilling to provide the insurer with satisfactory proof of his total disability;
 - iii) the date on which the participant turns 85.
- e) The participant may choose, in his application for insurance, to apply the present WAIVER OF PREMIUM provision to all or part of the sum insured. If the participant chooses not to apply the present waiver of premium provision to the sum insured in question, this choice is irrevocable unless the participant chooses to increase the sum insured under this benefit, or chooses to enrol in or increase the sum insured under the DISABILITY INSURANCE – INCOME PROTECTION benefit or the DISABILITY INSURANCE – OFFICE OVERHEAD benefit and provides evidence of insurability deemed satisfactory by the insurer.

CONVERSION PRIVILEGE

- a) If the insurance in force under this benefit terminates before the participant's 80th birthday and while the contract is in force due to the fact that the participant is no longer part of the group or if there is a reduction of the sum insured under the present benefit according to the attained age, the participant is entitled to convert the amount of group insurance reduced in whole or in part in an individual one-year term life insurance contract or a term-life insurance contract to age 65, 70 or 100, without having to provide evidence of insurability and subject to the following conditions:
- i) the participant must, within 31 days following the date of termination of his insurance or reduction of the sum insured, send a notice in writing to the insurer along with the initial premium for the proposed contract;
 - ii) the individual contract shall come into force on the date the participant is no longer a member of the group or on the date of the reduction of the sum insured under this benefit;
 - iii) the premium for the individual contract is determined based on the participant's age and sex, his smoking habits when the individual insurance comes into force, according to the insurer's usual rates, and according to the characteristics applicable to his coverage;
 - iv) in all cases of conversion, the first year premium of the individual insurance may not be higher than the premium of a one-year term life insurance, with the exception of this first year premium, the obtained premium is leveled;
 - v) the amount of the individual insurance may not be greater than the sum insured held by the participant on the date of his departure from the group or on the date the amount of insurance reduced. The amount of converted insurance may not be greater than \$500,000;
 - vi) If a reduced amount of insurance is converted, any future right of conversion may not exceed the \$500,000 maximum indicated in paragraph v) of the present provision for all contracts issued from the conversion right.

The individual contract that results from this conversion privilege does not contain a waiver of premium provision or an indexation provision for the sum insured.

If the participant dies during the 31-day period during which he was entitled to exercise his conversion right and before the conversion of his insurance, the amount of insurance which was entitled to convert is payable under the present benefit.

- b) In the event that this benefit should terminate without the possibility of replacing it with group insurance from another insurer, the insurer shall, within 31 days following the date of termination, automatically provide participants with a non-cancellable individual life insurance contract with guaranteed renewal for an amount that corresponds to the sum insured on the date of termination of this benefit. The insurer agrees to charge its customary individual life insurance rates in this regard.

The individual contract that results from this conversion privilege does not contain a waiver of premium provision and an indexation provision for the sum insured.

TERMINATION OF INSURANCE

Insurance for all participants shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the termination date of the plan or of this benefit, subject to the provisions set out in the WAIVER OF PREMIUM provision of this benefit;
- b) the due date of any premium that is not paid by the participant, if such premium is not paid before the end of the grace period;
- c) the date on which the participant is no longer a dental surgeon, except in the case of retirement;
- d) the date of termination requested by the participant, provided he sent a written request to this effect to the Administrator or the insurer before the date in question, otherwise on the date such written request is received;
- e) the date on which the participant collects or allows to be collected, due to false claims or misrepresentations by himself or a third party, benefits to which he is not entitled under this benefit, with the exception, however, of the non-smoker status, without regard for any other recourse that may be exercised by the insurer;
- f) the date on which he turns 85.

CLAIMS

All claims must be submitted on the forms provided by the insurer within 90 days immediately following the date of the event giving rise to the claim, and satisfactory written proof must be sent to the insurer within 12 months immediately following the date on which benefits are payable.

Failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of benefits provided the claim, proof and information are provided as soon as it is reasonably possible to do so. However, such claim, proof and information must be sent to the insurer no later than 12 months following the date of the event giving rise to the claim; otherwise, any benefits for the period elapsed between the deadline and the date on which proof of disability is sent to the insurer may not be paid.

The insurer reserves the right to request additional information or proof, and to have the insured examined by a physician of its choice.

ACCIDENTAL DEATH OR DISMEMBERMENT

SPECIAL DEFINITION

Loss

The total and permanent loss of speech, hearing or eyesight, or loss of use of a limb as indicated in the Schedule of Losses under this benefit. In the case of toes, however, the term “loss” means the severing of all the toes on the foot at the metacarpophalangeal joint.

ELIGIBILITY

Any dental surgeon under 65 years of age who performs his usual professional functions in Canada or the United States is eligible for this benefit on the date he enrolls in the following benefits of this plan: PARTICIPANT'S LIFE INSURANCE, DISABILITY INSURANCE – INCOME PROTECTION or DISABILITY INSURANCE – OFFICE OVERHEAD. The same is true for any dental surgeon who is a new graduate and who is not totally disabled under the meaning of this plan.

Any student is also eligible for this benefit, provided he is a duly enrolled student studying in Quebec, and is not disabled under the meaning of this plan.

A student who does not pass his last study session and who wishes to maintain his status as a 4th-year dentistry student for the purposes of this benefit must confirm in writing that he is retaking the session in question during the same year. He will then maintain this status until the earliest of the following dates:

- a) the date of completion of the retake session if he still does not pass;
- b) the actual date of graduation or, if earlier, the date that represents the end of the 12-month period from the date he would normally have graduated.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

Enrolment in this benefit is optional, and conditional upon enrolment in one of the following benefits under this plan: PARTICIPANT'S LIFE INSURANCE, DISABILITY INSURANCE – INCOME PROTECTION or DISABILITY INSURANCE – OFFICE OVERHEAD.

Eligible persons who wish to enrol in this benefit must complete an application for insurance to this effect, and must also provide evidence of insurability deemed satisfactory by the insurer.

Subject to all other provisions of this benefit, any participant who wishes to amend his coverage must provide evidence of insurability deemed satisfactory by the insurer if the requested amendment is more advantageous than the coverage previously held.

EFFECTIVE DATE OF COVERAGE

a) The insurance shall take effect on one of the following dates:

- i) for all dental surgeons insured on December 31, 2011, under the accidental death or dismemberment benefit of the previous plan, the insurance under this benefit shall take effect on January 1, 2012, unless the participant is totally disabled, in which case the insurance shall take effect at the end of the total disability period if he is eligible for waiver of premium;
- ii) for an application that requires evidence of insurability, the insurance shall take effect on the date on which the evidence of insurability or the declaration of good health is approved, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer.

If the evidence of insurability or the declaration of good health is not provided within 60 days after the application for insurance is signed, said application shall become null and void;

- iii) for an application that does not require evidence of insurability, the insurance shall take effect on the date the application for insurance is received, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer.
- b) If a dental surgeon should die or become totally disabled due to an accident that occurred within 60 days after completing his application for insurance, but before the last evidence of insurability has been sent to the insurer or before the insurer has approved or declined his application and the evidence of insurability provided, the coverage applied for is deemed to have taken effect at the time of death or total disability, subject to no other conditions.

SPECIALIZED RESIDENCY

a) A participant who becomes a specialized resident as defined in the DEFINITIONS provision may interrupt or maintain the full amount or a reduced amount of coverage under this benefit for the scheduled specialized residency period, subject to the following provisions:

- i) The participant must inform the administrator or the insurer prior to the start of his specialized residency of the scheduled date of completion of said residency;
 - ii) The participant must continue to pay premiums to the administrator or the insurer for the entire duration of the specialized residency if he has chosen to maintain the full amount of coverage or reduce it, subject to the provisions of the WAIVER OF PREMIUM clause.
- b) If, during the specialized residency period, the participant interrupts his coverage or maintains a reduced amount of coverage, he may, upon completion of said period, become insured once again for the amount of coverage previously held under this benefit without having to prove his insurability, provided that he submits the request within 60 days immediately following the date of completion of the specialized residency period and provided that he did not become disabled during this period.

If the participant did become disabled during this period, he may become insured once again for the amount of coverage held prior to the residency period, as of the termination date of his disability if this date is later than the end of said period.

SUM INSURED IN CASE OF ACCIDENT

- a) The sum insured in case of an accident, or a percentage of this amount as set out in this provision, shall become payable when an accident results in death or a loss as defined under this benefit. This amount is equal to the multiple of \$1,000 chosen by the participant upon enrolment and for which the corresponding premium was paid, subject to the insurance minimums and maximums and any indexation set out in this provision.
- b) The sum insured selected may not be lower than \$20,000. As of January 1, 2026, it may not be higher than \$904,000, subject to indexation, however, in accordance with this provision. In addition, it may not exceed the higher of the following amounts:
 - i) the sum insured under the PARTICIPANT'S LIFE INSURANCE benefit,
 - ii) 100 times the sum insured under the DISABILITY INSURANCE – INCOME PROTECTION benefit,
 - iii) 20 times the sum insured under the DISABILITY INSURANCE – OFFICE OVERHEAD benefit.

The maximum amount applicable to dentistry students is limited to \$250,000.

- c) When an accident results in one of the losses indicated in the Schedule of Losses below and such loss occurs after the commencement of the insurance and within 365 days following the date of the accident, the insurer agrees to pay the participant or his beneficiary an amount equal to the percentage of the sum insured in case of an accident, in accordance with the percentages set out in the following schedule:

SCHEDULE OF LOSSES

Loss from the accident	Percentage
Death	100%
Hemiplegia	100%
Paraplegia	100%
Quadriplegia	100%
Loss of one hand	100%
Loss of one foot	100%
Loss of one arm	100%
Loss of one leg	100%
Loss of sight of one eye	100%
Loss of speech or hearing	100%
Loss of thumb or index	100%
Loss of one ear	100%
Loss of all toes of one foot	25%

When a participant sustains more than one loss (refer to Schedule of Losses above) as a result of the same accident, the sum insured to which he is entitled may not exceed 100% of the sum insured that he selected under this benefit and for which the corresponding premium was paid.

- d) In the event of the participant's accidental death, provided that the sum insured held by the participant under this benefit is \$150,000 or more and subject to all other provisions of this benefit, the insurer agrees to pay, in addition to the sum insured set out in the Schedule of Losses above:
- i) an annual benefit of \$5,000 for each dependent child who attends a recognized post-secondary institution, provided that registration takes place within 5 full years immediately following the date of death. The maximum benefit period for each child is 4 years;
 - ii) the amount of reasonable and necessary expenses incurred by the participant's spouse for professional training to qualify him for a position for which he would not otherwise be qualified, up to a maximum of \$10,000, and provided that such training is part of a specific program and the expenses in question are incurred within 36 months immediately following the participant's date of death.

- e) In the event of the participant's accidental death more than 50 kilometres from his home, and subject to all other provisions of this benefit, the insurer agrees to reimburse up to \$10,000 in expenses incurred to return the participant's remains to the first place of delivery in his city of residence, including the cost of preparing the body for transportation.
- f) The sum insured for participants aged 36 to 54 inclusive who perform the main tasks of their usual professional functions is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- g) The sum insured for participants who are 35 years of age or under and who perform the main tasks of their usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the higher of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- h) No increase in the sum insured can be applied during a total or partial disability period. After the participant's return to work, any indexation of the sum insured that was not applied due to a disability that began in 1994 or later shall be applied on the date of return to work for any new disability period.
- i) The maximum sum insured set out in this provision is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- j) The results of the indexation of the sum insured and the maximum sum insured are rounded off to the nearest multiple of \$1,000.

LIMITATIONS AND EXCLUSIONS

The insurer will not pay the sum insured in case of an accident if the accident occurs:

- a) During a trip or flight in any type of aircraft while the participant is a crew member or performing any function relative to the flight;
- b) Self-inflicted injuries, suicide or attempted suicide, regardless of the state of mind of the insured;
- c) As a result of a riot or a war, whether war is declared or not;
- d) Due to an illness or infection, except for infections that are the direct result of an accident;
- e) As a result of a criminal act committed by the participant or attempts to commit. However, this exclusion does not apply to impaired driving;
- f) The insured's active service in the armed forces;

- g) Poisoning, intoxication or drug use by the insured;
- h) Injuries exhibiting no visible external wound or contusion on the body, except in the case of drowning or internal injuries revealed by surgery or autopsy.

WAIVER OF PREMIUM

- a) Definition of total disability: a participant is totally disabled if, following an illness or accident, he is incapable of carrying out the main tasks of his usual professional functions and for which he is under medical supervision. In the case of a dentistry student or a specialized resident, the state of incapacity in question must prevent the participant from performing the main tasks of a dental surgeon's usual professional functions.

Definition of presumptive total disability: In the event of total and irrecoverable loss of speech, vision in one eye, hearing, the use of one hand or the use of both feet, the person who suffers the loss is deemed to be totally disabled, regardless of whether or not he holds another job and whether or not he is under the care of a physician, provided the loss is caused by an illness or accident.

- b) Definition of total disability period: for the purpose of applying the WAIVER OF PREMIUM provision, any continuous period of total disability or successive periods of total disability resulting from the same illness or the same accident and separated by a period of less than 12 consecutive months of regular work. If, during a given period, the total disability is the result of an illness or accident that is completely independent of the illness or accident that caused the previous total disability, it is considered to be a new total disability period. This definition applies to waiver of premium only.
- c) A participant under age 65 who has been totally disabled for at least 6 consecutive months is entitled to a waiver of premium under this benefit. All premiums paid during the first six months of total disability are then reimbursed to the participant.
- d) The waiver of premium shall terminate on the earliest of the following dates:
 - i) the date on which the participant is no longer totally disabled;
 - ii) the date on which the participant is unable or unwilling to provide the insurer with satisfactory proof of his total disability;
 - iii) the date on which the participant turns 71.

TERMINATION OF INSURANCE

Insurance for all participants shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the termination date of the plan or of this benefit, subject to the provisions set out in the WAIVER OF PREMIUM provision of this benefit;
- b) the due date of any premium that is not paid by the participant, if such premium is not paid before the end of the grace period;

- c) the date on which the participant is no longer a dental surgeon, except in the case of retirement;
- d) the requested date of termination, provided the participant sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- e) the date on which the participant collects or allows to be collected, due to false claims or misrepresentations by himself or a third party, benefits to which he is not entitled under this benefit, without regard for any other recourse that may be exercised by the insurer;
- f) the date on which he turns 71.

CLAIMS

All claims must be submitted on the forms provided by the insurer within 90 days immediately following the date of the event giving rise to the claim, and satisfactory written proof must be sent to the insurer within 12 months immediately following the date on which benefits are payable.

Failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of benefits provided the claim, proof and information are provided as soon as it is reasonably possible to do so. However, such claim, proof and information must be sent to the insurer no later than 12 months following the date of the event giving rise to the claim; otherwise, any benefits for the period elapsed between the deadline and the date on which proof of disability is sent to the Insurer may not be paid.

The insurer reserves the right to request additional information or proof, and to have the insured examined by a physician of its choice.

DISABILITY INSURANCE - LOSS OF INCOME

SPECIAL DEFINITIONS

Elimination Period

The period during which the participant is unable to perform, in whole or in part, the main tasks of his usual professional functions due to a partial or total disability resulting from an illness or accident, before being entitled to benefit payments under this contract.

Disability Period and Recurring Disability

For the purpose of applying the BENEFITS and the WAIVER OF PREMIUMS provisions of this benefit, any continuous period of total or partial disability or successive periods of disability resulting from the same illness or the same accident and separated by a period of less than 12 consecutive months of regular work. If, during a given period, the disability is the result of an illness or accident that is completely independent of the illness or accident that caused the previous disability, it is considered to be a new disability period.

Partial Disability

A state of incapacity resulting from an illness or accident, which reduces the participant's ability to perform his usual professional functions and which, consequently, results in a loss of net income.

Any dental surgeon suffering from an HIV infection (infection by the Human Immunodeficiency virus), from Hepatitis B or C or from any other transmissible critical disease will be in partial disability with respect to the period in which disclosure to his patients of his infection or disease or of practice restrictions due to his infection or disease are recommended or imposed.

In the case of a dental surgeon practicing dental surgery in Québec, disclosure of his state of health or practice restrictions can be issued by l'Ordre des Dentistes du Québec, or by a decree from the Ministère de la santé et des services sociaux, following a hospital ruling or any recommendations or decisions from any authority, any institution or any committee empowered in such matter.

In the case of a dental surgeon practicing dental surgery in a Canadian province other than the province of Québec, or in a state of the United States, such disclosure of his state of health or practice restrictions can be issued by a ruling authority, any institution or any committee empowered in such matter and having jurisdiction in the territory where the dental surgeon is practicing.

Total Disability

A state of incapacity resulting from an illness or accident, which prevents the participant from performing the main tasks of his usual professional functions and for which he is under medical supervision. In the case of a dentistry student or a specialized resident, the state of incapacity in question must prevent the participant from performing the main tasks of a dental surgeon's usual professional functions.

Any dental surgeon suffering from an HIV infection (infection by the human immunodeficiency virus), Hepatitis B or C or any other serious communicable disease is also considered to be totally disabled for the period in which he is prohibited from practising due to his state of health, whether prohibited by the Ordre des dentistes du Québec or by an order issued by the Ministère de la santé et des services sociaux, or in accordance with a hospital ruling.

In the case of a dental surgeon practicing dental surgery in Québec, disclosure of his state of health or practice restrictions can be issued by l'Ordre des Dentistes du Québec, or by a decree from the Ministère de la santé et des services sociaux, following a hospital ruling or any recommendations or decisions from any authority, any institution or any committee empowered in such matter.

In the case of a dental surgeon practicing dental surgery in a Canadian province other than the province of Québec, or in a state of the United States, such disclosure of his state of health or practice restrictions can be issued by a ruling authority, any institution or any committee empowered in such matter and having jurisdiction in the territory where the dental surgeon is practicing.

Presumptive total disability

In the event of total and irrecoverable loss of speech, vision in one eye, hearing, the use of one hand or the use of both feet, the person who suffers the loss is deemed to be totally disabled, regardless of whether or not he holds another job and whether or not he is under the care of a physician, provided the loss is caused by an illness or accident.

ELIGIBILITY

Any dental surgeon who is less than 70 years of age and who performs his usual professional functions in Canada or the United States is eligible for this benefit, as well as any dental surgeon who is a new graduate and who is not disabled under the meaning of this plan.

Any dentistry student is also eligible for this benefit, provided he is a duly enrolled student studying in Quebec, and is not disabled under the meaning of this plan.

A student who does not pass his last study session and who wishes to maintain his status as a dentistry student for the purposes of this plan must confirm in writing that he is retaking the session in question during the same year. He will then maintain this status until the earliest of the following dates:

- a) the date of completion of the retake session if he still does not pass;
- b) the actual date of graduation or, if earlier, the date that represents the end of the 12-month period from the date he would normally have graduated.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

Enrolment in this benefit is optional. Eligible persons who wish to enrol in this benefit must complete an application for insurance to this effect, and must also provide evidence of insurability deemed satisfactory by the insurer.

For a dentistry student who is not disabled under the meaning of this plan, no evidence of insurability is required for a sum insured of \$500 provided that the application for insurance form is signed before December 31 of the year of graduation.

Subject to all other provisions of this benefit, any participant who wishes to amend his coverage must provide evidence of insurability deemed satisfactory by the insurer if the requested amendment is more advantageous than the coverage previously held.

EFFECTIVE DATE OF COVERAGE

a) The insurance shall take effect on one of the following dates:

- i) for all dental surgeons insured on December 31, 2011, under the income protection benefit of the previous plan, the insurance under this benefit shall take effect on January 1, 2012, unless the participant is totally disabled, in which case the insurance shall take effect at the end of the total disability period;
- ii) for an application that requires evidence of insurability, the insurance shall take effect on the date on which the evidence of insurability or the declaration of good health is approved, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer, and provided that the dental surgeon is insurable at the regular premium rate on the date on which the evidence of insurability or the declaration of good health is approved.

If the evidence of insurability or the declaration of good health is not provided within 60 days after the application for insurance is signed, said application shall become null and void;

- iii) for an application that does not require evidence of insurability, the insurance shall take effect on the date the application for insurance is received, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer;
 - iv) for a dental surgeon who is insurable at a premium rate other than the regular rate, his insurance shall take effect on the date the extra premium is received by the administrator or the insurer.
- b) If a dental surgeon should become totally disabled due to an accident that occurred within 60 days after completing his application for insurance, but before the last evidence of insurability has been sent to the insurer or before the insurer has approved or declined his application and the evidence of insurability provided, the coverage applied for is deemed to have taken effect at the time of total disability, subject to no other conditions.

SPECIALIZED RESIDENCY

- a) A participant who becomes a specialized resident as defined in the DEFINITIONS provision may interrupt or maintain the full amount or a reduced amount of coverage under this benefit for the scheduled specialized residency period, subject to the following provisions:
 - i) The participant must inform the administrator or the insurer prior to the start of his specialized residency of the scheduled date of completion of said residency;
 - ii) The participant must continue to pay premiums to the administrator or the insurer for the entire duration of the specialized residency if he has chosen to maintain the full amount of coverage or reduce it, subject to the provisions of the WAIVER OF PREMIUM clause.
- b) If, during the specialized residency period, the participant interrupts his coverage or maintains a reduced amount of coverage, he may, upon completion of said period, become insured once again for the amount of coverage previously held under this benefit without having to prove his insurability, provided that he submits the request within 60 days immediately following the date of completion of the specialized residency period and provided that he did not become disabled during this period.

If the participant did become disabled during this period, he may become insured once again for the amount of coverage held prior to the residency period, as of the termination date of his disability if this date is later than the end of said period.

- c) In the event of a disability that occurs during the specialized residency period, the disability will be deemed to have begun the day after the scheduled completion date of the specialized residency. This delay, however, does not apply to the WAIVER OF PREMIUM provision.

BENEFITS

Monthly Sum Insured

The sum insured is a multiple of \$100 and may not be less than \$500. Furthermore, as of January 1, 2026, it may not be greater than \$20,200 for a dental surgeon. However, this maximum is indexed in accordance with this provision. For a dentistry student, the sum insured may not be greater than \$2,500, or greater than \$3,500 for a dentistry student in their last year of study.

The sum insured for participants aged 36 to 54 inclusive who perform the main tasks of their usual professional functions is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

The sum insured for participants who are 35 years of age or under and who perform the main tasks of their usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the higher of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

No increase in the sum insured can be applied during a total or partial disability period. After the participant's return to work, any indexation of the sum insured that was not applied due to a disability that began in 1994 or later shall be applied on the date of return to work for any new disability period.

The maximum sum insured set out in this provision is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

The results of the indexation of the sum insured and the maximum sum insured are rounded off to the nearest multiple of \$100.

Benefit payable

The benefits payable under this benefit are non-taxable, as long as premiums are fully paid by the participant. In the case where premiums, for this benefit, are paid by any other person or organization, it is possible that premiums have to be added to the taxable income of the participant insured under this benefit, in which case, the non-taxable portion of benefits may also be affected. It is the participant's full responsibility to adjust his income tax return accordingly.

Elimination Period

Participants may choose from the following elimination periods:

- a) 30 days;
- b) 60 days;
- c) 90 days;
- d) 120 days;
- e) 180 days.

The days that make up the elimination period can be accumulated in a non-consecutive manner, provided that the relapse is the result of the same illness or the same accident and occurs within 180 days following the return to work.

When calculating the elimination period for a partial disability, any days included in a disability period during which the dental surgeon is required to reduce his professional activities due to a partial disability, including days when the dental surgeon performs his functions, are taken into account in the calculation.

For a dentistry student, the elimination period begins on the date the participant interrupts his studies due to a disability.

Total Disability

When a participant becomes totally disabled, he is entitled to the sum insured upon expiry of the applicable elimination period, provided that the premium paid corresponds to the coverage selected, taking into account any indexation set out in this benefit.

Presumptive Total Disability

If there is presumptive total disability due to one of the losses described in the definition of total disability, the monthly benefit entitlement begins on the day the participant sustains the loss if that day is prior to the day on which the benefit entitlement would otherwise have begun.

Partial Disability

- a) To give rise to benefits, a partial disability does not have to be preceded by a total disability period. The elimination period applies in the same manner as for a total disability.
- b) In the event of partial disability, the participant's monthly benefit entitlement corresponds to a portion of the sum insured. This portion is equal to the percentage of the after-tax net income lost by the participant due to his disability.
- c) The percentage of net income lost by the participant due to his partial disability is determined based on the participant's pre-disability net income that correspond to the higher of the following two amounts:
 - i) the highest average monthly income for 12 consecutive months during the 24-month period prior to the disability period, excluding any period of maternity or paternity leave and any period during which the dental surgeon is taking a specialized residency;
 - ii) the average monthly income for the period of 24 consecutive months preceding the disability period, excluding any period of maternity or paternity leave and any period during which the dental surgeon is taking a specialized residency.

Prorated Benefit

The monthly benefit is prorated, where applicable, at a rate of 1/30 for each day of disability. The amount payable may not, under any circumstances, exceed the amount that would have been payable for a full month of disability.

Commencement of Benefits

Benefit payments shall begin at the end of the elimination period.

Termination of Benefits

- a) Under the “age 65” option, if the disability begins before the participant’s 63rd birthday, benefit payments shall continue for the duration of the disability, but not beyond age 65. If the disability begins after the participant’s 63rd birthday, benefit payments shall continue for a maximum of 24 months, but may not continue beyond the end of the disability or beyond the participant’s 71st birthday.
- b) Under the “age 60” option, if the total disability begins before the participant’s 58th birthday, benefit payments shall continue for the duration of the disability, but not beyond age 60. If the disability begins after the participant’s 58th birthday, benefit payments shall continue for a maximum of 24 months, but may not continue beyond the end of the disability or beyond the participant’s 65th birthday.
- c) Under the “age 55” option, if the total disability begins before the participant’s 53rd birthday, benefit payments shall continue for the duration of the disability, but not beyond age 55. If the disability begins after the participant’s 53rd birthday, benefit payments shall continue for a maximum of 24 months, but may not continue beyond the end of the disability or beyond the participant’s 65th birthday.
- d) Benefit payments shall cease on the date the participant fails to submit to an examination by a physician appointed by the insurer.
- e) Benefit payments shall cease on the date the participant fails to submit the proof requested by the insurer.
- f) Benefit payments shall cease upon the death of the participant.

Indexation of Disability Benefit

- a) If selected at the time of enrolment and if the required premium was paid to the insurer when the disability began, the benefits payable due to disability are indexed after each consecutive 12-month indemnity period.

This annual indexation cannot be negative, and is equal to the lesser of 3% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending 6 months prior to the date on which the indexation should be applied. The results of the indexation are rounded off to the nearest multiple of \$1.

- b) For the purpose of calculating the benefit payable due to partial disability, the participant’s pre-disability income is also indexed in the manner set out in the previous paragraph.

Reintegration Program

When the totally disabled participant's state of health allows it, he must take part in a program to integrate him back into his occupation of dental surgeon, subject to approval from the insurer. The benefit payable is then reduced by 50% of the after-tax net income that he receives under the program. The expenses associated with the application of such a program, when approved by the participant and the insurer, are paid by the insurer.

LIMITATIONS AND EXCLUSIONS

No benefits will be paid for a disability period:

- a) that results from participation in a riot or a war, whether war is declared or not;
- b) that results from voluntarily self-inflicted injuries, unless such injuries are due to the progression of a previously identified mental illness;
- c) that results from a criminal act committed by the participant. However, this exclusion does not apply to impaired driving;
- d) that results from a normal, uncomplicated pregnancy;
- e) during which the participant is not receiving medical treatment or is not under the regular care of a physician, unless the person's medical condition is stable, as certified by a physician;
- f) during which the participant does not participate in a rehabilitation program recommended by the insurer.

WAIVER OF PREMIUM

- a) A participant who has been totally disabled for at least 6 consecutive months, is eligible for benefits due to total disability under this benefit, and is under age 65 for a participant insured under the "age 65" option, under age 60 for a participant insured under the "age 60" option, and under age 55 for a participant insured under the "age 55" option, is entitled to a waiver of premium under this benefit. As a result, all premiums paid during the first 6 months of total disability are then reimbursed to the participant.
- b) The waiver of premium shall terminate on the earliest of the following dates:
 - i) the date on which the participant is no longer totally disabled;
 - ii) the date on which the participant is unable or unwilling to provide the insurer with satisfactory proof of his total disability;
 - iii) the date on which the participant turns 71 for a participant insured under the "age 65" option;
 - iv) the date on which the participant turns 65 for a participant insured under the "age 60" option or under the "age 55" option.

CONVERSION PRIVILEGE

In the event that this benefit should terminate without the possibility of replacing it with group insurance from another insurer, the insurer shall, within 31 days following the date of termination, automatically provide participants with non-cancellable individual income protection insurance with guaranteed renewal and offering similar coverage, in accordance with its customary rates for individual income protection insurance.

The individual income protection insurance that results from this conversion privilege is similar to the group insurance held by the participant in terms of the benefit, the sum insured and the cut-off age for coverage; it differs from the group insurance in the following ways:

- a) the minimum elimination period is 30 days;
- b) the indexation of benefits is equal to the lesser of 3% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending 6 months prior to the date on which the indexation should be applied;
- c) the individual contract that results from this conversion privilege does not contain an indexation provision for the sum insured.

TERMINATION OF INSURANCE

The insurance for all participants shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the date of termination of the plan or of this benefit, subject to the provisions set out in the WAIVER OF PREMIUM provision of this benefit;
- b) the due date of any premium that is not paid by the participant, if such premium is not paid before the end of the grace period;
- c) the date on which the participant is no longer a dental surgeon;
- d) the requested date of termination, provided the participant sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- e) the date on which the participant collects or allows to be collected, due to false claims or misrepresentations by himself or a third party, benefits to which he is not entitled under this benefit, with the exception, however, of the non-smoker status, without regard for any other recourse that may be exercised by the insurer;
- f) the date on which the participant retires;
- g) the date on which the participant no longer meets the definition of 4th-year dentistry student if he does not become insured as a dental surgeon;
- h) the date on which the dentistry student interrupts his studies;

- i) the date on which the participant turns 71 for a participant insured under the “age 65” option;
- j) the date on which the participant turns 65 for a participant insured under the “age 60” or the “age 55” option.

CLAIMS

All claims must be submitted on the forms provided by the insurer within 90 days immediately following the date of the event giving rise to the claim.

Satisfactory proof regarding the cause and duration of the disability, including a medical report, must be submitted to the insurer within 90 days following the onset of disability, but no later than 15 days after the date on which the participant resumed his usual professional functions. The participant must also submit proof of continuing disability whenever requested by the insurer, within 31 days following the date of such request. If proof is not submitted within the prescribed periods, the participant may lose his entitlement to benefits for the period from the end of the time period granted to the date on which proof of the participant’s disability is received by the insurer.

Failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of benefits provided the claim, proof and information are provided as soon as it is reasonably possible to do so. However, such claim, proof and information must be sent to the insurer no later than 12 months following the date of onset of the disability; otherwise, any benefits for the period elapsed between the deadline and the date on which proof of disability is sent to the insurer may not be paid.

The insurer reserves the right to request additional information or proof, and to have the insured examined by a physician of its choice.

DISABILITY INSURANCE - OFFICE OVERHEAD

SPECIAL DEFINITIONS

Elimination Period

The period during which the participant is unable to perform, in whole or in part, the main tasks of his usual professional functions due to a partial or total disability resulting from an illness or accident, before being entitled to indemnity payments under this benefit.

Disability Period and Recurring Disability

For the purposes of the application of the INDEMNITY and the WAIVER OF PREMIUMS provisions, any continuous period of disability or any successive periods of disability resulting from the same illness or the same accident and separated by a period of less than 12 consecutive months of regular work. If in the course of the same period of disability, a disability occurs due to a new cause, the latest will be considered to have occurred at the same time as the first one and the period of disability will not be extended for this reason alone.

Partial Disability

A state of incapacity resulting from an illness or accident, which reduces the participant's ability to perform his usual professional functions and which, consequently, results in a loss of net income.

Any dental surgeon suffering from an HIV infection (infection by the Human Immunodeficiency Virus), from Hepatitis B or C or from any other transmissible critical disease will be in partial disability with respect to the period in which disclosure to his patients of his infection or disease or of practice restrictions due to his infection or disease are recommended or imposed.

In the case of a dental surgeon practicing dental surgery in Québec, disclosure of his state of health or practice restrictions can be issued by l'Ordre des Dentistes du Québec, or by a decree from the Ministère de la santé et des services sociaux, following a hospital ruling or any recommendations or decisions from any authority, any institution or any committee empowered in such matter.

In the case of a dental surgeon practicing dental surgery in a Canadian province other than the Province of Québec, or in a State of the United States, such disclosure of his state of health or practice restrictions can be issued by a ruling authority, any institution or any committee empowered in such matter and having jurisdiction in the territory where the dental surgeon is practicing.

Total Disability

A state of incapacity resulting from an illness or accident, which prevents the participant from performing the main tasks of his usual professional functions and for which he is under medical supervision. In the case of a dentistry student or a specialized resident, the state of incapacity in question must prevent the participant from performing the main tasks of a dental surgeon's usual professional functions.

Any dental surgeon suffering from an HIV infection (infection by the Human Immunodeficiency Virus), Hepatitis B or C or any other serious communicable disease is also considered to be totally disabled for the period in which he is prohibited from practising due to his state of health, whether prohibited by the Ordre des dentistes du Québec or by an order issued by the Ministère de la santé et des services sociaux, or in accordance with a hospital ruling.

In the case of a dental surgeon practicing dental surgery in Québec, disclosure of his state of health or practice restrictions can be issued by l'Ordre des Dentistes du Québec, or by a decree from the Ministère de la Santé et des services sociaux, following a hospital ruling or any recommendations or decisions from any authority, any institution or any committee empowered in such matter.

In the case of a dental surgeon practicing dental surgery in a Canadian province other than the province of Québec, or in a State of the United States, such disclosure of his state of health or practice restrictions can be issued by a ruling authority, any institution or any committee empowered in such matter and having jurisdiction in the territory where the dental surgeon is practicing.

Presumptive total disability

In the event of total and irrecoverable loss of speech, vision in one eye, hearing, the use of one hand or the use of both feet, the person who suffers the loss is deemed to be totally disabled, regardless of whether or not he holds another job and whether or not he is under the care of a physician, provided the loss is caused by an illness or accident.

ELIGIBILITY

Any dental surgeon who is less than 70 years of age and who performs his usual professional functions in a private clinic in Canada or the United States is eligible for this benefit.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

Enrolment in this benefit is optional. Dental surgeons who wish to enrol in this benefit must complete an application for insurance to this effect, and must also provide evidence of insurability deemed satisfactory by the insurer.

The application for insurance of any dental surgeon paid on commission or on a percentage basis must also be signed by the premium payer.

Subject to all other provisions of this benefit, any participant who wishes to amend his coverage must provide evidence of insurability deemed satisfactory by the insurer if the requested amendment is more advantageous than the coverage previously held.

EFFECTIVE DATE OF COVERAGE

a) The insurance shall take effect on one of the following dates:

- i) for all dental surgeons insured on December 31, 2011, under the office overhead expenses benefit of the previous plan, the insurance under this benefit shall take effect on January 1, 2012, unless the participant is totally disabled, in which case the insurance shall take effect at the end of the total disability period;
- ii) for an application that requires evidence of insurability, the insurance shall take effect on the date on which the evidence of insurability or the declaration of good health is approved, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer, and provided that the dental surgeon is insurable at the regular premium rate on the date on which the evidence of insurability or the declaration of good health is approved.

If the evidence of insurability or the declaration of good health is not provided within 60 days after the application for insurance is signed, said application shall become null and void;

- iii) for an application that does not require evidence of insurability, the insurance shall take effect on the date the application for insurance is received, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer;
 - iv) for a dental surgeon who is insurable at a premium rate other than the regular rate, his insurance shall take effect on the date the extra premium is received by the administrator or the insurer.
- b) If a dental surgeon should become totally disabled due to an accident that occurred within 60 days after completing his application for insurance, but before the last evidence of insurability has been sent to the insurer or before the insurer has approved or declined his application and the evidence of insurability provided, the coverage applied for is deemed to have taken effect at the time of total disability, subject to no other conditions.

SPECIALIZED RESIDENCY

- a) A participant who becomes a specialized resident as defined in the DEFINITIONS provision may interrupt or maintain the full amount or a reduced amount of coverage under this benefit for the scheduled specialized residency period, subject to the following provisions:
- i) The participant must inform the administrator or the insurer prior to the start of his specialized residency of the scheduled date of completion of said residency;
 - ii) The participant must continue to pay premiums to the administrator or the insurer for the entire duration of the specialized residency if he has chosen to maintain the full amount of coverage or reduce it, subject to the provisions of the WAIVER OF PREMIUM clause.

- b) If, during the specialized residency period, the participant interrupts his coverage or maintains a reduced amount of coverage, he may, upon completion of said period, become insured once again for the amount of coverage previously held under this benefit without having to prove his insurability, provided that he submits the request within 60 days immediately following the date of completion of the specialized residency period and provided that he did not become disabled during this period.

If the participant did become disabled during this period, he may become insured once again for the amount of coverage held prior to the residency period, as of the termination date of his disability if this date is later than the end of said period.

- c) In the event of a disability that occurs during the specialized residency period:
- i) If the participant is not required to bear eligible office overhead expenses in a reasonable and customary manner during his specialized residency period, the disability will be deemed to have begun the day after the scheduled date of completion of the specialized residency. This delay, however, does not apply to the WAIVER OF PREMIUM provision;
 - ii) If the participant is required to bear eligible office overhead expenses in a reasonable and customary manner during the specialized residency period, indemnity payments will be made at the end of the elimination period. The amount of the benefit will be based on the portion of expenses that the participant is required to bear in a reasonable and customary manner from the start date of his specialized residency to the start date of his disability, subject to all other provisions regarding indemnity payments. After the scheduled date of completion of the specialized residency, the amount of the indemnity will be determined in accordance with the terms and conditions of this benefit.

INDEMNITY

Monthly Sum Insured

The sum insured corresponds to a multiple of \$100 and may not be less than \$500. As of January 1, 2026, the sum insured chosen at the time of membership may not be greater than \$50,100 for Options 1, 2 and 3, and \$10,700 for Option 4. These maximums are indexed in accordance with this provision.

The sum insured for participants aged 36 to 54 inclusive who perform the main tasks of their usual professional functions is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

The sum insured for participants who are 35 years of age or under and who perform the main tasks of their usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the higher of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

No increase in the sum insured can be applied during a total or partial disability period. After the participant's return to work, any indexation of the sum insured that was not applied due to a disability that began in 1994 or later shall be applied on the date of return to work for any new disability period.

The maximum sum insured set out in this provision is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.

The results of the indexation of the sum insured and the maximum sum insured are rounded off to the nearest multiple of \$100.

Elimination Period

Participants may choose from the following elimination periods:

- a) 7 days
- b) 14 days
- c) 30 days

For participants with a 30-day elimination period, the days that make up the elimination period can be accumulated in a non-consecutive manner provided that the relapse is a result of the same illness or the same accident and occurs within 180 days following the return to work.

When calculating the elimination period for a partial disability, any days included in a disability period during which the dental surgeon is required to reduce his professional activities due to a partial disability, including days when the dental surgeon performs his functions, are taken into account in the calculation.

Total Disability

- a) When a participant becomes totally disabled, the beneficiary is entitled, after expiry of the applicable elimination period, to reimbursement of the office overhead expenses as defined in this benefit, up to the maximum monthly indemnity established based on the Option chosen by the participant, subject to the insurance minimums and maximums and any indexation set out in this benefit.

- b) In the event of total disability, the maximum monthly indemnity that can be paid to the beneficiary corresponds to a percentage of the sum insured, in accordance with the following and subject to any limits set out in this benefit:

Duration of total disability after the elimination period	Percentage
Option 1	
•for each of the first 3 months	100%
•for each of the next 6 months	65%
•for each of the next 3 months	40%
Option 2	
•for each of the first 12 months	100%
Option 3	
•for each of the first 3 months	100%
•for each of the next 4 months	75%
•for each of the next 17 months	50%
Option 4 ⁽¹⁾	
•for each of the first 2 months	100%
•for each of the following 2 months	75%
•for each of the following 2 months	50%

- ⁽¹⁾ Only Option 4 is offered to participants who are dental surgeons paid on commission or on a percentage basis with a contractual agreement binding this dental surgeon and the dental surgeon that owns the dental clinic or the dental clinic.

Partial Disability

- a) To give rise to indemnity payments, a partial disability does not have to be preceded by a total disability period. The elimination period applies in the same manner as with a total disability.
- b) In the event of partial disability, the benefit is a monthly indemnity that corresponds to the net operating expenses actually incurred by the participant during the partial disability period, up to a maximum of the monthly indemnity the beneficiary would have received in the case of total disability.

Net operating expenses means the amount of the monthly expenses eligible as office overhead expenses as defined in the eligible office overhead expenses provision that are actually incurred by the participant during the partial disability, minus any gross professional fees actually billed.

Presumptive Total Disability

If there is presumptive total disability due to one of the losses described in the definition of total disability, the monthly indemnity entitlement begins on the day the participant sustains the loss if that day is prior to the day on which the indemnity entitlement would otherwise have begun.

Eligible Office Overhead Expenses

- a) Eligible office overhead expenses under this benefit include the participant's share of the following expenses that are incurred in a reasonable and customary manner in the practice of his profession in a private clinic, it being understood that expenses relating to periods extending over more than one month are prorated:
 - i) employee remuneration and the participant's contribution as an employer to various government plans and to the employees' group insurance and pension plans;
 - ii) the cost of public utilities such as hydro, telephone and water;
 - iii) rent, property taxes, and either the depreciation or the monthly payments on a mortgage taken out for the portion of the building encompassing the dental surgeon's clinic (the participant must choose between depreciation or monthly mortgage payments at the beginning of the disability period);
 - iv) the cost of laundry, caretaking and maintenance services;
 - v) fees for professional services such as accounting, legal services or billing;
 - vi) the payments arising from a direct financing lease, and either the depreciation or the equivalent principal and interest payments for the furniture, equipment or materials required by the participant to exercise his profession; these payments include taxes and maintenance expenses;
 - vii) the participant's membership fees for the various professional associations;
 - viii) supplies used by dental hygienists in the dental surgeon's office;
 - ix) other day-to-day expenses.
- b) The following expenses are not considered to be eligible office overhead expenses:
 - i) salaries, professional fees or other income payable to the Participant, as well as the portion of the professional fees that represents the personal compensation for the dental surgeons paid on commission or on a percentage basis or the replacement dental surgeons to perform the participant's tasks during his total disability;
 - ii) the cost of purchasing merchandise, pharmaceutical products and other supplies, with the exception of those set out in subsection viii) of paragraph a);
 - iii) expenses for which the participant was not responsible prior to his disability.

- c) Subject to paragraph a) and b) of this provision, the office overhead expenses that are eligible under this benefit for dental surgeons paid on commission or on a percentage basis who signed a agreement are those amounts that must be remitted to the beneficiary for the disability period in accordance with a contractual agreement that existed prior to the disability period binding this dental surgeon and the dental surgeon that owns the clinic or the dental clinic.
- d) When more than one dental surgeon practices within the same dental clinic and subject to paragraph a) and b) of this provision, the eligible office overheads are determined by taking into account:
 - i) in the presence of a written agreement providing the distribution of the office overhead expenses, other than based on fees billed, the percentage allocated to the participant, in accordance with this agreement.
 - ii) if there is no written agreement, the percentage of fees billed by the participant compared to the total fees billed by all dental surgeons practicing within the same dental clinic, based on the last 12 months before the participant's disability.

This rule does not apply to the case provided for in paragraph c) above.

Coordination by indirect offset

Monthly benefits are reduced in a way that the total monthly benefits payable under the disability insurance - office overhead benefit and similar benefits of other sources shall not exceed 100% of the eligible office overhead expenses, as defined above. Benefits payable under other sources are any benefits received or that the participant would be entitled to receive under any individual, group or association insurance plan.

Extension of Indemnity Period

If the disability continues beyond the end of the indemnity period provided in the case of total or partial disability, this period can be extended, up to the earliest of the following dates:

- a) the date on which an additional period of 12 months ends;
- b) the date on which the total of all reimbursements received from the insurer corresponds to
 - i) 8.1 times the sum insured held by the participant under Option 1, or
 - ii) 12.0 times the sum insured held by the participant under Option 2, or
 - iii) 14.5 times the sum insured held by the participant under Option 3, or
 - iv) 4.5 times the sum insured held by the participant under Option 4.

This extension is conditional upon continuing disability.

The percentage of the sum insured used to determine the maximum indemnity during such extension is the same as the percentage used at the end of the normal indemnity period.

Prorated Indemnity

The monthly indemnity is prorated, where applicable, at a rate of 1/30 for each day of disability for the month in which the disability begins or ends.

Commencement of Indemnity

Indemnity payments shall commence after expiry of the elimination period.

Termination of Indemnity

Indemnity payments shall terminate on the earliest of the following dates:

- a) the date on which the total disability ends after the elimination period indicated in paragraph b) of the total disability provision of this benefit;
- b) if the total disability continues beyond the indemnity period, the date the extension under the Extension of Indemnity Period provision of this benefit ends;
- c) the date on which the Participant is no longer disabled;
- d) the date on which the participant fails to submit to an examination by a physician appointed by the insurer;
- e) the date on which the participant fails to submit the evidence of insurability requested by the insurer.

Death of Participant

Should the participant die while entitled to an indemnity under this benefit, the insurer shall continue to make indemnity payments to the appointed beneficiary, or, if no beneficiary is appointed, to the participant's estate in order to cover the participant's portion of the office overhead expenses for a maximum period of 3 months immediately following his death. The amount paid for each month may not, under any circumstances, exceed the maximum amount that would have otherwise been paid if the participant were still alive.

Should the participant die while not entitled to an indemnity under this benefit, the insurer shall make indemnity payments for the first 3 months to the appointed beneficiary, without regard for the elimination period or, if no beneficiary is appointed, to the participant's estate, upon submission of supporting documents.

LIMITATIONS AND EXCLUSIONS

No indemnity will be paid for a disability period:

- a) that results from participation in a riot or a war, whether war is declared or not;

- b) that results from voluntarily self-inflicted injuries, unless such injuries are due to the progression of a previously identified mental illness;
- c) that results from a criminal act committed by the participant. However, this exclusion does not apply to impaired driving;
- d) during which the participant is not receiving medical treatment or is not under the regular care of a physician, unless the person's medical condition is stable, as certified by a physician.

WAIVER OF PREMIUM

- a) A participant under age 65 who has been totally disabled for at least 6 consecutive months and who is eligible for an indemnity under this benefit due to total disability, is entitled to a waiver of premium under this benefit. As a result, all premiums paid during the first six months of total disability are then reimbursed to the participant.
- b) The waiver of premium shall terminate on the earliest of the following dates:
 - i) the date on which the participant is no longer totally disabled;
 - ii) the date on which the participant is unable or unwilling to provide the insurer with satisfactory proof of his total disability;
 - iii) the date on which the participant turns 71.

CONVERSION PRIVILEGE

In the event that this benefit should terminate without the possibility of replacing it with group insurance from another insurer, the insurer shall, within 31 days following the date of termination, automatically provide participants with non-cancellable individual office overhead expenses insurance with guaranteed renewal and offering similar coverage, in accordance with its usual rates for individual office overhead expenses insurance.

The individual office overhead expenses insurance that results from the conversion privilege is similar to the group insurance held by the participant, except for the following:

- a) the minimum elimination period is 30 days;
- b) the individual contract does not contain an indexation provision for the sum insured.

TERMINATION OF INSURANCE

The insurance for all participants shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the date of termination of the plan or of this benefit, subject to the provisions set out in the WAIVER OF PREMIUM provision of this benefit;

- b) the due date of any premium that is not paid by the participant, if such premium is not paid before the end of the grace period;
- c) the date on which the participant is no longer a dental surgeon;
- d) the requested date of termination, provided the participant sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- e) the date on which the participant collects or allows to be collected, due to false claims or misrepresentations by himself or a third party, benefits to which he is not entitled under this plan, with the exception, however, of the non-smoker status, without regard for any other recourse that may be exercised by the insurer;
- f) the date on which the participant retires;
- g) the date on which the participant turns 71.

CLAIMS

All claims must be submitted on the forms provided by the insurer within 90 days immediately following the date of the event giving rise to the indemnity.

Satisfactory proof regarding the cause and duration of the disability, including a medical report, must be submitted to the insurer within 90 days following the onset of disability, but no later than 15 days after the date on which the participant resumed his usual professional functions. The participant must also submit proof of continuing disability whenever requested by the insurer, within 31 days following the date of such request. If proof is not submitted within the prescribed periods, the participant may lose his entitlement to indemnity payments for the period from the end of the time period granted to the date on which proof of the participant's disability is received by the insurer.

Failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of indemnities provided the claim, proof and information are provided as soon as it is reasonably possible to do so. However, such claim, proof and information must be sent to the insurer no later than 12 months following the date of onset of the disability; otherwise, any indemnities for the period elapsed between the deadline and the date on which proof of disability is sent to the insurer may not be paid.

The insurer reserves the right to request additional information or proof, and to have the insured examined by a physician of its choice.

SPOUSE'S AND DEPENDENT CHILDREN'S LIFE INSURANCE AND ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

SPECIAL DEFINITION

Loss

The total and permanent loss of speech, hearing or eyesight, or loss of use of a limb as indicated in the schedule of losses under this benefit.

SPECIFIC CONDITION

Dependent children must be at least 24 hours old to be eligible for this benefit.

ELIGIBILITY

The spouse or less than 70 years of age or a dependent child of a participant becomes eligible for insurance on the later of the following dates:

- a) the effective date of this plan if, on such date, this person is recognized as the spouse or dependent child of a participant;
- b) the date on which this person becomes the spouse or dependent child of a participant.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

- a) Enrolment in this benefit is optional. Enrolment of the dependent children must be accompanied by enrolment of the spouse, where applicable. Dependent children can be enrolled, however, in cases where there is no spouse. Dependent children must enrol at the same time as the participant, otherwise evidence of insurability deemed satisfactory by the insurer must be provided for said dependent children.

The participant must submit an application for insurance for his eligible spouse and his eligible dependent children.

The spouse and the dependent children must submit evidence of insurability deemed satisfactory by the insurer.

- b) Subject to all other provisions of this benefit, any participant who wishes to amend the coverage for his spouse must submit evidence of insurability for the spouse deemed satisfactory by the insurer if the requested amendment is more advantageous than the coverage previously held.
- c) Participation to the ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE of the present benefit is optional and conditional to the participation of the spouse or the dependent children to the LIFE INSURANCE of the present benefit.

EFFECTIVE DATE OF COVERAGE

- a) The spouse's insurance shall take effect on one of the following dates:
- i) for all persons insured on December 31, 2011, under the accidental death or dismemberment benefit of the previous plan, the insurance under this benefit shall take effect on January 1, 2012, unless the participant is totally disabled, in which case the insurance shall take effect at the end of the total disability period;
 - ii) if the spouse is required to submit evidence of insurability, the insurance shall take effect on the date on which the evidence of insurability or the declaration of good health is approved, provided that at least 1/12 of the annual premium has been paid to the administrator or the insurer, and provided that the spouse is insurable at the regular premium rate on the day on which the evidence of insurability or the declaration of good health is approved;

If the evidence of insurability or the declaration of good health is not provided within 60 days after the application for insurance is signed, said application shall become null and void;
 - iii) if the spouse is insurable at a premium rate other than the regular rate, her insurance shall take effect on the date the extra premium is received by the administrator or the insurer;
- b) Subject to all other provisions of this benefit, the insurance for any dependent child who is not hospitalized shall take effect on the later of the following dates:
- i) the effective date of the participant's insurance if the latter applies for dependent children's coverage at the time of insuring himself;
 - ii) the effective date of the spouse's insurance if the participant applies for such coverage without first applying for dependent children's coverage;
 - iii) the date on which the dependent child becomes eligible for the coverage;
 - iv) the date on which evidence of insurability is approved by the insurer if the application for the dependent children is completed on a date other than the date of the participant's or spouse's application;
 - v) the date on which at least 1/12 of the annual premium for the dependent children has been paid to the administrator or the insurer.
- c) Subject to all other provisions of this benefit, if a dependent child is hospitalized on the day his insurance would normally take effect, such dependent child shall not become insured until 24 hours following his return to the participant's home. For participants who already have coverage for their dependent children, however, a newborn shall become insured 24 hours after birth.

SPECIALIZED RESIDENCY

- a) A participant who becomes a specialized resident as defined in the DEFINITIONS provision may interrupt or maintain the full amount or a reduced amount of coverage under this benefit for the scheduled specialized residency period, subject to the following provisions:
 - i) The participant must inform the administrator or the insurer prior to the start of his specialized residency of the scheduled date of completion of said residency;
 - ii) The participant must continue to pay premiums to the administrator or the insurer for the entire duration of the specialized residency if he has chosen to maintain the full amount of coverage or reduce it, subject to the provisions of the WAIVER OF PREMIUM clause.
- b) If, during the specialized residency period, the participant interrupts his coverage or maintains a reduced amount of coverage, he may, upon completion of said period, become insured once again for the amount of coverage previously held under this benefit without having to prove his insurability, provided that he submits the request within 60 days immediately following the date of completion of the specialized residency period and provided that he did not become disabled during this period.

If the participant did become disabled during this period, he may become insured once again for the amount of coverage held prior to the residency period, as of the termination date of his disability if this date is later than the end of said period.

SUM INSURED

- a) The sum insured payable upon the death of a spouse who is under age 65 is equal to the multiple of \$1,000 selected by the participant upon enrolment and for which the corresponding premium was paid, subject to the insurance minimums and maximums and any indexation set out under this benefit.
- b) On the plan renewal date following the spouse's 65th birthday, the sum insured stipulated for the spouse on that date is reduced by 50%.
- c) On the plan renewal date following the spouse's 70th birthday, the sum insured stipulated for the spouse on that date is once again reduced by 50%.
- d) On the plan renewal date following the spouse's 75th birthday, the sum insured stipulated for the spouse on that date is once again reduced by 50%.
- e) The sum insured selected upon enrolment may not be less than \$20,000. However, the sum insured may become less than \$20,000 following the stipulated reductions in the sum insured on the spouse's 65th, 70th and 75th birthdays.

Notwithstanding any other provisions of this benefit, any sum insured resulting from a reduction of the spouse's initial sum insured due to her age is rounded off to the nearest multiple of \$1,000.

- f) As of January 1, 2026, the sum insured may not be greater than the following amounts, which are, however, indexed in accordance with this provision:
 - i) \$904,000 for a spouse under age 65;
 - ii) \$400,000 for a spouse who is 65 to 69 years old.
- g) The sum insured in case of death for the spouse of a participant between the ages of 36 and 54 inclusive, who performs the main tasks of his usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- h) The sum insured in case of death for the spouse of a participant who is 35 years of age or under and who performs the main tasks of his usual professional functions, is indexed on January 1 of each year. This annual indexation is equal to the higher of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- i) No increase in the sum insured can be applied during a total or partial disability period giving entitlement to the waiver of premiums. After the participant's return to work, any indexation of the sum insured that was not applied due to a disability that began in 1994 or later shall be applied on the date of return to work for any new disability period.
- j) The maximum sum insured set out in this provision is indexed on January 1 of each year. This annual indexation is equal to the lesser of 5% or the annual rate of variation in the Consumer Price Index as published by Statistics Canada for the 12-month period ending the previous June 30. This indexation, however, cannot be negative.
- k) The results of the indexation of the sum insured are rounded off to the nearest multiple of \$1,000.
- l) For Participants whose spouse's or dependent children's life insurance took effect prior to January 1, 1999, the sum insured payable on the death of a dependent child is equal to \$10,000 if the sum insured for the spouse is \$150,000 or less.

The sum insured payable on the death of a dependent child is equal to \$20,000 if the sum insured for the spouse is greater than \$150,000 upon enrolment.

- m) For participants whose spouse's or dependent children's life insurance took effect on January 1, 1999 or later, the sum insured payable on the death of a dependent child is equal to \$10,000, \$15,000 or \$20,000 according to the choice made by the participant.

Notwithstanding the above article l), participants whose spouse or dependent children's life insurance took effect before January 1, 1999 may modify the sum insured payable on the death of any child according to the previously mentioned provisions.

PREPAYMENT

- a) For a spouse whose life expectancy is less than 24 months, as certified by her attending physician and subject to approval by the Insurer, the participant may obtain prepayment of a portion of the sum insured for the spouse under this benefit. The amount paid, however, is limited to 50% of said sum insured, up to a maximum of \$100,000.

Upon the death of the spouse, the sum insured payable will be reduced by the amount of the prepayment and the interest accrued on said amount until the date of death.

- b) The interest rate used for the prepayment is the interest rate credited by the insurer upon payment of the death benefits.
- c) The participant is still responsible for paying the entire premium, unless premium payments are waived.
- d) In addition, the following conditions must be met:
 - i) This plan must be in force at the time of the prepayment request;
 - ii) The beneficiary appointed by the spouse must be a revocable beneficiary. If the beneficiary is irrevocable, authorization from this beneficiary is required and must be attached to the prepayment request;
 - iii) The spouse's state of health must not be due to a voluntarily self-inflicted injury.

EXCLUSION

If the insured should die during the first two years following the date of enrolment in the insurance and this person's death is the result of a suicide, regardless of the state of mind of the insured, the sum insured for this person will not be payable and the insurer's liability shall be limited to refunding the premium paid for said insured's life insurance.

This exclusion also applies to any portion of the sum insured that constitutes an increase other than an increase due to indexation. In this case, the two-year exclusion period begins on the effective date of the increase in the sum insured.

SUM INSURED IN CASE OF ACCIDENTAL DEATH OR DISMEMBERMENT

- a) The sum insured is the one defined in the article SUM INSURED and may be equal or lesser than the one effective under the LIFE INSURANCE article of the present benefit.
- b) Then an insured spouse or dependent child sustains an accident that results in one of the losses indicated in the schedule of losses below, and such loss occurs after the commencement of insurance and within 365 days following the date of the accident, the insurer agrees to pay the participant an amount equal to the percentage of the sum insured payable for the person in question and for which the corresponding premium was paid, in accordance with the percentages set out in the following schedule:

SCHEDULE OF LOSSES

Résultat de l'accident	Pourcentage
Death	100%
Hemiplegia	100%
Paraplegia	100%
Quadriplegia	100%
Loss of both legs	100%
Loss of both hands or both feet	100%
Loss of the sight of both eyes	100%
Loss of one foot and the sight of one eye	100%
Loss of one hand and the sight of one eye	100%
Loss of speech or hearing	100%
Loss of an arm or a leg	75%
Loss of an hand or a foot	66 2/3%
Loss of the sight of one eye	66 2/3%
Loss of speech or hearing	66 2/3%
Loss of thumb or index	33 1/3%
Loss of hearing for one ear	16 2/3%

- c) When the insured sustains more than one loss set out in the schedule of losses above as a result of the same accident, the sum insured to which the participant is entitled may not exceed 100% of the sum insured provided for this person under this benefit, and for which the corresponding premium was paid.

EXCLUSIONS REGARDING THE SUM INSURED IN CASE OF DEATH OR ACCIDENTAL DISMEMBERMENT

The insurer will not pay the sum insured in case of accident if the accident occurs:

- a) During a trip or flight in any type of aircraft while the insured is a crew member or performing any function of a crew member;
- b) Self-inflicted injuries, suicide or attempted suicide, regardless of the state of mind of the insured;
- c) As a result of a riot or a war, whether war is declared or not;
- d) Due to an illness or infection, except for infections that are the direct result of an accident;

- e) As a result of a criminal act committed by the participant or attempts to commit. However, this exclusion does not apply to impaired driving;
- f) The insured's active service in the armed forces;
- g) Poisoning, intoxication or drug use by the insured;
- h) Injuries exhibiting no visible external wound or contusion on the body, except in the case of drowning or internal injuries revealed by surgery or autopsy.

WAIVER OF PREMIUM

- a) Definition of total disability: a participant is totally disabled if, following an illness or accident, he is incapable of carrying out the main tasks of his usual professional functions and for which he is under medical supervision. In the case of a dentistry student or a specialized resident, the state of incapacity in question must prevent the participant from performing the main tasks of a dental surgeon's usual professional functions.

Definition of presumptive total disability: In the event of total and irrecoverable loss of speech, vision in one eye, hearing, the use of one hand or the use of both feet, the person who suffers the loss is deemed to be totally disabled, regardless of whether or not he holds another job and whether or not he is under the care of a physician, provided the loss is caused by an illness or accident.

- b) Definition of total disability period: for the purpose of applying the WAIVER OF PREMIUM provision, any continuous period of total disability or successive periods of total disability resulting from the same illness or the same accident and separated by a period of less than 12 consecutive months of regular work. If, during a given period, the total disability is the result of an illness or accident that is completely independent of the illness or accident that caused the previous total disability, it is considered to be a new total disability period. This definition applies to the waiver of premium only.
- c) A participant under age 65 who has been totally disabled for at least 6 consecutive months is entitled to a waiver of premium under this benefit. As a result, all premiums paid during the first 6 months of total disability are then reimbursed to the participant.

However, the waiver of premium applies only to the premium that corresponds to the sum insured for which this provision was selected.

Proof of the participant's total disability must be deemed satisfactory by the insurer.

- d) The waiver of premium shall terminate on the earliest of the following dates:
 - i) the date on which the participant is no longer totally disabled;
 - ii) the date on which the participant is unable or unwilling to provide the insurer with satisfactory proof of his total disability;
 - iii) the date on which the participant turns 80.

- e) This provision applies if the participant is also covered by the WAIVER OF PREMIUM provision under the participant's life insurance.

CONVERSION PRIVILEGE

- a) While this benefit is in force, any insured whose life insurance terminates for any reason other than his age or the death of the participant is entitled to obtain, without having to provide evidence of insurability, an individual one-year term life insurance contract or a term-life insurance contract to age 65, 70 or 100 (with or without the accidental death or dismemberment benefit, it being understood that the accidental death or dismemberment insurance can only apply to individuals under the age of 65) of a type normally issued by the insurer, and subject to the following provisions:
 - i) the insured must, within 31 days following the date of termination of his insurance, send a notice in writing to the Insurer along with the initial premium for the proposed contract;
 - ii) the individual contract shall come into force on the date of termination of coverage under this benefit;
 - iii) the premium for the individual contract is determined based on the age and sex of the person whose insurance is being converted when the individual insurance comes into force, according to the insurer's usual rates;
 - iv) the amount of individual insurance is selected by the insured, and may not be less than the amount stipulated in the insurer's general rules or greater than the sum insured under this benefit for the person in question, without exceeding \$500,000;
 - v) for the first individual policy year, the insured may opt for yearly convertible term insurance or term 65 insurance at the end of the one-year period, provided the insured is under age 65 when he exercises his conversion privilege.

The individual contract that results from this conversion privilege does not contain a waiver of premium provision or an indexation provision for the sum insured.

- b) In the event that this benefit should terminate without the possibility of replacing it with group insurance from another insurer, the insurer shall, within 31 days following the date of termination, automatically provide the participant's spouse and dependent children with a non-cancellable 5-year term individual life insurance contract with guaranteed renewal for an amount that corresponds to the sum insured under this benefit on the date of termination. The insurer agrees to charge its customary individual life insurance rates in this regard.

The individual contract that results from this conversion privilege does not contain a waiver of premium provision or an indexation provision for the sum insured.

CONTINUATION OF COVERAGE FOLLOWING THE PARTICIPANT'S DEATH

Upon the participant's death, the coverage for his spouse and dependent children insured under this benefit can be maintained in force. The request must be submitted to the Insurer within 31 days following the date of the participant's death. The spouse then obtains the status of participant for the purpose of applying the plan provisions. Any person not previously insured as a spouse or dependent child of the deceased participant may not subsequently be insured under this coverage. Furthermore, in the event of the participant's death, the spouse shall be responsible for paying the premiums required to maintain the coverage in force.

TERMINATION OF INSURANCE

The spouse's and dependent children's insurance shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the date of termination of the plan or of this benefit, subject to the provisions set out in the WAIVER OF PREMIUM provision of this benefit;
- b) the due date of any premium that is not paid under this benefit, if such premium is not paid before the end of the grace period;
- c) the date on which they are no longer eligible for the benefit in their capacity as spouse and dependent children;
- d) the date of termination requested by the participant, provided he sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- e) the date on which the participant, the spouse or a dependent child collects or allows to be collected, due to false claims or misrepresentations by himself or a third party, benefits to which he is not entitled under this benefit, without regard for any other recourse that may be exercised by the Insurer, with the exception, however, of the non-smoker status for the spouse's life insurance benefit;
- f) the date on which the spouse turns 80 for sum insured under the Life Insurance benefit and 70 for the sum insured under the Accidental Death or Dismemberment benefit.

CLAIMS

All claims must be submitted on the forms provided by the insurer within 90 days immediately following the date of the event giving rise to the claim, and satisfactory written proof must be sent to the insurer within 12 months immediately following the date on which benefits are payable.

Failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of benefits provided the claim, proof and information are provided as soon as it is reasonably possible to do so. However, such claim, proof and information must be sent to the insurer no later than 12 months following the date of the event giving rise to the claim; otherwise, any benefits for the period elapsed between the deadline and the date on which proof of disability is sent to the insurer may not be paid.

The insurer reserves the right to request additional information or proof, and to have the insured examined by a physician of its choice.

HEALTH INSURANCE

SCHEDULE OF INSURANCE

Coverage	ESSENTIAL	BALANCED	ENHANCED
Prescription Drugs ⁽¹⁾			
Per service deductible	\$20	\$20	\$15
Percentage of reimbursement	According to the BPDIP ⁽²⁾	According to the BPDIP ⁽²⁾	75% ⁽²⁾
Drugs with SSQ card – Direct payment system *	Products on the RAMQ list		
Prescription drugs – Patient’s contribution (Quebec residents only) *			
Smoking cessation product *	According to the BPDIP		
Sclerosing injections *	\$20 eligible per day		

⁽¹⁾ If you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons, by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by the insurer.

⁽²⁾ Once the annual out-of-pocket maximum provided under the BPDIP is reached, expenses incurred subsequently during the same calendar year for drugs covered by the RAMQ are reimbursed at 100%. The annual out-of-pocket maximum only includes expenses incurred for drugs covered by the RAMQ. This annual out-of-pocket maximum applies to each insured person and only your own out-of-pocket amount includes drug expenses for your dependent children.

Hospitalization			
Percentage of reimbursement	N/A	100%	100%
Hospital room	Not covered	Semi-private room	

SCHEDULE OF INSURANCE (SUITE)

Coverage	ESSENTIAL	BALANCED	ENHANCED
Specialized Health Care Establishments			
Percentage of reimbursement	N/A	100%	100%
Convalescent home *	Not covered	Semi-private room 180 days per 12 consecutive months per insured	
Rehabilitation centre *		Semi-private room 180 days per 12 consecutive months per insured	
Health Care Professionals			
Percentage of reimbursement	N/A	N/A	75%
Audiologist	Not covered	Not covered	\$50 reimbursement per treatment or consultation
Chiropractor (including X-rays)			
Occupational therapist			
Physiotherapist, physical rehabilitation therapist and certified athletic therapist			Combined maximum reimbursement of \$500 per calendar year per insured, including X-rays per a chiropractor or a podiatrist / chiropodist
Podiatrist / Chiropodist (including X-rays)			
Speech therapist			
Career counsellor (including psychoeducator)			\$75 reimbursement per consultation
Psychologist			
Psychotherapist			Combined maximum reimbursement of \$750 per calendar year per insured
Social worker			
Vision Care			
Percentage of reimbursement	N/A	N/A	100%
Eye exam	Not covered	Not covered	1 exam per 24 consecutive months per insured

SCHEDULE OF INSURANCE (SUITE)

Coverage	ESSENTIAL	BALANCED	ENHANCED
Other Medical Expenses			
Percentage of reimbursement	N/A	75%	75%
Ambulance and transport by air or train *	Not covered		
Blood glucose monitor *		\$250 reimbursement per 36 consecutive months per insured	
Breast prostheses *		\$1,000 reimbursement per 24 consecutive months per insured	
CAT scans *		Not covered	Combined maximum reimbursement of \$500 per calendar year per insured
Electrocardiograms (ECG) *			
Laboratory analyses *			
Magnetic resonance imaging *			
Ultrasound examinations *			
X-rays *			
External prosthesis and artificial limb *		\$5,000 reimbursement per prosthesis 1 prosthesis per limb lost	
Hearing aid		\$600 reimbursement per 60 consecutive months per insured	
Orthopaedic devices *			
Ostomy appliances *			
Preventive vaccine *		Not covered	\$200 reimbursement per calendar year per insured
Wig *		\$350 reimbursement for the duration of the contract per insured	

SCHEDULE OF INSURANCE (SUITE)

Coverage	ESSENTIAL	BALANCED	ENHANCED
Travel			
Percentage of reimbursement	N/A	100%	100%
Travel insurance and assistance	Not covered	\$5,000,000 reimbursement per trip	
Travel cancellation insurance		\$5,000 reimbursement per trip	
Other Services			
Percentage of reimbursement	N/A	100%	100%
Telemedicine Service	Not covered		

* Medical prescription required

SPECIAL DEFINITIONS

Deductible

The amount of eligible health care expenses that you must pay before being entitled to any reimbursement. The deductible is usually payable each year, but it may also become payable at other intervals, or at the time of each claim as is sometimes the case for prescription drugs.

Hospital

Any establishment considered a hospital under applicable federal or provincial laws.

Rehabilitation or Convalescence Home

An institution or ward duly authorized by an appropriate government body.

Nursing homes, retirement homes, rest homes, residential homes and centres for the care of alcoholics and drug addicts are not included in this definition.

Hospitalization Period

A continuous period of hospitalization, or successive periods of hospitalization resulting from the same illness or accident and separated by a period of less than 180 consecutive days during which the Insured was not hospitalized. If, during a given period, the hospitalization is the result of an illness or accident entirely independent of the illness or accident that caused the previous hospitalization, it is considered to be a new hospitalization period.

ELIGIBILITY

- a) Any dental surgeon who performs his usual professional functions is eligible for this benefit, provided that this person has satisfied one of the following conditions:
 - i) is a resident of Quebec, is covered under the Quebec Health Insurance Plan, and is an active member of ACDQ;
 - ii) is a resident of Canada, but outside Quebec, and covered under the Health Insurance Plan of his province of residence.
- b) The spouse and dependent children of any dental surgeon become eligible for this benefit on the date the dental surgeon is enrolled in this benefit if they are recognized as the spouse or dependent children, otherwise on the date on which they obtain the status of spouse or dependent child of a dental surgeon enrolled in this benefit.

APPLICATION FOR INSURANCE AND EVIDENCE OF INSURABILITY

Enrolment in this benefit is optional for all dental surgeons residing outside Quebec and is mandatory for all dental surgeons and all new dental surgeon graduates residing in Quebec and active members of ACDQ. The dental surgeon must complete an application for insurance for himself, his spouse and his dependent children within 31 days following his eligibility date and that of his spouse and dependent children, where applicable.

During the initial enrollment period of the modular plan, if you are already eligible for insurance as a participant, you must choose the status of protection and the plan that will apply to the Health Insurance benefit. If you become eligible at a later time, your choice will have to be made in the 31 days following your eligibility.

For residents of Quebec, if the dental surgeon is exempted from insuring himself or his spouse and dependent children due to the existence of a similar benefit, such exemption shall terminate at the same time as the other benefit terminates, and the dental surgeon must then complete an application for insurance for himself, his spouse and dependent children within 31 days following the date of termination of the benefit that gave rise to the exemption.

Dental surgeons who return to Quebec after residing outside Canada must complete a new application for insurance within 31 days following the date of return to Quebec for himself, his spouse and his dependent children, provided he is an active member of ACDQ.

Unless otherwise indicated in this benefit, the spouse and the dependent children may not be insured under this benefit if the participant himself is not insured.

INSURED PERSONS AGE 65 OR OVER RESIDENTS OF QUEBEC

Insured persons who are residents of Quebec when they reach age 65 become automatically covered under the Quebec public drug insurance plan. Individuals who would like to continue their coverage for drugs under their group insurance plan after they turn 65 must cancel their coverage under the public plan in order not to pay the premium for such coverage. They must also notify SSQ accordingly and in advance and pay the premium applicable to individuals age 65 or over who are not covered under the public plan. However, dependents cannot continue their coverage if the participant does not remain insured. Individuals who elect to become insured under the public drug insurance plan cannot become insured again under the group health insurance coverage.

EFFECTIVE DATE OF COVERAGE

- a) The insurance for all eligible persons shall take effect on one of the following dates:
 - i) the date on which the person becomes eligible;
 - ii) the date on which the person is no longer exempted, provided that the application for insurance is completed within 31 days following the date of termination of the coverage that gave rise to the exemption;
 - iii) the date on which his application for insurance and at least 1/12 of the annual premium is received by the administrator or the insurer.
- b) Notwithstanding the foregoing, the effective date of coverage for late enrolments may not, at any time, be retroactive more than 16 months provided that the premiums are also paid retroactively to the effective date of coverage and in accordance with the following conditions:

- i) if the application for insurance is received by the insurer between January 1 and April 30, the coverage shall take effect on the earliest of the following dates:
 - the eligibility date if that date is within the current year;
 - the date of termination of the other coverage that gave rise to the exemption, if that date is within the current year;
 - January 1 of the current or previous year (maximum 16 months).
- ii) if the application for insurance is received by the insurer between May 1 and December 1, the coverage shall take effect on the earliest of the following dates:
 - the eligibility date if that date is within the current year;
 - the date of termination of the other coverage that gave rise to the exemption, if that date is within the current year;
 - January 1 of the current year.
- c) If the spouse or a dependent child is hospitalized on the day the insurance would normally take effect, such person shall not become insured until 24 hours following his return to the participant's home. For participants who already have coverage for their Dependent Children, however, a newborn shall become insured at birth.

MODIFICATION OF THE PLAN SELECTED DURING RE-ENROLLMENT PERIODS

The frequency of re-enrollment periods will be as agreed between the Policyholder and the insurer.

Outside designated re-enrollment periods, it is possible to select a new plan only after one of the following events occurs, provided your request is made in the 31 days following that event:

- a group insurance plan by which your spouse or your dependent child was covered as a participant is involuntarily lost;
- a person becomes or ceases to be your spouse;
- a person becomes your dependent child through birth or adoption;
- a person ceases to be your sole dependent child.

SPECIALIZED RESIDENCY

This benefit is maintained in force during any period of specialized residency in Canada.

For a specialized residency in the United States, only the TRAVEL ASSISTANCE INSURANCE incurred during the first 180 days of specialized residency are eligible.

ELIGIBLE EXPENSES

The expenses described below may or may not be eligible for reimbursement, depending on the category to which you belong and the plan you have chosen, if applicable. When covered, these expenses are listed in the "Schedule of Insurance".

a) **Prescription Drugs**

To be eligible, expenses for prescription drugs must be incurred for the purchase of the products described below for an individual who is insured at the time of purchase. The coverage maximums applicable to these expenses are specified in the “Schedule of Insurance”, along with information about applicable deductibles and reimbursement percentages. However, the out-of-pocket maximum provided for under the Quebec Basic Prescription Drug Insurance Plan (BPDIP) applies to expenses incurred by participants who are residents of Quebec, either for themselves or their insured dependents, following application of the deductible and percentage of reimbursement provided for under this coverage. The percentage of reimbursement applicable thereafter to eligible expenses incurred during the same calendar year is 100%.

- i) Eligible drug expenses under this benefit are those drugs and other products that are eligible under Quebec’s Universal Drug Insurance Plan.
- ii) The contribution required of a patient towards payment of the cost of pharmaceutical services and medications for an insured who is covered under a public prescription drug insurance plan, either in the form of a deductible or coinsurance.
- iii) Expenses incurred for the purchase of a magistral preparation are eligible provided that such preparation is eligible under the insurer’s policy concerning extemporaneous compounding products.
- iv) Smoking cessation products.
- v) Only expenses for sclerosing injections that are not eligible under other provisions of the contract and that are provided and administered by a physician for curative and not aesthetic purposes. For the purposes of this insurance contract, the professional fees charged by the physician are not considered to be expenses for sclerosing injections.
- vi) Diabetic products. Insulin, syringes, lancets, needles, test strips and glucose sensors, for the treatment of diabetes. For test strips and glucose sensors for intermittent blood glucose monitors to be considered eligible expenses, the following conditions must be met:
 - the number of test strips that can be reimbursed is limited to an annual maximum; this maximum may be increased based on the insured’s medical condition, provided prior approval by SSQ is obtained;
 - the number of glucose sensors that can be reimbursed is limited to an annual maximum, and prior approval by SSQ is required.
- vii) Prior approval by SSQ is required for some prescription drugs commonly referred to as “exception” or “prior approval” drugs. For these drugs to be covered, their use must meet all of the following conditions:
 - Comply with the specific clinical criteria and directions for use determined by the government authorities
 - Comply with the usage criteria suggested by the recognized appropriate medical and governmental authorities of the medical sector
 - Comply with the necessary, customary and reasonable standards of practice generally accepted in the health care sector, including the ratio between their cost and their effectiveness

b) Hospitalization in Canada

- i) Hospitalization expenses for insureds that are covered at the time such services are obtained. Any coverage maximums applicable to these expenses are specified in the Schedule of Insurance, along with information about applicable deductibles and reimbursement percentages.

c) Specialized Health Care Establishments in Canada

- i) Accommodation expenses in a rehabilitation or convalescence home, for insureds that are covered at the time such services are obtained. Any coverage maximums applicable to these expenses are specified in the Schedule of Insurance, along with information about applicable deductibles and reimbursement percentages.

d) Health Care Professionals

To be eligible, expenses must be incurred for services provided by the health care professionals described below, for an individual who is insured at the time the services are obtained. The coverage maximums applicable to these expenses are specified in the “Schedule of Insurance”, along with information about applicable deductibles and reimbursement percentages and the cases in which a prescription is required.

Only one treatment by the same professional or specialist is covered per day, per insured, or one treatment per day per profession or specialty, regardless of the number of fields of specialization the professional or specialist is licensed to practise in.

- i) Audiologist: professional fees.
- ii) Career counsellor (including psychoeducator): cost of consultation.
- iii) Chiropractor: cost of treatment, including X-rays.
- iv) Occupational therapist: cost of treatment.
- v) Physiotherapist, physical rehabilitation therapist and certified athletic therapist: professional fees or cost of treatment.
- vi) Podiatrist/Chiropodist: cost of treatment, including X-rays.
- vii) Psychologist: professional fees.
- viii) Psychotherapist: cost of consultation.
- ix) Social worker: cost of consultation.
- x) Speech therapist: professional fees.

e) Vision Care

To be eligible, expenses must be incurred for eye examinations by an optometrist or ophthalmologist as described below, for an individual who is insured at the time the services are obtained. The coverage maximums applicable to these expenses are specified in the “Schedule of Insurance”, along with information about applicable deductibles and reimbursement percentages and the cases in which a prescription is required.

f) Other Medical Expenses

To be considered eligible, expenses must be incurred for the services or articles described below, for an individual who is insured at the time such services or articles are obtained. The coverage maximums applicable to these expenses are specified in the “Schedule of Insurance”, along with information about applicable deductibles and reimbursement percentages.

- i) The cost of ambulance transportation (round trip) to the nearest hospital that can provide the required care, including air or train transportation in case of emergency.
- ii) The cost of purchasing or repairing hearing aids, including batteries, earmolds and accessories.
- iii) The cost of purchasing orthopaedic devices: corsets, splints, crutches, casts and items for severe burn victims. For all orthopaedic devices, expenses may be considered eligible up to an amount deemed reasonable by SSQ for the device necessary for the insured to carry out basic activities of daily living. For the purposes of this insurance contract, orthopaedic shoes and foot orthoses are not considered to be orthopaedic devices.
- iv) The cost of purchasing external prostheses and artificial limbs required due to the loss of a natural limb occurring while the insured is covered under this benefit. For the purposes of this insurance contract, the following articles are not considered to be external prostheses or artificial limbs: dentures, breast prostheses, wigs, hearing aids, eyeglasses, contact lenses and intraocular lens implants.
- v) The cost of purchasing ostomy appliances prescribed by a physician, in excess of the amount reimbursed by the government.
- vi) The cost of purchasing a monitor equipped with a lancing device and used to measure blood glucose levels. Purchase of an intermittent blood glucose monitor requiring glucose sensors may also be eligible, provided prior approval by the insurer is obtained.
- vii) The cost of purchasing breast prostheses following a mastectomy.
- viii) The cost of purchasing capillary prostheses required following chemotherapy.
- ix) Preventive vaccines.
- x) Analyses of tissue or body fluids (blood, urine, etc.), if carried out in a private laboratory for preventive or diagnostic purposes and of the same type as those carried out in a hospital.
- xi) Ultrasound examinations.
- xii) Electrocardiograms.
- xiii) X-rays other than those covered under other provisions of the contract. For the purposes of this insurance contract, MRI and CAT scans are not considered X-rays.
- xiv) Magnetic resonance imaging (MRIs).
- xv) CAT scans.

g) **Expenses for TRAVEL ASSISTANCE INSURANCE and TRIP CANCELLATION INSURANCE as described in Appendixes I and II.**

h) **Telemedicine Service**

The telemedicine service may or may not be covered, depending on the category to which you belong and the plan you have chosen, if applicable. When covered, this service is listed in the "Schedule of Insurance".

The insured has access to a telemedicine service via the virtual platform of the insurer's telemedicine provider, in order to obtain virtual medical consultations, medical care and other medical services. The insured must be in Canada at the time he or she uses this service.

The following services are offered by the provider at no additional cost:

- Medical consultations via text messaging and videoconferencing with registered nurses, nurse practitioners and physicians (general practitioners), mandated by the provider
- Referrals to specialist physicians mandated by the provider or to external specialist physicians practicing in public or private clinics
- Issuance, renewal and processing of prescriptions, delivered at no cost everywhere in Canada
- Requisitions for diagnostic and laboratory analyses
- Accompaniment of the insured towards the appropriate resources in the health care system
- Access to the insured's complete medical profile with the provider (access to conversations, care plans, prescriptions and referrals)

Other services are offered by the provider at additional cost, including consultations via videoconference with psychologists, nutritionists, dieticians, work and life coaches, and other health care and well-being professionals. A receipt is issued for any service offered at additional cost. You may submit it to the insurer for reimbursement if such service is covered under this plan.

Availability of the telemedicine service is subject to continuation of an agreement between the insurer and the telemedicine service provider, and the service provider's capacity to offer such services.

EXCLUSIONS, LIMITATIONS AND RESTRICTIONS

a) **General exclusions**

- i) Expenses payable by another insurer and expenses covered under any public plan or government program or that would have been covered had the service provider opted to participate in such plan or program.
- ii) Expenses incurred for products or treatments of an experimental nature or obtained under a federal program providing special access to health products.
- iii) Expenses incurred due to:
 - a criminal act the insured commits or attempts to commit;
 - the insured's active participation in a riot or insurrection;
 - war, whether declared or undeclared;

- the insured's active service in the armed forces;
 - attempted suicide or self-inflicted injuries, regardless of the state of mind of the insured.
- iv) Expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract.
 - v) Expenses for products or services related to the treatment of cellulite or obesity.
 - vi) Expenses for dietary supplements or infant formula.
 - vii) Expenses for products or services designed as smoking cessation products that are not covered under the Prescription drugs benefit of this plan.
 - viii) Expenses for products or services designed to treat sexual dysfunction.
 - ix) Expenses for products or services designed to stimulate hair growth or prevent hair loss.
 - x) Expenses for products or services designed for the treatment of infertility.
 - xi) Expenses for which you are unable to prove that they were incurred by the insured and that they have been paid.
 - xii) Expenses incurred for items, care or services obtained from health care professionals whom SSQ can prove that they behave fraudulently or break the law as a result of issuing documents, bills, statements or evidence that contain false information or that do not exactly represent the obtained items, care or services.
 - xiii) Expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes or incurred further to a request by a third party.
 - xiv) Expenses incurred in relation to services that are not provided while the individual is insured.
 - xv) Expenses incurred for service contracts or maintenance fees.
 - xvi) Expenses for surgically-implanted prostheses.
 - xvii) Expenses incurred in relation to eye refraction examinations, or for the purchase of eyeglasses or contact lenses not explicitly insured under the contract.
 - xviii) Expenses for which a third party is liable, except in the case of subrogation
 - xix) Expenses for delivery or mailing costs
- b) Exclusions - Prescription Drugs
- i) Expenses incurred for products used for aesthetic, cosmetic or personal hygiene purposes.
 - ii) Expenses incurred for substances or drugs used or administered for preventive purposes, except in cases where eligible expenses are explicitly provided for such substances or drugs.
 - iii) Expenses incurred for experimental drugs or products or those obtained under a federal program providing special access to health products.
 - iv) Expenses incurred for homeopathic or natural products.

- v) Expenses incurred for dietary supplements intended as a meal supplement or replacement. However, dietary supplements prescribed as treatment for a clearly diagnosed metabolic disease are covered, provided they are used in compliance with official conditions and directions for use. A complete medical report detailing all conditions justifying the prescription of such products must be presented to the insurer.
 - vi) Expenses incurred for sunscreens.
 - vii) Expenses incurred for drugs used for artificial insemination or in vitro fertilization.
 - viii) Expenses incurred for growth hormones. However, growth hormones can be eligible, upon submission of a detailed medical report to SSQ, if they are prescribed in compliance with the conditions and directions for use determined by the provincial prescription drug insurance programs.
 - ix) Expenses incurred for drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital.
 - x) Expenses incurred for the medical procedure related to drugs injected by a health care professional in a private clinic.
- c) Exclusions - Hospitalization and Specialized Health Care Establishments
- i) Expenses for administrative or incidental fees (TV, telephone, etc.) charged to the patient by the hospital or the establishment are not eligible for reimbursement under this insurance contract.
- d) Exclusions - Health Care Professionals, Vision Care and Other Medical Expenses
- i) the cost of purchasing dentures.
 - ii) the cost of purchasing foot orthoses.
 - iii) the cost of purchasing or renting materials and equipment such as an orthopaedic mattress, exercise equipment, an air conditioner, humidifier, air purifier or whirlpool.

Under no circumstances may the exclusions, limitations and restrictions that apply to this plan render the plan less generous than the Basic Prescription Drug Insurance Plan of the Régie de l'assurance maladie du Québec (RAMQ).

COORDINATION OF BENEFITS AND ORDER OF PAYMENT

Coordination of Benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not you have submitted a claim for such benefits.

The total amount of benefits paid under all insurance plans for a given person may not, at any time, exceed the amount of the expenses actually incurred. The insurer may, subject to the insured's consent if prescribed by law, obtain from any person or disclose to said person any information that may be necessary to apply this provision or that may facilitate the payment of benefits under this benefit.

Order of Payment

If the person insured under this benefit is also insured under another plan, and such plan does not contain an order of payment provision, the reimbursement provided by the other plan must be paid first, and the insurer's liability is then limited to the balance of the insurable expenses.

If the other plan does contain an order of payment provision, however, the initial reimbursement prior to coordination shall be paid by the plan under which the insured is not the spouse or a dependent child. Subsequently, all non-reimbursed expenses shall be the responsibility of the plan under which the insured is recognized as a spouse or a dependent child.

In the case of dependent children, the initial reimbursement prior to coordination shall be paid by the plan that covers the insured spouse whose birthday falls earlier in the calendar year. Subsequently, all non-reimbursed expenses shall be the responsibility of the other spouse's plan.

TERMINATION OF PARTICIPANT'S INSURANCE

The insurance for all participants shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the date of termination of the plan or of this benefit;
- b) the date of the participant's death;
- c) the due date of any premium that is not paid for the participant, if such premium is not paid in advance;
- d) the date the participant is no longer a member in good standing of the ACDQ, if a resident of Quebec, or of a regulatory body in Canada, if a resident of another province;
- e) the date on which the participant starts practising dentistry exclusively outside Canada;
- f) the date on which the participant retires,
- g) the requested date of termination, provided the participant sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- h) the date on which the participant ceases to reside in Canada;
- i) the date on which the participant ceases to correspond to the eligibility conditions of the present benefit;
- j) On the date you submit any claim or collect any benefits founded on misrepresentations, irrespective of the compulsory nature of any coverage or any other action the insurer may take.

TERMINATION OF SPOUSE'S OR DEPENDENT CHILDREN'S INSURANCE

The insurance for all insureds shall terminate at 11:59 p.m. on the earliest of the following dates:

- a) the date of termination of the plan or of this benefit;
- b) the due date of any premium that is not paid for the participant's spouse or dependent children, if such premium is not paid in advance;
- c) the date on which the participant is no longer insured under this benefit;
- d) the date on which the insured is no longer eligible for coverage in his capacity as spouse or dependent child;
- e) the requested date of termination, provided the participant sent a written request to this effect to the administrator or the insurer before the date in question, otherwise on the date such written request is received;
- f) the date on which the insured ceases to reside in Canada.

CLAIMS

- a) All claims, except when the drug payment card is used, must be submitted using the claim form available on the insurer's web site or from the insurer's Customer Service. The participant must complete the form and send it to the insurer along with the originals of all receipts or paid invoices. As the insurer does not return receipts, the participant is advised to always keep copies for its records.

Upon request, reimbursements may be issued by direct deposit.

- b) When the participant uses the direct drug payment card, the pharmacist will obtain payment directly from the insurer for the portion of prescription drug expenses payable under the contract. The participant is then responsible for paying the portion of expenses that is not covered by the insurer.
- c) The claim, proof and information must be sent to the insurer no later than 15 months following the date on which expenses were incurred. However, failure to send the claim or to provide proof and information within the prescribed periods shall not prevent payment of benefits provided such claim, proof and information are provided as soon as it is reasonably possible to do so.
- d) A claim accompanied by supporting documents must be sent to the insurer every 6 months where applicable, or more often when justified by the amount of the claim.

EXTENSION OF COVERAGE

When a participant's coverage terminates for a reason other than termination of the plan or of this benefit, the insurer shall continue to pay the hospital expenses set out in the BENEFITS provision for any insured who is hospitalized upon termination of the coverage, when such expenses are incurred due to the uninterrupted continuation of hospitalization following termination of coverage, without exceeding a maximum extension period of 12 months, and provided that:

- a) the hospitalization began prior to termination of coverage and continues without interruption after termination of coverage;
- b) this benefit remains in force during the extension.

In the event of the participant's death, the TRAVEL ASSISTANCE INSURANCE shall continue to apply to the participant's spouse and dependent children who are travelling outside their province of residence at the time of said death. Such extension of coverage shall continue until the earliest of the following dates:

- a) the 31st day following the participant's death;
- b) the date on which the trip in progress ends.

CONVERSION PRIVILEGE

Individuals whose insurance ends because they are no longer eligible may obtain individual health insurance coverage from the insurer without having to provide evidence of insurability, provided they apply to the insurer in writing within 31 days following the termination of their group insurance coverage. In other cases, individual health insurance coverage may only be obtained on presentation of evidence of insurability deemed satisfactory by the insurer.

APPENDIX I

Travel Assistance Insurance

For information before travelling, to obtain approval before incurring or paying any eligible expenses, or to request assistance, the participant must contact the insurer's travel assistance service at one of the numbers below:

From Canada or the United States: 1 800 465-2928

From elsewhere in the world: (514) 286-8412 (collect call)

The participant must provide the contract number specified on the card when calling.

This benefit provides the insured with medical assistance in case of emergency during the first 180 days of a vacation or business trip, for any accidental injury or illness that is sudden and unexpected and that occurs outside Canada, subject to the conditions that follows.

1. Special Definitions

Some of the terms used to describe the group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Close relative

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Family member

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

Province

Used to refer to the provinces of Canada, as well as the Yukon, Northwest Territories and Nunavut.

Trip

A trip taken outside the insured's usual province of residence. In this case, the term trip also applies to the insured's transportation between the departure and the return.

2. Expenses covered

Coverage under this benefit is limited to the period while individuals are outside their province of residence and are also covered under their public health and hospitalization plans. For any trip scheduled for a period of time exceeding the period covered by these public plans, all excess days are not covered by this coverage. Furthermore, coverage under this benefit only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the insured's province of residence.

In the event that the insured dies during the coverage period, or suffers accidental injury or a sudden and unexpected illness during such period, emergency expenses incurred by or for the insured as described below are eligible, up to the maximum reimbursement specified in the "Schedule of Insurance".

Travel Insurance only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the insured's province of residence. Insureds planning a trip scheduled to last more than 180 days must contact the insurer in advance for information about applicable conditions.

In the following cases, approval must be requested as soon as possible from the insurer's travel assistance service, either by the insured or by any other adult able to do so: hospitalization, medical care, transportation by ambulance.

In the following cases, insureds must obtain prior approval from the insurer's travel assistance service: treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist; repatriation; medical escort; living expenses and transportation of a close relative of the insured; transportation of the insured's body if deceased; return of a vehicle; expenses described under the "Services, products and articles" section.

For the expenses described below to be considered eligible, insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, services must be obtained from an individual who does not reside with the insured and is neither a close relative nor a travel companion of the insured.

Insureds who already have a known disease or illness before the trip must ensure before departure that:

- Their health condition is good, and stable. The insured's state of health is considered unstable, and its effects are not considered to be those of a sudden and unexpected illness, in the following cases:
 - Symptoms worsen;
 - A relapse is suffered;
 - The disease or illness is in its terminal phase;
 - The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip.

- They are able to carry out usual daily activities; and
- They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the trip outside the province of residence.

The insurer's travel assistance service can clarify the term "sudden and unexpected illness" and confirm whether coverage may be limited in any way by the insured's condition.

Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

Physician fees

Professional fees of a physician for medical, surgical or anaesthetic care, other than fees for dental care.

Nursing fees

When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed \$5,000 per Insured per trip.

Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees

Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed \$1,000 per insured per trip.

Prescription drugs

Expenses for the purchase of drugs available only on prescription from a health care professional legally authorized to do so.

Transportation by ambulance

The cost of transportation by ambulance to the nearest hospital by a licensed ambulance service.

Repatriation of the insured

The cost of returning the insured to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the insured's health condition into account.

Transportation by plane of a medical escort

The cost of economy class return air fare for a medical escort who is neither a member of the Insured's family nor a travel companion, when required by the air carrier or the attending physician of the insured.

Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class return transportation for a close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days. Eligible expenses, including transportation costs incurred in order to identify the deceased insured's body prior to return, are subject to the following limits:

- Transportation: \$2,500 per trip for all insured family members;
- Accommodation and meals: \$300 per day for all insured family members, up to a maximum of \$2,400 per trip.

Eligible transportation expenses are limited to the cost of making the trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

Transportation of the insured's body if deceased

The expenses of preparing and returning the remains of the insured by the most direct route home, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of \$10,000 for preparation of the body and transportation.

Return of vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of \$2,000 per trip.

The vehicle must be returned by a recognized commercial agency. The insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the insured's travel companions, if applicable, must also be unable to return the vehicle.

Services, products and articles

Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator;
- X-rays and laboratory analyses;
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices.

Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home due to hospitalization of the insured, a family member or a travel companion.

The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of \$300 per day, or \$2,400 per trip abroad, for all individuals covered.

Travel assistance services

This insurance provides access to certain travel assistance services when the participant needs them. These services may not be available in all countries and are subject to change by the insurer without notice.

The following services are available:

- a) Directing the insured to an appropriate clinic or hospital;
- b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front;
- c) Ensuring the proper follow-up of the insured's medical file;
- d) Coordinating the return and transport of the insured as soon as medically possible;
- e) Providing emergency support and coordinating settlement applications;
- f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured;
- g) Arranging for the return of insured persons to their home (return expenses not included);
- h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident;
- i) Communicating with the insured's family or employer;
- j) Acting as an interpreter for emergency calls;
- k) Recommending a lawyer in the event of legal difficulties.

3. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel Assistance Insurance.

The following expenses are not eligible for reimbursement under the Travel Assistance Insurance benefit of this plan:

- a) Expenses incurred as a result of the insured's refusal to be repatriated to the province of residence, upon the insurer's request
- b) Expenses incurred by the insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the insured's life or health
- c) Expenses incurred in a location for which the Government of Canada issued an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the insured is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline
- d) Expenses payable under any public plan
- e) Expenses related to elective or non-emergency surgery or treatment
- f) In the case of a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the trip is taken, whether or not the trip is taken upon the recommendation of a physician
- g) Expenses for chronic care incurred in a facility treating chronic illnesses
- h) Expenses incurred for insureds in thermal spa facilities or extended care homes
- i) Expenses incurred due to injury or death as a result of practising any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to.
- j) Expenses related to an event occurring during the trip, or shortly thereafter, that insureds may reasonably have predicted due to their state of health at the start of the trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter
- k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the public health or hospitalization plan of the insured's province of residence

APPENDIX II

Trip Cancellation Insurance

In the event of trip cancellation prior to departure due to a travel advisory issued by the Government of Canada, the participant must contact the insurer's travel assistance service for the procedure to follow either 72 hours before a deposit becomes due or 72 hours before the scheduled date of departure, whichever comes first.

In the event of trip cancellation prior to departure for any reason other than a travel advisory, the participant must contact the insurer's travel assistance service for the procedure to follow at the latest 48 hours following the event causing cancellation.

The telephone numbers to contact the insurer's travel assistance service are the following:

From Canada or the United States: 1 800 465-2928

From elsewhere in the world: (514) 286-8412 (collect call)

The participant must provide the contract number specified on the card when calling.

1. Special Definitions

Some of the terms used to describe the group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Business partner

An individual with whom the insured is associated for business purposes as part of a corporation comprised of 4 shareholders or fewer, or a commercial or non-commercial corporation comprised of 4 partners or fewer.

Commercial activity

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

Host at destination

An individual at whose principal residence the insured is planning to stay for at least part of the trip.

Prepaid travel expenses

Refers to the following:

- Expenses incurred by the insured to purchase a trip, including tickets from a public carrier, rental of motor vehicles or accommodation from a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services
- Amounts paid by the insured for travel arrangements usually included in a package trip
- Amounts paid by the insured in relation to registration fees for a commercial activity

Public carrier

Refers to any carrier approved by the appropriate authorities and operating with a transport licence for the transportation (air, sea, land) of passengers for remuneration.

Travel companion

Refers to the person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the Insured.

Trip

An occasional trip made by an insured from the usual place of residence to temporarily visit a place at least 200 kilometres away. To be recognized as a trip under Travel Cancellation Insurance, the trip must also require a period of absence of at least 2 consecutive nights and must be for tourism, pleasure or attendance at a commercial activity. In addition, in the case of a cruise, it must be operated under the responsibility of a business which is accredited or authorized by the appropriate authorities to operate such a business or provide such services.

2. Reasons for cancellation

For cancellation expenses to be considered eligible, the trip must be cancelled, extended or interrupted due to one of the following causes:

- a) An illness or accident suffered by the insured, a travel companion or a business partner of the insured, or suffered by a member of the insured's family or travel companion's family. The illness or accident must prevent the individual from performing his or her usual activities and must be sufficiently serious to justify or force the cancellation or interruption of the insured's trip
- b) Death of: the insured; the insured's spouse; the insured's or spouse's child; the insured's travel companion; or the insured's business partner
- c) Death of a family member of any of the following individuals: the insured; the insured's spouse; the insured's child; the insured's travel companion. The funeral must be scheduled to take place during the period extending from 31 days before and 31 days after the planned trip
- d) Death, illness or accident suffered by a person for whom the insured is the legal guardian

- e) Notwithstanding any other provision of the contract, suicide or attempted suicide of the insured's travel companion or a member of the insured's family
- f) Death of a person for whom the insured is the testamentary executor
- g) Death or emergency hospitalization of the host at destination
- h) 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 trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or is a police officer and has been subpoenaed as part of his or her regular duties
- i) Quarantine of the insured, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the trip
- j) Hijacking of the airplane on which the insured is travelling
- k) Damage rendering the principal residence of the insured or of the host at destination uninhabitable. The residence must remain uninhabitable 7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the trip
- l) Transfer of the insured, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required by the employer within the 30 days preceding the scheduled date of departure

m) **For trip cancellation**

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured plans to travel; or
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship.

The advisory must be issued after the insured has made the travel arrangements. The advisory must be in force on the scheduled date of departure.

For trip interruption

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured is on a trip; or
- to avoid all cruise ship travel when the insured is already on a cruise ship.

The advisory must be in force during the trip. The insured must comply with the advisory within 14 days following its issuance.

- n) Delay of the transportation used by the insured to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report

- o) Weather conditions such that:
 - the departure of the public carrier used by the insured, at the point of departure of the planned trip, is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the trip;
 - or
 - the insured is unable to make a scheduled connection after departure with another public carrier, provided the scheduled connection after departure is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the trip;
- p) Damage occurring to a commercial establishment or to the location where a commercial activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity
- q) Death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation

3. Expenses covered

To be eligible, expenses must be incurred by the insured following the cancellation, extension or interruption of a trip, provided such expenses are related to amounts paid in advance by the insured and that, at the time travel arrangements were made, the insured was not aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation.

Eligible expenses are described hereafter and are reimbursed according to the indications in the "Schedule of Insurance":

In the event of cancellation prior to departure

- a) The non-refundable, unusable, non-transferrable and irrecoverable portion of prepaid travel expenses. Any form of credit, compensation or indemnification (with or without restriction on use) offered by a travel provider, a travel agency, a public carrier, an accommodation facility or an agency is considered as a reimbursement of prepaid travel expenses
- b) Additional expenses incurred by the insured if the travel companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation and the insured decides to proceed with the trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel
- c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the insured decides not to proceed with the trip

In the event of missed departure, flight cancellation or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination. Departure must be missed due to a delay in the means of transportation used by the insured, subject to the conditions specified in the eligible reasons for cancellation. In the event of interruption of a trip, the interruption must be due to an illness or accident suffered by the insured or travel companion, subject to the conditions specified under the eligible reasons for cancellation.

If the return is earlier or later than planned

- a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure. These expenses must be pre-approved by the insurer's travel assistance service
- b) The unused and non-refundable portion of the ground portion of prepaid travel expenses

Restriction

If the insured's return is delayed by more than 7 days, the expenses incurred are eligible, provided the insured or the insured's travel companion was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

If travel expenses were not paid in advance, the expenses incurred by the insured are covered provided that before the scheduled date of departure, the insured was not aware of any event that could reasonably lead to the interruption of the planned trip.

Round-trip transportation

The cost of transportation by the most economical means, following approval by the insurer's travel assistance service, for the insured to return to the province of residence and then back to the trip destination, provided the return to the province of residence is due to one of the following reasons:

- a) Death or hospitalization of a member of the insured's family, a person for whom the insured is the legal guardian or a person for whom the insured is the testamentary executor
- b) A disaster that has made the principal residence of the insured uninhabitable or has caused significant damage to the insured's business establishment

4. Exclusions, limitations and restrictions

In addition to the exclusions, restrictions and limitations applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel Cancellation Insurance.

- 1) Travel Cancellation Insurance does not cover losses due to the following causes or to which such causes have contributed:
 - a) Active participation of the insured in a riot or insurrection, perpetration or attempted perpetration of a criminal act by the insured or the insured's travel companion or participation of the insured or the insured's travel companion in a criminal act.
 - b) Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences
 - c) Intentional self-inflicted injury by the insured or travel companion, or suicide or attempted suicide by the insured, regardless of the state of mind of the person
 - d) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to
 - e) The reason for which the trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician
 - f) In the event that the trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person
 - g) A cause which, beyond any possible doubt, does not prevent the insured from proceeding with the trip
- 2) No expenses are payable if the insured made travel arrangements while a Government of Canada advisory was in effect recommending:
 - to avoid all travel to a location where the insured plans to travel; or
 - to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply:

- to any trip cancellation for an eligible reason for cancellation other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure; and
- to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure or during the insured's trip.

- 3) No trip interruption expenses are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending:

- to avoid all travel to a location where the insured plans to travel; or
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level during the insured's trip.

- 4) No trip interruption expenses caused by the following advisory are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending to avoid non-essential travel to a location where the insured plans to travel.

However, this exclusion does not apply to any trip interruption caused by the advisory, if there is a change to the risk level of the advisory to a higher risk level during the insured's trip.

- 5) No trip interruption expenses caused by one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel or to avoid non-essential travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

- 6) No trip interruption expenses for an eligible reason for interruption other than one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

If notice of cancellation of a trip prior to departure is not provided within the time specified herein, the insurer's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and any adult accompanying the insured on the planned trip provide proof deemed satisfactory by the insurer that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and the insurer's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

APPENDIX IV

Guaranteed Insurability Option

1) OPTION DESCRIPTION

The participant who chooses the guaranteed insurability option is allowed to increase the monthly sum insured without having to submit evidence of insurability. The additional sum insured can be obtained during the period of option and provided the guaranteed insurability option is in force.

2) ELIGIBILITY

Any individual under age 55 is eligible for this option on the date they become a insured under the disability insurance - loss of income benefit.

3) APPLICATION TO THE OPTION AND EVIDENCE OF INSURABILITY

Application to this option is optional and conditional to application to the disability insurance - loss of income benefit. Evidence of insurability satisfactory to the insurer must be solely submitted at the time of application to the option, for the potential total amount the participant may receive.

4) EFFECTIVE DATE OF THE OPTION

Subject to any other provisions of the disability insurance - loss of income benefit, a member's guaranteed insurability option is effective on the date the insurer approves their insurability.

5) BENEFITS

a) Sum insured for students

The sum insured under this option is equal to an increase of \$1,000 per year. The sum insured may be increased 5 times. However, in any circumstances can the total sum insured owned by the participant exceed the maximum provided for under the disability insurance - loss of income benefit.

b) Sum insured for other participants

The sum insured under this option is equal to an increase of 10% of the current sum insured or \$500, at the participant's choice when they exercise their guaranteed insurability right. The sum insured may be increased 5 times. However, in any circumstances can the total sum insured owned by the participant exceed the maximum provided for under the disability insurance - loss of income benefit.

c) Guaranteed insurability exercise right

The participant must inform the administrator in writing of their choice to exercise their guaranteed insurability right.

The guaranteed insurability then becomes effective on the date the participant exercised their right, provided:

- i) the required additional premium is paid;

- ii) the participant is at work or was at work on the last scheduled work day, on a full-time basis;
- iii) the participant performs the main duties of their usual professional occupation, or if not at work, is able to perform the main duties of their usual professional occupation.

This right to exercise this option ends on the participant's 55th birthday.

6) ADDITIONAL PREMIUM

The first additional premium applicable to this option must be paid prior to the end of the annual period of option during which the participant exercised their guaranteed insurability rights.

The premium applicable to this option is payable as long as the participant is covered under the option, whether or not they exercised their guaranteed insurability rights.

An increase to the sum insured through the guaranteed insurability option is payable further to a disability, provided the participant paid the current monthly premium.

7) CONDITIONS, PROVISIONS, LIMITATIONS AND EXCLUSIONS

This option is subject to the conditions, provisions, limitations and exclusions provided for under the disability insurance - loss of income benefit.

8) WAIVER OF PREMIUM

This option is subject to the waiver of premium provision provided for under the disability insurance - loss of income benefit.

9) TERMINATION OF THE GARANTEED INSURABILITY OPTION

The guaranteed insurability option ceases at midnight, on the earliest of the following dates:

- a) the date this contract terminates;
- b) the due date of the additional premium that remains unpaid for that participant, if such premium is not paid before the end of the grace period;
- c) the date the participant reaches age 55;
- d) the date the disability insurance - loss of income benefit ceases;
- e) the date the participant has exercised their or guaranteed insurability right for the 5th time;
- f) the date the participant's total sum insured reaches the maximum provided for under the disability insurance - loss of income benefit.

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