1. DEFINITIONS

1.1 «**Academic Member**» shall mean a Member who is a Member of the University academic teaching staff.

1.2 «**Allowable Expense**» shall mean, for the purpose of Article 11 only, any necessary, reasonable and customary item of medical expense which is an Eligible Expense under this Plan and at least one other Medical Insurance Scheme covering the Beneficiary for whom a claim is made. When a Medical Insurance Scheme provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid under the Medical Insurance Scheme.

1.3 «**Administrator**» shall mean The Manufacturers Life Insurance Company.

1.4 «**Beneficiary**» shall mean a Member or covered Dependent.

1.5 «**Benefit Percentage**» shall mean the Percentage of Covered Expenses which is payable by Manulife Financial.

1.6 «**Benefit Year**» shall mean a period of twelve months commencing on the first day of January and ending the last day of December.

1.7 «**Chronic, Convalescent or Rehabilitative Hospital**» shall mean a legally operated institution for the provision of chronic, convalescent or rehabilitative care which is entitled to a daily allowance under the applicable provincial Hospital Plan of any Province of Canada.

1.8 «**Date of Incurral**» shall mean the date as of which treatment is given or articles supplied.

1.9 «**Dentist**» shall mean a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practising of dentistry in the location in which the person practices, and who is operating within the scope of that license.

1.10 «**Doctor**» shall mean a qualified physician or surgeon duly licensed to practice medicine.

1.11 «**Dependent**» shall mean the Member's spouse, and the Member's children as defined herein. The term "child" includes natural or legally adopted children, the Member's spouse's children if living with the Member, or children for whom the Member is a legal guardian who are wholly dependent upon the Member for support. The Member must have custody and control of the child.

In the case of full-time students, a "child" shall be under the age of 21, or under the age of 26 if a full-time student attending an education institution and wholly dependent on the Member for support. However, a «child» who attains the limiting age, shall also mean, a child is:

1. incapable of supporting himself/herself due to a physical or mental disability,
2. dependent on the Employee for support and maintenance, and
3. remains unmarried

is deemed to continue to be a Child for as long as these three conditions exist. This continuation is subject to the Plan Administrator receiving proof of the above conditions no later than 31 days after the Child attains the limiting age. Proof that the above conditions continue may be required periodically.

A «**spouse**» shall mean (i) a person of either sex with whom the Member has been living in a conjugal relationship for one year. The one-year cohabitation requirement does not apply if a child is born of this union, and (ii) as defined under the applicable legislation.

Note: Only one person at a time can be covered as a spouse.

1.12 «**Eligible Expenses**» shall mean the usual, customary and reasonable expenses incurred by a Beneficiary for the medical treatments and procedures listed in the Articles 7 and 8 of the Plan.

1.13 «**Employee**» shall mean a person employed by the University on a regular basis. For the purposes of this plan, "regular" shall refer to a salaried employee appointed for the whole period under the terms of Section 2.7.

1.14 «**Full-time Employee**» shall mean an Employee who is working two-thirds time or more. In the case of a non-academic Employee, full-time shall be two-thirds or more of the normal number of working hours for their role profile, established for Employees of the same classification as the Employee in accordance with University policy; in the case of an Academic Member, full-time shall be determined by the terms of employment as approved by the Board of Governors at the time of appointment.

1.15 «**Hospital**» shall mean a legally operated institution which:

(a) is primarily engaged in providing medical, diagnostic and surgical facilities for the treatment of illness on an inpatient basis, and

(b) provides such facilities under the supervision of Doctors with 24 hours nursing service, and

(c) is <u>not</u> a Chronic, Convalescent or Rehabilitative Hospital, a nursing home, a home for the aged, a tuberculosis hospital or sanatorium, a hospital or institution for the mentally ill, a place for the treatment of drug addiction or alcoholism, an infirmary or other institution the purpose of which is to provide custodial care.

1.16 «**Medical Insurance Scheme**» shall mean, for the purposes of Article 11 only, an insurance policy, benefit plan, or legislation of any nature providing medical benefits or services supplementary to Medicare for or by reason of dental or medical care or treatment to a Beneficiary.

1.17 «**Member**» shall mean a person who is a contributor to this Plan or whose membership has not terminated in accordance with Article 6.

1.18 «**Non-Resident Member**» shall mean a Member who is not eligible for benefits under the Medicare provisions of the Province of Québec or any other Canadian province and:

(a) who is a Pensioner who retires permanently outside Canada, or

(b) who is a specially named Employee on formal leave of absence outside Canada.

1.19 «**Out-of-Pocket Maximum**» shall mean that portion of eligible expenses, consisting of the Beneficiary's portion of the Percentage Payable, which must be paid out by the Member before the Plan will pay 100%.

1.20 «**Part-time Employee**» shall mean an Employee whose annualized rate of earnings is $25,000 or more and whose appointment is not less than nine (9) months.

1.21 «**Pensioner**» shall mean a person who is retired in accordance with the University's retirement policies.

1.22 «**Plan**» shall mean the Supplemental Health Plan for Employees of McGill University as set forth in this document.

1.23 «**Predecessor Plan**» shall mean the Supplemental Health Plan for Employees of McGill University as underwritten by the Manufacturers Life Insurance Company up to August 31st, 2007.

1.24 «**Referral**» shall mean a referral in writing from a Doctor located in the Beneficiary's province of residence for treatment of an illness for which the provincial medicare plan in the Beneficiary's province of residence has agreed, in writing, to pay benefits to the Beneficiary as a result of the referral. Such referral must be to a location in Canada if such services (irrespective of any waiting list) are available in Canada, or to a location out of Canada if such services are not available in Canada.

1.25 «**Supplementary Hospital Expenses**» shall mean expenses for private or semi-private accommodation provided to a Beneficiary while an in-patient at a Hospital, to the extent that such hospital is authorized to charge directly to the patient for such accommodation.

1.26 «**University**» shall mean The Royal Institution for the Advancement of Learning (McGill University) or the Board of Governors thereof, as the context requires.

1.27 «**Widow/Widower**» shall mean the Spouse of a deceased Pensioner.

2. ELIGIBILITY

2.1 A person who is a Full-time Employee, Part-time Employee, Pensioner or Widow/Widower as of September 1st, 2007, is eligible for membership as of that date.

2.2 An Employee on September 1st, 2007, who is not eligible for membership under the terms of Section 2.1 above will become eligible for membership on the date as of which the Employee becomes a Full-time or a Part-time Employee.

2.3 A person qualifying as an Employee after September 1, 2007, will become eligible for membership on the date as of which the person becomes a Full-time Employee or a Part-time Employee.

2.4 A person qualifying as a Widow/Widower after September 1, 2007 will become eligible for membership on the date as of which the person qualifies as a Widow/Widower provided the deceased member had family coverage at the time of death.

2.5 Late Application: A Full-time Employee or Part-time Employee who refuses coverage when eligible under the terms of Section 2.1 through 2.4 of this article by reason of being covered as a dependent under another supplemental health plan will become re-eligible for coverage on the first of the month following receipt of written notice certifying that such other coverage has terminated.

2.6 A Member who has a McGill University appointment as a GFT-H, and who is either unsalaried, or has a salary of less than $25,000 (applicable to class 010 only).

2.7 A person who is a salaried Employee appointed for a period of not less than three (3) consecutive months if the appointment is full-time, or for a period of not less than nine (9) consecutive months if the appointment is part-time.

2.8 Members shall be grouped in the following Classes and Plans.

Class Number(s)	Class Name
010	Active Employees – Geographical Full-Time-Hospital (Plan A)
011	Active Employees – Academic Tenure (Plan A)
012	Active Employees – Academic Non-Tenure (Plan A)
013	Administrative & Support Employees – Non-Union (Plan A)
014	Union Employees – MUNACA (Plan A)
015	Union Employees – Trades & Services (Plan A)
016	Other Employees (Plan A)
017	Retirees (Plan B)
018	Non Resident Retirees (Plan C)
019	Active Employees on Sabbatical - Academic (Plan S)
020	Survivors of Deceased Employees Who Were 65 Years Old or Over (Plan D)

Plan Number(s)	Plan Name
A	All Active Employees
B	Retirees
C	Non Resident Retirees
D	Survivor Benefit
S	Active Employees on Sabbatical

3. COMMENCEMENT OF COVERAGE

3.1 A person eligible under the terms of Section 2.1, who was a Member of the previous Plan as of August 31, 2007, will automatically become covered under this Plan as of September 1st, 2007.

3.2 A person becoming re-eligible for membership under the terms of Section 2.5 will become covered as of the date of re-eligibility upon which written application for membership is executed.

3.3 A Member's Dependent will be covered under the Plan as of the later date of the following dates:

(a) The date that the Member applies for and is granted Dependent coverage in accordance with the terms of Article 4.

(b) The date as of which the Dependent qualifies as an eligible Dependent.

3.4 Coverage will be suspended in respect of a Member for any period during which contributions are suspended under the terms of Section 5.4.

3.5 A person eligible under the terms of Section 2.6, will become covered under this Plan as of September 1st, 2010.

4. CLASSIFICATION

4.1 There shall be two categories of membership under this plan:

(a) Resident,
(b) Non-Resident (Expatriate)

4.2 Upon commencement of coverage, a Member who is a Non-resident Member will automatically be classified in the Non-resident category until such time as the Member ceases to be a Non-resident Member. All other Members will automatically be placed in the Resident category.

4.3 Each category of membership shall include coverage for: (i) single coverage only; or (ii) coverage with dependents.

4.4 A person applying for membership under this Plan will be required to specify in writing at the date the application is made, which type of coverage is desired: single coverage or coverage with dependents.

4.5 A member with single coverage may change to coverage with dependents by applying in writing to the University.

4.6 If a Member with Dependent coverage in effect on the date that an additional eligible Dependent is acquired, said additional Dependent will be extended full coverage automatically from the date of acquisition without any written application.

4.7 A Member with Dependent coverage may change to single coverage as of the first day of the month coinciding with or immediately following the date upon which written evidence is provided that the Member no longer has eligible Dependent or that all such eligible Dependents have become covered under another supplemental health plan or plans.

5. CONTRIBUTIONS

5.1 The amount of contribution required to fund the Plan shall be determined by the University. Such contribution shall be determined on an individual basis for each category of membership and class of coverage (single or with dependents).

5.2 The University and each Member shall contribute to the Plan an amount determined in accordance with the class of coverage elected by each Member and the category of membership of the Member and shall be paid by means of payroll deduction.

5.3 The University shall contribute to the Plan such amount as may be necessary to complete the funding of the Plan.

5.4 If, by reason of sessional or other leave of absence or temporary layoff, a Member temporarily ceases to be a salaried Employee while remaining in the service of the University, such Member shall have the option of suspending contributions to the Plan for the duration of such unpaid leave or of continuing contributions to the Plan on such basis as may have been agreed upon with the University in accordance with the terms of such unpaid leave.

5.5 For Class Number 010 employees will pay 100% of the contributions. However, for unsalaried employees, contributions will be made via automatic bank withdrawal .

6. TERMINATION OF COVERAGE

6.1 Coverage in respect of a Member will cease at the earliest of the following dates:

(a) the date of termination of service of the Member,

(b) the date as of which the Member is transferred to a category of employment ineligible for coverage hereunder,

(c) the date of termination of the Plan,

(d) the date as of which the Member elects to discontinue membership in the Plan in accordance with the terms of section 6.4.

6.2 Coverage in respect of a Dependent of a Member will cease on the earliest of the following dates:

(a) the dates as of which the coverage in respect of the Member ceases in accordance with Section 6.1,

(b) the date as of which the Dependent ceases to qualify under the definition of Dependent.

(c) the date as of which the Member changes from a coverage with dependents to a single coverage.

6.3 Notwithstanding Section 6.2, a Dependent who was the spouse of a deceased Member other than a Pensioner may opt to continue coverage hereunder for a period of three months following the month in which the death of the Member occurred.

6.4 A Member may voluntarily elect to terminate his coverage hereunder while remaining in the service of the University, as of the following dates:

(a) the date as of which the Member furnishes written evidence that he has been covered as a Dependent under another supplemental health plan,

(b) the Member's retirement date; however, class 010 is not eligible to plan B "Retirees".

6.5 For the purposes of items (a) and (b) of Section 6.1, a Member will be deemed to be continuing as an Employee during any period in which he is absent from work due to illness, scheduled vacation, temporary layoff, sessional leave or approved leave of absence provided that contributions in respect of the Member have been continued during any such period.

6.6 If an employee is a resident of a Province or Territory with compassionate care legislation or is an employee of a federally-regulated Employer, the employee and the employee's dependents may continue to be covered for all Benefits, if such employee's absence from active work is due to a compassionate care leave. The leave of absence must qualify according to the terms of the legislation and such continuation is subject to contributions.

7. SCHEDULE OF BENEFITS
RESIDENT CATEGORY OF MEMBERSHIP

Plans A, B, D and S

7.1 Deductible Per Benefit Year
- Nil

7.2 Percentage Payable

Hospitalization and Eye Exam
- 100% for all eligible expenses

All other eligible expenses (up to the Out-of-Pocket Maximum, and 100% thereafter)
- 80% for Generic Drug expenses
- 80% of the cost of the Generic Drug when the Brand Name Drug is prescribed without any restriction
- 80% for Brand Name Drug expenses when the interchangeable Generic Drug is not available or the Brand Name Drug is prescribed as not to be interchangeable or substituted (medical recommendation)
- 75% of expenses under Sections 7.8, 7.10 and 7.12
- 80% of all other expenses

7.3 Out-of-Pocket Maximum

Single Coverage
- $400 per Benefit Year

Dependent Coverage
- $800 per Benefit Year

7.4 Hospital Expenses In Canada: limited to the charges for semi-private accommodation which such hospital is allowed to make under the applicable provincial insurance. For Chronic, Convalescent or Rehabilitative Hospital, please refer to section «Services and Supplies» below.

7.5 Hospital Outside Canada: limited to usual and customary charges for semi-private accommodation and expenses for physician, surgeon and anaesthetist fees for covered health expenses rendered outside Canada as a result of referral or emergency care, less any portion of such charge payable under any provincial plan.

7.6 Hospital Outpatient Services: subject to services rendered to a Beneficiary who is not regularly admitted to a Hospital as a bed patient.

7.7 Drugs *

- Charges for drugs requiring a prescription including serums, preventive vaccines of $20 and above and medicines (oral or injected), oral contraceptives, life sustaining drugs and drugs listed on the current Régie de l'assurance-maladie du Québec (RAMQ) formulary, prescribed by a licensed doctor or dentist or other professional authorized by provincial legislation to prescribe drugs.
- Charges for drugs for the treatment of infertility, subject to a lifetime maximum of $2,400 per person.
- Expenses for insulin, including needles, syringes, reagent strips, cotton and alcohol swabs prescribed in writing by a doctor and required for the treatment of diabetes.
- Charges for anti-obesity drugs requiring a prescription, subject to a lifetime maximum of $2,400.
- Charges for varicose vein injections, unlimited.

* Claim for drug expenses will be processed through the Deferred Drug Card Program. Drug claim will be forwarded directly for processing by the Pharmacist and payment will be mailed to the claimant for the total amount covered under the Plan.

7.8 Ambulance: Charges in excess of the amount payable under the covered person's Provincial Health Plan for professional licensed ambulance service, which in the opinion of the Administrator are essential and justified, as follows:

- Licensed ambulance for local transportation of a person to and from the nearest qualified hospital, or
- from a hospital to a convalescent/rehabilitation hospital, or
- Licensed air ambulance for transportation to the nearest qualified hospital for necessary emergency care.

7.9 Private Duty Nursing: Charges for home nursing care (excluding custodial care*) limited to a maximum of $30,000 during any consecutive 60 month period, per person, when prescribed by a Doctor, for services provided outside a hospital by a private duty Registered Nurse, Registered Nurse Assistant (RNA) or Registered Trained Attendant not normally residing in the person's home and not a member of the beneficiary's family.

* Custodial care shall mean assistance with daily living or tasks which any layperson could perform and do not require the skill of a private duty Registered Nurse, Registered Nursing Assistant or Registered Trained Attendant.

7.10 Accidental Dental: Charges for dental care services by a licensed dentist for the repair of natural teeth resulting from an external, sudden and violent blow to the mouth that occurs while the person is covered under this Plan and provided services are received within six months after the date of the accident. Expenses will be limited to the amount payable under the current Provincial Dental Association Schedule of Fees.

7.11 Paramedicals: Charges up to the Benefit Maximum by the following practitioners who are registered and legally practising within the scope of their license, and not normally residing in the person's home:

(a) The expenses for the services of a licensed physiotherapist, occupational therapist, certified athletic therapist or a qualified speech therapist, subject to a combined maximum of $750 per person per benefit year.

(b) The expenses for the services of a licensed psychologist or social workers (who are a members of the Order of Social Workers), subject to an annual combined maximum of $1,000 per person each benefit year.

(c) The expenses for the services of a licensed chiropractor, osteopath, acupuncturist or dietician, subject to a combined maximum of $300, including one x-ray, per person, per benefit year.

(d) The expenses for psychoanalytic treatment at home or office, by a member of the Canadian Psychoanalytic Society or of similar society outside Canada, subject to a maximum of $15 per visit.

The reasonable and customary charges are applicable to paramedical services.

7.12 Services and Supplies

(a) Durable medical equipment: Charges for supplies and rental of or, at Manulife Financial's option, purchase of durable medical equipment of the type and model adequate for the covered person's medical needs based on the nature and severity of the disability, but not limited to:

- crutches, canes, walkers and wheelchairs for therapeutic use (including motorized wheelchairs);
- manual hospital beds, respiratory and oxygen equipment, and other durable medical equipment found only in hospitals;
- artificial limbs and eyes including necessary replacement (excluding myoelectric appliances);
- one insulin pump per lifetime of the covered person. This must first be pre-approved by Manulife Financial (based on the medical documentation provided by the employee);
- Synvisc, for the treatment of osteoarthritis;

BUT excluding items for personal comfort, convenience, exercise, safety, self-help or environmental control, or items which may also be used for non-medical reasons, such as but not limited to: heating pads or lamps, communication aids, air conditioners or cleaners or whirlpool baths or saunas.

Before incurring any of these major expenses, the covered person must submit details to Manulife Financial, in order for the latter to determine to what extent benefits are payable. In any event, a letter is required from a licensed doctor (MD) describing the nature and type of the disability, medical needs and estimated duration of any required durable medical equipment.

(b) Mammary prostheses: Expenses for mammary prostheses required as a result of surgery, limited to two prostheses at a maximum cost of $200 each, per person, per benefit year.

(c) Radiotherapy: When prescribed by a Doctor, expenses for radiotherapy or coagulotherapy services, oxygen, plasma and blood transfusions.

(d) Elastic Support Stockings: When prescribed in writing by a Doctor, expenses of up to $50 per person per benefit year.

(e) Glucometers: Expenses for the purchase of glucometers up to a maximum of $200 per person in every 36 consecutive month period.

(f) Colostomy supplies and ileostomy supplies: Expenses for the purchase of essential colostomy and ileostomy supplies.

(g) Orthotic inserts for shoes or orthopaedic shoes: Expenses for the purchase of one (1) pair of orthotics or orthopedic shoes per person per benefit year. In order to be eligible for payment the orthotics and/or orthopedic shoes must be specially designed and molded for the covered person and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- a description of the physical findings from the clinical examination;
- a brief description of the gait abnormality associated with the diagnosis; and
- confirmation that the product has been custom-made.

Also, in order to be eligible for reimbursement, orthopedic shoes and orthotics must be prescribed, on an annual basis, by providers with the following professional qualifications:

- Medical General Practitioner or Specialist (MD); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M); and

must be dispensed by one of the following provider types:

- Medical General Practitioner or Specialist (MD); or
- Orthotist Co(c) or CPO(c); or
- Pedorthist C Ped (C) or C Ped (MC); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M).

(h) Hearing Aids: When *provided by a certified, clinical audiologist, expenses up to a maximum of $500 per person in any five consecutive benefit years, excluding batteries and professional services. *retroactive to Nov. 15, 2000.

(i) Chronic, Convalescent or Rehabilitative Hospital: When prescribed by a doctor, expenses for confinement in a semi-private room, for rehabilitative purposes only, for a period of up to 120 days per disability in a Chronic, Convalescent or Rehabilitative Hospital, provided such confinement is preceded by a period of hospital confinement and commences within 14 days after the Beneficiary is released from the hospital.

(j) Diagnostic Services: when carried out by a licensed facility that is, in the Administrator's opinion, qualified to provide the required services. Covered services include laboratory tests (including allergy tests) and medical imaging. These services are covered up to a maximum of $750 per benefit year, per person. Tests performed in a doctor's office or pharmacy are not covered. Drawing of blood and hearing tests are not covered.

(k) Wigs and Hairpieces: for patients with temporary hair loss resulting from chemotherapy, expenses for the purchase of wigs and hairpieces subject to a lifetime maximum of $200 per person.

(l) Intra-ocular lenses: required as a result of cataract surgery to a limit of one lense per eye during the lifetime of the covered person.

7.13 Out-of-Country/Out-of-Province Services

Emergency Travel Assistance

Expenses for emergency medical care required as a result of a sudden and unforeseen illness, or accident are covered while the Member and/or the Member's dependents are travelling outside Canada or their province of residence.

Coverage is limited to the first 90 days of a trip, unless the Member is travelling on University business (such as on sabbatical leave), and are subject to a lifetime maximum of $5,000,000 per person.

Charges are reimbursed at 100%, provided emergency medical services are prescribed by a doctor (or dentist where applicable) and are eligible for reimbursement in part under the provincial health care plan in the province of residence.

Eligible expenses include the following benefits:

- Emergency hospital expenses incurred during the first 90 days of a trip outside of Canada and not lasting beyond 14 days, unless the attending physician certifies the covered person should not be moved back to his/her home province.
- Charges in accordance with the average rate for semi-private hospital accommodation in the locality where the facilities and services are provided. This includes admittance, coinsurance and utilization charges where permitted by law.
- Hospital services and supplies.
- Diagnosis and treatment of a licensed physician (reasonable and customary charge according to locality).
- Hospital out-patient charges.
- Medication.
- X-rays and laboratory tests.
- Emergency transportation to the nearest appropriate medical care facility, and if necessary, from the medical care facility to a hospital in Canada.
- Charges incurred for the return of a deceased Member or dependent.
- Charges incurred for the return of dependent children under age 16 to their residence in Canada in the event the Member or Member's spouse is hospitalized and the children are left unattended.
- Charges incurred if return trip is delayed due to hospitalization.
- Charges incurred for transportation of an immediate family member to visit a hospitalized individual.
- Charges incurred in connection with the return of a vehicle (does not include commercial vehicles or rented cars) in the event the Member is unable to return it due to illness, injury or death.
- Charges incurred for accommodation and meals while staying with a hospitalized covered family member when their trip is delayed due to an illness or an accident.
- Charges incurred for accommodation for the Member or the Member's dependents requiring convalescence following hospitalization.

This benefit does not include:

- Charges which are not incurred as a result of an emergency while travelling.
- Charges in connection with childbirth and medical complications resulting from childbirth when delivery takes place after the beginning of the 32nd week of pregnancy.

Non-Emergency Referrals

Expenses incurred for medical care unavailable in Canada, when referred to by a licensed physician and approved in advance by the provincial health plan and the Administrator, but not beyond 60 days, are covered and provided part of the charge is payable under the provincial health plan of the province of residence.

Eligible expenses include:

- Charges for the excess of the ward rate under the provincial health plan for hospital accommodation up to a daily maximum of $100.
- Charges for hospital services and supplies.
- Charges for laboratory tests and x-rays.
- Diagnosis and treatment by a licensed physician (reasonable and customary charge according to locality).
- Hospital out-patient services.

7.14 Charges for one eye exam performed by an optometrist or ophthalmologist, who is registered with Medicare, subject to a maximum of $70 every 24 consecutive months. If an ophthalmologist performs the eye exam, a detailed explanation of the services rendered, as well as separate charges, must be indicated on the receipt.

8. SCHEDULE OF BENEFITS
SPECIALLY NAMED NON-RESIDENT CATEGORY OF MEMBERSHIP

Plan C

8.1 Hospital: Limited to the usual and customary charge for semi-private accommodation provided to the Beneficiary while an in-patient at a Hospital.

8.2 Operation: Expenses for an operation performed by a surgeon in a Hospital, in the office of the surgeon, or in the home. If more than one operation is performed at the same time through the same incision, benefits will be payable only for that operation for which the highest maximum payment is provided. If all operations performed at the same time are not through the same incision, benefits will be payable for each additional operation.

8.3 Anaesthesia: Expenses for the administration of general or regional anaesthesia by a duly qualified physician other than the operating surgeon or his assistant. If more than one operation is performed at the same time, benefits will be subject to the same limitation as the surgical benefits for such operations, as described in Section 8.2.

8.4 Physician's Fees: In-hospital medical expenses for the fees of physicians, subject to one visit per day and a maximum of 70 visits for each period of hospitalization as an in-patient.

8.5 Care and Treatment Fees: Home and office medical expenses for the fees of a physician for care and treatment, subject to a maximum of one visit per day.

8.6 Consultation Fees: Subject to a maximum of two consultations per benefit year with a duly qualified specialist physician, when, in the opinion of the attending physician, such consultation is required, is within the specialty in which the specialist is certified, and results in a complete history and written report provided to the referring physician.

8.7 All Eligible Expenses described in Section 7.6 to 7.14 inclusive.

8A. SCHEDULE OF BENEFITS
NON-RESIDENT PENSIONER CATEGORY OF MEMBERSHIP OTHER THAN SPECIFICALLY NAMED NON-RESIDENT CATEGORY OF MEMBERSHIP

Plan C

8A.1 Hospital expenses (limited to the reimbursement levels as determined by the Québec Health Insurance Plan) up to $480 per day for accommodation and $50 per day for medical care provided to a Beneficiary while an in-patient at a Hospital.

8A.2 Expenses for an operation performed by a surgeon in a Hospital, in the office of the surgeon, or in the home up to 75% of the eligible amount under the Québec Health Insurance Plan. If more than one operation is performed at the same time through the same incision, benefits will be payable only for that operation for which the highest maximum payment is provided. If all operations performed at the same time are not through the same incision, benefits will be payable for each additional operation.

8A.3 Expenses for the administration of general or regional anaesthesia by a duly qualified physician other than the operating surgeon or his assistant up to 95% of the eligible amount under the Québec Health Insurance Plan. If more than one operation is performed at the same time, benefits will be subject to the same limitation as the surgical benefits for such operations, as described in Section 8A.2.

8A.4 In-hospital medical expenses for the fees of physicians, up to $13.80 per visit for a maximum of 70 visits limited to one visit per day, for each period of hospitalization as an in-patient.

8A.5 Home medical expenses for the fees of a physician for care and treatment, up to $36.25 per day and a maximum of one such visit per day.

8A.6 Office medical expenses for the fees of a physician for care and treatment up to $13.80 per visit for a routine examination or, up to $27.50 per visit for a complete examination but limited to one visit per day.

8A.7 Consultation expenses for a maximum of two consultations per Benefit Year with a duly qualified specialist physician, when in the opinion of the attending physician such consultation is required, is within the specialty in which the specialist is certified, and results in a complete history and written report provided to the referring physician.

8A.8 All Eligible Expenses described in Sections 7.6 through 7.14 inclusive.

9. EXCLUSIONS AND LIMITATIONS

9.1 Payment will not be made under the Plan for any of the following expenses:

(a) Services or supplies which are paid for under any government sponsored plan or program, to the extent that the provisions of such plans may require application by the Member to receive any benefit payment, the benefit payable under this Plan shall be calculated on the assumption that the Member had duly applied for such benefit payment and failure to apply for such benefit payment shall not serve to increase the amount of benefit payable under this Plan.

(b) Charges for patent and proprietary medicines, cough medicines, baby foods and formulas; anti-obesity treatments, anti-smoking treatments, dietary food supplements, minerals, proteins and vitamins; unless these exceptions are included under the RAMQ current Drug formulary; charges for collagen treatments and hair growth stimulants; charges for patent and proprietary medicines available without a prescription, including over-the-counter drugs; Drugs dispensed and distributed through prescription on-line sites (Internet pharmacies); charges for the administration of injections, serums and vaccines.

(c) Charges for equipment such as orthopaedic mattresses, exercise equipment, whirlpools, air-conditioning, air-purifying units and blood pressure monitors and any other equipment which the University considers not to be an Eligible Expense.

(d) Charges for eyeglasses, contact lenses and laser eye surgery, except where included as an eligible expense.

(e) Charges for medical treatment, surgery, care, service, examination or appliances that are:
- not medically necessary;
- provided for cosmetic purposes, except for dental treatment required as a result of an accident and for varicose vein injections;
- given or required for reasons other than curative;
- given or required in relation to an operation or treatment of an experimental nature or is in excess of what is ordinarily given or required in accordance with the current therapeutic practice.

(f) Any portion of an Eligible Expense which is in excess of the usual, reasonable and customary charge, unless otherwise specified, for the services or supplies in the locality where such service is provided.

(g) Any Hospital expenses incurred under Section 7.5 other than as a result of Referral, or accident or emergency illness while out of Canada.

(h) Charges in respect of any medical care directly or indirectly due to or resulting from:

- war, insurrection, or the hostile action of the armed forces of any country;
- participation in a riot, civil commotion, or commission of a criminal offence;
- any cause for which indemnity or compensation is provided under any Worker's Compensation Law or similar legislation.

(i) Expenses incurred for psychological disorders including functional nervous disorders where such expenses are incurred in an institution specializing in the treatment of such disorders or diseases.

(j) Expenses for custodial care, other than as otherwise specifically permitted herein.

(k) Rest cure or travel for reasons of health.

(l) Treatment or appliance (related directly or indirectly to full mouth reconstruction) to correct vertical dimension and temporomandibular joint dysfunction (TMJ).

9.2 With respect to section 8.1, when successive periods of hospitalization are not separated by an interval of three months or more between each such period, Hospital expenses shall be limited to a maximum of 70 days during all such periods. However, Beneficiaries receiving care or treatment for accident cases shall be entitled to the 70 day maximum for each separate accident.

9.3 Payment will not be made for expenses under Article 8 for periodic health examinations required for insurance, school, employment or other purposes, or mileage or travelling time of Doctors.

10. COORDINATION OF BENEFITS

Limitation on Benefit Amount

This provision is applicable to all benefits payable as Eligible Expenses under this Supplementary Health Expense Plan. Where the total benefits under this Plan and other Supplementary Health Expense Plans would exceed costs incurred for Eligible Expenses, reimbursement from all plans shall be limited to incurred expenses according to the following order of benefit determination.

Order of Benefit Determination

(a) Benefits shall be payable first from a group plan which does not have a provision to coordinate benefits, then subsequently in accordance with the rules of this and other group plans which do have coordination of benefits.

(b) Among the plans having coordination of benefits, priority shall be determined in the following order:

Employees:

1. The plan where the person is covered as an employee.

2. If a person is eligible for employee coverage under more than one plan, priority goes to:
   i) the plan where the employee is an active, full-time employee,
   ii) the plan where the employee is an active, part-time employee,
   iii) the plan where the employee is a retiree.

Dependents:

Spouse

3. The plan where the spouse is covered as an employee.

4. The plan where the spouse is covered as a dependent.

Dependent Children

5. The plan of the parent with the earlier birthdate (month/day) in the benefit year.

6. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.

7. In situations where parents are separated/divorced, then the following order applies,

   i) the plan of the parent with custody of the child,
   ii) the plan of the spouse of the parent with custody of the child,
   iii) the plan of the parent not having custody of the child,
   iv) the plan of the spouse to the parent in iii) above.

If priority cannot be established according to the above rules, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Facility of Administration

In order to coordinate benefits, the Administrator shall release information to and obtain information from such other insurance companies, organizations, or persons having knowledge relevant to claims of covered individuals without further notice.

The Administrator shall also have the right to pay directly to other insurance companies, organizations, and persons amounts which should have been chargeable under this coordination of benefits provision. Such payments shall be considered benefits under this Plan and shall discharge the Administrator from liability, to the extent of the payment. Additionally, the Administrator shall have the right to recover any amounts paid by the Administrator which were in excess of the maximum amounts contemplated by the coordination of benefits provision.

Such recovery shall be made without notice to the covered individual and the Administrator may recover such amounts from any other insurance company, organization, or from persons to whom or on whose behalf such payments were made.

11. CLAIMS

11.1 Written notice of claim must be given to the Administrator within ninety days following the end of the Benefit Year in which the Date of Incurral occurred.

11.2 Failure to give the aforesaid notice or to file the aforesaid claim within the said limited periods shall not invalidate or diminish any claim under the Plan, if it shall be shown not to have been reasonably possible to give such notice or to file such claim and that such was given or filed as soon as reasonably possible.

11.3 In the event that benefits payable hereunder are reduced as a result of the application of Article 11 of this Plan, such reduction will be limited to the settlement most favourable to the Member.

11.4 All benefits hereunder will be paid immediately upon receipt by the Administrator of proof of claim.

11.5 If the Member is physically or mentally incapable of giving a valid discharge for payments due or if the Member dies while any such payments due remain unpaid, the Administrator may, at its option, make payment:

(a) to the Member's relative, by blood or by marriage;

(b) to any person or institution appearing to the Administrator to be equitably entitled to such payment by reason of incurring expense for the maintenance, care, medical attendance or burial of the Member; or

(c) to any person entitled to give a valid discharge of such payment on behalf of the Member or the Member's estate.

11.6 The Administrator shall be under no obligation to see to the application of any monies paid under the terms of Section 11.5 and payment to any such person or institution will constitute a complete discharge of the responsibilities of the Plan to the extent of the amount of the payment.

12. AMENDMENT AND TERMINATION

12.1 The University expects to continue this Plan indefinitely but reserves the right to change, modify, or terminate the Plan at any time by giving the Administrator's at least 30 days notice.

12.2 The Plan may be amended at any time and from time to time by the University and all such amendments shall be binding upon the University and on every Member.

12.3 Notice of each such amendment shall be given to the Administrator. If the amendment directly or indirectly affects the benefits due to Members, notice thereof shall be given to the Members.

12.4 No such amendment shall adversely affect the right of a Member to receive benefits equal to those to which he was entitled under the Plan prior to such amendment in respect of Eligible Expenses incurred prior to the date of such amendment.

12.5 In the event that the Plan is terminated, contributions by the Members and the University shall cease. The University will retain all contributions made or required to be made up to the date of termination of the Plan and to the extent that such funding permits will continue to make benefit payments for a period of 90 days in respect of Eligible Expenses incurred by Beneficiaries prior to the date of termination. Any funds remaining after the expiration of the 90 days period shall be retained by the University for distribution for the benefit of the Members, or as otherwise may be determined or directed by the University.

13. ADMINISTRATION

13.1 The University shall have full power to administer the Plan, such power to include, but not be limited to the following:

(a) to appoint such Administrator as it shall deem necessary or proper for the efficient administration of the Plan,

(b) to make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan,

(c) to interpret the Plan, its interpretation thereof to be final and conclusive,

(d) to compute the amounts of benefits or other payments which shall be payable to any Member in accordance with the provisions of the Plan, and to determine the person or persons to whom such amounts shall be paid,

(e) to authorize all payments to be made for such purposes,

(f) to ensure the proper accounts and records showing the detailed operation of the Plan are made on the proper basis and to arrange for the audit of such records and accounts as required,

(g) to maintain a continuing review of the performance of the Administrator and, if necessary, to make changes from time to time as required.

13.2 Whenever in the administration of the Plan any action by the University or the Administrator is required, such action shall be uniform in nature as applied to all persons similarly situated.

13.3 In administering the Plan, neither the Board of Governors nor the University nor any officer or employee thereof shall be liable for any acts of omission or commission, except for his or its own individual, willful, and intentional malfeasance or misfeasance. The University and its officers and employees shall be entitled to rely conclusively on all tables, valuations, certificates, opinions and reports which shall be furnished by the Administrator, counsel or other expert who shall be employed or engaged by the University.

13.4 The Plan shall be chargeable with the fees of the Administrator and any expenses incurred by the same in respect of the Plan for which payment is not provided by the University.

13.5 This Plan shall be administered and construed in accordance with the applicable laws of the Province of Québec and Canada.

13.6 Each Member shall be advised of the general provisions of the Plan and shall be furnished by the University with information explaining the Member's status, rights and privileges under the Plan.

13.7 The Plan shall not of itself give a Member any right to be retained in the service of the University, nor prevent the University from discharging a Member at any time, nor give rise to any claim by any person against the University for damages for any cause whatsoever.

13.8 Contributions to the Plan and benefits under the Plan shall be payable in the lawful currency of Canada.

13.9 In the event that the age or the status of any Beneficiary is found to have been incorrectly stated, the Administrator shall make such adjustments respecting such Beneficiary for the purposes of the Plan as they shall deem equitable.

13.10 No assignment, pledge or encumbrance of any benefit under the Plan shall be permitted or recognized under any circumstances, nor shall any such benefit be subject to attachment or other legal process to recover debts.