# Your Plan

**Contract No. H6999**
**March 31, 2019**

Support Personnel in the Education Sector
Who Are Members of Unions Affiliated
With the FEESP (CSN)

## Message from the Executive Committee

To all members of the FESSP (CSN) education sector,

This booklet contains all provisions and conditions applicable to our group insurance plan.

This plan is structured in accordance with the mandates submitted during the general meetings to the Council of the Education Sector which groups the unions of support staff of school boards affiliated with the CSN. The Council also elects the three representatives on the insurance joint committee.

We invite you to attend your general meetings to discuss about insurance and other equally important subjects.

Finally, if you experience problems related to insurance, please contact your local union.

The Executive Committee

Please be advised that in this brochure SSQ designates SSQ, Life Insurance Company Inc.

This booklet is provided for information purposes only and in no way changes the provisions and conditions stipulated in your group insurance contract.

Cette brochure est disponible en français

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# 1. GENERAL INFORMATION

## 1.1 DEFINITIONS

The following definitions apply to the vocabulary used in this booklet, whenever applicable in context.

**Accident:** any bodily injury resulting exclusively from a sudden and unpredictable event of an external cause, independently of any other cause.

**Age:** the full age of an insured on the day an event stipulated under the contract occurs.

**Innovative drug:** original version of a patented drug when it is placed on the market for which at least one generic version is offered on the market.

**Business partner:** person with whom the insured is associated for business purposes in a company composed of four co-shareholders or fewer, or a commercial company or association composed of four partners or fewer.

**Certificate:** individual document issued by SSQ for employees and retirees to certify that they are insured under the contract. This document lists the insurance coverage held by the person, but does not grant the insured any rights. Should any person receive a certificate to which they are not entitled for any reason, this certificate is considered null and void. If there are any differences between the policy and the certificate, the provisions of the policy apply.

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

**Committee:** the insurance committee, which is made up of three members from the employer, three members from the union, and an independent president. In accordance with agreements, the Committee is responsible for setting up and implementing various group insurance plans.

**Date of retirement:** date on which the participant retires in accordance with the employer's retirement plan. In the case of participants who are totally disabled, the date of retirement is on December 31 following their 65th birthday or on December 31 following the termination of disability insurance benefits from the employer, the latest of the two dates.

**Dependent:** person who, in relation to a participant, meets the definition of spouse or dependent child, in accordance with what is stipulated in the contract.

**Dependent child:** eligible person who, at the time of the event giving right to benefits, lives in Canada and:

a) is under 18 and over whom the participant or spouse exercises parental authority; or

b) is unmarried, aged 25 or under and is enrolled as a full-time student in a recognized educational institution, for whom the participant or the spouse would exercise parental authority if they were a minor; or

c) is of full legal age, without a spouse, and suffering from a functional impairment stipulated in the regulation respecting the application of Quebec's act respecting prescription drug insurance. This impairment must have occurred when the person met one of the above definitions, it being understood that in order to be considered to be suffering from a functional impairment, they must not be receiving any benefits from a last resort financial assistance program stipulated under the act respecting income support, employment assistance and social solidarity and be living with a person who, in addition to being insured as a participant or a spouse, would exercise parental authority over the deficient person if this person was a minor.

**Sabbatical leave from school by a dependent child**

**A dependent child, aged between 18 and 25, who is on a sabbatical leave from school may continue to be covered by the insurance provided the participant meets the following conditions:**

- a written request must be submitted to SSQ and accepted before the leave begins;
- the request must indicate the date the leave is to begin.

The request to maintain the insurance during a sabbatical leave is only accepted once per lifetime per dependent child.

The sabbatical leave cannot last more than 12 months and must end at the beginning of a school year or term (September or January). The dependent child on sabbatical school leave must continue to be eligible under the Régie de l'assurance maladie du Québec (RAMQ) during the entire leave.

**Employee:** person who receives a salary and is a member of one of the bargaining units stipulated under an agreement, or person who is a member of any other group of support employees approved by the Committee.

**Employer:** school board or employer of a group of support employees approved by the Committee.

**Employer's disability insurance plan:** basic disability insurance plan whose benefits are payable by the employer as described in one of the collective agreements or union agreements that are constituent parts of the Committee.

**Family member:** spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, grandparent, grandchild, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, uncle, aunt, nephew, niece.

**Generic drug:** copy of an original drug for which the patent has expired.

**Hospital:** hospital centre within the meaning of the Act respecting health services and social services (R.S.Q., c. S-4.2) and its attendant regulations. In the case of establishments outside Quebec, the term designates centres meeting the same criteria.

**Host at destination:** person with whom the insured shares accommodation arranged in advance, provided the accommodation is at the main residence of the host at destination.

**Illness:** any deterioration of health or bodily disorder other than a pregnancy that is documented by a physician. For the purposes of the contract, organ donation and any related complications are considered illnesses.

**Insured:** person eligible for insurance, either as an employee or retiree or as the dependent of an employee or retiree.

**Participant:** person eligible for insurance as an employee or retiree.

**Physician:** person legally authorized to practice medicine, according to the rules that govern the practice of medicine where the care provided under the contract is given.

**Pregnancy:** pregnancy itself, labour, abortion or miscarriage and complications that can arise during these events.

**Prepaid travel expenses:** means expenses incurred by the insured to purchase a package trip or a ticket from a public carrier, or to rent a motor vehicle from an accredited firm; amounts paid by the insured for reservations for ground arrangements usually included in a package trip are also included, whether the reservations are made by the insured or a travel agency, as well as amounts paid by the insured in relation to registration fees for a commercial activity;

**Retiree:** participant who retires and receives a retirement pension under the employer's retirement plan.

**Salary:** remuneration received by the employee used to calculate disability insurance benefits paid by the employer, and from which the employer in question has deducted premiums, excluding any lump sum amount other than those stipulated in sections 6 2.16, 6 2.18 or 7 3.13 of the CSN School Sector's collective agreement and other corresponding clauses in other collective agreements.

**Single source drug:** innovative drug for which no generic version is offered on the market.

**Spouse:** eligible person who, at the time of the event giving right to benefits:

a) is joined with a participant through marriage or civil union; or

b) has been living with the participant for at least 12 months and has not been separated for more than 90 days due to the breakdown of their union; or

c) is living with the participant and has a child with this person and has not been separated for more than 90 days due to the breakdown of their union.

If there are two spouses, only one can be recognized by SSQ for all benefits of the same plan, the priority being given in the following order: first of all, subject to the approval of any evidence of insurability required under the contract, the eligible spouse who was the last one to be designated as such through a written notice of the participant to SSQ; then, the spouse with whom the participant is joined through marriage or civil union.

**Travel companion:** person with whom the insured shares a room or apartment at destination or whose travel expenses were paid along with those of the insured.

**Trip:**

For Travel Assistance Insurance purposes – trip taken outside the insured's usual province of residence. In this case, the term trip also applies to the insured's transportation between the departure and the return.

For Travel Cancellation Insurance purposes – trip taken, as a tourist or for pleasure, or for a commercial activity, which entails the absence of the insured from his or her place of residence for a period of at least two consecutive nights and requiring a trip of at least 400 kilometres (round trip) from his or her place of residence; a cruise lasting at least two consecutive nights, under the responsibility of an accredited firm, is also considered to be a trip.

**Total disability:** a state of incapacity requiring continuous medical care and resulting from an illness, accident or complications of a pregnancy rendering the participant totally incapable of carrying out the normal duties of his or her employment or any comparable employment with similar remuneration provided by his/her employer. If this state persists for more than 60 months, the participant must be totally unable to carry out any remunerative employment for which the individual is reasonably prepared by education, training or experience, regardless of the availability of such employment, and without necessarily needing continuous medical care.

## 1.2 ELIGIBILITY

### 1.2.1 Employees

a) All full-time and part-time employees or all temporary employees with an employment contract of at least 6 months become eligible for the insurance under the contract on the date they begin work at the school board.

b) Employees belonging to a new group approved by the Committee after this contract comes into force are eligible for the insurance on the date of approval.

c) Employees who are part of a new group that becomes subject to the agreements following a change of jurisdiction after the date on which this contract comes into force are eligible for the insurance on the date of the change.

d) The eligibility of employees is not interrupted by a temporary assignment to a position not covered under the agreement.

e) Temporary employees having worked less than six months since being hired, even if they were hired several times, are not eligible for insurance under the contract.

### 1.2.2 Retirees

Participants who retire continue to be eligible for participant's basic life insurance only.

### 1.2.3 Dependents

Any dependents of the participant become eligible for the insurance under the contract on the same day as the participant if they are already a dependent at the time the participant becomes eligible for the first time. Otherwise, they become eligible on the day they become the participant's dependent.

## 1.3 PARTICIPATION

### 1.3.1 Health insurance plan

a) Participation in Health 1 is compulsory for eligible employees and their eligible dependents, except in cases of exemption or other exceptions stipulated under Quebec's *Act respecting prescription drug insurance*. Employees can refuse or cease to participate in the plan if they provide prior written notice to their employer and are able to prove that they and their dependents, if any, are insured under a health insurance plan with similar coverages or that they are insured as a dependent under another health insurance plan. In no case can these provisions oblige an employee to register for two different plans providing similar coverages; however, it is the employee's responsibility to demonstrate this state of fact to the employer.

b) Participation in Health 2, Option 1 or Option 2 is optional for the eligible employees and for their eligible dependents. Participation in Option 1 and Option 2 is possible only when the participant has chosen Health 2.

c) The minimum duration of participation in Health 2, Option 1 or Option 2 is 24 months.

d) The minimum duration of participation is not suspended during a period of exemption, an absence without pay or a period following a layoff or an employment contract termination if the participant chooses to maintain the health insurance plan held only (as provided under section 1.7 "Temporary Absence from Work").

**Participants who reach age 65**

When participants reach age 65, they are automatically covered under the Basic Prescription Drug Insurance Plan (BPDIP) administered by the Régie de l'assurance maladie du Québec (RAMQ) and an exemption from the health insurance plan is granted by default.

However, participants can also choose one of the following options for the continuation of coverage under the health insurance plan:

– Cancel the registration for the BPDIP and maintain participation under the health insurance plan chosen (Health 1 or 2), including prescription drugs covered for participants under age 65 (an additional premium is applicable, see the health insurance plan table of the "At a glance" pamphlet for contract H6999 for the current year);
– Keep the automatic registration under the BPDIP and remain covered under the health insurance plan chosen (Health 1 or 2) for all benefits, excluding drugs that are eligible under the BPDIP.

Participants who choose to keep the automatic registration with the RAMQ and to exercise their right of exemption may not subsequently resume participation in the health insurance plan. The choice of becoming insured with the RAMQ can also be made by a spouse aged 65 and over.

### 1.3.2 Life insurance plan

Participation in the life insurance plan is optional for employees.

### 1.3.3 Long term disability insurance plan

Participation in the long term disability insurance plan is optional for employees.

### 1.3.4 Dental care insurance plan

a) Participation in the dental care insurance plan is optional for all employees eligible for coverage under the dental care insurance plan and who are members of a bargaining unit where this plan is in force.

b) The minimum duration of participation for the dental care insurance plan is 36 months. However, participants can terminate their participation to this plan during this minimum period of 36 months if they demonstrate, to SSQ's satisfaction, that they are covered by another group insurance plan that includes a dental care insurance coverage. Subsequently, if they choose to resume participation in the dental care insurance plan, a new 36-month minimum duration of participation begins on the new effective date of coverage under this plan.

c) The minimum duration of participation is not suspended during an absence without pay or a period following a layoff or an employment contract termination if the participant chooses to maintain the health insurance plan held only (as provided under section 1.7 "Temporary Absence from Work").

d) To resume participation under this plan following an interruption of insurance, the dental care insurance plan must still be in force in the bargaining unit where the participant is a member on the date he or she returns to work.

**Implementation and continuation of dental care insurance plan**

For the dental care insurance plan to be implemented in a bargaining unit, eligible employees of this bargaining unit must be consulted between January 1 and February 15.

- If the enrolment rate of the eligible employees in this bargaining unit is at least 40%, the plan is implemented on the following March 1.
- If the enrolment rate of the eligible employees in this bargaining unit is less than 40%, the plan is not implemented. The consultation cannot take place before the following January.

<u>For all bargaining units where the plan is in force</u>:

On January 1 of each year, the employer shall look at the participation rate of the employees eligible for insurance for each bargaining unit, and then inform the local union and the joint committee of the results:

- If the participation rate is at least 40%, the plan remains in force for this bargaining unit.
- If the participation rate is less than 40%, a new consultation will take place for this bargaining unit between January 1 and February 15.
    - If, following the new consultation, the participation rate is at least 40%, the plan remains in force for this bargaining unit.
    - If, following the new consultation, the participation rate is less than 40%, the plan terminates for this bargaining unit on March 1 following the new consultation, subject to an agreement between the joint committee and SSQ.

### 1.3.5 Participants who are retiring

Employees who are insured under the life insurance plan and retire remain eligible for the participant's basic life insurance plan, in accordance with the provisions in force for retirees on the date of the retirement.

## 1.4 APPLICATION, EXEMPTION AND EVIDENCE OF INSURABILITY

### 1.4.1 Employees

<u>Health insurance plan</u>

All eligible employees must complete an application request. Evidence of insurability is not required.

Eligible employees who refuse to fill out an application form or who cannot fill it out within the 30 days following the date they become eligible for insurance become insured automatically under Health 1 as participants without dependents.

Employees are entitled to an exemption from coverage under the health care insurance provided they demonstrate that they are covered under another group insurance plan offering similar coverages.

Participants who choose Health 2, Option 1 or Option 2 are entitled to an exemption from coverage, even if the 24-month minimum duration of participation is not completed.

The exemption comes into force on one of the following dates:

- For a newly eligible employee, if the employer receives the exemption request within 30 days following the eligibility date:

  The exemption comes into force retroactively to the eligibility date.

- While the insurance is in force, if the employer receives the exemption request within 30 days following the effective date of the insurance permitting the exemption:

  The exemption comes into force retroactively to the effective date of the insurance permitting the exemption.

- If the employer receives the exemption request more than 30 days after the eligibility date or the effective date of the insurance permitting the exemption:

  The exemption comes into force on the first day of the premium period coinciding with or following the date SSQ receives the request.

Employees who have chosen to be exempted from participating in the health insurance plan because they and their dependents, if applicable, were already insured under another group insurance plan with similar coverages, or because they were insured as dependents under the health insurance plan, can participate on the following conditions:

i) They must demonstrate to the employer's satisfaction:

   - that they were previously insured as dependents under the health insurance plan or under any other plan with similar coverage;

   - that it has become impossible to continue to be insured as dependents.

ii) Subject to the provisions stipulated in i) above:

   - the insurance comes into force on the date the insurance permitting the exemption ended, provided the employee submits an application within 30 days following the date it became impossible for the participant to continue to be insured under this other insurance plan;

   - if the employee submits the application more than 30 days following the date it became impossible for the participant to continue to be insured under this other insurance plan or if the end of the insurance permitting the exemption was voluntary, the insurance comes into force on the first day of the pay period following the date the application form is received by the employer.

Life insurance and long term disability insurance plans

To be eligible for the life insurance plan (except for participant's optional life insurance coverage) or the long term disability insurance plan, without having to provide evidence of insurability, eligible employees who are at work must fill out an application form within 30 days following the date they become eligible for the insurance. Eligible employees who are not at work must fill out an application form within 30 days following the date they return to work.

For any request that is filled out after the expiration of the above-mentioned deadline and request for participant's optional life insurance, employees must provide, at their expense, evidence of insurability deemed satisfactory by SSQ.

Participants who have refused or ceased to participate in the life insurance plan or the long term disability insurance plan can participate again on the following conditions:

i) They must fill out an application form.

ii) They must provide, at their expense, the evidence of insurability required by SSQ.

Dental care insurance plan

When the dental care insurance plan is in force in the bargaining unit of the eligible employee, the participation is optional.

The coverage status for the dental care insurance plan can be different from the coverage status for the health insurance plan. Particpants who are exempted from the health insurance plan will be granted the individual coverage status for the dental care insurance plan.

Upon receiving their new insurance certificate, participants have 30 days following the effective date of the dental care insurance plan to request a change of their coverage status and the change will become effective retroactively to the effective date of the dental care insurance plan. For any request received after the deadline, the change will become effective on the first day of the premium period coinciding with or following the date the employer receives the request.

Eligible employees are entitled to an exemption from coverage under the dental care insurance plan provided they demonstrate that they and their dependents, if applicable, are covered under another group insurance plan offering similar coverages.

### 1.4.2 Special provisions for temporary employees with an employment contract of at least 6 months

Temporary employees with a first employment contract of at least 6 months must submit an application form through the employer in accordance with the eligibility and participation rules stipulated in the contract.

For temporary employees who have previouly worked for the policyholder under an employment contract of at least 6 consecutive months, the insurance can be reinstated subject to the following conditions:

a) If the new employment contract comes into force within 55 business days following the last day of work under the last employment contract, the insurance is reinstated, notwithstanding the ineligibility period between the two employment contracts, in order to continue the 24-month minimum duration of participation in the health care insurance.

b) If the new employment contract comes into force after the 55 business days deadline, the employee must submit a new application form in accordance with the eligibility and participation rules stipulated in the contract.

#### 1.4.3 Retirees

All retirees are eligible for participant's basic life insurance coverage without having to provide evidence of insurability, subject to the provisions of the contract regarding availability of the life insurance plan.

#### 1.4.4 Dependents

All participants who wish to insure their dependents must fill out an application form for them. If the application is made more than 30 days following the date the dependents became eligible for insurance, the coverage comes into force on the first day of the pay period after the application form is received by the employer. However, no dental care insurance benefits are payable to these dependents for the first 90 days of the insurance. No evidence of insurability is required for the health insurance and dental care insurance plans, but SSQ always requires evidence of insurability for spouse's optional life insurance coverage.

The application form must indicate the coverage status (individual, single-parent or family) the participant wishes to have.

| Coverage status | Insured person(s) |
|---|---|
| Individual | Participant only |
| Single-parent | Participant and dependent children |
| Family | Participant, spouse and dependent children, if applicable |

### 1.5 EFFECTIVE DATE OF INSURANCE

#### 1.5.1 Employees

Health insurance plan

The insurance of all employees who are eligible under the selected plan (Health 1, Health 2, Option 1, Option 2) comes into force on the date they become eligible for insurance, with the coverage status they have chosen (individual, single-parent or family).

Life insurance and long term disability insurance plans

The insurance of all eligible employees comes into force on the latest of the following dates:

a) The date the person becomes eligible for the insurance if they are at work on this date. Otherwise, the date they return to work, if the employer receives the request within 30 days following the eligibility date.

b) On the first day of the premium period coinciding with or following the date the employer receives the approval from SSQ of the evidence of insurability submitted, if the request is not received within the 30-day deadline.

Dental care insurance plan

For eligible employees of a bargaining unit where the plan is in force, the insurance comes into force on the latest of the following dates:

a) The eligibility date if the request is received by the employer within 30 days following the eligibility date.

b) On the first day of the premium period coinciding with or following the date the employer receives the request.

The coverage status (individual, single-parent or family) can be different than the coverage status for the health insurance plan.

The coverage status for participants and their dependents can be increased or decreased if one of the events mentioned in section 1.8.5 happens. Participants can then choose another coverage status among those offered in section 1.4.4.

In the absence of such an event, participants can still increase their coverage status and that of their dependents. However, they cannot decrease their coverage status unless they have been covered with the same coverage status for at least 36 months.

Participants must fill out the “Application/Request for Change” form and submit it to the employer’s plan administrator. The change will come into force on the following date:

a) If the employer receives the request within 30 days following the date of the event, the change comes into force on that date.

b) If the employer receives the request more than 30 days after the date of the event, or in the absence of an event, the change comes into force on the first day of the premium period coinciding with or following the date the employer receives the written request.

**1.5.2 Dependents**

The insurance of the spouse and dependent child comes into force on the latest of the following dates:

a) The date the employee’s insurance comes into force.

b) The date the dependents (dependent children only or dependent children and spouse, as the case may be) become dependents of the employee, if the employer receives the request within 30 days following the date they become eligible.

c) On the first day of the premium period coinciding with or following the date the employer receives the written request, if the employer receives the request more than 30 days after they become eligible.

d) The first day of the pay period following the date the employer receives SSQ's approval of the evidence of insurability submitted by the employee when such evidence is required for the given dependents (dependent children only or dependent children and spouse, as the case may be), and only for the amounts or coverage requiring of such evidence.

## 1.6 END OF INSURANCE

### 1.6.1 Participants and retirees

Except when stipulated otherwise in the contract, the participants's or retiree's insurance ends on the earliest of the following dates:

a) The date the contract is terminated.

b) The due date of premiums required from a participant if they are not paid to SSQ before the expiration of the grace period, subject to the provisions stipulated in the case of a temporary interruption of work.

c) The date the participant ceases to be eligible for insurance or quits his or her job for a reason other than retirement (31 days after this date for participant's basic life insurance coverage and participant's optional life insurance coverage).

d) In the case of the life insurance plan and the long term disability insurance plan, the first day of the pay period that coincides with or follows the date the employer receives the written notice from the participant asking for the insurance to be terminated, either in whole or in part.

e) In the case of the health insurance plan, the first day of the pay period that coincides with or follows the date the employer approves the participant's request to be exempted from participation in the given plan.

f) In the case of the health insurance plan, the long term disability insurance plan and the dental care insurance plan, the first day of the pay period that coincides with or follows the date of retirement.

g) In the case of the life insurance plan, except for the retired participant's basic life insurance plan, the first day of the pay period that coincides with or follows the date of retirement.

h) In the case of the dental care insurance plan, on March 1 following the annual consultation if, after the consultation, the participation rate is less than 40%.

i) In the case of the participant's optional life insurance coverage, on December 31 coinciding with or following the date the participant reaches age 65.

j) In the case of the long term disability insurance plan, the date the participant reaches age 63.

k) For participants occupying a temporary position and having completed an employment contract of at least 6 consecutive months, on the 14th day following the last day of work under the employment contract.

### 1.6.2 Dependents

Except if stipulated otherwise in the contract, the insurance of dependents ends on the earliest of the following dates:

a) The date the participant's insurance ends.

b) The date the person no longer meets the definition of dependent in the contract.

c) The first day of the pay period that coincides with or follows the date the employer receives a request in writing from the participant to partially or totally terminate the dependent's insurance.

d) In the case of spouse's optional life insurance coverage, on December 31 coinciding with or following the date the participant reaches age 65.

## 1.7 TEMPORARY ABSENCE FROM WORK

In all cases of temporary absence from work, participants may maintain their participation in insurance, when such a choice is offered, and the decision to maintain the participation must be made at the beginning of the absence. This choice will apply for the duration of the absence, except in the case where the participant wants to reduce the coverage, where applicable.

In the case where a participant decides not to maintain the participation in the plans other than the health insurance plan, when such a choice is offered, the participation resumes automatically on the date the participant returns to work.

Any total disability that begins during a temporary absence and continues afterwards will be considered to start on the date the person returns to work

### 1.7.1 Preventive withdrawal and paid leave

Participation in all plans is maintained, and the amount of insurance and the premium are determined in accordance with the situation prevailing before the absence. The participant and the employer must pay their respective premium.

### 1.7.2 Temporary unpaid absence

In accordance with the conditions stipulated in the applicable collective agreements, participants can either:

a) maintain all the plans held before the temporary unpaid absence; or

b) maintain the health insurance plan only, without Options 1 and 2.

The premiums and salary used to calculate the benefits are then determined based on the participant's salary immediately before the beginning of absence.

However, the salary of a part-time participant is determined based on the average salary for the last 5 months preceding the beginning of absence.

<u>Temporary unpaid absence resulting from a suspension or grieved dismissal</u>

Participants must at least maintain their participation in the health insurance plan in force before the beginning of the absence. They may also maintain their participation in Options 1 and 2 and in the life insurance and dental care insurance plans by paying the entire premium stipulated in the contract (employee portion + employer portion), until the final decision of the arbitration award is made.

Participation in the long term disability insurance plan is suspended until the final decision of the arbitration award is made. If the final decision is favourable to the participant, the premium is payable retroactively to the suspension or dismissal date and any total disability that has started during that period is recognized in accordance with the conditions stipulated in the insurance contract.

<u>Temporary unpaid absence resulting from a strike or lockout</u>

Participation in the health insurance plan is maintained for a minimum period of 30 days. The participant and the employer must pay their respective premium.

Participants can maintain participation in the other plans, subject to the payment of the applicable premiums.

<u>Temporary absence resulting from a part-time unpaid leave</u>

Participation is maintained in all plans that are in force before the absence. The participant and the employer must pay their respective premium, based on the salary the particpant would be receiving if they were not on a part-time unpaid leave. The amounts of insurance are also maintained based on the reference salary.

**1.7.3 Cyclical layoff**

Participation is automatically maintained in all plans but participants can:

a) maintain all plans that are in force before the cyclical layoff; or

b) maintain the health insurance plan only, without options 1 and 2.

The salary of a part-time participant is determined based on the average salary for the last 5 months preceding the beginning of absence

<u>Cyclical layoff occuring between October 1 and April 30</u>

Participants must contact their employer for more information about this type of absence.

#### 1.7.4 Sabbatical leave with deferred salary

Participation may be maintained in all plans during the leave. For the participant's life insurance plan and long term disablity plan, the amount of insurance and the premium are determined based on the salary the participant would be receiving if the salary had not been reduced due to the leave.

#### 1.7.5 Progressive or gradual retirement

Participation may be maintained in all plans. For the life insurance plan, the coverage and the premium are determined based on the salary the participant would be receiving if they had not participated in the progressive or gradual retirement program, and the amount of insurance for the long-term disability insurance and the premium of the participant are determined based on the salary actually paid by the employer.

Participation in insurance terminates on the earliest of the following dates, and the participant then becomes a retiree eligible to the basic life insurance offered to retirees:

a) 36 months after the beginning of the progressive or gradual retirement program; or

b) the date the progressive or gradual retirement program ends.

## 1.8 CHANGE OF COVERAGE STATUS AND COVERAGE LEVEL IN THE HEALTH INSURANCE PLAN

#### 1.8.1 Change of coverage status

If a participant chooses the single-parent or family status, it is granted for the health insurance plan as of the first day of the premium period coinciding with or following the date the employer receives the request.

#### 1.8.2 Increase in the coverage level

Participants may, at any time, change their current coverage level for a higher level plan.

To make this change, the participant must make a request using the appropriate form and submit it to the employer's plan administrator. The change will come into force on the first day of the premium period that coincides with or follows the date the employer receives the form.

Despite the preceding, participants who are on disability leave cannot increase their health insurance coverage.

#### 1.8.3 Decrease in the coverage level

Participants must maintain their participation in the plan they currently hold for at least 24 months before they can change for a lower level plan.

To make this change, the participant must make a request using the appropriate form and submit it to the employer's plan administrator. The change will come into force on the first day of the premium period that coincides with or follows the date the employer receives the form.

#### 1.8.4 Period of exemption, absence or waiver of premiums used to calculate the minimum duration of participation

The duration of the following periods is included as part of the minimum duration of participation stipulated above: a period of exemption, a period during which the participants maintained their insurance under the health insurance plan only due to a temporary absence from work, or a period during which they benefited from a waiver of premiums.

#### 1.8.5 Specific events allowing changes to the plan

Participants can change their coverage status and coverage level under the health insurance plan regardless of the minimum duration of participation if a request in writing is received by the employer within 30 days after one of the following events: involuntary termination of the health insurance enabling the exemption; marriage; cohabitation for at least a year; birth or adoption of a first child; involuntary loss of spouse's or dependent children's health insurance; separation; divorce; death of the spouse or dependent child.

### 1.9 WAIVER OF PREMIUMS IN THE EVENT OF TOTAL DISABILITY

Participants who are totally disabled while insured are entitled to a waiver of premium payments as of the first day of the first complete pay period during which they receive benefits or indemnities in the second year of disability, whether it be under the employer's disability insurance plan or a government plan.

For the purposes of the contract, the total disability ends on the earliest of the following dates:

- The date the person retires for a reason other than the disability.
- The date the person is incapable or refuses to provide satisfactory evidence of the total disability to SSQ.

#### 1.9.1 Furthermore, for life insurance plan and long term disability insurance plan:

- The date the person reaches age 65 if the total disability began on July 1, 1999, or after.
- On the December 31 coinciding with or following the date they reach age 65 if the total disability began before July 1, 1999.

#### 1.9.2 Furthermore, for health insurance plan and dental care insurance plan:

- After 48 months of total disability, but never after the person reaches age 65, in cases where the total disability began on July 1, 1999 or after.
- On the December 31 coinciding with or following the date they reach age 65 if the total disability began before July 1, 1999.

# 2. HEALTH INSURANCE PLAN

## 2.1 INSURANCE

Insureds who incur eligible expenses while they are covered under the health insurance plan are entitled to have part or all of these eligible expenses reimbursed by SSQ to the participant, subject to the provisions of this plan and applicable legislation.

## 2.2 CONDITIONS RELATED TO ELIGIBILITY OF EXPENSES

**Medical necessity** – Expenses covered under the health insurance plan apply to supplies, treatments or services that are necessary for the treatment of the insured person following an illness, accident or pregnancy, and unless otherwise specified, were prescribed by a physician. The supplies must have been purchased and the treatments or services must have been received when the insurance in force provided such reimbursement.

**Complement to public insurance** – For the purposes of the health insurance plan, all insureds are considered to be covered under the public health and hospitalization plans of their province of residence in Canada. In no case may the amounts paid by SSQ be superior to those that would have been paid if the person had been covered under these insurance plans.

**Date the expenses were incurred** – Expenses must have been incurred while the person was insured under the health insurance plan. Expenses are considered to have been incurred on the date the services were provided.

**Customary and reasonable costs** – Expenses cannot exceed the customary and reasonable costs normally paid for such services in the region they were provided. They must apply to supplies, treatments or services usually provided for a similar condition.

**Professional health services** – To be eligible, expenses incurred for treatments or services provided by a health professional must be for fees payable to a person who is a member in good standing of the professional corporation relevant to the care or treatments involved or, if such a corporation does not exist, to a related professional association recognized by SSQ. Only one treatment per day, per professional, per insured is eligible for reimbursement. Also, the person providing the care and the insured cannot be living in the same home or be closely related.

## 2.3 ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN | | | |
|---|---|---|---|
| **HEALTH 1** | **HEALTH 2** | **OPTION 1** | **OPTION 2** |

**GENERAL INFORMATION**

The following table describes expenses that are eligible under one of the two health insurance plans and the two options available, provided they also meet the above-mentioned conditions for eligible expenses and coordination as well as the exclusions, limitations and restrictions stipulated in sections 2.4 to 2.6 inclusive. Option 1 and Option 2 are described at the end of the table presenting the two health insurance plans.

When a maximum of eligible expenses is expressed, it must be multiplied by the reimbursement percentage to calculate the eligible amount. The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for expenses incurred during the same calendar year.

When a medical prescription is required, the letters "**PR**" appear in the "**SUBJECT**"column. In these cases, the prescription must indicate the name of the drug or, in the case of other products or services, the diagnosis, the medical reasons and therapeutic indications to justify its use as well as the planned duration of use.

Unless indicated otherwise, the maximums indicated in this table are per insured and per calendar year. Also, unless indicated otherwise, any maximum indicated on a given line applies to all the elements that appear in the "**SUBJECT**" column of that line, rather than each of these elements separately.

Insureds can use an electronic benefit claims transmission service for prescription drug expenses. A payment card is given to participants so that they can benefit from this service.

The terms "Innovative drug", "Generic drug" and "Single-source drug" are defined as the following:

**Innovative drug**
Original version of a patented drug when it is placed on the market for which at least one generic version is offered on the market.

**Generic drug**
Copy of an original drug for which the patent has expired.

**Single-source drug**
Innovative drug for which no generic version is offered on the market.

An **innovative drug** can be reimbursed with the same reimbursement percentage as the **generic drug** if there are medical reasons that are accepted by SSQ. Participants must obtain the appropriate form from SSQ or on SSQ's secure site for insureds, have it completed by their attending physician and send it to SSQ for approval.

<table>
<tr><th colspan="4">ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.)</th></tr>
<tr><th colspan="4">The general information that completes this table can be found on the first page.</th></tr>
<tr><th colspan="2">SUBJECT<br>Prescription drugs</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td>1</td><td colspan="3">The insurance for prescription drugs that belong to one of the categories below applies only to drugs that meet the following requirements:<br>• They have a drug identification number (DIN) issued by the federal government and can only be obtained by prescription from a person legally authorized to do so.<br>• They are only available at a pharmacy.<br>• They are sold by a person authorized to do so, in accordance with section 37 of the Pharmacy Act.</td></tr>
<tr><td></td><td>Prescription drugs that are not on the RAMQ list but require prescription from a physician<br>PR</td><td>Not covered</td><td>Prescription drugs listed in the current edition of the Association québécoise des pharmacies propriétaires (AQPP) and whose use complies with indications approved by government authorities or, failing such authorities, with indications provided by the manufacturer.<br>In the case of medication injected at a doctor's office, only the cost of the injected substance is eligible for reimbursement. The cost of the medical procedure and the substance not actually injected are not eligible</td></tr>
<tr><td></td><td>Prescription drugs and products on the RAMQ list<br>PR</td><td colspan="2">Prescription drugs and products covered under the Basic Prescription Drug Insurance Plan (BPDIP), subject to the same conditions as those applicable under said plan.<br><br>Prescription drugs, commonly called "exception drugs" in the RAMQ list, are only covered in cases determined by the regulation applicable to the BPDIP, in accordance with the conditions and therapeutic indications specified therein. These exception drugs require prior authorization from SSQ.</td></tr>
</table>

<table>
<tr><th colspan="4">ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.)</th></tr>
<tr><td colspan="4">The general information that completes this table can be found on the first page.</td></tr>
<tr><th colspan="2">SUBJECT<br>Prescription drugs (cont.)</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td></td><td>Smoking cessation products<br>Sclerosing injections<br>Intrauterine device<br>PR</td><td colspan="2">For smoking cessation products, the maximum amount of expenses eligible is updated annually based on the RAMQ's recommendations.<br><br>For sclerosing injections: these must be provided and administered for curative (non-aesthetic) purposes by a physician and eligible expenses are limited to $20 per day. The medical procedure is not covered.</td></tr>
<tr><td colspan="2">Deductible</td><td>$5 per purchase</td><td>$60 per calendar year per certificate</td></tr>
<tr><td></td><td>Percentage of reimbursement</td><td>75% for single-source and generic drugs and 68% for innovative drugs, until the maximum payment stipulated under the BPDIP is reached and 100% afterwards for expenses incurred during the same year</td><td>80% for single-source and generic drugs and 68% for innovative drugs, until the maximum payment of $750 per year is reached and 100% for other expenses incurred during the same year</td></tr>
<tr><th colspan="2">SUBJECT<br>Trip</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td rowspan="3">2</td><td>Travel insurance<br>PR</td><td colspan="2">See section 2.4 "Travel insurance"<br><br>Emergency care for a temporary trip outside the province of residence for a person covered under provincial health and hospitalization insurance plans</td></tr>
<tr><td>Percentage or reimbursement</td><td colspan="2">100%</td></tr>
<tr><td>Maximums</td><td colspan="2">Maximum reimbursement of $5,000,000 per trip</td></tr>
<tr><td rowspan="3">3</td><td>Trip cancellation insurance</td><td colspan="2">See section 2.5 "Trip cancellation insurance"</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">100%</td></tr>
<tr><td>Maximums</td><td colspan="2">Maximum reimbursement of $5,000 per trip</td></tr>
</table>

<table>
<tr><th colspan="4">ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.)</th></tr>
<tr><th colspan="4">The general information that completes this table can be found on the first page.</th></tr>
<tr><th colspan="2">SUBJECT<br>Hospitalization</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td rowspan="3">4</td><td>Hospitalization<br>PR</td><td colspan="2">Occupation of a hospital room for short-term care</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">100%</td></tr>
<tr><td>Maximums</td><td colspan="2">Difference between the cost of a two-bed room (semi-private) and a room with more than two beds (room)</td></tr>
<tr><th colspan="2">SUBJECT<br>Medical services</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td rowspan="3">5</td><td>Transportation by ambulance</td><td colspan="2">When justified by the person’s state of health, land transportation, to or from the nearest hospital offering appropriate care, including the cost of oxygen therapy received immediately before and during transportation.<br><br>Transportation by airplane (or helicopter, if not covered by a third party), boat or train is also covered when such means of transportation is required for part of the trip if the insured must be bedridden and takes the equivalent of two seats. Medical necessity must be demonstrated to the satisfaction of SSQ.<br><br>In all cases, transportation must be carried out by a licensed ambulance service.</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
<tr><th colspan="2">SUBJECT<br>Medical services</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td rowspan="3">6</td><td>Lab tests<br>PR</td><td colspan="2">For the analysis of tissue or body fluid (blood, urine, etc.) for preventive or diagnostic purposes.<br>The analyses must be carried out in a private laboratory for persons who are not hospitalized and of a type similar to those supplied by a hospital.</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
</table>

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT** <br> **Medical services (cont.)** | | **HEALTH 1** | **HEALTH 2** |
| 7 | Cosmetic surgery necessary following an accident | The accident must occur while the person is insured under the current plan. <br> Care must begin within 12 months following the accident and end at most 36 months after the accident. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | $5,000 reimbursement per accident | |
| 8 | Dental care necessary following an accident | Professional fees of a dental surgeon, specialist or denturist, to repair damage to natural, healthy teeth (including the purchase of a dental prosthesis) or to treat an accidentally fractured jaw. <br> The accident must occur while the person is insured under the current plan. <br> Care must be provided no later than 12 months after the accident. <br> Expenses related to implants are not eligible, nor are expenses for teeth broken while eating. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | Rate recommended by the ACDQ for the year of the treatments | |
| 9 | Nursing care **PR** | Fees of a duly licensed nurse in continuous and exclusive attendance on the insured | |
| | Percentage of reimbursement | 80% | |
| | Maximums | $4,000 reimbursement <br> $160 reimbursement per day | |

<table>
<tr><th colspan="4">ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.)</th></tr>
<tr><th colspan="4">The general information that completes this table can be found on the first page.</th></tr>
<tr><th colspan="2">SUBJECT<br>Medical items</th><th>HEALTH 1</th><th>HEALTH 2</th></tr>
<tr><td rowspan="3">10</td><td>External prosthesis<br>Artificial limbs</td><td colspan="2">The loss of a natural limb must occur while the person is insured under this coverage.<br>The following items are not covered: dentures, hearing aids, glasses, contact lenses and other articles that are already covered under another section of this plan.</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
<tr><td rowspan="3">11</td><td>Wheelchair<br>Walker<br>PR</td><td colspan="2">Rental (or purchase if SSQ believes it is more economical) for temporary use only</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">For wheelchair: eligible expenses up to the cost of a non-motorized wheelchair of the type generally used in a hospital</td></tr>
<tr><td rowspan="3">12</td><td>Hospital bed<br>PR</td><td colspan="2">Rental (or purchase if SSQ believes it is more economical) for temporary use only</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">Eligible expenses up to the cost of a non-motorized hospital bed of the type generally used in a hospital</td></tr>
<tr><td rowspan="3">13</td><td>Insulin pump<br>PR</td><td colspan="2">Purchase, adjustment, replacement or repair</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">$7,500 reimbursement per 60-month period</td></tr>
<tr><td rowspan="3">14</td><td>Insulin pump accessories<br>PR</td><td colspan="2">Purchase of accessories used exclusively with an insulin pump</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
</table>

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT**<br>**Medical items (cont.)** | | **HEALTH 1** | **HEALTH 2** |
| 15 | Support stockings<br>**PR** | Purchase of support stockings (20 mm Hg or more) for insufficiency of the circulatory or lymphatic system and obtained in a health establishment or a pharmacy | |
| | Percentage of reimbursement | 80% | |
| | Maximums | 3 pairs | |
| 16 | Transcutaneous electrical nerve stimulator<br>**PR** | Purchase, rental, adjustment, replacement or repair | |
| | Percentage of reimbursement | 80% | |
| | Maximums | $800 reimbursement per 60-month period | |
| 17 | Orthopaedic shoes<br>**PR** | Purchase of shoes designed and made to measure from a cast in order to compensate for a foot defect; or prefabricated open, flared, straight shoes; or shoes needed to maintain so-called Dennis Browne splints; or deep shoes.<br><br>These shoes must be obtained in a specialized laboratory holding a permit issued by the appropriate legal authority.<br><br>Cost of additions or alterations made to orthopaedic shoes.<br><br>Sandals are not considered to be orthopaedic shoes for the purposes of this coverage. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | No maximum | |

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT**<br>**Medical items (cont.)** | | **HEALTH 1** | **HEALTH 2** |
| 18 | Orthopaedic devices<br>Foot orthoses<br>**PR** | Purchase, adjustment, replacement or repair<br>Corsets, medicated dressings, crutches, splints, casts, trusses and other orthopaedic devices as well as special bandages in the case of serious burns<br>To be considered eligible as foot orthoses, the orthoses must be provided by a specialized laboratory holding a permit issued by the appropriate legal authority.<br>SSQ's Customer Service, whose telephone numbers appear on the back of this booklet, can confirm whether an orthopaedic device is covered under the health insurance plan. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | For foot orthoses: Amounts provided by the Association nationale des orthésistes du pied | |
| 19 | Respiratory apparatus<br>**PR** | Rental. Upon prior agreement with SSQ, expenses for purchase may also be eligible as well as expenses for replacement and repair.<br>**Examples of devices covered:**<br>Aerosol therapy devices; respiratory monitors in case of respiratory arrhythmia; intermittent positive pressure respirators.<br>**The following devices are not covered:**<br>Devices already covered under another section of this plan.<br>SSQ's Customer Service, whose telephone numbers appear on the back of this booklet, can confirm whether a respiratory device is covered under the health insurance plan. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | No maximum | |

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT**<br>**Medical items (cont.)** | | **HEALTH 1** | **HEALTH 2** |
| 20 | Orthopaedic devices<br>**PR** | Rental. Upon prior agreement with SSQ, expenses for purchase may also be eligible as well as expenses for replacement and repair.<br>**Examples of devices covered:**<br>Probes; catheters and other similar sanitary articles required following a total and irrevocable loss of use of an organ or limb; fracture consolidation stimulators; burn treatment garments; diapers for incontinence.<br>**The following devices are not covered:**<br>Transcutaneous electrical nerve stimulators; monitoring devices such as stethoscopes, sphygmomanometers or other similar devices; domestic devices such as whirlpool baths, air purifiers, humidifiers, air conditioners or other devices of similar nature; articles or devices already covered under another section of this plan.<br>SSQ's Customer Service, whose telephone numbers appear on the back of this booklet, can confirm whether a given therapeutic device is covered under the health insurance plan. | |
| | Percentage of reimbursement | 80% | |
| | Maximums | Lifetime reimbursement of $10,000 | |
| 21 | Intraocular lenses<br>**PR** | Purchase, if required to correct an eye disease whose effects cannot be sufficiently corrected by wearing contact lenses or glasses | |
| | Percentage of reimbursement | 80% | |
| | Maximums | No maximum | |
| 22 | Surgical brassieres<br>**PR** | Purchase following a mastectomy or breast reduction | |
| | Percentage of reimbursement | 80% | |
| | Maximums | Lifetime reimbursement of $200 | |

<table>
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<tr><th colspan="4">The general information that completes this table can be found on the first page.</th></tr>
<tr><th colspan="2">SUBJECT</th><th rowspan="2">HEALTH 1</th><th rowspan="2">HEALTH 2</th></tr>
<tr><th colspan="2">Medical items (cont.)</th></tr>
<tr><td rowspan="3">23</td><td>Breast prostheses<br>PR</td><td colspan="2">Purchase, if required following a mastectomy</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
<tr><td rowspan="3">24</td><td>Ostomy appliances<br>PR</td><td colspan="2">Purchase</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">No maximum</td></tr>
<tr><td rowspan="3">25</td><td>Blood glucose monitor<br>PR</td><td colspan="2">Purchase of a monitor equipped with a lancing device and used to measure blood glucose levels. Purchase of an intermittent blood glucose monitor requiring glucose sensors may also be eligible, provided prior approval by SSQ is obtained.</td></tr>
<tr><td>Percentage of reimbursement</td><td colspan="2">80%</td></tr>
<tr><td>Maximums</td><td colspan="2">$1,000 reimbursement</td></tr>
</table>

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT** | | **HEALTH 1** | **HEALTH 2** |
| **Paramedical services** | | | |
| 26 | Psychoanalyst<br>Psychiatrist<br>Psychologist<br>Psychotherapist<br>Social worker | Not covered | Professional fees in a private clinic by authorized persons |
| | Percentage of reimbursement | | 50% |
| | Maximums | | $700 reimbursement for all these expenses |
| 27 | Physiotherapist<br>Physical rehabilitation therapist | Not covered | Professional fees in a private clinic by authorized persons |
| | Percentage of reimbursement | | 50% |
| | Maximums | | $700 reimbursement for all these expenses |

<table>
<tr><th colspan="4">ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.)</th></tr>
<tr><td colspan="4">The general information that completes this table can be found on the first page.</td></tr>
<tr><td colspan="4">Options 1 and 2 described below are available only when the Health 2 plan is chosen. The coverage status (individual, single-parent or family) may be lower or equal to the coverage status of the Health 2 plan. For example, a participant can choose the Health 2 plan with a family status and add Option 2 with an individual status.</td></tr>
<tr><th colspan="2">SUBJECT</th><th rowspan="2">OPTION 1</th><th rowspan="2">OPTION 2</th></tr>
<tr><th colspan="2">Elective services</th></tr>
<tr><td rowspan="3">28</td><td>Dietitian PR<br>Chiropractor<br>Acupuncture<br>Osteopath<br>Naturopath PR<br>Podiatrist<br>Kinesitherapist<br>Orthotherapist<br>Massage therapist PR</td><td colspan="2">Professional fees in a private clinic by authorized persons<br>Expenses for X-rays for professional chiropractic services<br>As for the services of a naturopath, only the following are covered: consultation to obtain dietary advice, check-up, establishing a diet based on natural products; the cost of the natural products is not covered.</td></tr>
<tr><td>Percentage of reimbursement</td><td>50%</td><td>80%</td></tr>
<tr><td>Maximums</td><td>For all expenses on lines 28 and 29:<br>$500 reimbursement</td><td>For all expenses on lines 28, 29 , 30 and 31:<br>$1,000 reimbursement</td></tr>
<tr><td rowspan="3">29</td><td>Optometrist<br>Ophthalmologist</td><td colspan="2">Professional fees in a private clinic by authorized persons<br>Eye examinations are only covered for persons under age 65 up to one exam per calendar year.</td></tr>
<tr><td>Percentage of reimbursement</td><td>50%</td><td>80%</td></tr>
<tr><td>Maximums</td><td>For all expenses on lines 28 and 29, the maximum is indicated on line 28</td><td>For all expenses on lines 28, 29 , 30 and 31, the maximum is indicated on line 28</td></tr>
</table>

| ELIGIBLE EXPENSES UNDER THE HEALTH INSURANCE PLAN (cont.) | | | |
|---|---|---|---|
| **The general information that completes this table can be found on the first page.** | | | |
| **SUBJECT** | | **OPTION 1** | **OPTION 2** |
| **Elective services (cont'd)** | | | |
| 30 | Glasses **PR** | Not covered | Purchase or repair |
| | Percentage of reimbursement | | 100% |
| | Maximums | | For all expenses on lines 28, 29, 30 and 31, the maximum is indicated on line 28.<br><br>For all expenses on lines 30 and 31, there is also a maximum reimbursement of $300 every 24 months. |
| 31 | Contact lenses **PR** | Not covered | Purchase |
| | Percentage of reimbursement | | 100% |
| | Maximums | | For all expenses on lines 28, 29, 30 and 31, the maximum is indicated on line 28.<br><br>For all expenses on lines 30 and 31, there is also a maximum reimbursement of $300 every 24 months. |

## 2.4 TRAVEL INSURANCE AND ASSISTANCE

**Eligibility –** To be eligible for travel insurance, insureds must be eligible for benefits under the government health insurance and hospitalization insurance program of their province of residence in Canada for the entire duration of their stay outside their province of residence.

**Scope** – Subject to the provisions of this travel insurance coverage, SSQ pays the expenses incurred by the insured following an accident or a sudden and unexpected illness requiring emergency care and occurring while the person is temporarily outside their province of residence, provided the expenses incurred are usual, reasonable and necessary and apply to supplies, care or services that are **prescribed by a physician** as necessary for the treatment of an illness or injury.

**IMPORTANT**

Insureds who are aware that they are suffering from an illness must make sure, before departure, that their health condition is good and stable, that they are able to perform their ordinary activities and that no symptom leaves any reasonable doubt that complications may occur or that care may be required during the trip outside the province of residence.

For the insured to be covered, the illness or disorder must be under control prior to departure.

If the illness or disorder:

- has worsened;
- has relapsed or recurred;
- is unstable;
- is evolving into a terminal phase;
- is chronic and shows signs of deterioration or foreseeable complications during the trip,

it is recommended that the insured contact SSQ's travel assistance service a few weeks before departure.

You can obtain details on the exact definition of "sudden and unexpected illness" as well as a confirmation that the coverage applies or does not apply in your situation. The telephone numbers to reach the travel assistance service appear on the back of the card that is sent with the certificate issued by SSQ as well as on page 36 of this booklet.

Expenses covered under the travel insurance coverage are limited to $5,000,000 per insured for the duration of the trip outside the insured's province of residence. They are:

a) Expenses for hospitalization in a hospital where the patient receives curative treatment; expenses incurred are payable only for the portion exceeding the benefits payable under the hospitalization insurance plan of the insured's province of residence.

b) Professional fees charged by a physician for medical, surgical or anaesthetic care other than fees for dental care. The expenses incurred are payable only for the portion of eligible expenses incurred that exceeds the amount of benefits that is payable under the health insurance plan of the insured's province of residence.

c) Transportation by ambulance to the nearest hospital by a licensed ambulance service.

d) Expenses incurred for drugs that can only be obtained with a medical prescription.

e) Fees for a registered nurse for private nursing care provided exclusively in a hospital, when it is medically necessary and prescribed by the attending physician up to a maximum reimbursement of $5,000. The nurse cannot be related to the insured nor be a travel companion.

f) Professional fees for a chiropractor, podiatrist or physiotherapist.

g) Expenses for renting a wheelchair, a hospital bed or a breathing assistance device.

h) Expenses for lab tests and X-rays.

i) Expenses for purchasing trusses, corsets, crutches, splints, casts or other orthoses.

j) Professional fees of a dental surgeon for accidental injury to natural teeth for an accident that occurred outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident. Expenses must be incurred within 12 months following the accident and care must be obtained after the insured returns to the province of residence. Only expenses incurred while this travel insurance coverage is in force are eligible.

k) Expenses for the repatriation of the insured to the province of residence for immediate hospitalization and expenses for transporting the insured to the nearest location where appropriate medical services are available. Expenses for the transportation or repatriation must be agreed upon beforehand with SSQ's travel assistance service and benefits are limited to the lowest possible cost, according to SSQ's evaluation, taking into account the insured's state of health.

l) The cost of economy class return air travel for a medical escort, when it is required by the air carrier or the insured’s attending physician. These expenses require the prior authorization of SSQ. The medical escort cannot be related to the insured nor be a travel companion.

m) The cost of returning the insured’s personal or rented vehicle, by means of a commercial agency, to the residence or the proper and nearest car rental agency, if the insured is unable to do so due to illness or accident, up to a maximum reimbursement of $2,000 per trip. The insured must present a certificate from the attending physician indicating this.

n) In the event of the death of the insured outside the province of residence, expenses incurred for the preparation and return of the remains, excluding the cost of the casket, by the most direct route to the insured’s place of residence in Canada, up to a maximum of $10,000. These expenses require the prior authorization of SSQ.

o) Accommodation and meal expenses in a commercial establishment, which the insured must incur when obliged to modify the planned trip due to hospitalization of the insured, an immediate family member or a travel companion, for a minimum duration of 24 hours, up to a maximum of $300 per day and $2,400 per stay abroad for all individuals insured under this coverage.

p) Accommodation and meal expenses in a commercial establishment, as well as economy class round-trip transportation expenses for a close relative or friend, to visit the insured who has been hospitalized for at least seven days or to identify the deceased insured before the remains are returned. These expenses must be agreed upon beforehand with SSQ and the insured must present a document from the attending physician or from local authorities certifying in writing that the visit was necessary. For all individuals insured under the same certificate, expenses for such a trip outside the insured’s province of residence can be reimbursed as follows:

   - For transportation: $2,500
   - For accommodation and meals: $300 per day up to a maximum of $2,400 total.

q) Travel assistance services. These services are not available in all countries and may be modified by SSQ without notice

**IMPORTANT**

Neither SSQ nor the travel assistance service are responsible for the availability and quality of the medical and hospital care provided, nor for the possibility of obtaining such care.

If the insured travels elsewhere than to the United States and Western Europe, it is recommended that they contact the travel assistance service before departure. Useful advice on health issues can be provided.

You can contact a representative of the travel assistance service at the following telephone numbers:

A) CANADA - United States: 1-800-465-2928

B) ELSEWHERE IN THE WORLD, COLLECT CALL: 514-286-8412

These telephone numbers appear on the back of the plastic card issued by SSQ to the participant.

Insureds must provide their contract number when they call.

**Exclusions, limitations and restrictions applying to travel insurance** – See section 2.6.

**Coordination of travel insurance benefits** – If the insured is entitled to similar benefits under an individual or group contract purchased from an insurer, the benefits payable under this coverage are reduced by the benefits payable under any other contract. However, if the insured is entitled to similar benefits under other provisions of the health insurance plan, benefits are payable under travel insurance. When benefits are not payable under the current travel insurance coverage, this should not be interpreted as limiting the scope of any other provision of the health insurance plan.

## 2.5 TRIP CANCELLATION INSURANCE

**Eligibility** – Subject to the provisions of the trip cancellation insurance, SSQ pays expenses incurred by the insured following the cancellation or interruption of a trip, provided such expenses are related to amounts paid in advance by the insured and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip. Expenses covered under this benefit are payable by SSQ up to a maximum of $5,000 per insured per planned trip. To be eligible for this coverage, the trip must be cancelled or interrupted due to one of the following reasons:

a) An illness or accident suffered by the insured, a travel companion or a business partner of the insured, or suffered by a member of the insured's family or travel companion's family. The illness or accident must be reasonably serious to justify the cancellation or the interruption of the insured's trip and, at the time of cancellation or interruption of the trip, must prevent the person from carrying out his or her regular daily

functions.

b) The death of the participant, spouse, dependent child of the participant or the spouse, travel companion of the participant or business associate of the insured.

c) Provided the funeral takes place during the period extending from 31 days before and 31 days after the planned trip, the death of a family member:

- of an insured other than the participant; of the participant's spouse, of a child of the participant or a spouse of that child.
- of the insured's travel companion.

d) The illness, accident or death of a person for whom the insured is the legal guardian.

e) The suicide or attempted suicide of a member of the insured's family or a member of the travel companion's family.

f) The death or a person for whom the insured is the testamentary executor.

g) The death or emergency hospitalization of the insured's host at destination.

h) The summons of the insured or a travel companion to report for jury duty or receipt of a subpoena to appear as a witness in a trial to be heard during the period of the trip, provided the individual concerned has undertaken the necessary steps to have the trial postponed. Such an appointment **is not considered** eligible cause for cancellation or interruption of a trip when the person appointed is:

- filing suit; or
- the defendant in a trial; or
- carrying out the usual functions of their duties as a police officer.

i) The quarantine of the insured, provided it terminates seven days or less before the scheduled date of departure, or occurs during the time of the trip.

j) Regardless of the exclusion in cases of war or acts of war: the hijacking of the plane on which the insured is travelling.

k) Damage rendering the principal residence of the insured or of the host at destination uninhabitable, provided the residence remains uninhabitable seven days or less before the scheduled date of departure or the damage occurs during the trip.

l) Transfer of the insured, for the same employer, to a location more than 100 kilometres from the current residence, provided the transfer is required by the employer within 30 days preceding the planned date of departure.

m) Regardless of the provision in the case of war or acts of war: Terrorism, war, whether declared or not, an epidemic in the country where the insured is travelling, provided the government of Canada issues a recommendation

to Canadians not to travel to this country for a period covering the projected duration of the insured's trip and that the recommendation is issued after the insured made these travel arrangements.

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

o) Weather conditions such that:

  - the departure of the public transportation used by the insured at the starting point of the trip is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the trip; or that
  - the insured is unable to make a scheduled connection, after departure, with another carrier, provided the scheduled connection after departure is delayed by at least 30% (minimum 48 hours) of the scheduled duration of the trip.

p) Damage to the place of business or physical location where a commercial activity is to be held, such damage making it impossible to hold the planned activity, such that the official organization responsible for organizing the activity issues a written notice cancelling the activity.

q) The death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of three days of lodging.

**Expenses covered under trip cancellation insurance** – To be covered under trip cancellation insurance, the expenses must be part of the following list and be payable by the insured.

***In the event of cancellation prior to departure***

- The non-refundable portion of prepaid travel expenses.
- Additional expenses incurred by the insured in the event that the travel companion with whom the insured planned to share a room or an apartment at destination must cancel for one of the reasons mentioned under the contract and the insured decides to proceed with the trip as initially planned, up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.

- The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's departure is delayed due to weather conditions and the insured decides not to proceed with the trip.

***If the departure is missed due to a delay in the previous method of transportation used by the insured or a flight cancellation or if the trip after departure is temporarily interrupted due to an illness or accident suffered by the insured or a travel companion*** – The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination.

***If the return is earlier or later than scheduled***

The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned.

- If the means of transportation initially planned cannot be used, whether or not travel expenses have been prepaid, the expenses covered correspond to the expenses charged by a scheduled public carrier for economy class travel, by the most economical means of transportation and the most direct route, for the insured to return to the initial point of departure. These expenses require the prior authorization of SSQ.

  <u>Restrictions</u>

  If the insured's return is delayed for more than seven days due to an illness or accident suffered by the insured or the travel companion, the expenses incurred are covered provided the person in question is admitted to hospital as an inpatient for more than 48 hours within the aforementioned period of seven days.

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

The unused and non-refundable portion of the ground portion of prepaid travel expenses.

**Return-trip transportation** – Trip cancellation insurance covers expenses for transportation by the most economical means, subject to prior authorization by SSQ or by the company providing travel assistance service, to return the insured to the province of residence and then back to the trip destination, provided the return is for one of the following reasons:

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

**Exclusions, limitations and restrictions for trip cancellation insurance** –See section 2.6.

**Coordination of trip cancellation insurance benefits** – If the insured is entitled to similar benefits under an individual or group contract purchased from an insurer, the benefits payable under this coverage are reduced by the benefits payable under any other contract. However, if the insured is entitled to similar benefits under other provisions of the health insurance plan, benefits are payable under this trip cancellation insurance coverage. When benefits are not payable under this trip cancellation insurance, this should not be interpreted as limiting the scope of any other provision of the health insurance plan.

## 2.6 EXCLUSIONS, LIMITATIONS AND RESTRICTIONS

**Exclusions, limitations and restrictions applying to the health insurance plan**

The health insurance plan provides no reimbursement for:

a) Medical care which the person is entitled to or could be entitled to under any federal or provincial legislation.

b) Dentures, wigs, hearing aids or examinations carried out in order to prescribe or make adjustments to these devices, surgeries, treatments or prostheses for aesthetic purposes, except in cases where a reimbursement is explicitly stipulated because they are necessary following an accident.

c) Expenses that the person would not be required to pay in the absence of this contract.

d) Expenses incurred for medical examinations requested by a third party (insurance, school, work) or for a health trip.

e) Products or services used for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the competent authorities or, failing such authorities, with the indications given by the manufacturer.

f) Expenses resulting from active participation in an insurrection, a criminal act or active service in the armed forces, or resulting directly or indirectly from a war.

g) Expenses related to the treatment of obesity.

h) Expenses for the purchase of sunglasses or protective glasses.

i) Expenses whose cause renders them eligible for a reimbursement under the *Act respecting industrial accidents and occupational diseases* or under any other law or public plan.

j) Expenses for infertility treatment, artificial insemination or *in vitro* fertilization.

Benefits payable under any other public or private, individual or group plan or under any government initiative, including expenses covered by a plan financed wholly or partly by taxes and those which would have been covered had the provider of such services chosen to participate in such a plan, are deducted from any benefits payable under the health insurance plan:

**Exclusions, limitations and restrictions applying specifically to prescription drug insurance**

In addition to the exclusions, limitations and restrictions applying to the health insurance plan, the exclusion of the following products applies to prescription drugs, whether or not the products in question are considered prescription drugs:

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

b) Substances or drugs used or administered as a preventive measure.

c) Drugs of experimental nature or obtained under a federal emergency drug program.

d) Homeopathic or natural products.

e) Smoking cessation products, except those covered under the Basic Prescription Drug Insurance Plan.

f) Dietary supplements serving as meal supplements or replacements. However, dietary supplements prescribed for the treatment of a clearly diagnosed metabolic disease are covered, under the conditions and therapeutic indications determined by the regulation applicable to the Basic Prescription Drug Insurance Plan; the only evidence accepted is a complete medical report describing to SSQ's satisfaction all the conditions justifying the prescription of the product not otherwise covered.

g) Sun screens and self-tan lotions.

h) Drugs used for infertility treatment, artificial insemination or in vitro fertilization except for those covered under the Basic Prescription Drug Insurance Plan.

i) Growth hormones whose diagnostic characteristics do not permit them to be entered into the Basic Prescription Drug Insurance Plan on the basis of predetermined inclusion criteria.

j) Drugs used to treat erectile dysfunction.

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

The exclusions, limitations and restrictions of the contract must in no case render the health insurance plan more restrictive than the Basic Prescription Drug Insurance Plan.

**Exclusions, limitations and restrictions applying to travel insurance**

In addition to the exclusions, limitations and restrictions which apply to the health insurance plan, the following exclusions apply to travel insurance.

The travel insurance of the health insurance plan does not cover the following expenses:

a) Expenses incurred after the insured has refused to be repatriated to his or her province of residence upon request from SSQ.

b) Expenses incurred after the insured's return to the province of residence.

c) Expenses related to elective or non-emergency surgery or treatment, as well as expenses incurred in the case of a trip taken for the purpose of obtaining medical treatment, a medical consultation or hospital services, regardless of whether the trip is taken upon the recommendation of a physician.

d) Hospital or medical expenses incurred for care not covered under the health insurance or hospital insurance plan of the insured's province of residence.

e) Expenses incurred outside the insured's province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health, except for expenses required immediately following an emergency situation resulting from an accident or sudden illness. The fact that the quality of the services available in the province of residence may be inferior to that available outside the province does not represent, for the purposes of this exclusion, a danger to the insured's life or health.

f) Expenses incurred in a hospital specialized in chronic care or in a chronic care ward of a publicly-funded hospital, or in an extended care home or thermal spa facility.

This travel insurance does not cover expenses incurred due to the following causes or to which such causes have contributed:

- Intentional self-inflicted injury by the insured, suicide or attempted suicide, regardless of the state of mind of the person. However, in the case of death resulting from a suicide attempt, only expenses incurred for the preparation and return of the remains are covered as stipulated in the description of expenses covered under travel insurance.
- Abusive consumption of medications, drugs or alcohol and the ensuing consequences.
- Participation in any combat sports, gliding, mountain climbing, parachuting, skydiving or any other similar activity, or participation in any speed competition, or participation in any sporting or underwater activity for which the insured receives compensation.

- Pregnancy, miscarriage, childbirth or related complications occurring within the two (2) months preceding the normal expected date of delivery.

When an insured obtains a diagnosis or receives emergency treatment for a disorder and this disorder or diagnosis requires extended medical services, treatments or additional surgeries, SSQ does not pay the cost of these services, treatments or surgeries that the insured chooses to obtain outside the province of residence if medical evidence reveals that the person could have returned to the province of residence to obtain them.

**Exclusions, limitations and restrictions applying to trip cancellation insurance**

In addition to the exclusions, limitations and restrictions which apply to the health insurance plan, the following exclusions apply to trip cancellation insurance.

Trip cancellation insurance does not cover losses due to the following causes or to which such causes have contributed:

a) Intentional self-inflicted injury by the insured, suicide or attempted suicide, regardless of the state of mind of the person.

b) Abusive consumption of medication, drugs or alcohol and the ensuing consequences.

c) Participation in combat sports, gliding, mountain climbing, parachuting, skydiving or any other similar activity, or participation in any speed competition, or participation in any sporting or underwater activity for which the insured receives compensation.

d) Pregnancy, miscarriage, childbirth or related complications occurring within the two (2) months preceding the normal expected date of delivery.

e) Trip taken for the purposes of obtaining medical treatment, a medical consultation or hospital services, regardless of whether the trip is taken upon the recommendation of a physician.

f) Trip taken for the purpose of visiting or being at the bedside of a person who is ill or has suffered an accident, and whose medical condition or subsequent death leads to cancellation, early return or late return.

Hunting trips and fishing trips are not covered under trip cancellation insurance.

In the event of cancellation before departure, the trip must be cancelled through the travel agency or carrier within 48 hours, or, in the case of a holiday, on the next business day, and SSQ must be informed at the same time. SSQ's liability is limited to the applicable cancellation costs stipulated in the travel insurance contract 48 hours after the date of the event justifying the cancellation or the next business day in the case of a statutory holiday. However, this limitation will not apply if the insured and spouse provide proof deemed satisfactory by SSQ that they were totally incapable of doing so. In such a case, the trip must be cancelled as soon as one of these persons is able to do so. SSQ's liability is limited to the applicable cancellation expenses stipulated in the travel insurance contract at the time of cancellation.

### 2.7 EXTENSION OF INSURANCE

When the insurance of a participant who is on total disability ends because they are no longer eligible for a reason other than retirement, or when the insurance of a hospitalized dependent ends because they cease to be a dependent, SSQ pays, in accordance with the provisions of the contract, expenses incurred during the last three months immediately following the end of the insurance, subject to the following:

a) Before the insurance ends, the participant must have incurred the expenses covered under the health insurance plan for health, accident or pregnancy making the person totally disabled or for hospitalization of the dependent.

b) The participant's total disability or the dependent's hospitalization must be continuous.

### 2.8 CONVERSION PRIVILEGE OF HEALTH INSURANCE

The conversion privilege allows participants and their dependents to obtain an individual health insurance contract at the rates and conditions stipulated by SSQ that are in force for this type of insurance, without having to provide evidence of insurability.

To exercise this right, the person must make a request in writing to SSQ's Head Office within 31 days after one of the following events:

a) The participant ceases to be eligible for the health insurance plan before the termination of the contract. The participant can then exercise their right to conversion for them and their dependents if they were also insured.

b) One of the dependents ceases to be a dependent under the contract.

c) The death of the participant.

# 3. LIFE INSURANCE PLAN

## 3.1 PARTICIPANT'S BASIC LIFE INSURANCE

**Life insurance amount for a non-retired participant**

Until the December 31st that coincides with or follows the participant's 65th birthday, the amount of insurance payable upon the death of a non-retired participant is equal to the annual salary of this person. Afterwards, the insurance amount payable upon the death is equal to 50% of the annual salary.

If, upon his or her death, the participant was insured without payment of premiums due to total disability, the amount of insurance payable is based on the salary immediately before the start of the waiver of premiums.

**Exclusion in the case of suicide**

Life insurance amounts requested more than 30 days after the participant's date of eligibility are not payable if they commit suicide within 12 months following the date these amounts come into force.

As for retirees' basic life insurance, we refer you to section 7 of this booklet.

## 3.2 PARTICIPANT'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

**Subject of the insurance** – Subject to other provisions of the contract, SSQ agrees to pay the benefits indicated in the "Table of Losses" below if the participant, while covered under this coverage and not benefiting from a waiver of premiums due to total disability, suffers an accident (or is the victim of accidental drowning or asphyxia revealed by autopsy) causing one of the losses stipulated in the insurance, provided such a loss occurs within 90 days following the date of the accident.

**Amount of insurance and amount of benefits**

The amount of insurance for this coverage is equal to the participant's annual salary, while the amount of the benefit payable for a given loss is determined based on the indications in the "Table of Losses" below and corresponds to a percentage of the amount of insurance in force at the time of the accident that caused the loss. However, this amount of benefits is doubled if the accident suffered by the participant occurs in one of the following circumstances:

a) During a trip as a passenger in a public transportation car (including platforms, stairs or steps on a train or subway car) regularly used for the transportation of passengers by a licensed carrier (e.g. bus, taxi, subway, boat or commercial airplane).

b) In an escalator or elevator, unless it is a mining elevator.

c) During a fire in a public building, provided the participant was in the building when the fire started and does not usually work there.

d) During the collapse of an outside wall of a public building, provided the participant was inside the building at the time and does not usually work there.

e) The effects of lightning, an explosion or a rupture of a steam boiler.

f) The effects of a hurricane or cyclone, as reported by the weather office of the area where the accident occurs.

**Maximum benefit for multiple losses**: The total amount of benefits payable cannot exceed 100% of the amount of insurance under this coverage (or 200% of this amount if the accident occurs in one of the circumstances that doubles the amount of benefits, as described above) when, following an accident, a participant suffers more than one of the losses stipulated under the "Table of Losses" below.

**Table of Losses**

| Accidental loss | Benefit as a percentage of salary | |
|---|---|---|
| | **Before reduction*** | **After reduction*** |
| Death | 100% | 50% |
| Loss of two hands | 100% | 50% |
| Loss of two feet | 100% | 50% |
| Loss of sight in both eyes | 100% | 50% |
| Loss of one hand and one foot | 100% | 50% |
| Loss of one hand and sight in one eye | 100% | 50% |
| Loss of one foot and sight in one eye | 100% | 50% |
| Loss of one hand or one foot | 50% | 25% |
| Loss of sight in one eye | 50% | 25% |
| Loss of one finger | 10% | 5% |

* The reduction applies if the person reached age 65 before the year of the accident.

Definitions

- Loss of sight in one eye: total and irrecoverable loss of sight in one eye.
- Loss of a finger: total and irrecoverable loss of use of one finger, or its amputation at the articulation between the hand and the first phalanx, without losing the hand.
- Loss of one hand: total and irrecoverable loses of the use of one hand, or its amputation at the wrist or higher.
- Loss of a foot: total and irrecoverable loss of use of a foot, or its amputation at the ankle or higher.

**Exclusions, limitations and restrictions**

SSQ does not pay any benefits under the accidental death and dismemberment insurance for a loss occurring due to one of the following circumstances:

a) Any infection, disability or illness that existed before the date of the accident.

b) Any trip aboard any type of plane, if the person is acting as a member of the crew or is carrying out any duty in regard to such a flight, whether or not it is related to piloting the plane. However, this exclusion does not apply if the participant is carrying out his or her duties as an employee.

c) Active participation in an insurrection or a war or active service in the armed forces of any country that is at war, whether the hostilities are declared or not, or active participation in a riot.

d) Poisoning by gas, poison, drugs or prescription drugs, whether or not this poisoning was voluntary. However, this exclusion does not apply to an accidental poisoning caused by the participant's job.

e) Suicide or attempted suicide, or injuries which the participant inflicted or was inflicted intentionally, regardless of the state of mind of the participant.

f) Active participation in a crime.

g) A breach or attempt to breach the Criminal Code, except in cases where the only infraction was driving a motorized vehicle under the influence.

SSQ pays no benefits under the accidental death and dismemberment insurance for a loss that occurs while the person is benefiting from a waiver of premiums due to total disability.

### 3.3 PARTICIPANT'S OPTIONAL LIFE INSURANCE

Any non-retired participant can choose to be insured under participant's basic life insurance and participant's optional life insurance, subject to the presentation of evidence of insurability deemed satisfactory by SSQ. The amount of additional life insurance they can choose can be equal to 1, 2 or 3 times the annual salary.

If a person dies while they are covered under this insurance and this person benefits from a waiver of premiums due to total disability, the amount of insurance payable under this coverage is based on the salary that applied to this person immediately before the start of the waiver of premiums.

**Exclusion in the case of suicide** – If the participant commits suicide and dies within 12 months following the effective date of the optional life insurance amounts that were requested more than 30 days after the date of eligibility, these amounts are not payable by SSQ.

### 3.4 DEPENDENT'S LIFE INSURANCE

Upon the death of a dependent insured under this coverage, SSQ agrees to pay to the participant the amount of $4,000 in the case of the death of the spouse and $2,000 in the case of the death of a dependent child aged 24 hours or over.

### 3.5 SPOUSE'S OPTIONAL LIFE INSURANCE

Any non-retired participant can choose to insure his or her spouse under the dependent's life insurance and under this coverage, subject to the presentation of evidence of insurability deemed satisfactory by SSQ. The amount of optional life insurance the spouse can hold can be equal to $10,000, $20,000, $30,000, $40,000 or $50,000.

**Exclusion in the case of suicide** – If the spouse commits suicide and dies within 12 months following the effective date of the optional life insurance amounts that were requested more than 30 days after the date of eligibility, these amounts are not payable by SSQ.

### 3.6 CONVERSION PRIVILEGE

If a person's life insurance ends while the contract is still in force, because the participant ceases to belong to the group for a reason other than retirement, this participant is entitled to convert in whole or in part their life insurance to an individual contract, without having to provide evidence of insurability. To be able to exercise this right, the participant must make a request in writing to SSQ within 31 days following their departure from the group.

However, this right only applies to persons whose insurance was terminated at the latest on their 65th birthday, and only if the participant ceases to belong to the group at the latest on their 65th birthday. The types of individual insurance it is possible to obtain by exercising the right to transform an insured's group life insurance are as follows:

a) Life insurance comparable to the person's group insurance in terms of amount and duration, but the amount cannot exceed $400,000 for all of this person's group life insurance coverage, whether this insurance is held as a participant, a spouse or a dependent child.

b) One-year term life insurance that can be converted to the insurance described in a) above.

Individual life insurance policies issued after exercising the conversion privilege do not provide for a premium waiver.

If a person dies during the 31-day period during which the participant could have exercised the right to convert his or her group life insurance and this insurance was never converted, the amount of life insurance the participant was entitled to convert for this person is payable under the group insurance contract.

In all cases of conversion, the premium for the first year of individual insurance cannot be higher than that of one-year term insurance. Except for the first year, premiums for individual insurance are level premiums. The premiums are calculated according to the individual insurance rates in force based on the gender of the person to be insured and age and smoking habits on the date the participant ceases to belong to the group, as well as the particularities that apply to the coverage, if applicable. SSQ must have

received the first individual insurance premium within 31 days following the date the participant ceases to belong to the group.

### 3.7 PAYMENT OF THE INSURANCE

Benefits under the life insurance plan are based on the amount in force at the time of the event subject to the insurance. In the case of accidental dismemberment of a participant or the death of a dependent, benefits are payable to the participant. In the case of death of a participant, benefits are payable to the designated beneficiary or to the participant's heirs.

The person who requests benefits must provide the evidence required by SSQ.

- To establish their rights.
- To certify that the accidental death or loss has occurred.
- To demonstrate the cause of the accidental death or loss.
- To prove the exactitude of the participant's declared date of birth.

The payment is made only if the insurance is in force at the time of the death or loss.

### 3.8 PREPAYMENT PRIVILEGE

When the participant's life insurance is extended without payment of premiums following the provisions stipulated in section 1.9 and their life expectancy is 12 months at the most, they are entitled, if they make a request in writing to SSQ's Head Office, to receive disability insurance benefits of either $25,000 or 50% of the total life insurance amount for which the participant is insured, whichever is lower. In this last case, the amount of life insurance takes into account any possible reduction in coverage that could occur during the 24-month period following the date the participant makes the request.

Participants who wish to exercise this right must provide SSQ with evidence showing:

- that their life expectancy is less than 12 months at the date of the request;
- the approval of the beneficiary, unless the beneficiary is the executor of the participant's will or the participant's heirs.

Upon the death of the participant, the amount otherwise payable by SSQ to the beneficiary is reduced by the amount paid to the participant as disability benefits under this entitlement, accumulated with interest based on a formula established annually by SSQ in accordance with the evolution of the financial markets.

### 3.9 BENEFICIARY IN CASE OF DEATH

Subject to applicable legislation, the participant can designate one or several persons as beneficiaries of the insurance, including heirs, or change the beneficiary designation by signing a written declaration to this effect and sending it to SSQ's Head Office. SSQ is not responsible for the legal validity of designations and beneficiary changes.

The rights of beneficiaries who die before the participant revert to the participant. If, at the time of death, the participant had not designated a beneficiary in writing, the amount of insurance is payable to the heirs.

# 4. LONG TERM DISABILITY INSURANCE PLAN

## 4.1 INSURANCE

Once SSQ receives and approves the proof establishing that a participant has become totally disabled while insured and the total disability has continued until the expiration of the elimination period of the long term disability insurance plan, SSQ pays a benefit to this person as a monthly benefit, subject to any other provision of the contract. If applicable, the amount of the monthly benefit is calculated based on the number of days of total disability during the month for which it is paid.

## 4.2 ELIMINATION PERIOD

The elimination period is 104 weeks following the start of the total disability.

## 4.3 BENEFIT PERIOD

The totally disabled participant is entitled to receive the long term disability benefit at the end of the elimination period and for as long as the participant remains totally disabled, though no longer than the earliest of the following dates:

- The date of retirement, except if the retirement is due to disability.
- The participant's 65th birthday.

## 4.4 AMOUNT OF THE MONTHLY BENEFIT

The initial amount used to calculate the monthly benefit is equal to one-twelfth of 65% of the annual gross salary used to calculate the 104th week of disability insurance benefits paid by the employer, as stipulated under the collective agreement. However, the amount of the benefit may be reduced due to other sources of income, or increased afterwards due to indexation, in accordance with what is indicated in the contract.

The benefit payable under this coverage is reduced by disability benefits payable under the *Automobile Insurance Act*, the *Act Respecting Industrial Accidents* and *Occupational Diseases*, the *Quebec Pension Plan*, the *Canada Pension Plan*, the employer's retirement plan (subject to what is indicated in section 4.4 a), b) and c) hereinafter), any social legislation and any insurance policy. It is also reduced by any remuneration received from the employer, given that for the purposes of the long term disability insurance plan, payments from sick leave banks and separation premiums are not considered remuneration received from the employer. For any disability that started on January 1, 2013 or after, the payment of vacation days accumulated before the beginning of the disability is not considered as remuneration received from the employer.

The benefit payable under this plan is also reduced by 50% of the amount of any retirement pension received from the employer's retirement plan, or by 75% of the amount of any retirement pension received from the employer's retirement plan if the total disability starts on January 1, 2019 or after. For the purposes of this plan, however, the participant is not obligated to request the payment of a retirement pension if this request brings about the application of an actuarial reduction.

Provided the provisions of the employer's retirement plan allow it, disability benefits under such a plan will not be entered into the calculation of the reduction of the pension payable under the contract, provided all of the following conditions apply:

a) The disabled person continues to contribute to the employer's retirement plan.

b) The disabled person has not completed 35 years of recognized service under the employer's retirement plan.

c) The disabled person is not receiving disability insurance benefits under the employer's retirement plan.

Participants must provide proof that they are not eligible for benefits under any of the above-mentioned sources. However, for the purposes of the contract, cost-of-living indexation of the amounts payable under social legislation is not taken into account.

The participant does not need to request payment of a retirement pension while they are benefiting from a waiver of contributions to the retirement plan. However, this applies only to the usual retirement pension and not to any disability benefit provided for under certain retirement plans. It does not apply to persons with 35 credited years of service for the purposes of calculating the retirement pension.

The calculation of the disability benefits payable under this insurance does not take into account the indexation of amounts payable under the above-mentioned sources of income.

The total incomes from all sources and the benefit payable under the long term disability insurance plan can never exceed 100% of the salary that was payable to the participant immediately before the total disability began.

### 4.5 INDEXATION

The initial amount of the benefit provided under the long term disability insurance plan is adjusted on January 1 of each year under the same indexation provisions as those of the *Quebec Pension Plan*, less 3%. This indexation is also limited to a maximum of 5% per year. The first adjustment is carried out on January 1 following 12 months of long term disability insurance payments.

## 4.6 EXCLUSIONS, LIMITATIONS AND RESTRICTIONS

SSQ is absolved of any obligation towards any period of total disability resulting from one of the following causes:

a) Attempted suicide or injuries that the participant inflicted intentionally or was inflicted intentionally, regardless of the state of mind of the person who carried out the act.

b) A war, whether declared or not.

c) The participant's active participation in a riot or insurrection.

d) Alcoholism or drug addiction, if the participant was not effectively receiving medical treatments or care for rehabilitation purposes.

e) Any trip aboard any type of plane, if the person is acting as a member of the crew or is carrying out any duty in regard to such a flight, whether or not it is related to piloting the plane. However, this exclusion does not apply if the participant is carrying out his or her duties as an employee.

f) A breach or attempt to breach the Criminal Code.

In addition, no payments are made for the following periods of total disability.

- A period during which the employee was not under the personal and regular care of a physician due to the illness or injury causing the total disability, except in cases when the participant's condition is deemed stable as attested by a physician to the satisfaction of SSQ.
- A period during which the employee is in jail following a conviction due to an infraction.
- A period during which the employee is living outside of Canada or the United States of America.

No benefit is payable if the participant is not under the supervision of a physician. When the medical care of a specialist is required, this care must be provided by a specialist in the appropriate field for the total disability to be recognized as such.

## 4.7 RECURRENCE OF TOTAL DISABILITY

**During the period when benefits are being paid under the employer's disability insurance plan**, successive periods of total disability are considered to be the continuation of the same period of disability if they are interrupted by less than 32 days of active full-time work or availability for full-time work, or by less than eight days of active full-time work or availability for full-time work if the continuous period of disability that preceded the employee's return to work is equal to or less than three months. However, two periods of total disability are considered distinct in cases where they are caused by an illness or accident that is totally unrelated to the previous one.

**Afterwards**, successive periods of total disability are considered to be an extension of the same period of disability if they are interrupted by less than six months of continuous work. However, two periods of total disability are considered to be distinct in cases where they are caused by an illness or accident that is totally unrelated to the previous one, provided the second period begins after the employee has returned to full-time work.

### 4.8 REHABILITATION

Disabled participants may, with the approval of SSQ, perform rehabilitation work while continuing to benefit from the long term disability insurance plan for the disability in progress, for as long as SSQ considers that said work qualifies as rehabilitation work. The indemnity amounts payable by SSQ for the duration of this rehabilitation work is reduced by 60% of the total remuneration earned from such work.

# 5. DENTAL CARE INSURANCE PLAN

## 5.1 INSURANCE

Insureds who incur eligible expenses while covered under the dental care insurance plan are entitled to have part of these expenses reimbursed by SSQ to the participant, subject to the provisions of this contract.

The maximum reimbursement of benefits payable for all dental care services combined is $1,000 per calendar year for each insured.

## 5.2 CONDITIONS RELATED TO THE ELIGIBILITY OF EXPENSES

**Complement to public insurance** – For the purposes of the dental care insurance plan, all persons insured are considered to be also covered under the health insurance plan of their province of residence in Canada. In no case may the amounts paid by SSQ be higher than those that would have been paid if the person was covered under the public insurance.

**Date the expenses were incurred** – Expenses must have been incurred while the person was insured under the dental care insurance plan. Expenses are considered to have been incurred on the date the services were provided.

**Customary and reasonable costs** – Expenses are eligible up to the rates suggested for the current period during which the care is provided by the following professional reference association: for the services of a general or specialist dentist, the association of general dentists for the province where the professional practices; for the services of a denturist, the association of denturists of the province where the denturist practices. However, eligible lab test expenses are limited to 50% of the fees detailed in the fee guide of the reference association for the treatment in question. In the absence of rates suggested by a reference association, the eligible expenses will be limited to reasonable amounts that uninsured persons must usually pay for the same services, taking into account the standards that according to SSQ must apply to the province where the dentist or denturist practices.

**Professional services** – To be eligible, the expenses related to care or treatments provided must be incurred for fees payable to general dentists or specialists. Expenses incurred for the fabrication of a denture by a person who is recognized as a member of the *Ordre des denturologistes du Québec* are also eligible under the contract.

## 5.3 DENTAL EXPENSES COVERED BY INSURANCE

**Current expenses** – The following dental care expenses are reimbursed at 80%.

**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) emergency examination: 2 examinations per calendar year

   iv) specific oral examination: 2 examinations per calendar year

   v) examination for children under age 10, if not covered under the RAMQ plan: one examination per period of 12 months

b) Radiographs

   i) intraoral films
      - periapical film
      - occlusal film
      - bitewing film

   ii) extraoral films
      - extraoral film
      - sinus examination
      - sialography
      - use of radiopaque dyes to demonstrate lesions
      - temporomandibular joint
      - panoramic film: one film per period of 36 months

   iii) cephalometric film

   iv) interpretation of X-rays from another source: one film per calendar year

   v) duplicate radiograph or file: 2 times per calendar year

c) Bacterial cultures to determine pathological agents

d) Biopsy of soft tissue or hard tissue

e) Cytological tests

   i) cytological smear from the oral cavity

   ii) vital staining of oral mucosal tissues for diagnosis

f) Diagnostic cast (excluded if associated with restorative services)
  i) unmounted
  ii) mounted
  iii) diagnostic wax-up
g) Diagnostic photographs

**Prevention and space maintainers**

a) Preventive services
  i) Polishing of coronal portion of teeth: one visit per period of 9 months
    - primary dentition
    - mixed dentition
    - permanent dentition
  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 covered)
  iv) Nutritional counselling: once per lifetime
  v) Oral hygiene instruction: once per lifetime
  vi) Oral hygiene reinstruction: once per lifetime
  vii) Plaque control program: 5 times per calendar year
  viii) Finishing restorations
  ix) Pit and fissure sealants: only for posterior permanent teeth of children aged under 14 and once per period of 36 months for the same tooth
  x) Topical application of an antimicrobial agent
  xi) Interproximal discing: 2 times per calendar year (only children under age 14 are covered)
  xii) Prophylactic odontotomy (included as part of pit and fissure sealants if done at the same visit)
b) Space maintainers (once per period of 24 months for a given replaced tooth - only children under age 14 are covered)
  i) Soldered lingual arch (bilateral)
  ii) Pontics tied to a lingual arch to replace missing incisors
  iii) Removable lingual arch – Ellis arch

iv) Stainless steel crown or band
   - band type, unilateral
   - stainless steel with attachments, unilateral
   - stainless steel crown or with intra-alveolar attachment

v) Space maintainer
   - removable acrylic
   - removable acrylic with teeth
   - pontic with acid link

**Minor restorative services** (The insurance covers a same surface or class on a same tooth and once per period of 12 months.)

a) Sedative filling

b) Sedative filling with use of a matrix band for retention and support

c) Recontouring and polishing of traumatized tooth

d) Non-bonded amalgam restoration

e) Bonded amalgam restoration

f) Composite restoration (the equivalent non-bonded amalgam is eligible when a claim is made for a composite restoration on molars)

g) Laboratory processed veneer for anteriors and premolars: once per period of 48 months per tooth (an X-ray is required to confirm the non-esthetic nature of the procedure.)

h) Chairside veneer application

i) Retentive pins

**Periodontal treatments**

a) Treatment of acute infection and other inflammation

b) Application or desensitizing agent

c) Periodontal surgery (except periodontal guided tissue regeneration)

d) Splint

e) Maryland type splints: once per period of 48 months for same tooth

f) Additional services

   i) minor occlusal equilibration: 3 times per calendar year

   ii) major occlusal equilibration: once per calendar year

   iii) periodontal appliance: once per period of 48 months

   iv) appliance repairs: once per period of 12 months

   v) appliance rebase

**Oral surgery**

a) Removal of erupted teeth (uncomplicated)

b) Complex surgical removal of erupted teeth, impacted teeth and roots

   i) Approval of the request by SSQ with supporting X-rays

c) Alveolectomy

d) Alveoloplasty

e) Osteoplasty

f) Tuberoplasty

g) Removal of hyperplasic tissue

h) Removal of excess mucosa

i) Extension of mucous folds

j) Surgical excision of cyst or tumor

k) Surgical incision and drainage

l) Reduction of fracture

m) Frenectomy

n) Dislocation of mandible

o) Treatment of salivary glands

p) Recovery of dental root or foreign body from antrum

q) Antrum lavage

r) Closure of oro-antral fistula

s) Hemorrhage control

t) Post-surgical treatment

**General services**

a) Palliative treatment of dental pain

b) Unusual time and responsibility required in addition to usual procedure

c) Local anaesthesia

**Restorative dental care** – The following dental care expenses are reimbursed at 50% for major restoration and fixed prosthodontics expenses and 60% for all other expenses.

**Major restoration and fixed prosthodontics**

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

b) Inlay: once per period of 48 months for same tooth

   i) gold

   ii) retentive pins for inlays and onlays

   iii) porcelain, ceramic or resin

c) Crowns: once per period of 12 months for same tooth

   i) preformed, stainless steel

   ii) plastic or other similar material

d) Individual crowns

   i) Acrylic processed

   ii) Gold and acrylic or acrylic processed to metal

   iii) Porcelain or ceramic

   iv) Porcelain processed to metal

   v) Precious or non-previous metal (full crown)

   vi) Crown, 3/4 - porcelain, ceramic or metal (precious or non-precious)

e) Cast post

f) Recementation of inlays, crown, veneer, post or broken tooth: 2 times per calendar year for same tooth

g) Prefabricated post

h) Prefabricated post with reconstruction

i) Reconstruction of tooth in preparation for crown

**Endodontics**

a) Endodontic emergency

   i) Pulpotomy

      - Opening through metal or porcelain crown

   ii) Emergency pulpectomy

      - primary tooth (including trepanning the crown)
      - permanent anterior and premolar tooth
      - permanent molar

- emergency open and drain, anterior and premolar tooth
- emergency open and drain, molar

b) Endodontic traumatism

   i) Relieving traumatic occlusion as a separate procedure

   ii) Reimplantation of avulsed tooth

   iii) Repositioning of traumatically displaced tooth

c) General endodontic treatment

   i) Preparation of tooth for treatment

   ii) Root canal treatment

   - 1 canal
   - 2 canals
   - 3 canals
   - 4 canals

   iii) Root canal retreatment

d) Apexification

   i) 1 canal

   ii) 2 canals

   iii) 3 canals

e) Endodontic surgery

   i) Apicoectomy

   ii) Retrofilling (separate procedure from root canal)

   iii) Root amputation

   iv) Hemisection

   v) Intentional reimplantation

   vi) Endo-osseous implants for root stabilization

**Removable dentures**

a) Complete dentures

   i) complete dentures

   ii) immediate dentures

   iii) immediate transitional dentures

   iv) overdenture

b) Partial removable dentures (expenses for equilibrated dentures are eligible based on the cost of normal equivalent dentures.)

   i) Partial immediate dentures, permanent or transitional

   ii) Partial dentures with cast

   iii) Partial dentures with precision attachments

   iv) Semi-precision cast partial dentures

   v) Impression

   vi) Remake of partial dentures: once per period of 48 months) prothèse partielle avec base coulée

   vii) Denture adjustments

   viii) Remount and equilibration of complete or partial dentures

**Rebase, reline and repair of removable dentures**

a) Repairs with or without impression

b) Structure additions to partial dentures

c) Rebase, reline

d) Temporary therapeutic tissue conditioning

e) Resetting of denture teeth

**Fixed bridges**

a) Pontics [except acrylic during healing (transitional) and temporary acrylic, acid etched bonded to adjacent teeth]

b) Butterfly bridge (Maryland, Rochette or other)

c) Californian bridge

d) Abutment [Except acrylic, transitional during healing and rententive bar secured to implants to retain removable dentures]

e) Precision attachment

f) Retentive pins for crown and abutment

**Repair of fixed bridges** - Repairs (except for removal of a bridge needing replacement, per unit of abutment)

## 5.4 EXCLUSIONS, LIMITATIONS AND RESTRICTIONS APPLYING TO DENTAL CARE INSURANCE

When a less expensive treatment than the one received by the insured would have given appropriate results, the calculation of eligible expenses can be done using the least expensive treatment, while taking into account the applicable rate in accordance with the provisions of the dental care insurance plan.

The dental care insurance plan does not cover the procedures, treatments or prostheses, regardless of their nature, that are linked to an implant.

No reimbursement is carried out under the dental care insurance plan for the following:

a) Dental care received for aesthetic purposes, when the form and function of teeth is satisfactory and no pathological state exists.

b) Dental care aiming the reconstitution of the entire mouth, the correction of vertical space, occlusal restoration or the correction of temporomandibular joint dysfunction or permanent melding of teeth.

c) Expenses incurred for appointments that the insured person does not keep and expenses incurred for filling out benefit claims or for telephone consultations.

d) Expenses related to the replacement of dentures or devices that were lost or stolen.

e) Dental care that has not yet been approved by the Canadian Dental Association or that is given for experimental purposes only.

f) The services, care or products that the person received free of charge or for which coverage is forbidden.

g) Eligible expenses that are directly or indirectly the result of one of the following:

   - Injuries that the insured self-inflicted intentionally, regardless of the insured's state of mind.
   - A breach or attempt to breach the Criminal Code, except in cases where the only infraction was driving a motorized vehicle under the influence.
   - A case for which expenses are eligible for a reimbursement under the Act respecting industrial accidents and occupational diseases or under any other legislation or public plan.
   - A war, whether declared or not; participation in the armed forces of a country, a riot, an insurrection or popular unrest.

h) When the word "Sextant" or "Quadrant" is used to describe treatments in the appropriate guide for the health professionals association of reference, the codes corresponding to these treatments are limited to 6 sextants and 4 quadrants, respectively, per calendar year per insured.

i) When benefits have been paid for a prosthesis (individual crown, cast post, prefabricated post, removable dentures or fixed bridge), no replacement prosthesis is eligible for benefits if it is installed within 48 months following the installation of the previous one. However, expenses for a permanent removable denture, partial or full, are eligible for reimbursement if it replaces a transitional removable denture (partial or full) and is installed within six (6) months of the date the transitional denture was installed.

j) If more than one person is participating in the same treatment as a dentist or denturist, the benefits SSQ pays are limited to those it would have paid if the entire treatment had been provided by a single person.

### 5.5 PRIOR ASSESSMENT

If the cost of a treatment is expected to exceed $500, the insured may ask the person performing the procedure to complete an evaluation and send it to SSQ. The evaluation of the treatment must include the results of the orodental examination and the care required for the treatment of the ailment, as well as the fees requested by the person performing the procedure.

## 6. HOW TO MAKE A BENEFIT CLAIM

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

**Use SSQ's electronic services and be reimbursed within 48 hours!**

**It's easy:**

1. Complete your registration on the **Customer Centre** website at **customer-centre.ssq.ca**.
2. When registering, have your insurance card on hand, as well as a personal cheque showing your bank account number, in order to register for direct deposit.
3. Submit your claims online, using the **Customer Centre** website, or downloading the free **SSQ Mobile Services (ssq.ca/mobile)** application on your smartphone.
4. Receive your reimbursement **within 48 hours***!

**In addition, take advantage of many other features available in your Customer Centre:**

- Simulate claims to ascertain the eligibility of expenses
- Consult benefit statements
- Order statements for tax return purposes
- Print additional SSQ insurance cards
- Make a change of address
- Confirm that a dependent child is still eligible
- Change beneficiary designations
- Find information on Travel Insurance and Trip Cancellation Insurance and on Life Insurance for retirees and their spouses.

**And more!**

* To obtain reimbursement within 48 hours, you must be registered for direct deposit. 48-hours reimbursement is available for most types of health care expenses.

## 6.1 HEALTH INSURANCE

**Hospital**

For hospital expenses incurred in Canada, insureds present their SSQ Card at the hospital.

**Prescription drugs**

Two distinct claim methods are available for the reimbursement of prescription drug expenses and the insured may choose one of these methods.

### 6.1.1 Direct payment card

The electronic claim transmission service allows benefit claims for prescription drugs to be transmitted directly from the pharmacy to SSQ.

Insureds must present their SSQ Card to the pharmacist when purchasing prescription drugs. If the drug purchase is eligible for reimbursement, the insured person only needs to pay the amount not covered under the health insurance plan, as SSQ reimburses the rest directly to the pharmacist. The pharmacist is obligated to invoice the usual and standard price, which is the same price charged to any other client.

**Electronic coordination of benefits at the pharmacy**

If an insured person is covered under two group insurance plans that each provide prescription drug insurance coverage (double insurance) with a direct payment, the insured can present both cards to the pharmacist so that the benefits can be coordinated at the time of purchase.

First use

When participants who have a single-parent or family coverage status first use their SSQ Card for a member of their family, the pharmacist must complete the file by entering the first name and date of birth of the insured. SSQ recommends that the participant provide the pharmacist with this information, if not already recorded in the file. This information will remain confidential. Proof of age may be required by the pharmacist, which can be done by presenting the card of the *Régie de l'assurance maladie du Québec* (RAMQ).

Dependent children: Full-time students aged 18 to 25, inclusive

Prescription drug expenses for dependent children aged 18 to 25 inclusive, who are full-time students are covered upon presentation of a statement of school attendance. Submitting claims electronically eliminates the need to complete a declaration of school attendance on the back of each claim stub.

A declaration of school attendance must be provided to SSQ once every school year (September 1 to August 31) to enable prescription drug claims to be processed directly at the pharmacy. This declaration may be submitted on line via the Access | Plan Members site, by contacting SSQ Customer Service, or by writing to SSQ at the address provided in section 6.10.1. SSQ reserves the right to request a declaration of school attendance. If SSQ does not receive this document before September 1, a message will appear on the receipt issued by the pharmacist when the drug is purchased.

**6.1.2 By mail**

Insureds who are unable to use their SSQ insurance card (lost or stolen card or the pharmacist doesn't participate in the electronic claims transmission service) can submit a benefit claim to SSQ by mailing the appropriate form, which is available on SSQ's secure site for insureds at ssq.ca.

Pharmacy receipts must indicate 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 and they must be duly paid.

Drugs supplied by the physician where this practice is legally authorized are also eligible upon presentation of invoices indicating the name and quantity of the drugs.

We recommend that originals of paid invoices be submitted **every 3 months**. The invoices will not be returned. The insured must therefore keep copies. **All claims submitted more than 12 months after the expenses were incurred will not be reimbursed**. The use of the SSQ Card for prescription drug purchases helps insureds avoid the risk of invoices being submitted late.

SSQ's mailing address is indicated in section 6.10 "Contact us".

**Other health insurance expenses**

All other health insurance expenses must be submitted by the participant directly to SSQ.

Many health insurance expenses can be submitted online on the secure site for insureds. The participant may also submit a benefit claim using a smart phone with the SSQ Mobile Services application.

A benefit claim may also be submitted by mailing the appropriate form, which is available on SSQ's secure site for insureds at ssq.ca. The invoices must be paid and originals must be attached to the claim.

The invoices will not be returned. The insured must therefore keep copies. **All claims submitted more than 12 months after the expenses were incurred will not be reimbursed**.

All claims and correspondence must include your contract number and be sent to the following address:

**Note**: The contract number, the patient's name, the dates of visits or treatments received, and the name, address and professional association membership number of the practitioner consulted must always be provided. If the patient is a dependent child who is a full-time student, the back of the claim stub must also be completed.

SSQ's mailing address is indicated in section 6.10 "Contact us".

### 6.1.3 Hospital or medical expenses resulting from a workplace or traffic accident

In the case of a workplace or automobile accident, all medical and hospital expenses incurred following this accident may be reimbursed by the *Commission des normes, de l'équité, de la santé et de la sécurité du travail* (CNESST) or the *Société de l'assurance automobile du Québec* (SAAQ). These expenses must be submitted to the CNESST or the SAAQ and not SSQ.

## 6.2 TRAVEL ASSISTANCE INSURANCE AND TRIP CANCELLATION INSURANCE

For information about travel assistance insurance or trip cancellation insurance benefit claims, participants can consult the document titled "Travel assistance insurance and trip cancellation insurance", available in electronic version on SSQ's secure site for insureds.

## 6.3 DENTAL CARE INSURANCE

Insureds must present their SSQ insurance card at the dentist's office and pay the portion of expenses not covered by SSQ. If the dentist does not offer an electronic claim transmission system, the insured must complete the *Dental Care Insurance Benefit Claim* form (FDEN121A), sign it and return it to SSQ at the address indicated in section 6.10 "Contact us".

To obtain reimbursement for covered dental treatment, insureds may also submit a claim using a duly completed and signed form provided by the dentist.

Thereafter, the insured can either submit the claim online on SSQ's secure site for insureds or send it by mail at the address indicated in section 6.10 "Contact us".

## 6.4 DIRECT DEPOSIT OF HEALTH AND DENTAL CARE INSURANCE BENEFITS

Direct deposit enables you to obtain reimbursement of your claims more quickly and eliminates any risk of loss or theft of your benefit cheques.

You may register for direct deposit on SSQ's secure site for insureds. When registering, be sure to have your SSQ Card on hand, as well as a personal cheque showing your bank account number. Section 6.9 of this booklet provides more information about SSQ's online services.

If you do not have access to the Internet, or if you require assistance in any way, contact SSQ Customer Service at one of the numbers provided in section 6.10 "Contact us".

## 6.5 PARTICIPANT'S AND DEPENDENT'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 about obtaining the form required and how to submit a claim, please refer to section 6.10 "Contact us".

## 6.6 LONG TERM DISABILITY INSURANCE

Claims for long term disability insurance benefits must be submitted to SSQ 90 days before the expected benefit start date.

To do so, participants must complete and submit to SSQ the disability claim form, available from the employer or from SSQ.

Participants must submit the claim form even if they receive disability benefits under another plan (for example, CNESST, Retraite Québec).

## 6.7 CHANGE OF ADDRESS

Participants must inform SSQ of any change of address. To do so, you may contact SSQ Customer Service at the address or telephone numbers indicated in section 6.10 "Contact us", or you may change your address yourself online if you are registered to use SSQ's secure site for insureds. Section 6.9 of this booklet provides more information about SSQ's online services.

## 6.8 PROTECTION OF PERSONAL INFORMATION

Notice of new file creation

To maintain the confidentiality of information concerning each person it insures, SSQ, Life Insurance Company Inc. opens an insurance file to contain personal information about the insurance application and about 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, underwriting and claim requests processing, as well as reinsurers and any other person authorized by the insured person. SSQ keeps these insurance files in its offices.

Insureds 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 for information 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 legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned, in particular, for processing most prescription drug, dental care and travel insurance claims. SSQ's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When you apply for a group insurance plan, and also when you make a claim (e.g. when you use your prescription drug insurance card), you are actually giving your consent that the insurer and its legal agents and service providers may use your personal information for the above-mentioned purposes. It is understood that not giving this consent would compromise the processing of your insurance file and the quality of the services SSQ can offer you.

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

Insurance document

If the contract is modified after the production date of the present document, there may be wording differences between the present document and the contract. If so, the contract wording prevails. Participants are entitled to consult the contract at the policyholder's address and obtain a copy thereof.

### 6.9 SSQ ONLINE SERVICES

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

- Register for direct deposit of health insurance, dental care insurance and disability insurance benefits
- Consult an electronic claim statement online
- Print a health insurance or dental care insurance benefit claim form
- Order tax receipts for medical expenses incurred
- Print a temporary SSQ Card if the existing card has been lost or stolen
- Change or update your address
- Print the form required for exception drug claims
- Submit a declaration of school attendance
- View and make changes to the designated life insurance beneficiary
- View the coverage included in your file
- View the balance remaining for the coverage involved.

To register and benefit from the various advantages offered by SSQ's online services, simply go to **www.ssq.ca**. Then, click on the link in the group insurance area of the site. Online instructions will guide you through the registration process.

## 6.10 CONTACT US

### 6.10.1 By mail

Please indicate your contract number on all claims and any other correspondence sent to SSQ at the following address:

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

### 6.10.2 By telephone

Insureds can contact SSQ Customer Service between 8:30 a.m. and 4:30 p.m., Monday to Friday, at the following telephone number:

- **Montreal region: 514-223-2500**
- **Other regions: 1-888-651-8181**

### 6.10.3 By fax

At 418-652-2739

### 6.10.4 By Internet

By consulting SSQ's Web site at **www.ssq.ca**. Go to the *Group Insurance* section of the site, click on *Contact Us* and then click on the *Contact us by e-mail* link. Then, simply write a message and one of our Customer Service agents will get back to you as soon as possible.

# 7. WHAT TO DO WHEN YOU RETIRE

When the participant retires, he or she may maintain the following coverage:

## 7.1 BASIC LIFE INSURANCE

Participants who are insured under the basic life insurance plan at the time of retirement are eligible for an amount of $10,000 in life insurance (with payment of premiums) as of the date of their retirement. SSQ will then send the appropriate documentation indicating the steps to follow. Participants can also obtain a pamphlet from their employer.

## 7.2 "SSQ PRIVILEGE PRODUCTS" INDIVIDUAL INSURANCE

Any person insured under this contract may keep their health insurance coverage (excluding prescription drug coverage) and dental care insurance coverage, if applicable, in a distinct individual contract, premiums of which are payable directly to SSQ, provided the participant makes a request in writing to SSQ within 31 days following the date of retirement.

As soon as SSQ is informed of the participant's date of retirement, Customer Service will mail the documents and information required to register for the SSQ Privilege insurance plan.

Insureds must register for the Basic Prescription Drug Insurance Plan administered by RAMQ for the reimbursement of eligible prescription drug expenses on the date of the participant's retirement. An online electronic registration system is also available from RAMQ. Simply go to **www.ramq.gouv.ca**.

SSQ Privilege offers an entire line of individual insurance products to meet your various coverage needs. For more information, please contact SSQ Customer Service at **1-866-777-0711**.

## 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
Tel.: 1-888-651-8181

**ssq.ca**


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