INFO ASSURANCE No. 41
October 20, 2025

2026 Insurance Contract Renewal

Unlike last year, the FNEEQ-CSN group insurance contract is being renewed for 2026 without any rate changes. Following the meeting of the unions enrolled in group insurance policy 1008-1010 (the RSA) in Laval on September 11-12, 2025, the unions accepted the RSA's recommendations, which will have the effect of improving the policy with no impact on premiums. As will be seen below, some rates will even remain unchanged in 2027.

Here are the changes that will take effect on January 1, 2026:

Elimination of coverage modification period in November

As of January 1, 2026, insured members will be able to make the following changes at any time:

- reduce their health and dental coverage after a minimum 36 months of coverage
- increase their health and dental coverage for a minimum of 36 months
- enroll in dental insurance for a minimum of 36 months

Optional life insurance for spouse

To ensure a smooth transition between the FNEEQ and Association des retraitées et retraités de l'enseignement de la FNEEQ (AREF) policies, it will now be possible to increase the spouse's optional life insurance at age 70 by one or two increments of $25,000. It will be recalled that the same change was made last year for participants.

Medical arbitration clause

Current text	Changes
7.15 This process is a consensual process through which the Insurer and the Policyholder agree to settle between themselves any dispute related to the recognition of a participant's disability in order to specifically avoid court proceedings to settle such disputes.	7.15 This process is a consensual process through which the Insurer and the Policyholder agree to settle between themselves any dispute related to the recognition of a participant's disability in order to specifically avoid court proceedings to settle such disputes.

Current text	Changes
The participant can contest any of the Insurer's decisions related to the absence or termination of disability. In such a case, a medical arbitration process will begin, based on the following provisions:	A participant who disagrees with any of the Insurer's decisions related to the absence or termination of disability must request a review within 30 business days of receipt of said decision from the Insurer and provide any additional documentation, if applicable. The Insurer must render its decision within 20 business days after receiving the request for review. If the participant disagrees with the Insurer's decision on review, he or she may contest it within 90 business days after receiving the review decision by sending the Insurer and the Policyholder a request for medical arbitration. The time limits in this paragraph apply unless the Insurer and the Policyholder agree otherwise in writing. In such a case, a medical arbitration process must begin, based on the following provisions:
7.15.1 The Insurer informs the FNEEQ-CSN and the employer of its decision and the fact that the participant is contesting it.	7.15.1 The Insurer informs the Policyholder and the employer of its decision and the fact that the participant is contesting it.
7.15.2 The Insurer, the FNEEQ-CSN and the participant's attending physician agree on the choice of a medical adjudicator and on the mandate to be assigned to the adjudicator. The Insurer proposes three medical examiners, favouring physicians practising in clinics. Failing agreement on one of these examiners, the attending physician may suggest other examiners.	7.15.2 The Insurer, the Policyholder and the participant's attending physician agree on the choice of a medical adjudicator. The Insurer proposes three medical examiners specialized in a field relevant to the disability diagnosis, giving preference to those practising with an independent medical expertise firm; failing agreement, the attending physician may propose up to three other names, according to the same criteria. If the medical examiners proposed by the attending physician decline the adjudication mandate or if the Insurer's medical advisor does not agree with the proposal, a call between the attending physician and the

Current text	Changes
	medical advisor will take place in order to reach an agreement.
7.15.3 The Insurer and the FNEEQ-CSN jointly send the mandate to the medical adjudicator, with a copy of this article. A copy of the mandate is also sent to the participant at the same time.	7.15.3 The Insurer and the Policyholder jointly send the mandate to the medical adjudicator, with a copy of this article. A copy of the mandate is also sent to the participant at the same time. The Insurer also provides the medical adjudicator with all the medical information in its possession.
7.15.4 The Insurer sends to the attending physician, in a confidential letter, a copy of any reports, files or assessments the Insurer intends to submit to the medical adjudicator.	~~7.15.4 The Insurer sends to the attending physician, in a confidential letter, a copy of any reports, files or assessments the Insurer intends to submit to the medical adjudicator .~~
7.15.5 The medical adjudicator meets with the participant and examines him or her, if deemed pertinent, in the official language selected by the participant.	7.15.4 The medical adjudicator meets with the participant and examines him or her, if deemed pertinent, in the official language selected by the participant, or if this is not possible, with a translator present.
7.15.6 The participant must attend any appointment scheduled by the medical adjudicator to avoid forfeiting his or her right to benefits, unless the participant has a valid reason supported by proof.	7.15.5 The participant must attend any appointment scheduled by the medical adjudicator to avoid forfeiting his or her right to benefits, unless the participant has a valid reason supported by proof.
7.15.7 The participant may bring any document he or she believes is useful for the case to the medical adjudicator.	7.15.6 The participant may bring any document he or she believes is useful for the case to the medical adjudicator in order to enable the adjudicator to make an informed decision.
	7.15.7 If the participant incurs travel expenses in connection with his or her assessment by the medical adjudicator, they may request reimbursement from the Insurer for certain reasonable expenses. Reimbursement will be

Current text	Changes
	made in accordance with the Policyholder's rates applicable at the time the expenses are incurred.
7.15.8 The medical adjudicator must render a decision within 60 days of the date of the assessment.	7.15.8 The medical adjudicator must render a decision in writing within 60 days of the meeting with the participant. The decision must include a list of all medical documents that were submitted.
7.15.9 The medical adjudicator's decision must be rendered in the official language selected by the participant. The decision must include a list of all medical documents that were submitted.	7.15.9 The medical adjudicator's decision must be rendered in the official language selected by the participant, as far as possible. In the event that the language in which the adjudication decision is written is not the Canadian official language chosen by the participant for the handling of his or her case, the Insurer undertakes to have the examiner's report translated.
7.15.10 The medical adjudicator must send a copy of the decision to both principals and the participant, unless the adjudicator believes sending such decision is medically contraindicated, in which case the participant's copy will be sent to the attending physician.	7.15.10 The medical adjudicator must send a copy of the decision to the Insurer and the Policyholder, as well as to the participant, unless the adjudicator believes sending such decision is medically contraindicated, in which case the participant's copy will be sent to the attending physician.
7.15.11 Copies sent to both principals are limited to the following: a) The list of medical documents submitted; b) Duration of the assessment; c) Indication of the participant's collaboration or lack thereof; d) Diagnosis; e) Prognosis, if any; f) Medical-administrative recommendations;	7.15.11 Copies sent to the Insurer and the Policyholder are limited to the following: a) The list of medical documents submitted; b) Duration of the assessment; c) Indication of the participant's collaboration or lack thereof; d) Diagnosis; e) Prognosis, if any; f) Medical-administrative recommendations;

Current text	Changes
g) Answers to other questions included in the mandate do not explicitly include medical history, family history or any other information about a person other than the participant.	g) Answers to other questions included in the mandate do not explicitly include medical history, family history or any other information about a person other than the participant.
7.15.12 The medical adjudicator's decision is final and irrevocable, enforceable and binds the principals and the participant and therefore excludes any court proceedings unless the medical adjudicator raises an issue not related to his or her specialty. In such a case, a new medical arbitration will be requested with a medical adjudicator from the relevant specialty.	7.15.12 The medical adjudicator's decision is final and irrevocable, enforceable and binds the Insurer and the Policyholder, as well as the participant, and therefore excludes any court proceedings unless the medical adjudicator raises an issue not related to his or her specialty and determines, in his or her written decision, that a second adjudication in this other specialty is necessary to settle the dispute related to the recognition of the disability. In such a case, a new medical arbitration will be requested with a medical adjudicator from the relevant specialty, bearing only on this specific aspect.
7.15.13 Without prejudice to the Insurer's rights, disability benefits are paid during medical arbitration, up to a maximum period of six months.	7.15.13 Without prejudice to the Insurer's rights, the participant is entitled, as of the date of transmission of a request for adjudication and adherence to the adjudication agreement, to compensatory allowances equal to the disability benefits that would have been paid had the participant been recognized as disabled, until the month following receipt of the adjudicator's written decision determining the absence or termination of the participant's disability, but up to a maximum period of six months, whichever comes first.
7.15.14 Expenses and fees of the medical adjudicator are not assumed by the participant.	7.15.14 Expenses and fees of the medical adjudicator are not assumed by the participant. They are billed to the Insurer.

Current text	Changes
7.15.15 If the medical adjudicator's decision entails the end of benefits and such decision is rendered between June 15 and August 15, benefits will be paid until August 15.	7.15.15 If the medical adjudicator's decision entails the end of the compensatory allowance during the vacation period of the participant's school, the allowance will be paid until the end of the vacation period.
	7.15.16 If the adjudication decision recognizes the existence or continuation of the disability, the Insurer will begin payment of the disability benefits provided for in the contract retroactively to the date of refusal or cessation of payments, but will subtract the compensatory allowances paid in accordance with article 7.15.13.

Definition of "disability" and "disabled"

Current text	Changes
1.25.4 For a disability that started on or after January 1, 2008 A state of incapacity, resulting from an illness, accident or surgical procedure directly related to family planning that requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment. Furthermore, a disability claim cannot be denied solely on the basis that at the end of the elimination period, the participant is making a gradual return to work or is taking part in a rehabilitation program under the terms of the collective agreement.	1.25.4 For a disability that started on or after January 1, 2008 A state of incapacity, resulting from an illness, accident or surgical procedure directly related to family planning that requires continuous medical care and completely prevents the participant from carrying out the usual duties of his or her regular employment. ~~Furthermore, a disability claim cannot be denied solely on the basis that at the end of the elimination period, the participant is making a gradual return to work or is taking part in a rehabilitation program under the terms of the collective agreement.~~

Current text	Changes
Medical care is not required if the disability is the result of loss of limbs or loss of sight and such loss can be definitively established to the Insurer's satisfaction.	Medical care is not required if the disability is the result of loss of limbs or loss of sight and such loss can be definitively established to the Insurer's satisfaction.

Rehabilitation service, professional reorientation, gradual return to work

Current text	Changes
7.10 Rehabilitation	7.10 Rehabilitation services Subject to an assessment by the Insurer, the participant may use rehabilitation services offered by the Insurer, the costs of which are covered by the Insurer.
7.10.1 The Insurer must approve in advance any rehabilitation program.	~~7.10.1 The Insurer must approve in advance any rehabilitation program.~~
7.10.2 Participants enrolled in a rehabilitation program receive monthly rehabilitation benefits from the Insurer, as described in article 7.10.3. These benefits end when one of the following events occurs: a) Expiry of a 24-month period following the start of the rehabilitation program; b) Interruption of the rehabilitation program; c) Withdrawal of the Insurer's approval of the rehabilitation program.	~~7.10.2 Participants enrolled in a rehabilitation program receive monthly rehabilitation benefits from the Insurer, as described in article 7.10.3. These benefits end when one of the following events occurs:~~ ~~a) Expiry of a 24-month period following the start of the rehabilitation program;~~ ~~b) Interruption of the rehabilitation program;~~ ~~c) Withdrawal of the Insurer's approval of the rehabilitation program.~~
7.10.3 Subject to article 7.10.2, monthly rehabilitation benefits are equal to the amount of the participant's disability benefits that would be payable in the absence of a rehabilitation program, reduced by 50% of the remuneration for work carried out under the rehabilitation program.	~~7.10.3 Subject to article 7.10.2, monthly rehabilitation benefits are equal to the amount of the participant's disability benefits that would be payable in the absence of a rehabilitation program, reduced by 50% of the remuneration for work carried out under the rehabilitation program.~~
7.10.4 If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program, exceed 100% of the basic net monthly salary the participant would have received if	~~7.10.4 If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program, exceed 100% of the basic net monthly salary the participant would have received if~~

Current text	Changes
actively at work, monthly rehabilitation benefits are reduced by the excess amount.	~~actively at work, monthly rehabilitation benefits are reduced by the excess amount.~~
New clause	7.11 Professional reorientation program
	7.11.1 The Insurer must be informed of and approve any participation in a professional reorientation program.
	7.11.2 Only participants who have been found to be permanently disabled for their own jobs and who wish to find other gainful employment are eligible for a professional reorientation program.
	7.11.3 Participants enrolled in a professional reorientation program continue to receive disability benefits from the Insurer. However, their benefits are reduced by 50% of the net income received for their new income-generating activity under the professional reorientation program.
	7.11.4 If the participant's income from disability benefits and remuneration for work carried out under the professional reorientation program exceed 100% of the basic net monthly salary the participant would have received had they returned to their pre-disability employment, their monthly disability benefits are reduced by the excess amount.
7.11 Gradual return to work	7.12 Gradual return to work
7.11.1 The Insurer must pre-approve any period of gradual return to work.	7.12.1 The Insurer must pre-approve any period of gradual return to work.

Current text	Changes
7.11.2 Participants making a gradual return to work continue to receive monthly disability benefits from the Insurer as described in article 7.11.3. These benefits end when one of the following events occurs: a) Expiry of a 12-month period following the start of the gradual return to work; b) Interruption of the gradual return to work; c) Withdrawal of the Insurer's approval of the gradual return to work.	7.12.2 Participants making a gradual return to work receive monthly disability benefits from the Insurer as described in article 7.12.3. These benefits end when one of the following events occurs: a) Expiry of a 12-month period following the start of the gradual return to work; b) Interruption of the gradual return to work; c) Withdrawal of the Insurer's approval of the gradual return to work. The period of gradual return to work during the elimination period for this benefit is counted as part of the 12-month period provided for in paragraph a).
7.11.3 Subject to article 7.11.2, during the gradual return to work period, monthly disability insurance benefits will be reduced by the percentage of time the participant normally works each month in that period compared to the time the participant normally worked each month before becoming disabled.	7.12.3 Subject to article 7.12.2, during the gradual return to work period, monthly disability insurance benefits will be reduced by the percentage of time the participant normally works each month in that period compared to the time the participant normally worked each month before becoming disabled.
7.11.4 Subject to the Insurer's approval, the participant who began a gradual return to work can benefit from waiver of premiums if the gradual return to work began during the elimination period, as defined in article 7.2.	7.12.4 Subject to the Insurer's acceptance of the disability file, the participant who began a gradual return to work can benefit from waiver of premiums if the gradual return to work began during the elimination period, as defined in article 7.2.
7.13 **Exclusions and reduction of coverage** No benefits are payable under this benefit for a disability that results, directly or indirectly, from one of the following causes:	7.14 **Exclusions and reduction of coverage** No benefits are payable under this benefit for a disability that results, directly or indirectly, from one of the following causes:

Current text	Changes
7.13.5 Alcoholism, drug addiction or compulsive gambling, except for a disability period during which the participant is receiving treatment or uninterrupted medical care for the purposes of rehabilitation.	7.14.5 Alcoholism, drug addiction or compulsive gambling, except for a disability period during which the participant is receiving treatment or uninterrupted medical care for the purposes of recovery.

Exemption from short-term and long-term disability insurance

Current text	Changes
2.2.4 b) Exemption and termination of exemption under the Short-Term Disability Insurance benefit As soon as they become eligible for Short-Term Disability Insurance benefits, individuals indicated in Schedule I, may waive or terminate coverage under this benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits, or if they certify that they will not accept any course load for a period of 6 months during the insurable calendar year.	2.2.4 b) Exemption and termination of exemption under the Short-Term Disability Insurance benefit As soon as they become eligible for Short-Term Disability Insurance benefits, employees may waive or terminate coverage under this benefit upon written notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits. Individuals indicated in Schedule I may also waive or terminate coverage under this benefit if they certify that they will not accept any course load for a period of 6 months during the calendar year.
2.2.5 c) Exemption and termination of exemption under the Long-Term Disability Insurance benefit As soon as they become eligible for Long-Term Disability Insurance benefits, individuals indicated in Schedule I may waive or terminate coverage under this benefit upon written	2.2.5 c) Exemption and termination of exemption under the Long-Term Disability Insurance benefit As soon as they become eligible for Long-Term Disability Insurance benefits, employees may waive or terminate coverage under this benefit upon written notice to the employer, if they

Current text	Changes
notice to the employer, if they certify that they are covered under another group insurance contract offering similar benefits.	certify that they are covered under another group insurance contract offering similar benefits.

Cost-of-living adjustment and integration of the pension benefit

Current text	Changes
7.5 **Cost-of-living adjustment** During the disability period and for as long as the participant is disabled, monthly benefits are indexed annually on January 1 in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 6% for participants whose disability start date is on or after January 1, 1981, and 4% for participants whose disability start date is prior to January 1, 1981, for the purposes of this insurance benefit.	7.5 **Cost-of-living adjustment** During the disability period and for as long as the participant is disabled, monthly benefits are indexed annually on January 1 in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the annual indexation is limited to 6% ~~for participants whose disability start date is on or after January 1, 1981, and 4% for participants whose disability start date is prior to January 1, 1981, for the purposes of this insurance benefit.~~ When, under clause 7.8, a pension is integrated in December, indexation is based on the residual benefits paid during that month. The indexation thus calculated is then added to the January monthly benefit amount.
7.8.5 **Integration (new article, the following ones will be renumbered)**	7.8.5 **Integration** Of any long-term disability benefits under another group insurance plan entitling the participant to disability benefits for the same disability.

Elimination period

Current text	Changes
7.2 **Elimination period** The elimination period is a 104-week period following the start of disability extended by any unused credits in the participant's sick leave bank.	7.2 **Elimination period** Monthly benefits are payable upon expiry of the elimination period, which ends on the latest of the following dates: 7.2.1: The end of the first 104 weeks of total disability in the same period of total disability, extended by any unused credits in the participant's sick leave bank. 7.2.2: the termination of payment of disability benefits under the collective agreement, another group disability insurance plan or another collective agreement for which the participant is eligible.

Other mandates given to the Comité fédéral des assurances et des régimes de retraite (CFARR) by the RSA

At its meeting on September 11 and 12, the RSA also mandated CFARR to:

- Continue its examination of the tendering process for choosing an insurer, in collaboration with the AREF (as originally mandated in 2024) and report back at the September 2026 meeting;
- Maintain the business relationship with BMO for the management of amounts on deposit.

Premiums as of January 1, 2026

After consulting the unions participating in group insurance policy 1008-1010, the current premiums will remain unchanged in 2026 (and in some cases in 2027):

- Health insurance premiums stay at current level for 12 months (0% increase);
- Dental insurance premiums stay at current level for 12 months (0% increase);
- Basic life insurance, dependents' life insurance, optional life insurance and critical illness insurance stay at current levels for 12 months (including extension of the 50% premium holiday

granted in 2025 for all life insurance coverage) (0% increase);
- Short-term disability insurance premiums stay at current level for 24 months (0% increase);
- Long-term disability insurance premiums reduced by 7.4% and the 50% premium holiday granted in 2025 terminated, which will have the effect of keeping the premiums at their current level for 24 months (0% increase).

The documentation on the 2026 renewal of the FNEEQ insurance plan is available at the following links:

- 2026 coverage summary and premiums
- 2026 insurance premium calculator

Annual period for changes to coverage

Since the modular insurance plan was introduced in January 2013, members have been able to make changes to their health insurance coverage (Module A, B or C) and/or their optional dental care coverage (Option 1 or 2) once a year, under certain conditions.

Under the current annual renewal, the rules for changing your coverage are being relaxed. You will be able to change the two types of coverage mentioned above any time this fall and the changes will come into effect on January 1, 2026.

When will the requested changes take effect?

- Change requests received by Beneva by December 31, 2025 will take effect on January 1, 2026.

- Change requests made after January 1, 2026 will take effect on the date they are received by Beneva.

As before, any changes requested within 30 days after a life event will apply from the date of the event.

What changes can be requested?

If you wish to increase your level of health insurance coverage, you can upgrade to Module B or C if you have Module A in 2025, or you can upgrade to Module C if you have Module B in 2025.

As well, if you would like to add dental insurance to your plan, you can choose Option 1 or 2. If you currently have Option 1, you can upgrade to Option 2.

Participants who have been enrolled in the plan for at least 36 months will also be able to downgrade their coverage.

You can opt out of dental insurance if you have been enrolled in Option 1 or 2 for at least 36 months; if you have been enrolled in Option 2 for at least 36 months, you can downgrade your coverage to Option 1, irrespective of the health insurance module you have selected for 2026.

Individuals who are exempt from health insurance (for example, those covered under their spouse's group insurance policy) can opt for Option 1 or Option 2 dental insurance (for a minimum period of 36 months), if they wish.
Note that you will still be able to change your coverage status at any time in accordance with the usual contract terms, i.e. within 30 days after an eligible life event.

To request a change in coverage, please fill out the "Group insurance application or modification" form and submit it to your employer. You can find the forms online at the following addresses:

CEGEPs:
https://www.beneva.ca/sites/beneva/files/2022-08/C1008-0F_adhesion-modification-assurance-collective.pdf

Private colleges and universities:
https://www.beneva.ca/sites/beneva/files/2022-08/C1010-0F_adhesion-modification-assurance-collective.pdf

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For CFARR