SSQ insurance

Communities make us

Group insurance

Your Group Insurance Plan

FSSS (CSN)
public sector
April 1st, 2022

The Inukshuk is an Inuit figure that symbolizes the importance of interpersonal relationships, mutual aid and solidarity.

FSSS CSN

Please note that in this booklet, "SSQ" designates SSQ, Life Insurance Company Inc.

The present document is provided for information purposes only and in no way affects the terms, conditions and provisions of the group insurance contract.

Cette brochure est disponible en français.

PERSONAL INFORMATION PROTECTION

File and personal information

In order to maintain the confidentiality of information concerning the persons it insures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to reinsurers and any other person the participant may authorize. SSQ keeps its insurance files in its offices.

All persons insured with SSQ have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of SSQ's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request will be informed beforehand of the approximate amount that will be charged.

Legal agents and service providers

SSQ may exchange information of a personal and confidential nature with its reinsurers, legal agents and service providers only for the purpose of allowing them to carry out the tasks SSQ asks of them, including processing most prescription drug, dental care and travel insurance benefit claims. SSQ's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When enrolling in a group insurance plan and also when making a claim (e.g. using the prescription drug insurance card), the participant consents that the insurer and its legal agents and service providers may use their personal information for the purposes mentioned above. It is understood that not giving this consent compromises the management of the insurance coverage and the quality of the services SSQ can offer.

For more information, consult the SSQ Personal Information Protection Policy available at ssq.ca.

Available information on your group insurance plan

You are entitled to consult the policy at the policyholder's address and obtain a copy thereof.

Please note that even though this booklet is effective April 1, 2022, the definition of "Total disability period" in section 5.1 has been effective since July 1, 2021.

Table of Contents

SUMMARY OF BENEFITS

This table summarizes the modalities applicable to each benefit. For a more complete description of the applicable conditions, consult the other provisions of this booklet.

HEALTH PLAN

OVERVIEW

This table presents the expenses that are eligible under each of the three Health Plans (Health 1, Health 2 and Health 3), provided the eligibility provisions for expenses described in Section **1** - "**Health Plan**" are respected, as are the coordination provisions and the exclusions, limitations and restrictions of the Health benefit.

When a maximum of eligible expenses is indicated, it must be multiplied by the percentage of reimbursement to determine the reimbursable amount. The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for expenses incurred during a single calendar year. The note **PCRP** (planned calculated reimbursement percentage) in the "COVERAGE" column indicates that the amount (ceiling) at which the reimbursement percentage indicated for prescription drugs is increased to 100% applies to all coverage marked PCRP.

When a medical prescription is required, the note **PR** appears in the "COVERAGE" column. In this case, the prescription must indicate the name of the medication or, in the case of other products or services, the diagnosis, medical reasons, indications for use justifying the prescription and the planned duration of use.

Unless specified otherwise:

- the maximums indicated in this table are maximums **per insured person per calendar year**;
- any maximum indicated on a given line applies as a total for all of the items in the "COVERAGE" column of this line and not to each item separately;
- in the case of expenses incurred for the services of health care professionals, eligible expenses are limited to a single treatment per day per health profession.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Prescription drugs			
Deductible per prescribed drug	$5	$5	$5
Percentage of reimbursement for all coverage with PCRP mention	65% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate	75% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate	80% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate
Prescription drugs* PR and PCRP RAMQ List (Health 1) Regular List (Health 2 and Health 3)	Drugs that appear on the list of drugs covered by the BPDIP[(1)] and meet the requirements	Drug that meets the following requirements: • It bears a valid DIN (Drug Identification Number) issued by the federal government. • It is available only on prescription from a health care professional legally authorized to prescribe it. • It is available exclusively in pharmacies and sold by a health care professional in accordance with the *Pharmacy Act*. • It is used in compliance with government-approved indications for use or, in the absence of such indications, the indications for use provided by the manufacturer.	
Exception drugs* PR and PCRP	Prescription drugs named "exception drugs" that are part of the list of drugs whose cost is covered under the BPDIP according to the conditions and instructions for use specified in the Regulation Respecting the Basic Prescription Drug Insurance Plan. These drugs require prior authorization from SSQ.		

[(1)] BPDIP means Quebec Basic Prescription Drug Insurance Plan.

Medication injected at a doctor's office* PR and PCRP	Only the cost of the injected substance is eligible; the expenses incurred for the medical procedure and the portion of the product that is not actually injected are not eligible.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Smoking cessation products* PCRP	Those that are covered under the BPDIP.		
Eligible pharmaceutical services* PR and PCRP	Those that are covered under the BPDIP.		
Intrauterine devices* PR and PCRP	Those that bear a valid DIN, containing an active medicinal ingredient and that are covered under the BPDIP.		
Diabetic products PR and PCRP	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.		

*** Reimbursement of brand name drugs**

If the insured chooses 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 SSQ.

Brand name drugs are those which are sold under the original maker's trademark and for which there is at least one generic equivalent on the market.

Direct payment of prescription drug expenses

The insured can use the electronic claims transmission service offered by SSQ. For instructions on how to use this service, please refer to section **6** "**How to submit claims**".

Certain provisions exist to limit the payment of monthly expenses by **high-cost prescription drug users** who meet the criteria established by SSQ. The insured may contact SSQ to learn more about these criteria.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Sclerosing injections PR and PCRP	For substances provided and administered by a physician for curative and non-aesthetic purposes. Medical procedure not covered.		
Maximum	Reimbursement of $25 per day of treatment.		
Emergency Care			
Travel Insurance with Assistance	The Travel Insurance provisions can be found in a separate electronic format document entitled "Travel Insurance with Assistance and Trip Cancellation Insurance" on the secure site for insureds at ssq.ca.		
Percentage of reimbursement	100%	100%	100%
Maximum	Reimbursement of $5,000,000 for the duration of the trip.		
Trip Cancellation Insurance	The Travel Insurance provisions can be found in a separate electronic format document entitled "Travel Insurance with Assistance and Trip Cancellation Insurance" on the secure site for insureds at ssq.ca.		
Percentage of reimbursement	100%	100%	100%
Maximum	Reimbursement of $5,000 per trip.		
Transportation by an ambulance service PCRP	When the person's state of health requires it, ground transportation to or from the nearest hospital offering care, including oxygen therapy treatments received immediately prior to and during transport.Transportation by plane (or by helicopter in cases where it is not covered by a third party), by boat or by train is also covered when part or all of the journey requires the use of one of these means of transportation and the insured is bedridden and must occupy the equivalent of two seats. In this case, medical necessity must be demonstrated to the satisfaction of SSQ. In all cases, transportation must be provided by a licensed ambulance service.		
Percentage of reimbursement	65%	75%	80%
Maximum	Customary and reasonable expenses.		

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Other medical expenses			
Insulin pump accessories PR	Not covered	Purchase of accessories used exclusively with an insulin pump.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Hearing aid	Not covered	Purchase, adjustment or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $480 per period of 48 months.	
Therapeutic devices and breathing assistance apparatus PR	Not covered	Rental. Upon prior agreement with SSQ, expenses for purchase can also be eligible, as well as expenses for replacement or repair. Breathing assistance apparatus: The items must be used to replace, compensate for or improve the functional respiratory capacities of the insured. Therapeutic devices: The items must be necessary for the healing or treatment of the insured.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $10,000.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Orthopaedic devices PR and PCRP	Not covered	Purchase, adjustment, replacement, repair. To be covered as an orthopaedic device, the item must be used to support or maintain part of the insured's body to prevent and correct body deformities or to treat disorders of the bone structure, muscles or tendons. It must also be considered as such by SSQ. Foot orthoses must be provided by an officially licensed specialized laboratory.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Ostomy appliances PR and PCRP	Not covered	Purchase.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Support stockings PR	Not covered	Purchase of support stockings (20 mm Hg or above) for venous or lymphatic system deficiency, if obtained from a health-care establishment or a pharmacy.	
Percentage of reimbursement		75%	80%
Maximum		3 pairs.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Cannabis for medical purposes PR	The purchase of cannabis for medical purposes requires prior approval by SSQ and must meet the following conditions in order to be considered an eligible expense: a. the cannabis for medical purposes must be prescribed by a physician or nurse practitioner according to their respective definitions provided in the federal regulations governing access to cannabis for medical purposes b. the cannabis for medical purposes is only covered if its use is for conditions and therapeutic indications determined by SSQ c. the insured must submit to SSQ for approval, at the time of the first claim and upon the renewal of the prescription afterwards: • the Health Canada medical document authorizing the use of cannabis for medical purposes duly completed by a physician or authorized nurse practitioner • the SSQ "Prior authorization request" form duly completed by the insured and that same physician or authorized nurse practitioner d. the cannabis for medical purposes must be purchased only from a holder of a licence for sale duly authorized by Health Canada.		
Percentage of reimbursement	65%	75%	80%
Maximum	Reimbursement of $2,000.		

<table>
<tr><th colspan="4">HEALTH PLAN (continued)</th></tr>
<tr><td colspan="4">The general information that complements the information below can be found at the top of this table.</td></tr>
<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Orthopaedic shoes
PR and PCRP</td><td rowspan="3">Not covered</td><td colspan="2">Purchase of shoes:
• designed and made to measure from a cast when such shoes are required to correct or compensate for a foot defect; or
• prefabricated open, flared or straight shoes; or
• shoes needed to support Denis Browne splints.
These shoes must have been obtained from an officially licensed specialized laboratory.
Cost of additions or alterations made to orthopaedic shoes.
For the purposes of this coverage, deep shoes and sandals are not considered to be orthopaedic shoes.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Customary and reasonable expenses.</td></tr>
<tr><td>Deep shoes
PR and PCRP</td><td rowspan="3">Not covered</td><td colspan="2">Purchase and replacement of prefabricated deep shoes, when these shoes are required to correct a foot defect and are obtained from an officially licensed specialized laboratory.
For the purposes of this coverage, sandals are not considered to be deep shoes.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Reimbursement of $150.</td></tr>
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<tr><th colspan="4">HEALTH PLAN (continued)</th></tr>
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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Gender affirmation surgery</td><td rowspan="3">Not covered</td><td colspan="2">Expenses incurred while undergoing gender-affirming surgery performed by a physician to modify the insured's sexual characteristics so that they correspond to those associated with their self-identified gender. Expenses incurred for hair removal through electrolysis or laser treatment are also eligible expenses.

The surgery or hair removal must meet the following conditions to be considered an eligible expense:

• The insured must have received a gender dysphoria diagnosis from a physician;

• The surgery or hair removal must be performed in Canada;

• The surgery or hair removal must not be covered under the health insurance plan of the insured's province of residence.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Reimbursement of $10,000 per calendar year.
Lifetime reimbursement of $30,000.</td></tr>
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HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Dental care required following an accident	Not covered	Fees of a dental surgeon, dental specialist or denturist, to repair accidental damage to sound natural teeth or to treat an accidentally fractured jaw. The accident must occur while the person is insured under Health 2 or Health 3. The treatments must begin within 12 months of the date of the accident and must end within 36 months of the date of the accident. Expenses related to implants and damage to teeth while eating are not covered. However, dentures attached to implants can be recognized as eligible, up to the cost and maximum applicable to a covered alternative treatment and payable only at the time of the final insertion of the dentures attached to the implant.	
Percentage of reimbursement		75%	80%
Maximum		Rates recommended by the ACDQ for the year the treatments are received.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Detoxification PR	Not covered	Detoxification therapies provided by a clinic specialized in rehabilitation treatment for alcoholism or drug or gambling addiction, including all treatment-related expenses. For expenses incurred for this type of treatment to be considered eligible, the following conditions must apply: • the clinic must be recognized by SSQ • the insured must be receiving curative treatment • the clinic must be run by a licensed physician and be under the continuous supervision of a registered nurse	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $50 per day. Lifetime reimbursement of $3,000.	Reimbursement of $85 per day. Lifetime reimbursement of $5,000.
Wheelchair and walker PR	Not covered	Rental or purchase, whichever is most economical, for a temporary need.	
Percentage of reimbursement		75%	80%
Maximum		For a wheelchair: eligible expenses up to the cost of a non-motorized wheelchair of a type generally used in a hospital	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Blood glucose monitor PR	Not covered	Purchase, adjustment, replacement or repair. Flash systems are covered under **Diabetic products** (see page 3).	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $240 per period of 36 consecutive months.	
Intraocular lens implants PR and PCRP	Not covered	Purchase, if required to correct the symptoms of an eye disease in cases where the use of contact lenses or eyeglasses is not sufficient to correct such symptoms.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Hospital bed PR	Not covered	Rental or purchase of a hospital bed, whichever is more economical. The hospital bed must be similar to the type normally used in a hospital.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
External prostheses and artificial limbs PR and PCRP	Not covered	The loss of a natural limb must occur while the person is insured under this benefit. Items already covered under another section of this table **are not covered as external prostheses or artificial limbs**.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Transcutaneous electrical nerve stimulator PR	Not covered	Purchase, rental, adjustment, replacement or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $560 per period of 60 consecutive months.	
Insulin pump PR	Not covered	Purchase, adjustment, replacement or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $6,400 per period of 60 consecutive months.	
Wig PR	Not covered	Purchase of an initial wig following: • chemotherapy; or • any form of alopecia, provided the wig is medically required.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $300.	
Breast prostheses PR and PCRP	Not covered	Purchase if required following a mastectomy.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Surgical brassieres PR	Not covered	Purchase following a mastectomy or breast reduction.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $200.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Intrauterine devices (IUDs) PR and PCRP	Purchase of IUDs not covered under the prescription drug insurance benefit of this plan.		
Percentage of reimbursement	65%	75%	80%
Maximum	Customary and reasonable expenses.		
Transportation and accommodation in Quebec to consult a medical specialist or receive specialized treatment PR and PCRP	Transportation of at least 400 kilometres (round trip), from the insured's place of residence by the most direct route to the nearest establishment, and accommodation in a public establishment. Also, if the insured is under age 18, transportation of an accompanying parent. • Supporting documents for accommodation expenses must be attached to the claim. • In the case of use of a private vehicle, receipts for the purchase of gas are required. • A report signed by the attending physician demonstrating that specialized consultation or treatment is required and indicating where it will take place must be sent to SSQ. It must be demonstrated to the satisfaction of SSQ that the medical specialist and the specialized treatment are not available in the region, and that accommodation is necessary if accommodation expenses are claimed.		
Percentage of reimbursement	65%	75%	80%
Maximum	• Reimbursement of $48 per day. • Reimbursement of $1,000. Eligible transportation expenses limited to the average cost of the most economical means of transportation, regardless of whether the person uses a public or private means of transportation.		

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<tr><td colspan="4">The general information that complements the information below can be found at the top of this table.</td></tr>
<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td colspan="4">Health Care Professionals</td></tr>
<tr><td colspan="4">Expenses covered: Fees for services in a private clinic.</td></tr>
<tr><td>Dietitian</td><td rowspan="11">Not covered</td><td rowspan="4">Not covered</td><td rowspan="11">80%, combined maximum reimbursement of $750
Furthermore, for kinesitherapist, massage therapist and orthotherapist: reimbursement of $65 per treatment</td></tr>
<tr><td>Nutritionist</td></tr>
<tr><td>Kinesitherapist (including kinotherapist)</td></tr>
<tr><td>Massage therapist</td></tr>
<tr><td>Orthotherapist</td><td rowspan="7">75%, combined maximum reimbursement of $500</td></tr>
<tr><td>Acupuncturist</td></tr>
<tr><td>Chiropractor (including X-rays)</td></tr>
<tr><td>Osteopath</td></tr>
<tr><td>Physiotherapist</td></tr>
<tr><td>Physicial rehabilitation therapist</td></tr>
<tr><td>Podiatrist</td></tr>
<tr><td>Audiologist</td><td rowspan="11">Not covered</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Occupational therapist</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Speech language pathologist</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Psychoanalyst</td><td rowspan="8">50%, maximum reimbursement of $1,000</td><td rowspan="8">50%, maximum reimbursement of $1,500</td></tr>
<tr><td>Psychiatrist</td></tr>
<tr><td>Psychoeducator</td></tr>
<tr><td>Psychologist</td></tr>
<tr><td>Psychotherapist</td></tr>
<tr><td>Career counsellor</td></tr>
<tr><td>Social worker</td></tr>
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HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Vision Care			
Eye exams	Not covered	Not covered	Eye examinations by an optometrist or ophthalmologist.
Percentage of reimbursement			80%
Maximum			**Adults and dependent children age 18 or over:** Reimbursement of $80 per period of 36 consecutive months
• **Laser eye surgery** • **Contact lenses** • **Eyeglasses** PR	Not covered	Not covered	A prescription from an ophthalmologist or optometrist is required. Laser surgery must be carried out to correct myopia, hypermetropia, astigmatism or presbyopia.
Percentage of reimbursement			80%
Maximum			**Adults and dependent children age 18 or over:** Reimbursement of $400 per period of 36 consecutive months

DENTAL CARE

OVERVIEW

This table presents the expenses eligible under the Dental Care Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.

The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for the expenses incurred in a calendar year.

Unless specified otherwise:

- the maximums indicated in this table are **per insured per calendar year**;
- the maximum indicated on a line applies to all items in the "COVERAGE" colum of this line and not to each separate item.

COVERAGE	DESCRIPTION
Basic Dental Care	• Diagnosis • Prevention and space maintainers • Minor restorative services • Periodontics • Oral surgery • Local anesthesia See *Article* ***2.1*** "**Eligible expenses under the Dental Care Insurance**".
Percentage of reimbursement	80% Eligible laboratory expenses are limited to **50%** of the fees detailed in the fee guide for the orodental act in question.
Maximum	Fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.

DENTAL CARE (continued)	
The general information that complements the information below can be found at the top of this table.	
COVERAGE	**DESCRIPTION**
Restorative Dental Care	• Major restorative services • Endodontics • Fixed prosthodontics • Removable prosthodontics See *Article* ***2.1*** "**Eligible expenses under the Dental Care Insurance**".
Percentage of reimbursement	60%
Maximum	Reimbursement of $1,000. Fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.

LONG TERM DISABILITY INSURANCE	
OVERVIEW This table presents the insurance coverage under the Long Term Disability Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.	
COVERAGE	**DESCRIPTION**
Option O	
Amount payable	80% of the net benefit received from the employer at the 105th week of disability
Maximum duration	Until age 65
Option O+	
Amount payable	90% of the net benefit received from the employer at the 105th week of disability
Maximum duration	Until age 65

LIFE INSURANCE	
OVERVIEW	
This table presents the insurance coverage under the Life Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.	
COVERAGE	**DESCRIPTION**
Participant's Basic Life Insurance	1 times insurable annual salary
AD&D (Accidental Death and Dismemberment)	Accidental death = 1 times insurable annual salary Accidental dismemberment = 10% to 100% of insurable annual salary, depending on the loss suffered
Participant's Optional Life Insurance	1 to 5 times insurable annual salary
Spouse's and Dependent Children's Life Insurance	$5,000/deceased person; if proof is provided that the participant has no spouse at the time of death: $10,000/deceased child
Spouse's Optional Life Insurance	1 to 10 units of $10,000

1 - HEALTH PLAN

The expenses covered under the Health Plan are those that apply to supplies, care or services necessary for the treatment of the insured person following an illness, an accident, a pregnancy, complications arising from a pregnancy, a surgical intervention related to family planning or organ or bone marrow donation, or to dental care that is explicitly covered, and when specified, have been prescribed by a physician.

The expenses must not exceed **customary and reasonable expenses** normally paid for these services in the region they are given in. They must apply to care commonly provided for a similar condition.

Limitations – Health care professionals

To be eligible, expenses related to care and treatments by health care professionals must be incurred for fees payable to a person who is a member in good standing of the professional order relevant to the care or treatments that were rendered or, if no such order exists, a relevant professional association recognized by SSQ. Eligible expenses only cover one treatment per day per health profession per insured. The health professional and the insured cannot ordinarily reside in the same home or be closely related.

1.1 Tax credits

The portion of certain medical expenses not reimbursable by the Health Plan, insurance premiums for the Health Plan and certain other medical expenses may entitle participants to provincial and federal tax credits.

For more information, refer to publication IN-130 on medical expenses, found on the *Ministère du Revenu du Québec* website at **www.revenu.gouv.qc.ca** or consult the most recent income tax package found on the Canada Revenue Agency Web site at **www.cra-arc.gc.ca**.

1.2 Exclusions, limitations and restrictions

1.2.1 Exclusions, limitations and restrictions applicable to all benefits of the Health Plan

The Health Plan does not provide reimbursement for the following:

a. For services or items that do not comply with the customary and reasonable standards of current practices of the health professions concerned.

b. For expenses incurred for care, services or items for which the insured would not be required to pay in the absence of this plan.

c. For expenses incurred for medical examinations further to a request by a third party (insurance, school, employment, etc.) or for trips for health reasons.

d. For products or services used for experimental purposes or in the medical research stage, or whose use does not comply with the indications for use approved by the appropriate government authorities or, in the absence of such indications, with those provided by the manufacturer.

e. For expenses incurred for aesthetic purposes not explicitly covered under this benefit.

f. For the patient's contribution required for an insured who is eligible for free prescription drugs under a government insurance plan.

g. For expenses incurred for services, products, examinations or care received collectively.

h. For services or products related to smoking cessation that are not explicitly covered under this benefit.

i. For preventive vaccines, care, services or products that are not explicitly covered under this benefit.

j. For expenses related to artificial insemination, infertility treatment or in vitro fertilization that are not explicitly covered under this benefit.

k. For expenses for purchasing non-oral contraceptives that are not explicitly covered under this benefit.

l. For surgically-implanted prostheses, except those covered under the "Gender affirmation surgery" benefit, intraocular lens implants and breast prostheses following a mastectomy.

m. For expenses resulting from active participation in a riot, insurrection, criminal act or from service in the armed forces, or resulting directly or indirectly from a war or civil war in Canada, whether declared or not.

Benefits payable under any public or private plan, individual or group, or under any government initiative, including expenses guaranteed by a plan financed entirely or partly by taxes and expenses that would have been incurred had the provider of these services been chosen to participate in such plans, are reduced from any payable benefits under the Health Plan.

1.2.2 Exclusions, limitations and restrictions specific to the "Prescription drug insurance" benefit

In addition to the exclusions, limitations and restrictions that apply to all benefits of the Health Plan, the following products are excluded from prescription drug insurance, regardless of whether or not the products are considered as medical drugs:

a. Products used for cosmetic purposes or for personal hygiene, including products used to compensate for hair loss.

b. Drugs obtained through the federal Emergency Drug Release.

c. Homeopathic and natural products.

d. Smoking cessation products, except for those specifically covered under Quebec's Basic Prescription Drug Insurance Plan (BPDIP).

e. Dietary supplements serving as meal supplements or replacements. However, dietary supplements prescribed for the treatment of a clearly diagnosed metabolic disease, in accordance with the conditions and indications for use determined by Quebec's Regulation respecting the BPDIP remain covered; the only acceptable evidence shall be a full medical report describing, to the satisfaction of SSQ, all the conditions justifying the prescription of such products not otherwise covered.

f. Sunscreens and tanning creams.

g. Growth hormones whose diagnostic characteristics do not permit them to be included under the BPDIP on the basis of predetermined inclusion criteria.

h. Drugs provided during hospitalization, or by a hospital's pharmacy department or administered in a hospital.

i. Drugs used to treat erectile dysfunction and that are administered orally only.

Under no circumstances may the exclusions, limitations and restrictions of this plan render the plan less generous than the BPDIP.

1.2.3 Exclusions, limitations and restrictions specific to the "Cannabis for medical purposes" benefit

In addition to the exclusions, limitations and restrictions that apply to all benefits of the Health Plan, the following apply:

The following are not considered eligible expenses:

a. The costs related to the production of cannabis for medical purposes (including, but not limited to, the cost of seeds and plants of cannabis for medical purposes).

b. The costs related to the administration of cannabis for medical purposes (including, but not limited to, the cost of vaporizers, water pipes and rolling paper).

c. The administrative costs related to the prescription of cannabis for medical purposes or to obtaining cannabis for medical purposes (including, but not limited to, file opening fees, postal fees, consultation fees and referral fees).

2 - DENTAL CARE

Expenses eligible under the Dental Care Insurance are those that are covered and provided by an accredited dentist or denturist.

Dental care eligible expenses cannot exceed the fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.

SSQ offers an electronic claims transmission service with direct payment for dental care. Information on how to use this system is provided in section **6 - "How to submit claims"**.

2.1 Eligible expenses for Dental Care

2.1.1 Basic dental care reimbursed at 80%

1) Diagnosis

   a) Clinical oral examination

      i) recall or periodic oral examination: one examination per period of 9 months

      ii) complete oral examination: one examination per period of 36 months

      iii) complete periodontal examination: one examination per period of 36 months

      iv) emergency examination: 2 examinations per calendar year

      v) specific oral examination: 2 examinations per calendar year

      (Only one recall, preventive or complete examination per period of 9 months)

   b) Dental X-rays

      i) Intraoral films

         - Periapical film
         - Occlusal film
         - Bitewing film
         - Soft-tissue film

ii) Extraoral films

- Extraoral film
- Panoramic film: one film per period of 36 months
- Cephalometric film
- Sinus examination
- Sialography
- Use of radiopaque dyes to show lesions
- Temporomandibular joint
- Duplicate radiograph or file: 2 times per calendar year

c) Lab examinations, tests and diagnostic casts

i) Pulpal test: 3 times per period of 12 months

ii) Bacteriological test

iii) Histological tests: Biopsy of soft tissue, biopsy of hard tissue

iv) Cytological test

v) Diagnostic casts (excluded if related to a restorative treatment, prostheses or other service)

2) Prevention and space maintainers

a) Preventive services

i) Polishing of coronal portion of teeth: once per period of 9 months

ii) Scaling: once per period of 9 months

iii) Topical application of fluoride: once per period of 9 months (only children under age 14 are eligible for this procedure)

iv) Analysis of diet and recommendation: once per lifetime

v) Oral hygiene instructions: once per lifetime

vi) Oral hygiene re-instruction: once per lifetime

vii) Plaque control program: 5 times per lifetime

viii) Finishing restorations

ix) Pit and fissure sealants, only on the occlusal surfaces of permanent premolar and molar teeth of children under age 14: once per period of 36 months for a same tooth

x) Removal of surplus subgingival filling material when local anesthesia is needed

xi) Interproximal discing: 2 times per calendar year (only children under age 14 are eligible for this procedure)

xii) Ameloplasty for non-aesthetic purposes (only children under age 14 are eligible for this procedure)

b) Space maintainers and appliances for the control of oral habits*

i) Space maintainer

- one fixed or removable device per period of 24 months

ii) Control of oral habits

- one fixed or removable device per period of 24 months
- one myofunctional evaluation per period of 24 months
- motivation of patient: once per lifetime
- myofunctional therapy: 5 times per lifetime

* Only children under age 14 are eligible for these procedures.

3) Minor restorative services*

a) Sedative filling

b) Recontouring and polishing of traumatized tooth

c) Bonding/cementation of broken tooth chip: 2 times per calendar year, per tooth

d) Preventive resin restoration: once per period of 12 months for a same tooth

e) Amalgam or composite restorations

f) Retentive pins

g) Laboratory processed veneer: once per period of 48 months, for a same tooth

h) Amalgam/composite restoration made to an existing denture clasp or rest

* Treatment for the same surface or class of the same tooth is covered under the insurance plan once per period of 12 months, regardless of the material used and the treating dentist.

4) Periodontics

a) Treatment of acute infection or inflammation

b) Desensitization

c) Periodontal surgery (except periodontal guided tissue regeneration)

d) Gingival curettage and root planing: one treatment per calendar year, per tooth

e) Splint (for cast metal splint, refer to restorative dental care reimbursed at 60%, ***section 1 h)*** of paragraph "Restorative dental care reimbursed at 60%")

f) Occlusal equilibration: one major and 3 minor treatments per calendar year

g) Periodontal appliance for bruxism: once per period of 48 months

h) Repair of appliance for bruxism: once per calendar year

i) Relining of appliance for bruxism

j) Periodontal irrigation

5) Oral surgery

a) Removal of erupted tooth, complex or uncomplicated

b) Supplement for suturing

c) Removal of impacted tooth, residual roots or tooth fragments

d) Surgical exposure of tooth, surgical movement of tooth, enucleation

e) Alveolectomy, alveoloplasty, osteoplasty, tuberoplasty, stomatoplasty, gingivoplasty

f) Removal of hyperplasic tissue, excess mucosa, surgical excision of cyst or tumour

g) Extension of mucous folds

h) Surgical incision and drainage

i) Frenectomy

j) Dislocation of mandible

k) Treatment of salivary glands

l) Sinus treatment or surgery

m) Hemorrhage control

n) Post-surgical treatment

6) General services

a) Palliative treatment of dental pain

b) Time and responsibility requirement, in addition to usual procedure

c) Local anesthesia

2.1.2 Restorative dental care reimbursed at 60%

1) Major restorative services and fixed prosthodontics

a) Gold foil: once per period of 48 months for a same tooth

b) Inlays and onlays with retentive pins: once per period of 48 months for a same tooth

c) Individual crown

d) Preformed crowns made of stainless steel, plastic or other similar material: once per period of 12 months for a same tooth

e) Coping, precious metal or not: once per period of 48 months for a same tooth

f) Prefabricated post and cast metal post

g) Build-up for crown restoration

h) Cast metal splint: once per period of 48 months for a same tooth

i) Supplement for preparation of crown under existing partial denture structure

j) Removal of cemented post

k) Repair of crown/veneer

l) Recementation of inlay, onlay, crown or veneer: 2 times per calendar year for a same tooth

2) Endodontics

   a) Endodontic emergency

      i) Pulpotomy

      ii) Pulpectomy

      iii) Open and drain

   b) Endodontic traumatism, reimplantation/repositioning, preparation of tooth for treatment

   c) Root canal therapy and periapical endodontic surgery

3) Removable prosthodontics

   a) Complete dentures

   b) Partial dentures

   c) Denture adjustments

   d) Remount and equilibration: once per period of 48 months per maxillary

   e) Structure additions to partial dentures

   f) Palatal obturator: once per period of 48 months

   g) Denture cleaning and polishing

   h) Duplication of a denture

   i) Rebasing and relining

   j) Therapeutic tissue conditioning

   k) Repairs with or without impression

   l) Resetting of denture teeth

   m) Remake of partial dentures

   n) Analysis for fabrication of a partial denture: once per period of 48 months

4) Bridges and fixed prosthodontics

   a) Pontics

   b) Abutment

   c) Metal cast retainer for butterfly bridge (Maryland, Rochette or Monarch)

   d) Abutment, inlay or onlay: metal, porcelain, ceramic or resin

   e) Retentive bar to be fixed to copings: once per period of 48 months

   f) Telescoping crown unit

   g) Precision attachment

   h) Sectioning of an abutment or pontic

   i) Removal of a fixed bridge to be recemented, solder indexing

   j) Recementation: 2 times per calendar year, per tooth

   k) Repair

5) Implant

   Dentures attached to implants may be eligible, up to the cost and maximum limitations applicable to an equivalent alternative treatment provided for under this benefit, and payable only at the time of the final insertion of the dentures attached to the implants.

2.2 Treatment plan

When the cost of a treatment is expected to exceed $800 or when the services planned are major restoration services, a treatment plan and X-rays may be submitted to SSQ before the beginning of the treatments. This allows SSQ to establish if the planned treatments are eligible and the amount of benefits the insured may be entitled to.

2.3 Tax credits

The portion of certain dental care expenses not reimbursable by the Dental Care Plan and insurance premiums for the Dental Care Plan may entitle participants to provincial and federal tax credits. For more information, refer to publication IN-130 on dental care expenses, found on the *Ministère du Revenu du Québec* website at **www.revenu.gouv.qc.ca** or consult the most recent income tax package found on the Canada Revenue Agency Web site at **www.cra-arc.gc.ca**.

2.4 Exclusions, limitations and restrictions

2.4.1 The following are excluded from Dental Care Insurance:

a. For services or items that do not comply with the customary and reasonable standards of current practices of the health professions concerned.

b. For expenses incurred for care, services or items for which the insured would not be required to pay in the absence of this benefit.

c. For expenses incurred for medical examinations further to a request by a third party (insurance, school, employment, etc.).

d. For products or services used for experimental purposes or in the medical research stage, or whose use does not comply with the indications for use approved by the appropriate government authorities or, in the absence of such indications, with those provided by the manufacturer.

e. For expenses incurred for aesthetic purposes not explicitly covered under this benefit; transformation or extraction and replacement of sound teeth to modify their appearance is not covered under this benefit.

f. Supplementary procedures and treatments related to implants (surgery, grafts, etc.).

g. An intra-oral appliance or services related to the treatment of temporomandibular joint dysfunction or correction of vertical dimension. However, a portion of the expenses incurred for an intra-oral appliance is eligible, i.e. an amount equal to the amount specified in the fee guide of the dentist's professional association for bruxism appliances.

h. Missed appointments, claims filed, treatment plans, written reports, travelling expenses, legal identification fees, court appearances as an expert witness or telephone consultations.

i. An appliance designed for protection when playing sports (mouth guards).

j. A dental appliance for the treatment of snoring or sleep apnea.

k. Transfer copings.

l. Transitional crowns, pontics or abutments.

m. Removal of crowns and bridges that did not need to be recemented.

n. Dental caries susceptibility tests or sampling and microscope viewing of bacterial plaque.

o. Diagnostic photographs.

p. Services or products that are charged by a third party or are received collectively.

q. Expenses paid under a public insurance or social security plan, or a government program, or under a law or regulation or decree adopted with regard to these laws, plans or programs.

Benefits payable under any public or private plan, individual or group, or under any government initiative, including expenses guaranteed by a plan financed entirely or partly by taxes and expenses that would have been incurred had the provider of these services been chosen to participate in such plans, are reduced from any payable benefits under the Dental Care benefit.

2.4.2 If an insured person changes dentists or denturists during a treatment, or if they must be transferred to another dentist or denturist, or if more than one dentist or denturist is participating in the same treatment, the amount of benefits payable by SSQ for this treatment is limited to the amount that would have been payable had services been provided by a single dentist or denturist.

2.4.3 In the case of a cast metal post, crown, removable denture or fixed bridge being subject to benefits, no replacement treatment can count as an eligible expense if the insertion occurs within 48 months following the previous installation. However, a permanent removable prosthesis (partial or full), may be eligible for reimbursement if it replaces a transitional removable prosthesis (partial or full) and is installed within 6 months of the date the transitional prosthesis was installed.

2.4.4 When the word “sextant” or “quadrant” is used in the description of a treatment that is covered by the insurance, the insured services corresponding to this treatment are limited to 6 different sextants per calendar year per insured and 4 different quadrants per calendar year per insured.

2.4.5 When a fee based on units of time is provided, expenses recognized for insurance purposes are limited to the recommended fee covering the maximum number of units of time for the treatment or service in question. Expenses for additional units are not considered when calculating eligible expenses.

3 - LONG TERM DISABILITY INSURANCE

This plan completes the disability insurance plan provided for in the collective agreement and provides disabled participants with income until their 65th birthday should a disability render them totally incapable of working for an extended period.

3.1 Amount of benefits

The initial amount of monthly benefits is calculated based on the net benefit that is payable or would be payable by the employer at the 105th week of disability, in accordance with the disability insurance plan provided for in the collective agreement.

For all options, Long Term Disability Insurance benefits are non-taxable.

3.1.1 Option O

The percentage used to establish the payable benefit is 80%.

3.1.2 Option O+

The percentage used to establish the payable benefit is 90%.

3.1.3 Income less than $10,000

For part-time employees earning less than $10,000 per year, the minimum income used to calculate the amount of the benefit is $10,000, provided the average salary is higher than $0 for the last 12 weeks preceding the start of the total disability.

3.2 Elimination period

The elimination period is 105 weeks.

3.3 Duration of benefits

At the end of the elimination period, benefits are paid monthly for as long as the total disability persists, until the last day of the month when the participant reaches age 65.

3.4 Rehabilitation employment

Totally disabled participants may perform rehabilitation work with the agreement of SSQ. Benefits payable are reduced by 50% of the gross income earned by the disabled participant for such work.

Benefits paid together with the income earned from such employment cannot exceed 100% of the net monthly salary of the participant at the time payment of the Disability Insurance benefits began.

3.5 Cost-of-living adjustment

When Long Term Disability Insurance benefits have been paid by SSQ for 12 full months, consecutive or not, for the same total disability period, the amount of the monthly benefit being paid is indexed on January 1 of each subsequent year according to the same terms as the Quebec Pension Plan, up to a maximum annual adjustment of 3%.

3.6 Reduction

Benefits paid by SSQ are reduced by the following amounts:

a) Remuneration from the employer

Any remuneration received from the employer, with the exception of the following sources of income:

- paid vacation days;
- any amount of money from the participant's sick leave bank used for the specific purpose of buying back past service from a pension plan, as long as the pension plan concerned so allows.

b) Retirement pension

65% of the retirement pension that is received under the employer's retirement plan or, if the participant does not receive such a pension, the pension the participant could receive without actuarial reduction if he or she ceased to benefit from the waiver of contributions in the case of disability stipulated under the employer's retirement plan.

However, when a totally disabled employee who is not retired ceases to participate in the private pension plan while being entitled only to a deferred pension, and decides to transfer the current value of this pension to a Locked-in retirement account (LIRA), SSQ will reduce the monthly pension payable under this plan by any amount received from a Life Income Fund (LIF) or an income fund obtained through the conversion of amounts accumulated in the LIRA. The amounts considered for the LIRA are only those transferred from the private retirement plan in force at the start of the disability.

c) Benefits from a public plan or social legislation

Any benefits payable under the Quebec Pension Plan (QPP) or the Canada Pension Plan (CPP), or under Quebec's *Automobile Insurance Act*, the *Employment Insurance Act*, he *Act respecting parental insurance*, the *Act respecting industrial accidents and occupational diseases* or any social legislation.

3.7 Exclusions

The Long Term Disability Insurance benefit does not provide coverage for:

- disability periods during which the participant does not follow the recommendations of a physician, except if the participant's condition is declared stable by a physician to the satisfaction of SSQ;

- disability periods during which the participant holds a position or performs work that may provide a salary or any profit whatsoever, subject to the provisions of the following box;

> The participant may be entitled to benefit payments when participating in a rehabilitation program as provided in section **3.4** "**Rehabilitation employment**" or when carrying out duties or performing work that provides an income lower than 10% of the effective Maximum Pensionable Earnings (MPE) stipulated under the Quebec Pension Plan. In the latter case, if the participant's condition meets the definition of "total disability", the Long Term Disability Insurance benefits are not reduced by the participant's income.

- disability periods resulting from alcoholism or drug addiction, from active participation in a riot, insurrection or criminal acts, or from service in the armed forces. However, a disability period resulting from alcoholism or drug addiction during which the participant is receiving continuous treatment or medical care for rehabilitation is recognized as a total disability period.

Moreover, a CNESST-approved preventive leave related to pregnancy or breast-feeding is not recognized as a total disability period for the purposes of this benefit.

3.8 Proof and medical examinations

SSQ may require the participant to provide additional information about the disability or to undergo a medical examination, the date of which is determined by SSQ. This request is submitted in writing.

For the period beginning 31 days after the date of the request, until the date SSQ actually receives the additional information requested, no benefits will be payable to the participant who has not submitted the information requested or undergone the required medical examination.

If SSQ's request remains unsatisfied for a period of 6 months, the participant forfeits the right to claim disability benefits for the total disability period retroactively to the date of the initial request made by SSQ.

4 - LIFE INSURANCE

4.1 Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

4.1.1 Participant's Basic Life Insurance

In the event of the participant's death, the designated beneficiary (or, if no beneficiary has been designated, the estate of the participant) receives an amount of life insurance that corresponds to one time the annual insurable salary of the participant.

4.1.2 Limitation

If the participant commits suicide within 12 months following the effective date of coverage amounts requested more than 30 days after the date of eligibility, no benefits are payable for these coverage amounts. However, SSQ will reimburse the premiums paid for these amounts.

4.1.3 Participant's AD&D Insurance

In case of accidental death or accidental loss of a limb, the designated beneficiary or the participant receives a certain percentage of the participant's annual insurable salary, not exceeding 100%, for the losses described in the following table.

Accidental loss	Percentage of insurable salary
Accidental death	100%
Loss (including loss of use):	
• of both hands, both feet or sight in both eyes	100%
• of one hand and one foot	100%
• of one hand or one foot, and sight in one eye	100%
• of one hand or one foot	50%
• of sight in one eye	50%
• of one finger or one toe	10%

4.1.4 Exclusions for AD&D Insurance

No insurance amount is payable under this benefit if the loss is attributable, directly or indirectly, in whole or in part, to one of the following causes:

a) Suicide, attempted suicide or intentional self-inflicted injuries, regardless of the state of mind of the participant.

b) Active participation in a riot, insurrection or criminal acts, or a war or civil war, whether declared or not.

c) Trip or flight in any kind of aircraft when the participant is a crew member or carries out any duties related to such flight.

d) Active service in the armed forces of any country.

e) 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).

f) Poisoning or intoxication.

4.2 Spouse's and Dependent Children's Life Insurance

In the event of the death of the spouse or a dependent child, the participant receives one of the following amounts of life insurance:

- $5,000 for the death of the spouse;
- $5,000 for the death of a dependent child age 24 hours or over.

In the event of the death of a dependent child, if the participant does not have a spouse at the time the event occurs, upon approval of supporting documents by SSQ, the amount to be paid is increased to $10,000.

4.3 Optional Life Insurance

4.3.1 Participant

Participants with Basic Life Insurance may opt for an additional amount of Optional Life Insurance up to 5 times their annual insurable salary.

Evidence of insurability deemed satisfactory by SSQ is always required.

4.3.2 Spouse

Participants with Basic Life Insurance can obtain units of $10,000 of Optional Life Insurance for their spouse up to $100,000.

Evidence of insurability deemed satisfactory by SSQ is always required.

4.3.3 Limitation

If the participant or the participant's spouse commits suicide within 12 months following the effective date of coverage amounts requested more than 30 days after the date of eligibility, no benefits are payable for these coverage amounts. However, SSQ will reimburse the premiums paid for these amounts.

4.3.4 Premium rates

The premium rates for Participant's Optional Life Insurance are based on the participant's age, gender and smoking habits.

The premium rates for Spouse's Optional Life Insurance are based on the age of the participant, but on the gender and smoking habits of the spouse.

To take advantage of the reduced rates offered to non-smokers, the declaration of non-smoker status on the "Application/Request for Change" form or on the "Declaration of Non-Smoker Status" form must be signed by the appropriate individual. These forms are available from the employer. If such declaration is not received, the premium rates for a smoker apply.

4.4 Life Insurance for the Retiree and the Spouse of the Retiree

Life insurance amounts are offered upon the participant's retirement. For more information, the participant may refer to the Optional Group Life Insurance Plan for the Retiree and the Spouse of the Retiree pamphlet available on the secure site for insureds (refer to section **6** "**How to submit claims**" to learn more about this service).

5 - GENERAL INFORMATION

5.1 Definitions

"**Accident**": an unintentional, sudden, unforeseen and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injury.

"Dependent":

a) Spouse

Spouse means persons:

- who are married or civilly united and living together;
- who are living as if they were married and are the father and mother of a same child;
- of the same or opposite sex who have been living as if they were married for at least one year.

However, dissolution of the marriage by divorce or annulment or annulment of the civil union causes the status of spouse to be forfeited, as does de facto separation for more than three months in the case of a common-law spouse. The insured who is not living with the spouse can designate another person to replace the legal spouse if this person meets the other provisions of this definition.

b) Dependent child

A child of the participant, of the spouse or of both, who is unmarried and not in a civil union, who is residing or domiciled in Canada, who is dependent on the participant for support and who meets one of the following conditions:

- be under age 18;
- be age 25 or under and be a duly registered full-time student in an accredited educational institution;
- regardless of the child's age, became totally disabled when he or she met one of the above conditions and has remained continuously disabled since that date;

- be a person of full legal age, without a spouse, suffering from a functional impairment defined in the *Regulation respecting the basic prescription drug insurance plan* of the RAMQ, impairment that occurred before the person reached 18 years of age, who does not receive any benefits under a last resort financial assistance program provided for in the *Act respecting income support, employment assistance and social solidarity*, who is residing with the participant and on whom the participant or the participant's spouse would exercise parental authority were the person a minor.

An unmarried child over whom the participant or spouse exercises parental authority or would have exercised such authority had the child been a minor is also considered a dependent child.

Furthermore, a dependent child on a sabbatical school leave maintains the dependent child status, provided that the participant meets the requirements under *section* ***5.13*** "**Dependent child on sabbatical school leave**" of this booklet.

A dependent child can also be any legally adopted child or any child for whom a legal adoption process is undertaken or an order of placement granted in compliance with the conditions for adoption.

"Employee": any person who is subject to a collective agreement specified in this group insurance plan.

"**Employer**": an establishment that is a member of a union association specified in the definition of "collective agreement", or any other employer or category of employer deemed acceptable by the Committee.

"**Event**":

- Involuntary termination of the health insurance enabling the exemption
- Marriage, civil union or cohabitation for a period of one year
- Birth or adoption of a first child
- Involuntary termination of the spouse's or dependent children's insurance
- Separation
- Divorce
- Termination of eligibility or death of the spouse or a dependent child

"**Hospital**": any establishment considered a hospital under the acts and regulations respecting health services and social services (R.S.Q., ch. S-4.2). A hospital centre is a facility or department whose mission is to provide diagnostic services, as well as general and specialized medical care, or physical or psychiatric rehabilitation services, excluding private clinics and nursing care centres where religious orders or teaching institutions accommodate their members or students, as well as the part of a hospital intended for long term care. Outside the province of Quebec, the term means any establishment meeting the same standards.

"Insured": the participant or the participant's dependents who are covered by this insurance.

"Participant": any employee participating in the insurance plan.

"Physician": an individual who is legally authorized to practise medicine where he or she practises.

"Salary (also called insurable salary)": salary following the rates of the scale applicable to the participant according to the collective agreement, including any regional disparity premiums and additional remuneration provided for in the collective agreement and used for the calculation of disability insurance benefits.

"Self-insured plans under the collective agreement": the life insurance and short term disability insurance plans included in the collective agreement.

"SSQ": SSQ, Life Insurance Company Inc.

"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.

"**Total disability**": from the 105th week of a total disability period until the 208th week thereof, a state of incapacity resulting from an accident or illness, complications of a pregnancy, tubal ligation, vasectomy, or similar cases related to family planning, or organ or bone marrow donation, provided this state of incapacity requires medical care and renders the participant totally incapable of carrying out the normal duties of his/her employment or any comparable employment with similar remuneration offered to the individual by the employer.

After this period, "total disability" is defined as a state of incapacity resulting from an accident or illness, or complications from a pregnancy or organ or bone marrow donation, provided this state renders the participant totally unable to carry out any remunerative employment for which the individual is reasonably qualified because of education, training and experience, regardless of the availability of such employment.

"Total disability period": any continuous total disability period or successive total disability periods separated by a period of active full-time work or availability for full-time work, unless the participant demonstrates, to the satisfaction of the employer or a representative thereof, that the subsequent period results from an illness or accident completely independent of the cause of the previous total disability.

This period of active full-time work or availability for full-time work must be:

- less than 15 days if the duration of the total disability is shorter than 78 weeks; and
- less than 45 days if the duration is 78 weeks or longer.

Any period of rehabilitation during the elimination period applying to the Long Term Disability Insurance will not interrupt the total disability period.

5.2 Eligibility

5.2.1 Employee eligibility

Employees become eligible for coverage under the group insurance plans insured by SSQ when they become eligible for the self-insured plans provided for under their collective agreement.

Despite the preceding, the employee becomes eligible for coverage under Health 1 after one month of continuous service.

However, employees are eligible for coverage immediately, if after having permanently left an employer they return to work for the same employer or start work for a new employer within the Health and social services sector no later than 30 calendar days following their departure.

In the above-mentioned cases, no evidence of insurability is required by SSQ, with the exception of the evidence required for a change in participation in Participant's Life Insurance or Long Term Disability Insurance following an opt out.

Dependents become eligible on the date of the employee's eligibility or on the date they become a dependent, if later.

5.2.2 Rehired retiree

Retirees who are rehired can maintain the life insurance coverage they hold under the retiree's Optional Life Insurance plan for themselves and their spouse, as the case may be. However, they do not become eligible for the other coverage of the group insurance contract.

5.3 Participation

5.3.1 Health Insurance Plan

Compulsory participation

Participation in this plan is **compulsory** for all eligible employees and their dependents, subject to the exemption entitlement (*section* **5.6** "**Exemption to Health Insurance**") or a valid claim slip issued by the *Ministère du Travail, de l'Emploi et de la Solidarité sociale*.

Coverage options and statuses

Participants must choose one of the available options (Health 1, Health 2 or Health 3) and a coverage status (individual, single-parent or family) for themselves as well as for dependents.

Participation in Health 2 and Health 3 is optional. However, participation in one of these plans must be maintained for at least 36 months before the insured can change to a lower option, except as provided under *section* ***5.10*** **"Changes to status and coverage options (Health Insurance and Dental Care)".**

Employees age 65 and over

Employees age 65 and over may choose to obtain coverage for themselves and their dependents under the RAMQ's Basic Prescription Drug Insurance Plan even if covered under Health 2 and Health 3 (with no minimum participation of 36 months requirement), or they may choose to continue coverage under their group insurance plan. Dependents under age 65 must be covered under the same plan as the participant.

When employees aged 65 and over elect to become insured under the RAMQ's Basic Prescription Drug Insurance Plan, they can take advantage of the exemption entitlement of their Health Insurance plan. In such a case, SSQ must be notified of the decision. A participant's or spouse's decision to obtain coverage under the RAMQ's BPDIP is irrevocable.

However, if the spouse has access to a private plan that provides a protection equivalent to the RAMQ's Basic Prescription Drug Insurance Plan, they must be insured under that plan as well as their dependent children. The participant has the choice of participating in the BPDIP or in the private plan of their spouse.

NOTICE
Under Quebec's *Act respecting prescription drug insurance*, all individuals eligible for coverage under a group insurance plan must participate in that plan and, depending on their situation, **pay the applicable premiums** for individual, single-parent or family coverage status. In the event of termination of the group insurance due to non-payment of premiums, individuals cannot register for coverage under the RAMQ's BPDIP but must pay the annual premium for such coverage to the RAMQ when filing their income tax return. Furthermore, neither SSQ nor the RAMQ will reimburse any prescription drug claims for expenses incurred during the period for which the premiums were not paid.

5.3.2 Dental Care

Optional participation with automatic enrolment

Participation is **optional** for all eligible employees and their dependents if the employee is covered under the Health Insurance plan or is exempted. Participation in the Dental Care benefit is automatically granted with an individual status.

The employee can opt out of this benefit at enrolment.

The employee can also opt out of this benefit during the minimum period of participation of 36 months (*section **5.7*** "**Opting Out of Dental Care Insurance**").

Coverage status

Participants must choose a coverage status (individual, single-parent or family) (*section **5.5*** "**Coverage statuses and options**").

Minimum period of participation of 36 months

Participants who have subscribed to the Dental Care Insurance must maintain their participation for at least **36 months** from the effective date of this benefit, even when an event stated in the contract occurs. However, the participant may change their coverage status (refer to *section **5.10*** **"Changes to status and coverage options (Health Insurance and Dental Care)").**

Participants may terminate their participation to this benefit during the 36-month period if they provide satisfactory evidence to SSQ that they are newly covered under another group insurance plan with a Dental Care benefit.

Thereafter, if participants want the Dental Care Insurance benefit back, a new minimum period of participation of 36 months starts from the new effective date to this benefit.

5.3.3 Calculation of the minimum period of participation of 36 months - Health Insurance and Dental Care

The following periods are included in the calculation of the minimum period of participation of 36 months:

- a period of temporary interruption of work during which participation in Health 1 was maintained;
- a period during which premiums were waived as a result of total disability;
- a period during which time worked was reduced to 25% or less of full-time, and during which Health 1 only was maintained;
- for Health Insurance only: an exemption period.

5.3.4 Long Term Disability Insurance

Participation in this benefit is **compulsory** for all eligible employees.

The option depends on the option chosen by the participant's certification unit (Option O or Option O+).

Participants may opt out of the Long Term Disability Insurance (refer to *section 5.8* "**Opting Out of Long Term Disability Insurance**").

The Long Term Disability Insurance coverage is not available to participants or coverage terminates at age 63.

5.3.5 Life Insurance

Optional participation with automatic enrolment

Participation in this benefit is **optional** for all eligible employees and their dependents.

Participation in Participant's Basic Life Insurance and Spouse's and Dependent Children's Life Insurance is granted **automatically** to all employees.

Participants may opt out of the Life Insurance (refer to *section 5.9* "**Opting Out of Life Insurance**").

Participation in the Participant's Basic Life Insurance and Participant's Accidental Death and Dismemberment Insurance is indissociable.

Participation in the Participant's Optional Life Insurance and Spouse's Optional Life Insurance is conditional to participation in the Participant's Basic Life Insurance.

5.4 Application for insurance and effective date of coverage

5.4.1 Application deadline

The eligible employees must complete the "Application/Request for Change" form available from their employer's human resources department. Once completed, this form is returned to the employer's group insurance plan administrator within 30 days of the effective date, who in turn submits it to SSQ.

Note : The *Act respecting prescription drug insurance* requires employees to insure their spouse, and dependent children if any, unless they are covered under another group insurance plan.

5.4.2 Automatic enrolment rule

Eligible employees **who fail or refuse to complete an application for insurance are automatically insured** under:

- Health 1 with an individual coverage status;
- Dental Care with an individual coverage status;
- Long Term Disability Insurance (depending on the option chosen by the participant's certification unit);
- Participant's Basic Life Insurance, Participant's Accidental Death and Dismemberment Insurance and Spouse's and Dependent Children's Basic Life Insurance.

5.4.3 Effective date of coverage for Health Insurance

The Health Insurance benefit comes into force on the person's date of eligibility (refer to section ***5.2.1*** **"Employee eligibility").**

If the employee is disabled when their insurance comes into force, their coverage status under the Health Insurance comes into force on their date of eligibility if SSQ receives their coverage status choice prior to the start of the disability.

5.4.4 Effective date of coverage for Dental Care

Employees must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 15 or 45 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***5.1*** "**Definitions**").

The insurance for new employees comes into force on the date they become eligible.

5.4.5 Effective date of coverage for Long Term Disability

Employees must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 15 or 45 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***5.1*** "**Definitions**").

The insurance for new employees comes into force on the date they become eligible.

When the certification unit submits written notice to SSQ that the majority of its members have voted in favour of one of the available options (O or O+), Long Term Disability Insurance comes into force on the first day of the pay period following the date the vote is held, with the option chosen .

5.4.6 Effective date of coverage for Life Insurance

Employees must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 15 or 45 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***5.1*** "**Definitions**"). The effective date for Spouse's and Dependent Children's Life Insurance is not subject to the employee's ability to work.

a) <u>Participant's Basic Life Insurance and Participant's Accidental Death and Dismemberment (AD&D) Insurance</u>

   The insurance comes into force on the date of eligibility, unless the insured opts out.

   Following an opting out, evidence of insurability is required and the insurance comes into force on the first day of the pay period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

b) Participant's and Spouse's Optional Life Insurance

Evidence of insurability is required for all applications for participation in the Optional Life Insurance.

The insurance comes into force on the first day of the premium period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

c) Spouse's and Dependent Children's Life Insurance

The insurance comes into force on the date of eligibility, unless the insured opts out.

When the "Application/Request for Change" form is submitted within 30 days following the date of one of the events below, the insurance comes into force on the date of the event:

- marriage or civil union;
- cohabitation for a period of one year;
- birth or adoption of a first child;
- involuntary termination of the spouse's or dependent children's insurance.

Following an opting out of more than 30 days after the eligibility date or the date of the event above, evidence of insurability is required and the insurance comes into force on the first day of the premium period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

Any employees who were previously covered under any benefits of this plan and who have since ceased to participate in these benefits must submit evidence of insurability and be accepted by SSQ to obtain coverage once again.

5.5 Coverage statuses and options

For the Health Insurance and Dental Care Insurance, the participant must choose a coverage status.

Available coverage statuses are the following:

Coverage status	Individuals covered
Individual	Participant
Single-parent	Participant and dependent children
Family	Participant, spouse, and dependent children, if any.

Participants can change their and their dependents' coverage status and option, according to the rules provided for in *section **5.10*** "**Changes to status and coverage options (Health Insurance and Dental Care)**".

5.6 Exemption to Health Insurance

5.6.1 Application for exemption

Employees may be exempted from the Health Insurance upon presentation of proof of coverage under a group insurance plan with prescription drug insurance coverage or a valid claim slip issued by the *Ministère du Travail, de l'Emploi et de la Solidarité sociale*.

Note: Employees must provide their employer with a copy of the insurance certificate or claim slip.

Any person age 65 and over who is insured under the BPDIP of the RAMQ can also be exempted from participating in the Health Insurance.

The exemption entitlement also allows participants to cease participation in Health 2 and Health 3, even if the minimum period of participation of 36 months has not yet been completed.

5.6.2 Start of exemption

a) The exemption of a new employee begins on the employee's **date of eligibility** if, within **30 days** after this date, the employer receives a duly completed written request. Otherwise, it begins on the first day of the premium period that coincides with or follows the date the employer receives the request.

b) The exemption of a participant begins on t**he date of the event** entitling the employee to an exemption if, within **30 days** after this date, the employer receives the duly completed written request. Otherwise, it begins on the first day of the premium period that coincides with or follows the date the employer receives the request.

5.6.3 End of exemption

Participants who wish to terminate their exemption must establish, to the satisfaction of SSQ and the employer, that they were previously insured under the Health Insurance or another prescription drug insurance plan and that they and their dependents, if any, are no longer covered by the plan that allowed the exemption.

Applications to terminate an exemption must be accompanied by supporting documents.

a) **Provisions applying to requests received by the employer within 30 days following the end of participation to the group insurance plan that allowed the exemption**

The insurance comes into force on the date the insurance allowing the exemption ended. The participant can take advantage of this opportunity to choose a new coverage package, without regard for the minimum period of participation of 36 months.

b) **Provisions applying to requests received by the employer more than 30 days following the end of participation to the group insurance plan that allowed the exemption**

The insurance comes into force on the first day of the premium period that coincides with or follows the date the employer receives the request.

Any participant who was participating in Health 2 or Health 3 before the beginning of the exemption cannot decrease their coverage or their dependents' coverage if the minimum period of participation of 36 months is not yet completed. The exemption period is considered to be part of the minimum 36-month period.

If the participant chooses to increase the Health Plan held before the exemption and they have been granted a waiver of premiums at the time they make their application, that increase becomes effective on the first day of the premium period that follows the date on which they come back to work for 15 or 45 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***5.1*** "**Definitions**").

5.7 Opting out of Dental Care Insurance

Eligible participants may opt out of the automatic enrolment to Dental Care Insurance.

To benefit from the opt out option, a written request must be received by the employer within 30 days following the effective date of the Dental Care Insurance. The benefit terminates retroactively on the effective date of the benefit.

However, if the request is received more than 30 days following the effective date of the benefit, the opt out is not granted and the employee must participate in this benefit for the minimum period of participation of 36 months.

The participant that did not choose to opt out from Dental Care Insurance at enrolment may do so during the minimum period of participation of 36 months.

To benefit from the opt out option, a written request must be received by SSQ and must establish, to the satisfaction of SSQ, that the participant is newly covered under an other group insurance plan with Dental Care Insurance. The benefit terminates retroactively on the date the request is received by SSQ.

If the participant wishes to be covered again by Dental Care Insurance afterwards, a new minimum period of participation of 36 months will begin on the date the insurance comes into force under the Dental Care Insurance.

5.8 Opting out of Long Term Disability Insurance

Participants may opt out, provided they:

- are age 53 or over, or
- present evidence to SSQ that they participate in a retirement plan with at least 33 years of service or more for purposes of eligibility for the RREGOP, or
- are already covered under a disability insurance plan for members of a professional order, provided such plan provides equivalent coverage.

Participants must make requests for change using the "Right to opt out of compulsory Long Term Disability Insurance coverage" form and hand them to the employer. The employer must forward a signed copy of this form to SSQ.

The opting out becomes effective on the first day of the premium period coinciding with or following the date the employer signs the form.

Participants who opt out can later return to the Long Term Disability Insurance if they provide evidence of insurability deemed satisfactory by SSQ.

5.9 Opting out of Life Insurance

Eligible participant may opt out of the automatic enrolment to Participant's Basic Life Insurance, Participant's Accidental Death and Dismemberment and Spouse's and Dependent's Basic Life Insurance.

To benefit from the opt out option, participants must submit a request to the employer.

If the request is received by the employer **within 30 days** following the effective date of these benefits, the opting out becomes effective retroactively to the effective date of these benefits.

However, if the request is received **more than 30 days** following the effective date of these benefits, the opting out becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

5.10 Changes to status and coverage options (Health Insurance and Dental Care)

Events	Effective date of the change	
	If the request is received by the employer <u>within 30 days following the event</u>	**If the request is received by the employer <u>more than 30 days following the event</u>**
Change of coverage status (individual, single-parent or family)[1]: • **Health Insurance** • **Dental Care**		
Events identified in *section* ***5.1*** "**Definitions**" The participant may choose a new coverage status among the statuses shown in *section* ***5.5*** "**Coverage statuses and options**"	On the date of the event	On the first day of the premium period that coincides with or follows the date the employer receives the written request
• **Increase of coverage option (Health 2 or Health 3)[1] of the Health Insurance; or** • **Addition of Dental Care**		
Events identified in section ***5.1*** **"Definitions"**	On the date of the event	On the first day of the premium period that coincides with or follows the date the employer receives the written request
	The increase of coverage option for Health Insurance is possible even if the minimum period of participation of 36 months is not completed. A new minimum period of participation of 36 months begins on the date the change is approved.	

<table>
<tr><th rowspan="2">Events</th><th colspan="2">Effective date of the change</th></tr>
<tr><th>If the request is received by the employer <u>within 30 days following the event</u></th><th>If the request is received by the employer <u>more than 30 days following the event</u></th></tr>
<tr><td colspan="3">Decrease of coverage option (Health 1 or Health 2)[1]:
• Health Insurance</td></tr>
<tr><td rowspan="2">Events identified in section 5.1 “Definitions”</td><td rowspan="2">On the date of the event, regardless of the minimum period of participation of 36 months</td><td>Request is declined, unless the minimum period of participation of 36 months is completed
In this case, the request is approved on the first day of the premium period that coincides with or follows the date the employer receives the written request</td></tr>
<tr><td colspan="2">A new minimum period of participation of 36 months begins on the date the change is approved, if the participant chooses Health 2.</td></tr>
</table>

[1] The participant must complete the “Application/Request for Change” form available from their employer’s human resources department.

5.11 Continuation of coverage and waiver of premiums during a total disability period

No premiums shall be payable by the participant as of the first day of the pay period that coincides with or follows 3 months of total disability.

Insurance is maintained in force for the duration of the same total disability period, until no later than any of the following dates:

<table>
<tr><th>Coverage</th><th>Waiver termination</th></tr>
<tr><td>Health Insurance</td><td rowspan="4">4 years after the onset of total disability, until no later that the date of the 71st birthday and the termination of the group insurance plan, provided the participant maintains their employment status with the employer</td></tr>
<tr><td>Dental Care</td></tr>
<tr><td>AD&D Insurance</td></tr>
<tr><td>Spouse's and Dependent Children's Life Insurance</td></tr>
<tr><td colspan="2">If any of the above-mentioned benefits is terminated for all the eligible employees, it is also terminated for the employees on disability.</td></tr>
<tr><td>Long Term Disability Insurance</td><td>At the age the participant's coverage under this benefit would have terminated, if it were not for total disability</td></tr>
<tr><td>Participant's Basic Life Insurance</td><td>• At age 65, regardless if the group insurance plan terminates or not, if the participant becomes totally disabled before age 61;
• 4 years after the onset of total disability, until no later that the date of the 71st birthday, if the participant becomes totally disabled at age 61 or over.</td></tr>
<tr><td>Participant's and Spouse's Optional Life Insurance</td><td>At age 65</td></tr>
</table>

In the event that the same total disability period persists for more than 2 years, the totally disabled participant must submit an application for a waiver of premiums to SSQ in order to continue to benefit from the waiver and insurance coverage.

These provisions regarding waiver of premiums do not apply to participants benefiting from a preventive leave related to pregnancy or breastfeeding and approved by the CNESST. In addition, they do not apply to disabled participants on a temporary work assignment who are receiving the equivalent of 100% of their salary prior to the onset of disability.

5.12 Temporary absences from work

5.12.1 Partial unpaid leave

Participation in the group insurance plan is maintained. Employers and participants pay their respective premiums, based on the salary employees would have received if not benefiting from the partial unpaid leave. The amounts of insurance in force are also maintained on the basis of this salary.

5.12.2 Authorized paid leave and authorized unpaid leave not exceeding 28 days (including suspension)

Participation in the group insurance plan is maintained. Employers and participants pay their respective premiums. The total premium is paid to SSQ through the employer.

5.12.3 Authorized unpaid leave over 28 days (including suspension)

Participation in the group insurance plan is suspended for the duration of the authorized leave, with the exception of Health 1. However, participation in all other plans (Health Insurance, Dental Care Insurance, according to the same coverage and status chosen, Life and Disability **indissociably**) can be maintained if the participant notifies their employer in writing of their decision to maintain participation prior to the start of the unpaid leave. Choices are the following:

- Participate in Health 1 only;

- Maintain participation in all benefits they held prior to the start of the unpaid leave.

If the participant does not submit a written request to the employer prior to the start of the leave, only the participation in Health 1 will be maintained.

Participants must pay the entire premium (both employee and employer contributions). **However**, the Quebec *Act respecting labour standards* requires employers to continue to pay their contribution in the case of a leave for family or parental reasons.

Arrangements for the payment of premiums must be made with the employer to ensure that coverage under Health 1 or any other benefits coverage is not interrupted due to non-payment of premiums.

For participants who maintain participation in Health 1 only, the previous coverage and status are automatically reinstated when they actively return to work, if applicable.

5.12.4 Deferred salary leave plan

a) <u>During the leave contribution period</u>

Participation is maintained.

For Life Insurance and Long Term Disability Insurance, the insurable salary is that agreed upon between the participant and the employer in the deferred salary leave plan agreement.

SSQ must be notified of the insurable salary agreed upon before the start of the deferred salary leave, i.e., before the start of the contribution period and not the period of leave itself. Premiums and benefits are therefore based on the insurable salary agreed upon.

b) <u>During the period of the leave</u>

Participation is suspended for the duration of the authorized leave, with the exception of Health 1. However, participation in all other plans (Health Insurance, Dental Care Insurance, according to the same coverage and status chosen, Life and Disability **indissociably**) can be maintained upon the participant's request. Participants must pay the entire premium (both employee and employer contributions).

Arrangements for the payment of premiums must be made with the employer before the start of the leave so as to ensure that coverage under Health 1 or all plans is not interrupted. The insurable salary is as defined in paragraph a) above.

5.12.5 Phased retirement program

Participation in Health 1 must be maintained.

If employees maintain participation in all plans (Health Insurance, Dental Care Insurance, according to the same coverage and status chosen, Life and Disability **indissociably**), the insurable salary for the purposes of Long Term Disability is the salary actually received during the phased retirement program.

For Life Insurance, the salary is the one that employees would have received had they not been participating in the phased retirement program.

The premiums for these plans are established based on the salary actually received.

- If the duration of the program is 24 months or less, participation in the Long Term Disability Insurance Plan ceases when the program begins.
- If the duration of the program is over 24 months, participation in the Long Term Disability Insurance Plan ceases no later than 24 months prior to the end of the program initially planned.

5.12.6 Dismissal grievance

In such a situation, participants MUST maintain participation in Health 1 and, if applicable, MAY maintain participation under the Health coverage package already in force and Life **plans indissociably** by paying the total premium provided for in the contract (both employee and employer contributions) until the final decision is made.

Participation in Long Term Disability Insurance is suspended until the decision is made in arbitration. If the decision is favourable to the employee, premiums for this plan are payable retroactive to the date of the dismissal and any disability that began during the period in question is recognized by SSQ.

5.12.7 Procedure during settlement of litigation regarding a disability not recognized by the employer

Insurance plans are maintained in force without payment of premiums until the earliest of the following:

- The date the employee actively returns to work.
- The date the employee withdraws the grievance.
- The date arbitration is made or an employer/union decision is made.

- The date the waiver of premiums would have terminated if total disability had been fully recognized by the employer.

5.12.8 Preventive leave and maternity leave (21 weeks)

Participation in insurance is maintained as though participants were at work.

5.13 Dependent child on sabbatical school leave

Dependent children between 18 and 25 years old who are on a sabbatical school leave can maintain their insurance coverage provided:

- a written request is submitted to SSQ before the beginning of the leave;
- the request specifies the start date of the sabbatical leave and its duration.

Each dependent child is only eligible for one sabbatical leave.

The leave may not exceed 12 months, subject to eligibility for RAMQ, and must end at the beginning of a school year or term.

5.14 Termination of insurance

5.14.1 Participants

a) <u>All plans</u>

Insurance terminates, subject to provisions regarding the waiver of premiums, on the earliest of the following dates:

- The date on which the contract ends.
- The date on which the participant ceases to be eligible
- The due date of any unpaid premiums.
- The date the participant retires.

b) <u>Health Insurance</u>

In addition to the dates specified in paragraph a) "All plans", insurance terminates on the earliest of the following dates:

- The first day of the premium period that follows the acceptance of a request for exemption from the Health Insurance."."
- The date the waiver of premiums ends, unless the participant remains eligible for insurance and pays premiums.

c) Dental Care Insurance

In addition to the dates specified in paragraph a) "All plans", insurance terminates on the earliest of the following dates:

- The end date of the premium period during which a request is received by the employer, indicating the participant's decision to terminate participation in the Dental Care benefit, as long as the minimum period of participation of 36 months is completed.
- The date SSQ receives a request indicating the participant's decision to terminate participation in the Dental Care benefit, if the participant provides satisfactory evidence that they are newly eligible to another group insurance plan with a Dental Care benefit, even if the minimum period of participation of 36 months is not completed.
- The date the waiver of premiums ends, unless the participant remains eligible to insurance and pays premiums.

d) Long Term Disability Insurance

In addition to the dates specified in paragraph a) "All plans", insurance terminates on the earliest of the following dates:

- The date on which the participant reaches age 63.
- The date the employer receives a written request and supporting documents attesting the employee's right to opt out (refer to *section **5.8*** "**Opting out of Long Term Disability Insurance**" for the conditions related to the right to opt out).

However, it is possible to cease participation in option O before the end of the minimum period of 36 months if the certification unit votes in favour of option O+. At that time, the minimum period of participation begins again for option O+. If the certification unit votes in favour of changing from option O+ to option O, the minimum period of participation of 36 months must be completed. Any change comes into force on the first day of the pay period following the date the vote is held.

e) Life Insurance

In addition to the dates specified in paragraph a) "All plans", insurance terminates on the earliest of the following dates:

- The end date of the premium period during which a request is received byt he employer, indicating the participant's decision to terminate participation in basic or optional life insurance.

- The date on which the participant reaches **age 65**, for the Participant's and Spouse's Optional Life Insurance benefits.

Termination of the Participant's Basic Life Insurance brings about termination of the Participant's and Spouse's Optional Life Insurance.

5.14.2 Dependents

a) Health Insurance and Dental Care Insurance

Insurance terminates on the earliest of the following dates:

- The date the participant's insurance terminates.
- The date the dependents cease to be eligible.
- The date the participant opts for an individual or single-parent coverage status.

b) Life Insurance

Subject to the waiver of premium provisions, insurance terminates on the earliest of the following dates:

- The date the participant's insurance terminates.
- The end date of the premium period during which a request is received by the employer, indicating the participant's decision to terminate participation in Spouse's and Dependent Children's Life Insurance or Spouse's Optional Life Insurance.
- The date the Participant's Basic Life Insurance terminates, for Spouse's Optional Life Insurance.
- The date the participant reaches age 65 for Spouse's Optional Life Insurance.

5.15 Life Insurance conversion privilege

The group life insurance of someone who ceases to belong to the group of persons eligible under the life insurance described in this document, e.g. in cases of resignation or termination of the insurance following the end of a waiver of premiums, may be converted into an individual life insurance without evidence of insurability, provided the written request is submitted to SSQ within 31 days following the date the person ceases to be eligible for coverage under the group plan and provided the entire first premium has been paid. It is possible to obtain a one-year term life insurance that can be converted into a whole or mixed life insurance policy normally offered by SSQ or in accordance with applicable legislation.

For an insured **under age 65**, the maximum amount of individual life insurance that can be converted cannot be higher than the lesser of the following amounts:

- $400,000;
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (refer to *section* ***5.17***).

For an insured **age 65 or over**, the maximum amount of individual life insurance that can be converted cannot be higher than the lesser of the following amounts:

- $25,000;
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (refer to *section* ***5.17***) , or under any other group insurance contract.

Individual life insurance policies issued after having exercised this conversion privilege do not provide for accidental death and dismemberment insurance nor for waiver of premiums.

5.16 Retiree – Life Insurance for the Retiree and the Spouse of the Retiree

In order to obtain life insurance for themselves and their spouse, participants who retire and those whose life insurance terminates as a result of retirement after having been maintained during their total disability must notify SSQ of their intention by submitting the life insurance application form provided in the retirees' life insurance booklet. This booklet is available from your employer or SSQ or on the secure site for insureds at **ssq.ca**. This form must be submitted to SSQ **within 60 days** following the date of retirement or following the termination of life insurance for disabled participants. Participants are encouraged to obtain a copy of the booklet well in advance to ensure that this deadline is respected.

This benefit is also available to participants not disabled at the time of retirement and who were not participating in SSQ's Life Insurance but who were participating in the self-insured plans under the collective agreement, provided their application is submitted within the above-mentioned deadline of 60 days.

5.17 Rehired retiree

Retirees who are rehired can maintain the life insurance coverage they hold under the retiree's Optional Life Insurance plan for themselves and their spouse, as the case may be. However, they do not become eligible for the other coverage of the group insurance contract.

5.18 Annual review of working time percentage

The review of working time percentage provided for in the collective agreement is performed once per year. Participants subject to this situation must notify their employer of their decision within 10 days following receipt of notice from the employer specifying the time worked during the reference period. Their decision takes effect the following January 1.

Participants who obtain a permanent position of more than 25% of full time become subject to all participation rules of this plan.

Working time percentage	Participant's situation before January 1	Participant's decision on January 1
Participant's working time % continues to be more than 25% of full time	Participation in the self-insured plans under the collective agreement and in all benefits of this plan	Continue participation in the self-insured plans under the collective agreement and in all benefits of this plan
Participant's working time % decreases to 25% or less of full time	Participation in the self-insured plans under the collective agreement and in all benefits of this plan	Continue participation in the self-insured plans under the collective agreement and in all benefits of this plan (1)
		Terminate participation n the self-insured plans under the collective agreement and participate in Health 1 of the Health Plan

Working time percentage	Participant's situation before January 1	Participant's decision on January 1
Participant's working time % increases to more than 25% of full time	Participation in the self-insured plans under the collective agreement and in all benefits of this plan	Continue participation in the self-insured plans under the collective agreement and in all benefits of this plan
	No participation in the self-insured plans under the collective agreement and participation in Health 1 of the Health Plan	Participate in the self-insured plans under the collective agreement and in all benefits of this plan (2)
Participant's working time % continues to be 25% or less of full time	Participation in the self-insured plans under the collective agreement and in all benefits of this plan	Continue participation in the self-insured plans under the collective agreement and in all benefits of this plan (2)
	No participation in the self-insured plans under the collective agreement and participation in Health 1 of the Health Plan	Terminate participation n the self-insured plans under the collective agreement and participate in Health 1 of the Health Plan
		Participate in the self-insured plans under the collective agreement and in all benefits of this plan 2)

(1) This option will automatically be granted to participants who do not notify their employer of their decision within the deadline.

(2) Participation in Participant's Basic Life Insurance, Spouse's and Dependent Children's Life Insurance and Dental Care Insurance (individual coverage status) is automatically granted to participants who participate in insurance for the first time or who participate again in the plans under the collective agreement if they do not opt out by submitting a request to their employer.

6 - HOW TO SUBMIT CLAIMS

The procedure and deadlines for submitting claims are described in this section. Participants should read them before they submit their claims.

6.1 Health Insurance

All health insurance claims must be received by SSQ no later than 12 months after the date the eligible expenses are incurred. Claims not received on time will all be declined by SSQ.

6.1.1 Prescription drug expenses

Insureds must present their insurance card to the pharmacist. The pharmacist will immediately validate whether the drug expenses are eligible for reimbursement.

a) Eligible prescription drugs

Insureds must present their insurance card to the pharmacist when purchasing prescription drugs. If the drug is eligible for reimbursement, the insured only needs to pay the cost of the drug that is not reimbursed by their Health Plan and SSQ pays the insured portion directly to the pharmacist. The pharmacist must charge the usual and reasonable price, that is, the same price as charged to any other client.

b) Non-eligible prescription drugs

If the drug purchased is not eligible for reimbursement, the pharmacist will also give you a receipt with different messages, for example:

Indication	Meaning
"Drug not covered"	Request for reimbursement refused, since the drug is not covered under the drug benefit.
"Maximum duration of treatment 90 days"	The quantity of drugs purchased cannot exceed a treatment period of 90 days. However, if for specific reasons your prescription exceeds a treatment period of 90 days, submit your claim, along with an explanatory note, directly to SSQ.

continued...

Indication	Meaning
"Submit to Insurer"	The drug cannot be processed by using the SSQ Card but could be eligible for reimbursement. Example: If the prescription must be prepared by the pharmacist (magistral prescription).
"Exception drugs"	Drugs for which prior authorization must be obtained from SSQ.

c) First use

When the insurance card is used for an insured member of the participant's family for the first time, the pharmacist must register the first name and date of birth of this insured person. Proof of age may be required by the pharmacist.

d) Dependent children ages 18 to 25, inclusive, studying full-time

For dependent children ages 18 to 25, inclusive, a school attendance statement must be presented to SSQ once every school year (September 1 to August 31) for the insured's claim to be processed directly at the pharmacy.

The school attendance statement can be submitted on the secure site for insureds, by calling SSQ Customer Service, or by writing to SSQ at the address specified in *section* ***6.7*** "**Contact SSQ**". SSQ reserves the right to request proof of school attendance.

If SSQ does not receive this statement before September 30, the child will not be considered as insured until it is received. An explanatory message will appear on the receipt issued by the pharmacist when the drugs are purchased.

Insureds who cannot use their insurance card (e.g.: forgotten, lost, pharmacist does not participate in the electronic claims submission service) can use the claim form available on SSQ's Web site at **ssq.ca** and on the secure site for insureds and submit it to SSQ with the original receipts. As SSQ does not return receipts, participants are advised to always keep copies for their records.

Receipts from the pharmacy must mention the name of the insured, the number and date of the medical prescription, the name of the physician and the name and quantity of the drug. In addition, invoices must be duly paid.

Claims must be sent to SSQ at the address specified in *section* ***6.7*** "**Contact SSQ**".

6.1.2 Hospital or medical expenses resulting from a work or traffic accident

All medical or hospitalization expenses resulting from a work or traffic accident are reimbursable by the *Commission des normes, de l'équité, de la santé et de la sécurité au travail* (CNESST) or the *Société de l'assurance automobile du Québec* (SAAQ). Claims for these expenses must be submitted to the CNESST or the SAAQ and not to SSQ.

6.1.3 Expenses covered under Health Insurance

Many claims can be submitted via the secure site for insureds. Participants can also use their smartphone and the free SSQ Mobile Services application.

Claim forms are also available on SSQ's website at **ssq.ca**, a customized version of which is also available on the secure site for insureds. These claim forms can be mailed to SSQ with the original receipts.

As SSQ does not return receipts, participants are advised to always keep copies for their records.

All claims must include the certificate number. Also, the patient's name and the dates of the visits or treatments received must be clearly indicated on the receipts and, when applicable, the name, address and professional association membership number of the practitioner consulted.

SSQ's address is specified in *section* ***6.7*** "**Contact SSQ**".

6.2 Travel Insurance and Assistance and Trip Cancellation Insurance

Information on how to submit claims for Travel Insurance and Assistance and Trip Cancellation Insurance is available in a separate electronic format document entitled "Travel Insurance and Assistance and Trip Cancellation Insurance", available online on the secure site for insureds at **ssq.ca**.

6.3 Dental Care Insurance

All dental care claims must be received by SSQ no later than 12 months after the date the eligible expenses are incurred. Claims not received on time will all be declined by SSQ.

Insureds must present their insurance card to the dentist's office and pay the portion of expenses not covered by SSQ. If the dentist does not offer an electronic claims submission service, the insured must have them fill out and sign the "Dental Care Insurance Claim" form or the form provided by the dentist. These claims can be submitted on the secure site for insureds website or by writing to SSQ at the address specified in *section **6.7***.

6.4 Participant's, Spouse's and Dependent Children's Life Insurance

A copy of the life insurance claim form may be obtained directly from SSQ. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. For more information, insureds can consult *section **6.7*** "**Contact SSQ**".

6.5 Long Term Disability Insurance

Claims for Long Term Disability Insurance benefits must be submitted to SSQ within 90 days of the expected start date of benefit payments.

To file such claims, the insured must complete the disability insurance claim form available from the employer or from SSQ.

Claims must be submitted even for insureds who receive disability benefits from other plans (e.g. CNESST, Retraite Québec).

6.6 Third-party liability and subrogation

The participant 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 the participant is 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.

6.7 Contact SSQ

By mail

Insureds must indicate their certificate number on their claims or any other correspondence sent to SSQ at the following address:

SSQ, Life Insurance Company Inc.
2525 Laurier Boulevard
P.O. Box 10500, Station Sainte-Foy
Quebec QC G1V 4H6

By phone

Insureds can contact SSQ's Customer Service department, from 8:00 a.m. to 8:00 p.m., Monday to Friday, at the following number: **1-888-651-8181**.

By fax

Insureds who prefer to contact SSQ by fax can dial **418-652-2739.**

By email

Insureds who prefer to contact SSQ by email can use the following address: **clientele@ssq.ca**

Change of address

Do not forget to inform SSQ of any change of address. To do so, use the **secure site for insureds** or contact SSQ's Customer Service department.

7 - SSQ'S INTERNET SERVICES

7.1 Customer Centre

This handy online service gives insureds access to their insurance file at any time. Here are a few of the operations that can be carried out quickly, securely and confidentially:

- register for direct deposit of Health Insurance benefits;
- consult electronic claim statements online;
- print customized claim forms;
- print tax receipts for claims;
- print a temporary SSQ card;
- make a change of address;
- view the coverage included as part of their insurance file;
- submit a claim online and get reimbursed in 48 hours with direct deposit (for most types of claims);
- change beneficiairy designations online;
- view the expenses covered, including drugs;
- view the balance of their counter for the coverage involved;
- print a proof of coverage for Travel Insurance benefits.

To register and take advantage of SSQ's online services, insureds can simply visit the Customer Centre website at **customer-centre.ssq.ca**. Online instructions will explain how to register. Please note that documents are available in the file for a period of 12 months.

If they require assistance, insureds can contact SSQ Customer Service, Monday through Friday, from 8:00 a.m. to 8:00 p.m., at one of the numbers indicated on the back of this booklet.

7.2 SSQ's Mobile Services

Participants who have a mobile device* can download SSQ's free Mobile Services application at **www.ssq.ca/mobile**.

The application enables them to carry out the same operations as they would on the Customer Centre website.

* Currently available on Apple and Android platforms.

Use our online services and get reimbursed in 48 hours!

Take advantage of the online claim service via the **Customer Centre** at **customer-centre.ssq.ca**.

Head Office

2525 Laurier Boulevard
P.O. Box 10500, Stn Sainte-Foy
Quebec QC G1V 4H6
1-888-651-8181

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