SSQ Financial Group

Values in the right place

CSQ GROUP INSURANCE PLAN

For members of unions affiliated with the Centrale des syndicats du Québec (CSQ)

Contract J9999 • January 2015

CSQ

In this booklet, SSQ designates SSQ, Life Insurance Company Inc.

This booklet is provided for information purposes only and in no way alters the stipulations and conditions of the group insurance contract in force on January 1, 2015.

Cette brochure est également disponible en français.

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1- GENERAL INFORMATION

1.1 Definitions

1.1.1 Dependent child

- A child of the employee, of the spouse, or of both;
- A child living with the employee and for whom legal procedures of adoption have been undertaken; or
- A child for whom the employee or the spouse has parental authority (or would if the child was a minor).

In all three cases, the child must be neither married nor civilly united, must reside or live in Canada, depend on the employee for support and meet one of the following criteria:

a) be less than eighteen 18 years old;

b) be under 26 years of age and attend a recognized educational institution as a duly registered full-time student.

A dependent child who is between the ages of 18 and 25 inclusive, who takes an extended leave from studies, may retain the status of dependent so long as the following conditions are met:

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

The sabbatical school leave is granted only once per lifetime for every dependent child. The leave may not exceed 12 months, subject to eligibility for the *Régie de l'assurance maladie du Quebec* (RAMQ), and must end at the beginning of a school year or term (September or January);

c) Regardless of her/his age, became totally disabled at a time when she/he met one of the above conditions and has remained continuously disabled since that date. Any person suffering from a functional deficiency, as defined in the regulation on the Prescription Drug Insurance Plan (PDIP), is also considered to be totally disabled.

1.1.2 Total disability

Plan A - Long Term Disability Insurance:

A state of incapacity resulting from an illness, including surgical procedures directly related to family planning, an accident or complication of a pregnancy, requiring medical care and which, **during the first 48 months** of disability, completely prevents the employee from carrying out the normal duties of the employment or any comparable employment with similar remuneration offered to the employee by the employer and, after the first 48 months of disability, completely prevents the person from carrying out any remunerative work for which the individual is reasonably prepared as a result of education, training and experience.

Plan B - Long Term Disability Insurance:

A state of incapacity resulting from an illness, including surgical procedures directly related to family planning, an accident or complication of a pregnancy, requiring medical care and which completely prevents the person from carrying out the normal duties of employment or any comparable employment with similar remuneration offered to the employee by the employer.

1.1.3 Total disability period

Any continuous period of total disability or successive periods of total disability resulting from a same illness or accident and separated by less than 22 consecutive days of effective work at full pay and availability for such work (this period of 22 consecutive days is replaced by a period of 8 consecutive days if the continuous period of disability preceding the return to work is lesser than or equal to 3 calendar months). Any total disability resulting from an illness or accident completely independent of the illness or accident which caused the preceding total disability is considered to be a new period of total disability.

For the following personnel, the above-mentioned period of 22 consecutive days is replaced as follows:

- **school boards teachers:** period of 35 consecutive days;
- **school boards support personnel:** period of 32 consecutive days;
- **school boards professional personnel:** period of 35 consecutive days;
- **Cégep teachers:** period of 32 consecutive days;

- **Cégep support personnel:** period of 32 consecutive days;
- **employees in the Health and Social Services sector**: period of 15 consecutive days if the total disability period lasts less than 78 weeks and period of 45 consecutive days if the total disability period lasts 78 weeks or more.

Any period during which a participant is on preventive pregnancy-related leave approved by the CSST is not recognized as a period of total disability for the purposes of this plan.

1.1.4 Dependent

Persons who are dependent on the employee are: the spouse and dependent children or, as the case may be, the spouse or dependent children.

1.1.5 Participant

Any employee participating in the group insurance plan.

1.1.6 Insured

The participant or the participant's dependents who are eligible for insurance.

1.1.7 Spouse

The person who so became following a marriage or civil union legally contracted in Quebec or elsewhere and recognized as valid under Quebec law, or following more than a year of **permanent** cohabitation with the participant (no minimum period is required in cases where a child has been born of the union or legal adoption procedures have been undertaken) with a person of the same sex or of different sex presented openly as the spouse.

Dissolution of the marriage or civil union by divorce or annulment causes the status of spouse to be forfeited as does de facto separation for more than 3 months in the case of a common law union (marriage not legally contracted).

The designation of a new spouse becomes effective as soon as we are notified of the change, at which time the coverage of the person previously designated as spouse is terminated.

Please inform SSQ in writing of any change related to your spouse so that we may correct the insurance file if necessary.

1.1.8 Employee

Any person who is subject to a national agreement or a collective working agreement concluded with a union affiliated with the CSQ or a service agreement and who belongs to one of the following categories:

- teaching personnel in the employ of a school board or Cégep;
- professional and support personnel of a school board or Cégep;
- personnel of the Health and Social Services sector;
- personnel who are part of any other group acknowledged by the policyholder.

The applicable national agreement or collective agreement determines the eligibility criteria for the CSQ group insurance plan.

1.1.9 Coverage status

The **individual** status covers the employee only.

The **single-parent** status covers the employees and their dependent children.

The **family** status covers the employees and their spouse and dependent children, if any.

1.1.10 Annual earnings (for insurance purposes)

Remuneration in current money calculated on an annual basis, in accordance with the applicable collective agreement, including premiums for regional disparities and any salary retroactivity but excluding any bonus, payment of overtime and severance pay. This remuneration is based on the annual salary used for calculating benefits of the disability insurance plan provided for in the collective agreement.

For any part-time employee, the salary is calculated in proportion to the time worked compared to a regular work week for a full-time employee. However, for a part-time teacher, the salary is calculated in proportion to the teaching workload the person assumes compared to the individual workload of a full-time teacher.

In all cases, the annual earnings used for contribution of premium purposes is the one given above, while the annual earnings used to establish benefits is also the one given above, without however going below $14,400.

For employees in the **Health and Social Services sector**, this definition is replaced by the one given in section 1.15.2 b).

For **support personnel of a school board working in the adult education sector**, this definition is replaced by the one given in section 1.15.3 d).

1.1.11 Monthly earnings (for insurance purposes)

1/12 of the annual earnings, even for employees who receive their annual earnings over a period of 10 months.

1.2 Eligibility for Insurance

1.2.1 Eligibility of the employee

Employees are eligible for all insurance plans as of the date they become an employee according to the provisions of the applicable national agreement or collective agreement.

Employees in the Health and Social Services sector working at 25% or less of full-time who do not participate in the insurance plans in accordance with the provisions of the national agreement are only eligible for the Health 1 Plan.

1.2.2 Eligibility of dependents

All dependents become eligible for the insurance plans which include coverage for dependents on the same date the employee became eligible, provided they were a dependent on that date. Otherwise they become eligible on the date they become a dependent of the employee.

1.2.3 Particulars regarding the Dental Care Plan

a) *Eligibility*

Employees whose Dental Care Plan is in force in the group they belong to are eligible for the Dental Care Insurance Plan.

b) *Implementation and maintenance of the Plan*

For the Dental Care Plan to become effective in a group, the members must take a vote.

- If the rate of enrolment of eligible employees in a group is of at least 40%, the plan will become effective for this group on the January 1 of the following year.
- If the rate of enrolment of eligible employees in a group is lower than 40%, the plan will not become effective for this group. A new vote cannot be taken for the next 12 months.

For all groups who vote in favour of the plan:

The plan must remain in force for at least 48 months.

A survey of participation rates will be carried out for each group on April 1 of each year:

- If the participation rate is of at least 40%, the plan will be maintained in this group.
- If the participation rate is lower than 40%, the survey will be repeated in September:
  - If at the beginning of November, the participation rate following the second vote is of at least 40%, the plan will be maintained in this group;
  - If at the beginning of November, the participation rate following the second vote is below 40%, the plan will be terminated in this group on December 31 following the date of the second vote.

1.2.4 Particulars regarding the Long Term Disability Insurance Plan

a) *Eligibility*

Employees who are covered under the Disability Insurance Plan in the collective agreement or by a Short Term Disability Insurance Plan are eligible for the Long Term Disability Insurance Plan.

b) *Implementation of the Plan*

Participants will be granted the Long Term Disability Insurance Plan chosen by their union (either Plan A or Plan B) in accordance with section 1.1.2.

Once the union has made the choice in accordance with the rules of participation described in section 1.3.3, all eligible employees must participate in the plan. Employees cannot participate in a plan that was not chosen by the union they belong to.

The choice made by the union between Plan A or B is irrevocable until the January 1 following a period of 36 months after the effective date of the chosen plan.

Regardless of the above, employees who are members of a union that decides to leave the CSQ, terminate its service agreement with the CSQ, or change its union allegiance under the provisions of the law, are only eligible for Plan A. For individuals who were covered under Plan B, Plan A will become effective on the first day of the pay period that coincides with or follows a period of 30 days after the date a written notice to this effect was issued by the policyholder to SSQ.

1.3 Participation in Insurance

To inform SSQ of the plans they wish to participate in or to be exempted from, employees may obtain an "Application/Request for Change" form available through their employer, complete it, and return it to their employer, who will send the completed form to SSQ.

1.3.1 Health Insurance Plan

a) *Compulsory feature*

All employees eligible for the Health Insurance Plan **must** participate in it, unless they are entitled to an exemption as described in section 1.3.1 b).

All eligible employees must participate in one of the 3 following health insurance plans:

- Health 1 Plan; or
- Health 2 Plan; or
- Health 3 Plan.

Important

The minimum duration of participation* is 12 months for the Health 2 Plan and 24 months for the Health 3 Plan.

Minimum duration of participation

The above-mentioned minimum duration of participation of 12 or 24 months is not interrupted by a leave without pay or a period following a layoff or end of contract, provided the participant decides to maintain participation in the Health 1 Plan only (according to what is stipulated in sections 1.9.1 and 1.11.1).

In Quebec, if employees are not covered by an insurance plan through their spouse or someone else, they are obligated to be insured under the CSQ Health Insurance Plan. Also, if their spouse and dependent children are not insured under another Group Insurance Plan that includes prescription drug coverage, they must also be insured under the CSQ Health Insurance Plan.

When you turn 65:

You will maintain all of your coverage under the CSQ Health Insurance Plan, including prescription drugs, with no change in premiums.

When your insured spouse turns 65:

You must inform SSQ Customer Service of your wish to continue to cover your spouse aged 65 for all coverage offered under the CSQ Health Insurance Plan, including prescription drugs, with no change in premiums.

IMPORTANT:

In both situations, because all Quebec residents who reach age 65 are automatically registered for the Basic Prescription Drug Insurance Plan of the *Régie de l'assurance maladie du Québec* (RAMQ), you and your spouse, as the case may be, must contact the RAMQ in order to opt out of this plan to avoid paying premiums.

b) *Right to exemption*

Employees can choose not to participate or terminate their participation in the Health Insurance Plan provided they prove that they are insured under another Group Insurance Plan which includes similar coverage.

As such, participants who are covered under either the Health 2 or Health 3 Plans can choose to be exempted even if the minimum duration of participation of 12 or 24 months has not been completed.

The exemption entitlement becomes effective on one of the following dates:

- For newly eligible employees, if the employer receives the request for exemption within 30 days following the date of eligibility:

  The exemption will become effective retroactively on the date of eligibility.

- For other employees, if the employer receives the exemption request within the 30 days following the beginning of the insurance that allows the exemption:

  The exemption will become effective retroactively on the date the insurance allowing the exemption began.

- If the employer receives the exemption request more than 30 days after the date of eligibility or the beginning of the insurance that allowed the exemption:

  The exemption becomes effective on the first day of the pay period following the date SSQ receives the request.

c) *Termination of exemption*

Employees exempted from participation in the Health Insurance Plan who prove that they are no longer eligible for the Group Insurance Plan having allowed the exemption may resume participation in the Health Insurance Plan on the following conditions:

- If the employer receives the request to terminate the exemption within 30 days following the end of the eligibility to the Group Plan having allowed the exemption:

  The employee may then choose the plan that meets their needs (Health 1, Health 2 or Health 3) with the desired coverage status (individual, single-parent or family). The insurance under the plan chosen will become effective on the date of termination of the insurance having allowed the exemption.

- If the employer receives the request to terminate the exemption more than 30 days after the end of the eligibility to the Group Plan having allowed the exemption:

  The Health 1 Plan becomes effective on the first day of the pay period following the date SSQ receives the request, according to the desired coverage status (individual, single-parent or family).

  Participation in the Health 2 Plan or Health 3 Plan requires evidence of insurability. The insurance under these plans becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

1.3.2 Dental Care Plan

a) *Optional feature*

Participation in this Plan is optional for all employees eligible to the Dental Care Plan and who belong to a group* in which this Plan is in force.

* These groups are formed by SSQ and consist of a 5-digit character beginning with the letter J (e.g. J9120). The first four characters identify the group name for plan eligibility purposes. This number is often associated with a union, association or establishment and appears on the participant's insurance certificate.

b) *Minimum duration of participation*

The minimum duration of participation for the participant in the Dental Care Plan is 48 months.

However, participants may terminate their participation before the end of this 48-month period if they provide proof to SSQ that they are covered under another group insurance plan with dental care coverage. Afterwards, if they wish to participate in the Dental Care Plan once again, a new minimum duration of participation of 48-months will begin as of the date the coverage comes in to force. The minimum duration of participation is not interrupted during leave without pay or consecutive periods following a layoff or end of contract when participants choose to maintain the Health 1 Plan only (as stipulated in sections 1.9.1 and 1.11.1). Participation in insurance may be reinstated after an interruption if the Dental Care Plan is still in force for the group to which the participant belongs on the date they return to work.

1.3.3 Long Term Disability Insurance

a) *Compulsory feature*

Participation is compulsory for all employees who are eligible for the Long Term Disability Insurance Plan, subject to the right to opt out described in section 1.3.3 b) hereinafter.

After a temporary absence from work during which participation in this Plan has not been maintained, participants will be covered under Plan A or B, depending on what plan is applicable to the union to which they belong.

b) *Right to opt out*

Employees may refuse or cease to participate in the Long Term Disability Insurance Plan if one of the following criteria is met:

- exclusive participation in the *Régime de retraite des enseignants* (RRE), the *Régime de retraite des fonctionnaires* (RRF) or the *Régime de retraite de certains enseignants* (RRCE);
- participation in the *Régime de retraite des employés du gouvernement et des organismes publics* (RREGOP) with 33 years of service or more;
- age 53 or older;
- membership in professional corporation with coverage under a long term disability insurance plan offered by this professional corporation as long as the coverage is equivalent to that provided by the CSQ Long Term Disability Insurance Plan;
- signature of a leaving agreement regarding retirement (without possibility of return) as long as the date of waiver and the date of leaving are separated by a period of 2 years or less.

If employees wish to take advantage of their right to opt out, they must send to SSQ, through their employer, the completed "Long Term Income Replacement Insurance Plan Waiver privilege" form. The waiver becomes effective on the first day of the pay period following the date SSQ receives the request.

Important

If you take advantage of the waiver privilege, you cannot reinstate your participation in the Long Term Disability Insurance Plan afterwards, with or without evidence of insurability.

However, if you have opted out of the Long Term Disability Insurance Plan but are rehired, you must complete another "Long Term Income Replacement Insurance Plan Waiver privilege" form and send it to SSQ.

1.3.4 Life Insurance Plan

a) *Compulsory with right to opt out*

Participation in Participant's Life Insurance is compulsory for a minimum coverage amount of $10,000 for all employees who are eligible for the Life Insurance Plan, unless they use their right to opt out as described in section 1.3.4 b) below.

Coverage for amounts greater than $10,000 for Participant's Life Insurance as well as coverage under other life insurance benefits is optional.

At the time of application, the individual can choose one of the following coverage options:

- Participant's Life Insurance (coverage amount in excess of the minimum amount of $10,000);
- Dependent's Basic Life Insurance;
- Participant's Life Insurance (coverage amount in excess of the minimum amount of $10,000) and Dependent's Basic Life Insurance;
- Dependent's Basic Life Insurance and Spouse's Optional Life Insurance;
- Participant's Life Insurance (coverage amount in excess of the minimum amount of $10,000), Dependent's Basic Life Insurance and Spouse's Optional Life Insurance.

b) *Right to opt out*

Participants have a maximum of 180 days, as of the date the $10,000 coverage in Participant's Life Insurance automatically granted becomes effective, to make a request to opt out.

If the employer receives the request to opt out:

i) Within 30 days following the date the coverage amount became effective:

   Participant's Life Insurance will cease on the date it becomes effective.

ii) After more than 30 days, but less than 180 days after the coverage amount became effective:

   Participant's Life Insurance will be terminated on the first day of the pay period following the date the employer receives your request.

iii) More than 180 days after the coverage amount became effective:

   The minimum coverage amount of $10,000 in Participant's Life Insurance coverage remains in force.

1.4 Effective Date of Coverage Under Each Plan

In order for coverage under each Plan to become effective on the dates that appear in the table below, employees must be at work or be capable of performing the regular duties of the job at this date; otherwise, the insurance will become effective on the date of their return to work or on the January 1 following the date of their return to work for the Dental Care Plan when the application request is received by the employer more than 30 days following their date of eligibility.

For newly hired participants who sign a contract of employment after the date on which the individual becomes eligible (contract with retroactive effect), the 30-day and 180-day periods indicated in the table below begin on the date the employment contract is signed.

1.4.1 Date the insurance becomes effective under the Health Insurance, Dental Care Insurance and Long Term Disability Insurance Plans

	Date the application for insurance is received by the employer	
Plan	**Within 30 days following the date of eligibility**	**More than 30 days after the date of eligibility**
Health Insurance	The Health Insurance Plan chosen (Health 1, Health 2 or Health 3) will become effective on the date of eligibility, according to the requested coverage status (individual, single-parent or family). For employees who requested to be exempted from participation in the Health Insurance Plan, the exemption will become effective on the date of eligibility.	By default, the Health 1 Plan is granted with an individual coverage status as of the date of eligibility. a) Employees who requested a single-parent or family coverage status, the coverage status will be granted under the Health 1 Plan as of the first day of the pay period following the date SSQ receives the request; b) Employees who requested to be exempted from participation in the Health Insurance Plan, the exemption will become effective on the first day of the pay period following the date SSQ receives the request; c) Employees who requested the Health 2 or Health 3 Plan are required to present evidence of insurability, and the insurance will become effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

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	Date the application for insurance is received by the employer	
Plan	**Within 30 days following the date of eligibility**	**More than 30 days after the date of eligibility**
Dental Care Insurance	The Dental Care Plan will become effective on the date of eligibility, according to the requested coverage status (individual, single-parent or family).	The insurance will become effective on January 1 of the year following the date the request is received by SSQ, with the requested coverage status (individual, single-parent or family).
	Note: The coverage status (individual, single-parent or family) may be different than the one chosen for the Health Insurance Plan. **An employee who is exempted from the Health Insurance Plan can still participate in the Dental Care Plan.**	
Long Term Disability Insurance	The insurance becomes effective on the date of eligibility.	

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1.4.2 Date the Life Insurance Plan becomes effective

	Date the application for insurance is received by the employer		
Coverage	**Within 30 days following the date of eligibility**	**More than 30 days but less than 180 days after the date of eligibility**	**More than 180 days after the date of eligibility**
Participant's Life Insurance	A $10,000 coverage amount becomes effective on the date of eligibility, with a right to opt out. Participants may increase this $10,000 coverage amount to $25,000 or $50,000 without evidence of insurability. The amount of insurance becomes effective on the date of eligibility. Coverage amounts greater than $50,000 are subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the pay period following the date SSQ approves the required evidence of insurability.	A $10,000 coverage amount becomes effective on the date of eligibility, with a right to opt out. Participants may increase this $10,000 coverage amount to $25,000 or $50,000 without evidence of insurability. The new amount of insurance becomes effective on the first day of the pay period following the date SSQ receives the request. Coverage amounts greater than $50,000 are subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the pay period following the date SSQ approves the required evidence of insurability.	A $10,000 coverage amount becomes effective on the date of eligibility. Coverage amounts greater than $10,000 are subject to the presentation of evidence of insurability. Any amount in excess of $10,000 becomes effective on the first day of the pay period following the date SSQ approves the required evidence of insurability.

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	Date the application for insurance is received by the employer		
Coverage	**Within 30 days following the date of eligibility**	**More than 30 days but less than 180 days after the date of eligibility**	**More than 180 days after the date of eligibility**
Dependent's Basic Life Insurance	The insurance is available without evidence of insurability and becomes effective on the date of eligibility.	The insurance is available without evidence of insurability and becomes effective on the first day of the pay period following the date SSQ receives the request.	The insurance becomes effective on the first day of the pay period following the date of acceptance of the evidence by SSQ.
	Note: Employees may participate in Dependent's Basic Life Insurance even if they opt out of Participant's Life Insurance.		
Spouse's Optional Life Insurance	The insurance is available only if Dependent's Basic Life Insurance is in force. Participants may request 1 to 10 units of $10,000 in Life Insurance. This insurance is subject to the presentation of evidence of insurability and becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ		

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1.5 Change in Coverage

1.5.1 Increase in coverage status

a) *Health Insurance and Dental Care Insurance Plans*

Participants may increase their **coverage status** in the following manner:

- change from an individual coverage status to a single-parent or family coverage status;
- change from a single-parent coverage status to a family coverage status.

The increase in coverage status can only be granted following the acknowledgement of new dependents due to one of the events listed below:

- marriage, civil union, separation or divorce;
- cohabitation for more than a year (there is no minimal period if a child is born of the union or if legal adoption procedures have been undertaken);
- birth or adoption of a child;
- termination of the insurance of the spouse or dependent children.

To do so, the participant must complete the "Application/ Request for Change" form and send it to the employer.

The coverage status chosen by the participant for the Health Insurance Plan may be different than the one chosen for the Dental Care Insurance Plan, if applicable.

Effective date of new coverage status

Health Insurance Plan

i) If the employer receives the "Application/Request for Change" form within 30 days following the date of acknowledgement of new dependents

The new coverage status becomes effective at the date of the event.

ii) If the employer receives the "Application/Request for Change" form more than 30 days after the date of acknowledgement of new dependents

The new coverage status becomes effective on the first day of the pay period following the receipt of the request by SSQ.

Please note that the new coverage status only becomes effective on the dates specified above if:

- the employee is in service or is capable of performing the regular duties of the job;

  or

- the employee is not in service or is incapable of performing the regular duties of the job, but has shown that new dependents they wish to cover under the plan are not eligible for any other group insurance plan that includes prescription drug coverage;

otherwise, the new coverage status becomes effective on the date of the return to work.

Dental Care Insurance Plan

i) If the employer receives the "Application/Request for Change" form within 30 days following the date of acknowledgement of new dependents

The new coverage status becomes effective at the date of the event.

ii) If the employer receives the "Application/Request for Change" form more than 30 days after the date of acknowledgement of new dependents

The new coverage status becomes effective on the January 1 following the date the request is received by SSQ.

Please note that the new coverage status only becomes effective on the dates specified above if, on this date, the employee is in service or is capable of performing the regular duties of the job. Otherwise, the new coverage status becomes effective:

- on the date the employee returns to work if the employer receives the request as described in paragraph i);

- on the January 1 following the date of return to work if the employer receives the request as described in paragraph ii).

b) *Life Insurance Plan*

Participants may increase their coverage as follows:

- apply for Participant's Life Insurance, if they were not covered;
- increase their coverage amount in Participant's Life Insurance;
- apply for Dependent's Basic Life Insurance;
- apply for Spouse's Optional Life Insurance, provided the Dependent's Basic Life Insurance is already in force;
- apply for Dependent's Basic Life Insurance and Spouse's Optional Life Insurance;
- increase the coverage amount of Spouse's Optional Life Insurance.

To do so, the participant must complete the "Application / Request for Change" form and send it to the employer.

Effective date of requested change

i) <u>If the employer receives the request for change within 30 days following one of these events:</u>

- marriage, civil union, separation or divorce;
- cohabitation for more than a year (there is no minimal period if a child is born of the union or if legal adoption procedures have been undertaken);
- birth or adoption of a child;
- the termination of the spouse's or dependent children's insurance (this event only allows enrolment in Dependent's Basic Life Insurance);
- the death of the spouse;
- the obtainment of regular employee status, according to the applicable collective agreement.

Coverage amounts of $10,000, $25,000 and $50,000 for Participant's Life Insurance and Dependent's Basic Life Insurance are available without evidence of insurability and **the insurance becomes effective on the date of the event**.

Coverage amounts for Participant's Life Insurance greater than $50,000 are always subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

Spouse's Optional Life Insurance is always subject to the presentation of evidence of insurability and becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

ii) If the employer receives the request for change more than 30 days but less than 180 days after the events described above:

Coverage amounts of $10,000, $25,000 and $50,000 in Participant's Life Insurance and Dependent's Basic Life Insurance are available without the requirement for evidence of insurability and **the insurance becomes effective on the first day of the pay period following the date the request is received by SSQ.**

Coverage amounts for Participant's Life Insurance greater than $50,000 are always subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

Spouse's Optional Life Insurance is always subject to the presentation of evidence of insurability and becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

iii) If the employer receives the request for change more than 180 days after the events described above or if there is no such event:

Evidence of insurability is required and the insurance becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

The change requested only becomes effective on the dates specified above if, on this date, the employee is in service or is capable of performing the regular duties of their job; otherwise, it becomes effective on the date of return to work.

1.5.2 Decrease in coverage status

a) *Health Insurance and Dental Care Insurance Plans*

Participants may decrease their coverage status as follows:

- change their coverage status from family to single-parent or individual;
- change their coverage status from single-parent to individual.

To do so, they must complete the "Application/Request for Change" form and send it to the employer.

The new coverage status becomes effective on the first day of the pay period following the receipt of the request by the employer.

The coverage status chosen by the participant for the Health Insurance Plan may be different than the one chosen for the Dental Care Insurance Plan, if applicable.

However, in Quebec, in accordance with the *Act respecting Prescription Drug Insurance*, participants must insure their spouse and dependent children, if any, under the prescription drug coverage. Since this coverage is part of the Health Insurance Plan, the coverage held by the participant in the plan chosen (Health 1, Health 2 or Health 3) must comply with the provided requirements of the law. Therefore, all insureds must be covered by the same Health Insurance Plan.

Important

Please make sure to inform your employer of any change regarding your dependents so SSQ can be notified. The coverage status you hold under the Health Insurance or Dental Care Insurance Plans (individual, single-parent or family) must correspond to your current family status, in accordance with the definition of "dependent" in section 1.1.4, to avoid paying unnecessary premiums.

b) *Life Insurance Plan*

Participants may decrease their coverage status as follows:

- terminate their Participant's Life Insurance, subject to respecting the delay for receiving the request for opting out specified in section 1.3.4 b);
- reduce their coverage amount for Participant's Life Insurance, subject to the minimum coverage amount of $10,000;
- terminate Dependent's Basic Life Insurance and Spouse's Optional Life Insurance, if any;
- decrease the coverage amount of Spouse's Optional Life Insurance;
- terminate Spouse's Optional Life Insurance.

Participants must complete the "Application/Request for Change" form and provide this to their employer.

The termination of participation in one of the benefits or in the new amount of coverage becomes effective on the first day of the pay period following the date the request is received by the employer, except in the following circumstances:

- If the employer receives the request to terminate participation in Dependent's Life Insurance or Spouse's Optional Life Insurance, if any, within 30 days following the death of a dependent child or of the spouse, the insurance is terminated on the date of death;
- If the participant is only participating in the minimum coverage amount of $10,000 for Participant's Life Insurance: if the employer receives the request to remove within 30 days following the effective date of this coverage amount, the insurance is terminated on the date upon which this amount became effective.

1.6 Change in Health Insurance Plan

1.6.1 Increase of the Health Insurance Plan

Participants can increase their coverage under the Health Insurance Plan in the following ways:

- Change from the **Health 1** Plan to the **Health 2** or the **Health 3** Plan;
- Change from the **Health** 2 Plan to the **Health 3** Plan.

To do so, the participant must complete the "Application / Request for Change" form and send it to the employer.

Effective date of new Plan

i) If the employer receives the "Application/Request for Change" form within 30 days following one of these events:

- marriage, civil union, separation or divorce;
- cohabitation for more than a year (there is no minimum period if a child is born of the union or if legal adoption procedures have been undertaken);
- birth or adoption of a child;
- termination of the spouse's or children's insurance coverage;
- obtainment of a regular employment status, according to the applicable collective agreement.

The new plan requested becomes effective at the date of the event.

ii) If the employer receives the "Application/Request for Change" more than 30 days after the events described in the previous paragraph, or if no such events have occurred:

The obtaining of the new Health Insurance Plan is subject to the presentation of evidence of insurability. The plan becomes effective on the first day of the pay period following the date the evidence of insurability is approved by SSQ.

The change requested only becomes effective on the dates specified above if, on this date, the employee is in service or is capable of performing the regular duties of their job; otherwise, it becomes effective on the date of return to work.

1.6.2 Decrease of the Health Insurance Plan

Participants can decrease their coverage under the Health Insurance Plan in the following ways:

- Change from the **Health 3** Plan to the **Health 2** or **Health 1** Plan;
- Change from the **Health 3** Plan to the **Health 2** Plan.

Important

The participant must have completed the minimum duration of participation of 12 months for the Health 2 Plan or 24 months for the Health 3 Plan before a decrease of the health insurance plan can be granted.

To do so, the participant must complete the "Application/Request for Change" form and send it to the employer.

The new plan becomes effective on the first day of the pay period following the receipt of the request by the employer.

1.7 Termination of Coverage

1.7.1 Participant

a) *All Plans*

Subject to the provisions related to the waiver of premiums, the insurance of any participant ends at 11:59 p.m. on the first of the following dates:

- the date the group insurance contract is terminated;
- the expiration date for premium payments in the case of non-payment of premiums;
- the date on which the participant is no longer an eligible employee for a reason other than retirement;
- the date on which the union the participant belongs to ceases participation in the plan;
- the date of retirement.

b) *Health Insurance Plan*

In addition to the dates mentioned in section a), the following are added:

- the date on which the beginning of exemption becomes effective for the Plan in question;
- the date on which the waiver of premiums ends, unless the participant remains eligible for insurance and the applicable premiums are paid.

c) *Dental Care Plan*

In addition to the dates mentioned in section a), the following are added:

- the date SSQ receives the request to terminate the employee's participation in the plan, subject to the minimum duration of participation described in section 1.3.2 b);
- the date on which the group the participant belongs to ceases participation in the Dental Care Plan, subject to the provisions described in section 1.2.3 b);
- the date on which the waiver of premiums ends, unless the participant remains eligible for insurance and the applicable premiums are paid.

d) *Long Term Disability Insurance Plan*

In addition to the dates mentioned in section a), the following are added:

- the date the participant reaches age 63;
- the date the right to opt out becomes effective according to the criteria described in section 1.3.3 b).

e) *Life Insurance Plan*

In addition to the dates mentioned in section a), the following are added:

- the date on which the provisions regarding waiver of premiums end while the participant remains disabled;
- the date the removal of Participant's Life Insurance becomes effective as described in section 1.3.4 b).

1.7.2 Dependents

Health Insurance, Dental Care Insurance and Life Insurance Plans

Subject to the provisions regarding waiver of premiums, the insurance of all dependents is terminated at 11:59 p.m. on the first of the following dates:

- for any given plan or coverage: the first day of the pay period following the date the employer receives a request to terminate the dependent's insurance;
- for the life insurance coverage only: the date of the spouse's or dependent child's death if the employer receives the request to terminate participation within 30 days following the date of death; otherwise, the first day of the pay period following the date the employer receives the request;
- the date the participant's insurance was terminated;
- the date the insured ceases to be a dependent as defined for the Health Insurance, Dental Care Insurance and Life Insurance Plans;
- the date of the participant's death.

1.8 Waiver of Premiums

1.8.1 Beginning of waiver (all plans)

Participants who become totally disabled before retirement and who remain totally disabled for more than 52 consecutive weeks remain insured without payment of premiums as of the first working day of the pay period following the 52nd consecutive week of total disability.

1.8.2 End of waiver – Health Insurance and Dental Care Insurance Plans

For total disability periods that began on January 1, 2006 or later, the participant's waiver of premiums continues until the **first** of the following dates for the Health Insurance and Dental Care Insurance Plans:

a) for insureds that became totally disabled **before reaching age 56**: the day of their 60th birthday;

b) for insureds that became totally disabled **after reaching age 56**: the date they were granted a 36-month waiver of premiums

for the disability period underway, without exceeding their 65th birthday;

c) the date the total disability period ends;

d) the date this group insurance contract is terminated;

e) for the Dental Care Plan only: the date the Plan is terminated in the group the participant belongs to.

For total disability periods having begun before January 1, 2006, the participant's waiver of premiums continues until the **first** of the following dates for the Health Insurance and Dental Care Insurance Plans:

a) the last day of the 36 month-period of waiver of premiums for a same total disability period, but no later than on the June 30 following the 65th birthday;

b) the date the total disability period ends;

c) the date this group insurance contract is terminated;

d) for the Dental Care Plan only: the date the Plan is terminated for the group that the participant belongs to.

When the waiver of premiums for the Health Insurance Plan is terminated, regardless of when the total disability period began, one of the two following situations applies to totally disabled participants:

a) if they are still eligible for health insurance coverage because the employer-employee relationship still exists, they must maintain their participation and pay the required premiums;

b) if they are no longer eligible for health insurance coverage, they become eligible for health insurance coverage under the Group Insurance Plan for retirees of the *Centrale des syndicats du Quebec* (CSQ) - ASSUREQ, provided the following:

- the end of their eligibility for insurance under this plan is not due to the end of their total disability or the termination of the plan
- they become a member of the *Association des retraitées et retraités de l'éducation et des autres services publics du Québec* – AREQ (CSQ);
- they must make a request to enrol to the AREQ and the ASSUREQ within 90 days following their date of eligibility.

1.8.3 End of waiver – Long Term Disability Insurance and Life Insurance Plans:

For total disability periods that began on January 1, 2006 or later, the participant's waiver of premium continues until the **first** of the following dates for the Long Term Disability Insurance and Life Insurance Plans:

a) the participant's 65th birthday;

b) the date the total disability period ends.

For total disability periods that began before January 1, 2006, the participant's waiver of premiums continues until the **first** of the following dates for the Long Term Disability Insurance and Life Insurance Plans:

a) the June 30 following the participant's 65th birthday;

b) the date the total disability period ends.

When the waiver of premiums for the Life Insurance Plan is terminated, regardless of when the total disability period began, one of the two following situations applies to totally disabled participants:

a) if they are still eligible for life insurance coverage because of the employer-employee relationship still exists, they must maintain their participation and pay the required premiums, subject to the provisions described in section 1.3.4;

b) if they are no longer eligible for life insurance coverage, they become eligible for life insurance coverage under the Group Insurance Plan for retirees of the *Centrale des syndicats du Quebec* (CSQ) - ASSUREQ, provided the following:

- the end of their eligibility for insurance under this plan is not due to the end of their total disability or the termination of the plan;
- they become a member of the *Association des retraitées et retraités de l'éducation et des autres services publics du Québec* – AREQ (CSQ);
- they must make a request to enrol to the AREQ and the ASSUREQ within 90 days following their date of eligibility.
- they must participate in or opt out of the health insurance plan of ASSUREQ.

1.8.4 Pre-retirement leave

Participants who are totally disabled and who take pre-retirement leave with pay may not benefit from the waiver of premiums during this pre-retirement leave.

1.8.5 Period during which participants receive at least 100% of their salary

The waiver of premiums does not apply for a period during which the disabled person is on a work assignment and receives the equivalent of at least 100% of the salary that was paid before the beginning of the disability.

1.9 Leave Without Pay

1.9.1 Maintaining plans

- During a leave without pay, participants must choose one of the following two options:

  a) maintain participation in all plans held before their leave without pay;

  b) maintain participation in the Health 1 Plan only.

- The choice made applies for the duration of the leave without pay for as long as participants remain eligible for insurance, provided they notify their employer within 30 days following the date their leave began and pay the applicable premiums. **However, employees of school boards must indicate their choice on the individual invoice that they receive from SSQ.**

- All participants who are on leave without pay and have chosen to maintain participation only in the Health 1 Plan will be granted the coverage they held before their leave without pay upon the date they return to work.

1.9.2 Disability during a leave without pay

- If a disability occurs during the leave without pay and that all coverage has been maintained, the disability is considered to have begun on the day the participant had planned to return to work.

- If participants only maintained coverage under the Health 1 Plan, no disability occurring during the leave without pay is recognized. Only the Health 1 Plan is maintained until the date of return to work. On this date, participants will be

granted the plans held before the leave. For the purposes of waiver of premiums of the Health 1 Plan, total disability will be considered to have begun on the date participants were scheduled to return to work.

1.10 Other Leave

	Types of leave	
Plan	- Part-time leave without pay - Gradual retirement - Deferred pay leave	- Pay leave related to parental rights
Health Insurance, Dental Care Insurance, Life Insurance	• Maintenance of coverage is compulsory for all plans held	• Maintenance of coverage is compulsory for all plans held
Long Term Disability Insurance	• Maintenance of coverage is compulsory for the plan • The premium payable is determined based on the full salary as if there was no leave or decrease in work • If a disability occurs during this period, the amount of coverage is established based on the annual salary that would apply at the end of the 104th week of total disability if there had been no leave or decrease in work	• Maintenance of coverage is compulsory for the plan • The premium payable is determined based on the salary that applies immediately before the leave • A disability beginning during the leave is considered to have begun on the date the participant was planning to return to work or the date the preventive withdrawal was to end

Union Leave with pay

Regarding the provisions applicable to union leaves with pay, in order to exercise a full-time position within the CSQ executive or one of CSQ's federations executive, the employee must refer to their group insurance policy for details.

1.11 Layoff or Termination of Contract

1.11.1 Maintaining coverage

a) In the case of a layoff or termination of contract, participants must choose one of the 2 following options:

- maintain participation in all plans held before the layoff or termination of contract;
- maintain participation in the Health 1 Plan only.

b) Subject to the provisions stipulated in section 1.11.3, the choice made applies for a period of 120 days beginning on the date of the layoff or termination of the contract, provided employees make a written request to the employer within 30 days following this date and pay the applicable premiums. **Employees of school boards must indicate their choice on the individual invoice that SSQ sends to them.**

c) An employee whose contract is renewed or to whom a new contract is offered with the same employer or a new employer within 120 days following the date of the layoff or termination of contract is not considered to be a new employee in terms of eligibility to the insurance plans. Subject to the provisions stipulated in section 1.15.1, the plans in force on the date of the layoff or termination of contract are reinstated on the date they are rehired. The premiums corresponding to this coverage are payable starting on the first pay period coinciding with or immediately following the date they are rehired.

However, only employees whose Dental Care Plan is in force in the group they belong to are eligible for reinstating the Dental Care Insurance Plan on the date they are rehired. Similarly, the Long Term Disability Insurance Plan applicable to the employee (A or B) is the one in force for their group at that date.

d) If, at the end of the 120-day period, the participant has not been rehired, all coverage is terminated.

1.11.2 Particularities for teachers with school boards

a) The provision described in paragraph 1.11.1 b) is replaced with the one described in section 1.15.1.

b) Teachers with school boards whose contracts terminate during the months of May, June, July or August continue to be covered until August 31. The above-mentioned 120-day period will then begin on September 1.

1.11.3 Disability followed by a layoff or termination of contract

a) Participants who become disabled are entitled to maintain their coverage, even if they are laid off or if their contract with their employer is not renewed. However, in this situation, they must contact SSQ as of the date of termination of employment. SSQ then makes arrangements directly with the participant in order to allow him or her to maintain their waiver of premiums and disability insurance benefits, if any.

b) No disability occurring after the layoff or termination of contract is recognized for the purposes of insurance plans for which participation was not maintained.

1.11.4 2-year extension of Life Insurance Plan

Participants who, at the time of the layoff or termination of contract, maintained participation in the Life Insurance Plan for the 120-day period may extend their coverage under the Life Insurance Plan for an additional period of 2 years (at the most). To do so, they must make a request in writing to SSQ within 31 days following the end of the 120-day period and continue to pay the required premiums.

1.12 Dismissal, Non-Rehiring, Suspension

a) Participants who are dismissed or not rehired, or dismissed and who file a grievance, or who are suspended must choose one of the following two options:

- maintain coverage under all plans held, except the Long Term Disability Insurance Plan in the case of a dismissal, non-rehiring or dismissal that has been contested by a grievance;

- maintain participation in the Health 1 Plan only.

b) Participants who cannot come to an agreement with their employer to pay the full premium through the employer must make their payments directly to SSQ. This method of payment must be requested in writing to SSQ within 90 days following the date of the dismissal, non-rehiring or suspension.

c) The choice made in accordance with the provisions provided for in section 1.12 a) applies until the decision regarding the grievance is made. However, participation in the Long Term Disability Insurance Plan cannot be reinstated as long as the final decision regarding the grievance is pending.

d) If the final decision is in favour of the participants, who can therefore be reinstated in their position:

- In cases where participants have maintained participation in the Health 1 Plan only, SSQ reinstates the plans to which they were participating immediately before the dismissal, non-rehiring or suspension on the date they return to work;

- In cases where participants have maintained participation in all insurance plans to which they were participating immediately before the event in question, participation in the Long Term Disability Insurance Plan is reinstated retroactively to the date of the event and the applicable premiums must be paid retroactively to this date. Any total disability that started between the date of the event and the date the decision is known is considered.

e) If the final decision is not in favour of the participants, the insurance coverage maintained under provisions provided for in section 1.12 a) is terminated when the grievance ends or when legal proceedings that are undertaken by both parties end.

1.13 Conversion Privilege

1.13.1 Health Insurance Plan

While this Plan is in force, all participants whose insurance ends because they cease to be eligible for a reason other than retirement or termination of waiver of premiums may apply for an individual health insurance contract **excluding prescription**

drug coverage, without evidence of insurability, at the rates and conditions established by SSQ. To do so, participants must inform SSQ in writing of their intention to exercise their conversion privilege before their coverage under the Health Insurance Plan ends, or within 31 days following the date of termination. Upon receiving SSQ's proposal, they will have 15 days to send their written approval and the first premium of the proposed contract. The conversion privilege also applies to insured dependents.

1.13.2 Life Insurance Plan

a) Participants who cease to be eligible while the Life Insurance Plan is in force for a reason other than termination of the Group Insurance contract or termination of waiver of premiums may obtain, without evidence of insurability and at the rates and conditions established by SSQ, one of the following individual life insurance plans:

- a permanent or term life insurance plan expiring at age 65;
- a one-year term life insurance plan that can be converted into the insurance described in the item above.

To do so, they must inform SSQ in writing of their intention to exercise their conversion privilege before their coverage under the Health Insurance Plan ends, or within 31 days following the date of termination. Upon receiving SSQ's proposal, they will have 15 days to send their written approval and the first premium of the proposed contract.

b) In the event of a death during the 31-day period and while participants have not already advised SSQ of their intent, the conversion privilege is deemed to have been exercised for the amount of life insurance participants were eligible to convert under the Group Insurance contract.

c) The life insurance under the individual contract becomes effective on the latest of the following dates:

- the date the participant requests the conversion;
- the date the life insurance plan under the Group Insurance contract terminates.

d) The premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the participant's age and

employment on the date the individual insurance plan becomes effective.

e) The amount of life insurance converted may not be less than the amount stipulated in SSQ's general rules nor exceed the amount of life insurance held under the Life Insurance Plan. If the participant signs up for the plan for retirees, the amount converted may not exceed the difference between the amount held under the Life Insurance Plan and the maximum amount available under the Life Insurance Plan for Retirees.

f) Individual life insurance policies issued after having exercised the conversion privilege do not include a premium waiver.

g) Dependents who cease to be eligible while the Life Insurance Plan is in force for a reason other than termination of the Group Insurance contract may exercise their conversion privilege for an amount that does not exceed the amount of life insurance held under the Life Insurance Plan, subject to the same conditions as the participant.

1.14 Plans Offered to Retirees

Group Health Insurance and Life Insurance Plans are available to individuals who are retiring.

To apply for these plans, you must become a member of the *Association des retraitées et retraités de l'éducation et des autres services publics du Québec* – AREQ (CSQ) and for the Group Insurance Plan for Retirees of the *Centrale des syndicats du Québec* (CSQ) – ASSUREQ within 90 days following the date you become eligible.*

As soon as you know your retirement date, you may ask SSQ for the necessary information. SSQ will then send you documentation on this subject.

* *Teachers with school boards who retire during the months of May, June, July or August become eligible for the plans offered to retirees on the following September 1.*

1.15 Special Provisions for Certain Personnel Categories

1.15.1 Teachers with school boards (Contract renewal)

a) *New contract*

In addition to the provisions of this group insurance contract, the following special provisions apply to teachers with a school board who sign a new contract with the same school board or with a new school board in a job making them eligible for group insurance. In this case, the date the new contract becomes effective will determine the date the insurance begins under the various plans and the payment of premiums.

b) *New contract becoming effective during the first 3 pay periods of the school year*

The insurance begins retroactively to the date of the beginning of the school year and premiums are deducted as of this date. The employee is granted the plans held at the end of the preceding school year. Therefore, the participant is not considered as a new employee for the purposes of eligibility for the plans.

c) *New contract becoming effective after the first 3 pay periods of the school year but within the 120-day period of continuation of insurance*

Individuals who have not returned to work in a job entitling to group insurance within the first 3 pay periods of the school year must choose, for a 120-day period, between either the Health 1 Plan only or all insurance plans held before the termination of the previous contract. The date premium deductions begin after the return to work will depend on the choice made.

i) *If participation was maintained in all plans held*

Deduction of premiums will begin only at the end of the 120-day period.

ii) *If the individual maintained the Health 1 Plan only*

Deduction of premiums for all plans held at the end of the preceding school year will begin on the date the individual returns to work and SSQ will reimburse the premium that has been paid for the Health 1 Plan for

the period beginning at the date of return to work and concluding with the end of the 120-day period.

The individual is not considered to be a new employee for the purposes of eligibility for insurance.

d) *New contract becoming effective after the 120-day period of continuation of coverage*

The individual is then considered to be a new employee for the purposes of eligibility for insurance.

1.15.2 Employees of the Health and Social Services sector

a) *Employees*

Any individual under a national agreement concluded with a union that is affiliated with the *Centrale des syndicats du Québec* (CSQ) or under a service agreement that belongs to one of the following categories: personnel of the health and social services sector or of any other institution that is approved by the contract holder.

b) *Annual earnings*

The definition of "**annual earnings**" given in section 1.1.10 is replaced by the following:

"**Annual earnings**": remuneration in current money calculated on an annual basis, in accordance with the applicable collective agreement, appearing on the salary scales of applicable job titles, including any bonuses and supplemental income stipulated in the collective agreement that is used to calculate disability insurance benefits stipulated under the collective agreement.

For employees working part-time, this amount is prorated based on the time worked during the 52 calendar weeks during which no sick leave, annual leave, maternity leave, paternity leave, adoption leave, preventive leave or unpaid leave was authorized. The rules that apply when changing employers or when being rehired with the same employer are also taken into account.

This calculation must include a minimum of 12 weeks. Otherwise, the employer takes into account the weeks preceding the period of 52 weeks until the calculation includes 12 weeks. If the calculation cannot include a

minimum of 12 weeks because the period does not allow it, the calculation is based on the period between the date of the last employment and the date of disability.

The annual earnings used to calculate premium contributions is the one defined in the preceding paragraphs, while the annual earnings used to establish benefits, which is also defined in the preceding paragraphs, can never be lower than $14,400. However, if the annual earnings defined in the above paragraphs is $0, no long term disability insurance payments are payable.

c) *Participation*

Employees working at 25% of full time or less and who do not participate in the insurance plans in accordance with the provisions of the national agreement are not eligible for the insurance plans, except for the Health 1 Plan.

1.15.3 School boards support personnel in the adult education sector

a) *Employee*

The definition of "**employee**" given in section 1.1.8 is replaced by the following:

"**Employee**": any salaried person member of a union affiliated with the *Centrale des syndicats du Québec* and working in the adult education sector (Ch. 10-1.00 of national agreement S3).

b) *Eligibility*

i) Any employee having a weekly work schedule of 18 hours or more, including hours worked as a "student supervisor" or as a "cafeteria employee" is eligible for the Group Insurance Plans.

ii) Eligibility for plans is verified twice a year, including once at the beginning of the school year, in September. Employees who qualify at this time are eligible for the first half of the school year. They remain eligible for the second half the school year provided they meet the eligibility criteria during the second verification, which occurs in December.

iii) Only employees who were eligible in September may be eligible in December.

c) *Declaration of disability*

Employees who are absent from work due to a disability for a period of more than 28 days must declare this absence to SSQ in order to pay the premiums and, thereafter, to benefit from the waiver of premiums.

d) *Annual earnings*

The definition of "**annual earnings**" indicated in section 1.1.10 is replaced by the following:

"**Annual earnings**": the total salary actually earned during the 12 months preceding the date of disability, including any allowance paid as part of working conditions and vacation, and income for time worked as a "student supervisor" or "cafeteria employee".

If the employee has been enrolled for less than 12 months on the date the disability begins, the annual salary is equal to the total salary actually earned since the beginning of the employment divided by the number of weeks worked. The result obtained is then multiplied by 40.

Periods of parental leave, maternity leave, without pay and union leave are not taken into consideration.

In all cases, the annual earnings used for contribution of premium purposes is the one given above, while the annual earnings used to establish benefits is also the one given above, without however being less than $14,400.

2- HEALTH INSURANCE PLAN

Eligible expenses are those applying to treatments, care or supplies required for the treatment of an illness or an injury and in the case of a pregnancy.

The only expenses covered are those incurred for treatments, care or supplies provided by a health professional who is a member in good standing of the professional corporation relevant to the treatments, care or supplies in question or, failing the existence of such corporation, a relevant professional association, subject to the provisions determined by SSQ for the acknowledgement of each association.

To be considered eligible, expenses for services or supplies must comply with the customary and reasonable standards of practice generally accepted in the health care sector concerned.

2.1 Description of Coverage

When a participant or an insured dependent incurs expenses that are covered as described below, SSQ reimburses these expenses, as long as the coverage is included in the Health Insurance Plan chosen by the participant, according to the conditions stated below.

The medical prescription, when required for the expenses incurred to be eligible for reimbursement, must indicate the name of the drug prescribed or, in the case of a product, treatment or service, the diagnosis, the medical reasons or therapeutic indications justifying the prescription of such product, treatment or service as well as the scheduled duration of use.

2.1.1 Acupuncture (Health 2 and 3)

Expenses for treatments administered by an acupuncturist.

Expenses reimbursed at 80% up to a maximum amount of:

Health 2	$20 / treatment	$400 / calendar year / insured
Health 3	$36 / treatment	$600 / calendar year / insured

2.1.2 Ambulance and transportation by plane (Health 1, 2 and 3)

Expenses for transportation by ambulance to the hospital (round trip) are reimbursed at 80%, including transportation by plane in case of emergency in remote regions, as well as the oxygen therapy received immediately before or during transportation.

2.1.3 Hearing aid (Health 2 and 3)

Expenses for purchasing, adjusting, replacing or repairing an hearing aid. This coverage also includes hearing aid practitioner fees.

Expenses are reimbursed at 80%, up to the following maximum:

Health 2 and 3	$560 / 48 months / insured

2.1.4 Breathing assistance device and oxygen (Health 2 and 3)
Medical prescription required

Expenses for renting or purchasing, if more economical, a breathing assistance device. The oxygen is also included in the eligible expenses for this benefit. These expenses are reimbursed at 80%.

2.1.5 Orthopaedic devices (Health 2 and 3)
Medical prescription required

Expenses for purchasing, renting or replacing trusses, corsets, casts, splints, crutches and other orthopaedic apparatus are reimbursed at 80%

2.1.6 Therapeutic devices (Health 2 and 3)
Medical prescription required

Expenses for renting or purchasing, if more economical, therapeutic devices, are reimbursed at 80%. This coverage also includes expenses for adjusting, replacing or repairing.

For example, the following devices are eligible for reimbursement:

- aerosol therapy devices, namely devices required for treating acute emphysema, chronic bronchitis or chronic asthma;
- non-union bone stimulators;
- respiratory monitors in the case of respiratory arrhythmia;
- intermittent positive pressure respirators;
- burn treatment garments;

- purchase of diapers for incontinence, probes, catheters and other similar hygienic items required following a total and irrecoverable loss of the vesical or intestinal function.

This coverage excludes control devices (such as stethoscope, thermometer, etc.) as well as domestic devices (such as whirlpool bath, air filter, humidifier, air conditioner) and other similar devices. This coverage also excludes items or devices which are already eligible for reimbursement under another provision of the health insurance plan.

If the total cost of the expenses to be incurred is greater than $2,000, prior authorization from SSQ must be obtained before any expenses are incurred.

2.1.7 Ostomy appliances (Health 2 and 3)
Medical prescription required

Expenses for purchasing the necessary products for ostomy. The portion of expenses in excess of what is paid by the government is reimbursed at 80%.

2.1.8 Trip cancellation insurance (Health 1, 2 and 3)

Expenses incurred by the insured following cancellation or interruption of a trip provided these expenses are related to travel expenses paid in advance by the insured and that the latter, **at the time the travel arrangements were finalized, was unaware of any event that could reasonably lead to the cancellation or interruption of the planned trip.** These expenses are reimbursed at 100%, up to a maximum of $5,000 per insured, per trip. To know the details of the expenses covered, limitations, restrictions and exclusions, please consult the document available on the **ACCESS | Plan Members** website at **ssq.ca** or contact SSQ Customer Service. The telephone numbers of the travel assistance service are printed on the back of the SSQ Card accompanying the certificate issued by SSQ.

2.1.9 Travel insurance with assistance (Health 1, 2 and 3)

Expenses incurred following a death, an accident or a **sudden and unexpected illness** occurring while the insured is temporarily outside the province of residence and that the insured's health status requires emergency care. Expenses must apply to supplies or services prescribed by a physician as necessary for the treatment of an illness or injury. These expenses are reimbursed at 100%, up to a maximum of $5,000,000 per insured for the duration of the stay abroad. To know the details of the expenses

covered, limitations, restrictions and exclusions, please consult the document available on the **ACCESS | Plan Members** website at **ssq.ca** or contact SSQ Customer Service. The telephone numbers of the travel assistance service are printed on the back of the SSQ Card accompanying the certificate issued by SSQ.

2.1.10 Support stockings (Health 2 and 3)
Medical prescription required

Expenses for purchasing medium or full support stockings (20 mm/Hg or more) in case of insufficiency of the circulatory or lymphatic system.

Expenses reimbursed at 80%, up to the following maximums:

Health 2 and 3	3 pairs / calendar year / insured

2.1.11 Orthopaedic shoes (Health 2 and 3)
Medical prescription required

Expenses for purchasing shoes designed and made-to-measure from a cast to correct a foot defect are reimbursed at 80%. Open, flared or straight shoes and those needed to maintain so-called Denis Brown splints are also covered. These shoes must be purchased from a specialized orthopaedic laboratory holding a licence from legal authorities. Expenses for corrections or modifications made to prefabricated shoes are also covered.

Expenses for the purchase of deep shoes as well as all types of sandals are not eligible under this coverage.

2.1.12 Chiropractic (Health 2 and 3)

Expenses for treatments administered by a chiropractor. X-ray expenses are also covered.

Expenses reimbursed at 80% up to a maximum amount of:

Health 2	$20/treatment $40 / X-ray	$400 / calendar year / insured
Health 3	$28 / treatment $40 / X-ray	$500 / calendar year / insured

2.1.13 Detoxification treatment (Health 3)
Medical prescription required

Daily cost for room and board in a clinic recognized by SSQ and specializing in the rehabilitation of alcoholics, drug addicts and gambling addicts, as long as the insured actually receives a curative treatment. The clinic must be located in Canada and supervised by a physician or a registered nurse.

Expenses reimbursed at 80%, up to the following maximum:

Health 3	$64 / day	30 days / calendar year / insured

2.1.14 Dietetics (Health 3)

Expenses for consultation with a dietitian.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$28 / consultation	$500 / calendar year / insured

2.1.15 Wheelchair, walker or hospital bed (Health 2 or 3)
Medical prescription required

Expenses for renting or purchasing, if more economical, a non-motorized wheelchair, a walker, or a hospital bed are reimbursed at 80%, but only if required for temporary use. The wheelchair or hospital bed must be similar to those generally used in a hospital. Expenses eligible for reimbursement by the *Régie de l'assurance maladie du Québec* (RAMQ) are excluded.

2.1.16 Hospital expenses in Canada (Health 2 and 3)

When an insured is hospitalized in Canada, room expenses in excess of hospital expenses in a regular ward, are covered up to the daily cost of a semi-private room, in accordance with the rates determined by the *ministère de la Santé et des Services sociaux* (MSSS), without limitation as to the number of days.

Limitations

Administrative expenses charged by the hospital to the insured are not eligible under this coverage.

The patient's contribution required by an establishment for lodging or extended care is not eligible under this coverage.

Expenses are reimbursed at 100%, up to the following maximum:

Health 2 and 3	Cost of a semi-private room

2.1.17 Blood glucose monitor (Health 2 and 3)
Medical prescription required

Expenses for purchasing, adjusting, replacing or repairing a blood glucose monitor.

Expenses are reimbursed at 80%, up to the following maximum:

Health 2 and 3	$240 / 36 months / insured

2.1.18 Homeopathy (Health 3)

Consultation fees of a homeopath. Upon written recommendation of the homeopath or a physician, homeopathic remedies and treatments are also eligible under this coverage.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$28 / consultation	$600 / calendar year / insured

2.1.19 Professional fees following an accidental injury to natural teeth (Health 2 and 3)

Professional fees of a dental surgeon, a specialist or a denturist to repair damage to healthy and natural teeth resulting from an accident that occurred while the insurance was in force (teeth broken while eating are not covered) are reimbursed at 80%, provided the care is given within the 24 months following the date of the accident. Expenses are eligible up to the amounts and procedures mentioned in the current fee guide of the *Association des chirurgiens dentistes du Québec* (ACDQ).

Any act, treatment, prosthesis, of any nature, related to a dental implant is excluded.

This benefit considers "accident" to mean any unintentional, sudden, fortuitous and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injuries. In addition, a tooth is considered "healthy" when it has not been affected by any pathology, either in the substance itself or in the adjacent structures. A tooth that has been treated or repaired and has recovered a normal function is also considered as healthy.

2.1.20 Intraocular lenses (Health 2 and 3)
Medical prescription required

Expenses for the purchase of intraocular lens implants required to correct the symptoms of an eye disease in cases where contact lenses or eyeglasses cannot be used to correct such symptoms. These expenses are reimbursed at 80%.

2.1.21 Massage therapy, kinesitherapy and orthotherapy (Health 3)

Expenses for treatments administered by a massotherapist, a kinesitherapist or an orthotherapist.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$28 / treatment	$600 / calendar year / insured for all these professionals including naturopathy expenses

2.1.22 Prescription drugs (Health 1, 2, and 3)
Medical prescription required

Any drugs available only by prescription or under pharmaceutical control, bearing valid DINs (Drug Identification Number), prescribed by a health professional authorized by law to do so, sold exclusively by a pharmacist or sold by a physician (or a nurse) in remote regions where permitted by law, upon submission of suitably itemized receipts.

Contraceptive pills and intrauterine devices are also covered.

Sclerosing injections that are not covered under other provisions of the contract are also covered if they are supplied and administered by a physician for curative and not aesthetic purposes, subject to a maximum of $28 per day (or $35 per day in cases where the applicable reimbursement percentage is 100%). The medical procedure is not covered.

Smoking cessation products covered under the Public Prescription Drug Insurance Plan are also covered under the Health Insurance Plan, up to a combined overall maximum expenses per calendar year, per insured. This combined overall maximum is determined and updated every year in accordance with the *Régie de l'assurance maladie du Québec* (RAMQ).

For administrative purposes only, drugs eligible under this coverage are those listed on the current edition of the schedule of the *Association québécoise des pharmaciens propriétaires* (AQPP) and

whose use is in compliance with the indications approved by the government authorities or, failing such authorities, indications provided by the manufacturer.

Expenses for any pharmaceutical supplies or services covered by the RAMQ plan are recognized as expenses covered under this benefit.

Some of these drugs, commonly called "exception drugs" on the RAMQ List, are covered only if they meet the conditions and therapeutic indications determined by the regulation applying to the RAMQ Plan. For an exception drug to be eligible, the insured must obtain prior authorization from SSQ.

The percentage differs depending on whether the drugs are single-source drugs (for which there is no equivalent on the market), brand-name drugs (sold under the original maker's trademark and for which there is at least one generic equivalent on the market) or generic drugs.

Health 1	$50 annual deductible / certificate
	Percentage of eligible expenses: - 80% for single-source or generic drugs and 68% for brand-name drugs* - 100% in excess of an out-of-pocket amount of $776 / certificate / calendar year
Health 2 and 3	Percentage of eligible expenses: - 80% for single-source or generic drugs and 68% for brand-name drugs* - 100% in excess of an out-of-pocket amount of $776 / certificate / calendar year

* When a brand-name drug cannot be substituted for a generic drug, it is possible to obtain reimbursement based on the percentage of reimbursement for a generic prescription drug by submitting the "Reimbursement Request for Brand-Name Prescription Drugs" form, duly completed by the attending physician, to SSQ for approval.

Exclusions

The following products are not covered:

1) drugs of an experimental nature or obtained under a federal emergency drug program as well as the so-called "orphan drugs";

2) drugs used for infertility treatment or for artificial insemination that are not covered under the government prescription drug insurance plan;

3) drugs used in the treatment of erectile dysfunction;

4) products used for aesthetic or cosmetic purposes;

5) dietary supplements serving as meal supplements or replacements;

However, diet supplements prescribed for the treatment of a clearly identified metabolic illness, in accordance with the conditions and therapeutic indications determined by the regulations applying to the RAMQ Plan, remain covered. The only evidence accepted will be a complete medical report describing, to SSQ's satisfaction, all the conditions justifying the prescription of the product not otherwise covered.

6) sunscreens;

7) smoking cessation products not covered by the RAMQ plan.

Limitation

Patient's contribution (deductible, coinsurance and annual premium) required by the RAMQ Prescription Drug Insurance Plan is not eligible under this coverage.

Rules of participation

The minimum duration of participation is 12 months for the Health 2 Plan and 24 months for the Health 3 Plan.

2.1.23 Artificial limbs and external prosthesis (Health 2 and 3)

Expenses for purchasing artificial limbs and other external prosthesis are reimbursed at 80% (dental and capillary prosthesis, hearing aids, eyeglasses and contact lenses are excluded).

2.1.24 Accidental Dismemberment (AD) (Health 2 and 3)

When a person insured under this Plan is subject to one of the losses listed in the "Table of Losses" and that this loss is caused, directly and independently of any other cause, by bodily injuries exclusively caused by external, violent and accidental means, (the loss must occur within 365 days following the date of the accident, provided the person was covered by this plan at the time of the accident) SSQ pays, in accordance with the provisions of this plan, the amounts stipulated in the "Table of Losses",

without however exceeding $50,000 for all losses sustained due to a single accident.

TABLE OF LOSSES	
LOSS	**AMOUNT**
• Loss of both hands, both feet or sight in both eyes	$50,000
• Loss of one hand and one foot	$50,000
• Loss of one hand and sight in one eye	$50,000
• Loss of one foot and sight in one eye	$50,000
• Loss of one hand	$25,000
• Loss of one foot	$25,000
• Loss of sight in one eye	$25,000
In this context, loss of a hand or foot means amputation from the wrist down or ankle down, or total and irrecoverable loss of their use; loss of sight means the total, definitive and irremediable loss of sight.	

Exclusions

No insurance benefit in case of accidental dismemberment is payable for a loss resulting from one of the following causes:

1) participation in a criminal act;

2) attempted suicide or self-inflicted injuries, whether the insured was sane or not;

3) war, riot or insurrection;

4) active service in the armed forces;

5) trip or flight in any kind of aircraft when the insured is carrying out any duty as an aircraft crew member, except if the insured is acting as a flight instructor as provided in the collective agreement or in the individual employment contract.

Beneficiary

The coverage amount payable for the accidental dismemberment of a participant or dependent is paid to the participant.

2.1.25 Naturopathy (Health 3)

Expenses for consultation with a naturopath.

Eligible expenses are those related to a consultation to obtain dietary advice, a health check-up or a diet based on natural products. Natural products, baths, posturology, physical exercises and other consultations are not covered.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$28 / consultation	$600 / calendar year / insured for naturopathy, massage therapy, kinesitherapy and orthotherapy expenses combined

2.1.26 Transcutaneous electrical nerve stimulator (Health 2 and 3) Medical prescription required

Expenses for purchasing, renting, adjusting, replacing or repairing a transcutaneous electrical nerve stimulator.

Expenses are reimbursed at 80%, up to the following maximum:

Health 2 and 3	$800 / 60 months / insured

2.1.27 Foot orthoses (Health 2 and 3) Medical prescription required

Expenses for purchasing foot orthoses (arch supports, shoe lifts) are reimbursed at 80%. The expenses are limited to the amounts provided in the price list of the *Association des orthésistes et prothésistes du Québec*.

Foot orthoses must be purchased from a specialized orthopaedic laboratory holding a licence from legal authorities.

2.1.28 Speech therapy, occupational therapy or audiology (Health 2 and 3)

Fees for services provided by a speech therapist, an occupational therapist or an audiologist are reimbursed at 80%.

2.1.29 Osteopathy (Health 3)

Expenses for treatments administered by an osteopath.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$36 / treatment	$700 / calendar year / insured for osteopathy and physiotherapy combined

2.1.30 Physiotherapy (Health 2 and 3)

Expenses for treatments administered by a physiotherapist or a physical rehabilitation therapist.

Expenses reimbursed at 80% up to a maximum amount of:

Health 2	$24 / treatment	$400 / calendar year / insured for all services from these professionals
Health 3	$36 / treatment	$700 / calendar year / insured for all services from these professionals and osteopathy expenses combined

2.1.31 Podiatry or podology (Health 2 and 3)

Expenses for consultation or treatment in foot care administered by a podiatrist, a podologist, a nurse specialized in foot care or a nursing assistant specialized in foot care.

Expenses reimbursed at 80% up to a maximum amount of:

Health 2	$20/treatment	$400 / calendar year / insured for all these professionals
Health 3	$36 / treatment	$600 / calendar year / insured for all these professionals

2.1.32 Insulin pump and accessories (Health 2 and 3)
Medical prescription required

Expenses for the purchase and repair of an insulin pump and expenses for the purchase of insulin pump accessories are reimbursed at 80%.

2.1.33 Capillary prosthesis (Health 2 and 3)
Medical prescription required

Expenses for purchasing a first capillary prosthesis following chemotherapy.

Expenses are reimbursed at 80%, up to the following maximum:

Health 2 and 3	$300 / lifetime / insured

2.1.34 Breast prosthesis (Health 2 and 3)
Medical prescription required

Expenses for the purchase of breast prosthesis if necessary because of a mastectomy are reimbursed at 80%.

2.1.35 Psychotherapy (Health 2 and 3)

Expenses for professional psychotherapy services or for services provided by a psychologist, psychiatrist, social worker, career counsellor, psychoeducator, marriage or family therapist, nurse or psychotherapist. All these professionals must hold a psychotherapist's permit issued by the *Ordre professionnel des psychologues du Québec*.

Health 2	Reimbursed at 50%	Maximum reimbursement of $500 / calendar year / insured for all of these professionals
Health 3	Reimbursed at 50% of the first $1,000 of eligible expenses and 80% of expenses in excess of this	Maximum reimbursement of $1,500 / calendar year / insured for all of these professionals

2.1.36 Nursing care (Health 3)
Medical prescription required

Fees of a registered nurse or licensed nursing assistant for care given exclusively and continuously to the insured at home. The nurse rendering the professional services must not usually reside with the insured nor be a member of the insured's family.

These professional services must be prescribed by the attending physician and must follow a hospitalization.

Expenses reimbursed at 80% up to a maximum amount of:

Health 3	$240 / day	$5,000 / calendar year / insured

2.1.37 Post-surgical brassieres (Health 2 and 3)
Medical prescription required

Expenses for the purchase of post-surgical brassieres following a mastectomy or breast reduction.

Expenses are reimbursed at 80%, up to the following maximum:

Health 2 and 3	$200 / lifetime / insured

2.1.38 Transportation and accommodation expenses in Quebec (Health 3)
Medical prescription required

Transportation and lodging expenses incurred in Quebec and resulting from a consultation to obtain professional services from a specialist physician not available in the insured's region of residence. Eligible expenses are:

- expenses for travelling by automobile or a public carrier (bus, plane, boat, train) and lodging expenses incurred in a public establishment, as long as the consultation or the treatment requires a stay.

However, the following conditions apply:

1) eligible expenses must be incurred, on medical prescription, for a consultation with a specialist physician who is not present in the insured's region of residence. Expenses for a treatment that is not available in the region of residence and administered by a specialist physician are also covered;

2) eligible expenses must be incurred for a trip of a least 200 kilometres from the insured's place of residence to the location of the consultation (one way only). The location must be the nearest to the insured's place of residence;

3) when travelling by automobile, eligible expenses are equal to those that would have been incurred had the trip been made by bus;

4) eligible expenses are reimbursed upon presentation of receipts or paid invoices except if the means of transportation used is the automobile;

5) eligible expenses include expenses incurred by an insured as well as the accompanying individual.

Expenses are reimbursed at 80%, up to the following maximum:

Health 3	$1,000 / calendar year / insured

COMMENT:

These expenses may be eligible for reimbursement in accordance with a program set by a number of regional health boards. However, this program is managed by the establishment responsible for the insured's treatment. In order to verify whether such a program exists in the region of residence, the insured must contact the hospital, the CLSC or the Regional board. These organizations are the "first payers" and only expenses that are not reimbursed by these organizations are eligible.

2.1.39 Transportation by plane or by train of a bedridden insured (Health 1, 2 and 3)
Medical prescription required

Expenses for transportation of a bedridden insured described below are reimbursed at 80%:

- Expenses for transportation by plane or by train of a bedridden insured occupying the equivalent of 2 single seats when part of the distance must be made through this means of transportation;
- Expenses for transportation by plane or by train of an insured requiring an immediate hospitalization to the closest hospital where care is available, as prescribed by a physician;
- Expenses for return home transportation of the insured, when medically justified.

2.2 Exclusions and Limitation

2.2.1 Exclusions

No benefits are paid for expenses incurred:

1) following a war;
2) following active participation in a riot, insurrection or criminal act;
3) while the insured is an active member of the armed forces;
4) for services the insured is not required to pay;
5) for aesthetic purposes, except if following an accident;

6) that were reimbursed or are payable by a government plan or organization or by any other private plan (individual or group). In no case shall SSQ allow reimbursements to exceed the expenses actually incurred, in cases where insureds are covered under several plans;

7) for medical examinations for work, insurance, control or verification purposes;

8) for services or supplies, examinations, care, expenses, or their surplus, that are not in compliance with the reasonable standards of the common practice of the health professionals involved;

9) for products, devices or services used or offered for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the proper authorities or, failing such authorities, with the indications given by the manufacturer;

10) for services or products used in the treatment of infertility or for artificial insemination that are not covered under the government prescription drug insurance plan.

Regardless of the above, all pharmaceutical supplies or services that are covered by the PDIP are not excluded.

2.2.2 Limitation

Treatments for a same insured are limited as follows:

1) Only one treatment per day, by the same health professional; and

2) Only one treatment per day, by any health professional of a same specialty regardless of the number of fields of specialization the professional or specialist is licensed to practise in.

2.2.3 Reduction of benefits

If an insured is entitled to benefits similar to those described in this provision but under an individual insurance contract or another group insurance contract, expenses eligible for reimbursement under this plan will be reduced by the amount of any benefit payable under the other contract. SSQ will request appropriate documents, if applicable.

3- ADDITIONAL PLAN 1 – DENTAL CARE INSURANCE

3.1 Eligible Expenses

Eligible expenses are those related to care or treatments administered by a legally licensed dental surgeon, specialist or denturist.

Eligible expenses are based on the codes of the Association des chirurgiens dentistes du Québec (ACDQ) Fee Guide for Dental Treatment Services for the year 2015. SSQ will administer this benefit so that the equivalent of this description continues to apply taking into account the evolution of dental techniques and codes updates as made by the ACDQ.

Expenses incurred for the services described below are eligible up to the amounts provided for in the ACDQ guide for the year during which the services are provided.

When a participant who is insured under the Dental Care Plan incurs eligible expenses for himself or for an insured dependent, SSQ reimburses these expenses in accordance with the provisions of the plan.

ELECTRONIC TRANSMISSION

Electronic transmission of your claims is available. In order to use this service, follow the steps described in section 6 of this booklet.

3.2 Preventive Dental Care

The following eligible expenses **are reimbursed at 80%** with no deductible:

3.2.1 Clinical oral examination

- dental examination for children under age 10, if not covered under the RAMQ: 1 examination per 12-month period
- recall or periodic preventive oral examination: 1 examination per 9-month period
- complete oral examination, stomatognatic examination or prosthodontic examination: 1 examination per 36-month period
- complete periodontal examination: 1 examination per 36-month period

- emergency examination: 2 examinations per calendar year
- specific oral examination: 2 examinations per calendar year

3.2.2 X-rays

a) intra-oral X-rays

b) extra-oral X-rays
   - extraoral film
   - sinus examination
   - sialography
   - radiopaque dyes
   - temporomandibular joint
   - panoramic film: 1 film per 36-month period
   - cephalometric film
   - duplicate file and/or radiograph : 2 times per calendar year

X-rays (except for panoramic X-rays) are included in complete or recall examinations.

3.2.3 Lab examinations, tests and diagnostic tests

- pulpal tests: 3 times per 12-month period
- bacteriologic test
- histological test
- cytological test
- diagnostic casts

3.2.4 Preventive measures

- prophylaxis, polishing of coronal portion of teeth: once per 9-month period
- fluoride, treatment*: once per 9-month period
- periodontal scaling: only one code per 9-month period
- nutritional counselling: once per lifetime
- oral hygiene instruction and re-instruction: twice per lifetime

- plaque control program: 5 times per calendar year
- finishing restorations
- pit and fissure sealants* (only on occlusal surfaces of premolar and permanent molar teeth): once per 36-month period per tooth
- interproximal disking*: 2 times per calendar year
- enameloplasty, per tooth

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

3.2.5 Control of oral habits* and space maintainers*

- myofunctional evaluation: once per 24-month period
- motivation: once per lifetime
- fixed or removable device: 1 device per 24-month period
- myofunctional therapy: 5 visits per lifetime

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

3.2.6 Additional services

- local anesthesia
- unusual time and responsibility requirement, in addition to usual procedure

3.3 Basic Dental Care

The following eligible expenses **are reimbursed at 80%** and are subject to the shared deductible indicated in section 3.5:

3.3.1 Minor restoration

- sedative dressing
- recontouring and polishing of traumatized tooth
- bonding/cementation of broken tooth chip: twice per calendar year
- amalgam, composite or resin restoration*
- veneer application - chairside

- supplement for restoration of a tooth or inlays or onlays under an appliance or supporting an existing removable partial denture
- retentive pins (amalgam or composite)

A same surface or class on the same tooth is eligible for reimbursement once per 12-month period.

* *The equivalent of a bonded amalgam is reimbursed when composite restoration on molars is claimed.*

3.3.2 Endodontics

- other endodontic services
- endodontic emergency
- general endodontic treatments
- root canal therapy
- periapical endodontic surgery

3.3.3 Periodontics

- treatment of acute infection or inflammation
- desensitization
- occlusal equilibration: 3 treatments per calendar year
- periodontal services, surgical (except for periodontal guided tissue regeneration) (see provision 3.8 a) below)
- root planing under local anesthesia: once per tooth per 12-month period
- splint or ligation
- removal or recementation of splint
- periodontal appliances: 1 appliance per maxilla per 60-month period
- repair of periodontal appliances : once per calendar year
- reline of periodontal appliances
- periodontal irrigation subgingival

3.3.4 Oral surgery

- removal of erupted teeth, complex or without complication
- removal of impacted teeth, residual roots or tooth fragment, removal
- surgical exposure of teeth: once per lifetime per tooth
- transplantation of tooth, including splinting: once per lifetime per tooth
- surgical repositioning of tooth: once per lifetime per tooth
- enucleation of an unerupted tooth: once per lifetime per tooth
- remodeling and recontouring of oral tissues (alveolectomy, alveoloplasty, stomatoplasty, osteoplasty, tuberoplasty) (see section 3.8 a) below)
- removal of hyperplasic tissue or excess mucosa
- frenectomy
- alveolar ridge reconstruction
- preservation of the ridge, after extraction with allogenous bone or other filling material
- extension of mucosal folds
- excisional biopsy, removal of tumor or cyst
- surgical incision and drainage
- oral trauma
- temporo-mandibular joint dysfunction, treatment
- salivary glands, treatment
- antrum, retrieval, foreign bodies, lavage
- oro-antral fistula, closure
- hemorrhage control
- post-surgical treatment

3.4 Major Restorative Dental Care

The following eligible expenses **are covered at 50%** and are subject to the shared deductible indicated in section 3.5 below:

3.4.1 Removable prosthodontics (see section 3.8 b) below)

- complete dentures
- partial dentures
- remake, partial dentures
- analysis in preparation for fabrication of removable partial denture: once per 60-month period

3.4.2 Dentures, complementary services

- adjustment
- remount and equilibration (complete or partial dentures): once per 60-month period
- structure additions to the partial denture
- cleaning
- duplication
- rebase and reline (complete or partial dentures)
- therapeutic tissue conditioning
- resetting of teeth
- obturator, palatal: once per 60-month period
- vertical dimension recuperation by addition of acrylic to existing prothesis

3.4.3 Fixed prosthodontics (see section 3.8 b) below)

- veneer - laboratory processed
- gold foil
- inlays and onlays
- full preformed crowns: once per 12-month period
- individual crown
- transitional crown: once per 60-month period

- supplement for the fabrication of a crown or abutment under an appliance or an existing removable partial denture
- coping, precious metal or not: once per 60-month period
- reconstruction, tooth in preparation for crown
- radicular post
- repairs crown/veneer
- recementation/rebonding of inlay, onlay, crown, veneer or post and supplement for acid etch technique: twice per calendar year
- splint with cast metal splint, acid etch bonded: once per 60-month period, per tooth
- pontics (except transitional)
- abutment for bridge (except transitional)
- retentive bar: once per 60-month period

3.4.4 Repair of fixed prosthodontics

- removal, fixed bridge
- recementation, fixed bridge: twice per calendar year per abutment
- repairs, fixed bridge
- other fixed prothetic services

3.5 Shared Deductible – Basic Dental Care and Major Restorative Dental Care

Basic dental care and major restorative care are subject to a shared deductible of $50 per certificate. This is a single deductible applying to expenses incurred by both the participant and the dependents.

3.6 Preauthorization of Dental Treatments

When the total cost of the treatment is expected to exceed $800 or major restorative services are scheduled, SSQ must be provided with a treatment plan including an X-ray before the beginning of the treatment to determine the amount of expenses that will be covered.

Furthermore, preoperative X-rays, periodontal scales, photographs, study casts or other supporting evidence can be required for the analysis and the authorization of some care (even if the care has already been received).

3.7 Maximum Reimbursement of Dental Care Expenses

All of the care described in sections **3.2, 3.3** and **3.4** is subject to a maximum reimbursement per insured, per calendar year, as specified in the following table. The first calendar year corresponds to the year during which Additional Plan 1 - Dental Care becomes effective for the group the insured belongs to.

Calendar year	Maximum reimbursement per insured
First	$600*
Second	$800
Third and following years	$1,000

* *The maximum reimbursement of $600 provided for the first calendar year applies regardless of the effective date of the plan (no prorate).*

3.8 Dental Care Restrictions

a) When the ACDQ fee guide uses the terms “sextant” or “quadrant” to describe a treatment, the procedures or services provided for such treatment are limited to 6 different sextants or 4 different quadrants, as the case may be, per insured, per calendar year.

b) When a benefit claim has been made for a prosthesis and that eligible expenses were acknowledged, a replacement prosthesis (individual crown, veneer, gold foil, inlay, cast post, prefabricated post, retentive pin, removable denture or fixed bridge) is not eligible for reimbursement if it is installed within 60 months following the installation of the previous one. However, a permanent removable prosthesis, partial or full, is eligible for reimbursement if it replaces a transitional removable prosthesis (partial or full) and is installed within 6 months of the date the transitional prosthesis was installed.

c) Eligible laboratory expenses are limited to 50% of the fees detailed in the fee guide for the applicable orodental act.

3.9 Dental Care Exclusions

No benefits are paid for expenses incurred:

a) following a war;

b) following active participation in a riot, insurrection or criminal act;

c) while the insured is an active member of the armed forces;

d) for services the insured is not required to pay;

e) for aesthetic purposes, except if otherwise specified;

f) that are reimbursed or payable by a government plan or organization;

g) for medical examinations for work, insurance, control or verification purposes;

h) that are reimbursed or payable by any other private, individual or group plan;

i) for services or supplies, examinations, care, expenses, or their surplus, that are not in compliance with the reasonable standards of the common practice of the health professionals involved;

j) for products, devices or services used or offered for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the proper authorities or, failing such authorities, with the indications given by the manufacturer;

k) for fees related to additional units.

Furthermore, any act, treatment, prosthesis, of any nature, related to a dental implant is not eligible.

4- ADDITIONAL PLAN 2 – LONG TERM DISABILITY INSURANCE

Additional Plan 2 - Long Term Disability Insurance is designed to complement the Disability Insurance Plan of the collective agreement or the equivalent short term disability insurance plan and to provide the participant with an income until the 65th birthday, should the individual become disabled and completely unable to work for an extended period.

For participants who become totally disabled, the provisions of this plan that are in force on the date the disability begins apply until the end of this total disability period.

4.1 Option of Plans

The Long Term Disability Insurance Plan may vary from one union to another, because each union opts for one of two available plans, "Plan A" and "Plan B". The only difference between these two choices is the applicable definition of total disability. The definitions used in each plan are given in section 1.1.2.

4.2 Beginning of Disability Pension

The monthly pension is payable on the last of the following dates:

a) the end of the first 104 weeks of total disability for a same total disability period;

b) termination of the disability benefit payments stipulated in the collective agreement or in the equivalent disability insurance plan;

c) for participants who receive their annual salary over a period of less than 12 months and for whom the monthly benefit becomes payable during the period when the payment of their salary by the employer is normally suspended, the monthly pension becomes payable on September 1 and follows the end of the payment of disability benefits planned in the collective agreement or by the equivalent disability insurance plan.

4.3 Amount of Disability Pension

The monthly pension is determined by dividing the sum of the following 2 annual amounts by 12:

a) A preliminary amount established based on the gross annual salary of the participant on the date of first payment of this pension*, as follows:

   1) 60% of the first $20,000 of the gross annual salary;

   2) 42.5% of the next $40,000 of the gross annual salary;

   3) 40% of the amount in excess of $60,000 of the gross annual salary.

b) If applicable, a second lump sum annual amount, established according to the family situation, for financial purposes, of the participant. The family situation is the one that was in force on the date the first pension payment was made and cannot be changed. This lump sum amount is equal to:

   1) a lump sum annual amount of $2,000 for a dependent spouse;

   2) a lump sum annual amount of $1,000 for a single-parent family;

   3) a lump sum annual amount of $400 for each dependent child aged 18 or over.

* If the participant's gross annual salary on the date the first pension payment is made is lower than the one that was in force at the beginning of this same total disability period, this amount will be used for the means of calculating the pension.

4.4 Reduction of Disability Pension

The amount of the monthly pension as determined in section 4.3 is reduced by the following amounts:

a) *Any salary paid by the employer*

   Any salary received from the employer, excluding vacation days and sick leave that are convertible into money.

b) *Retirement pensions*

   - 80% of the initial monthly amount of any retirement pension payable by a retirement plan for employees of the public and parapublic sectors (RREGOP, TPP, CSSP, RRCE, CRERP, etc.) or by another private retirement plan.

     However, when an employee who is not retired and suffering from total disability ceases to participate in the private pension plan, while being entitled only to a deferred pension, and decides to transfer the current value of this pension to a Locked-in retirement

account (LIRA), SSQ will reduce the monthly pension payable under this plan by any amount received from a Life Income Fund (LIF) or an income fund obtained through the conversion of amounts accumulated in the LIRA. The amounts considered for the LIRA are only those transferred from the private retirement plan in force at the start of the disability.

- The initial monthly amount of any retirement pension paid by the Quebec Pension Plan (QPP) or by the Canada Pension Plan (CPP).

c) *Public disability pension plan (QPP, CPP, CSST, SAAQ, etc.)*

The initial monthly amount of any disability pension payable in relation to the disability by the Quebec Pension Plan or by the Canada Pension Plan, or under the Act respecting industrial accidents and occupational diseases, the Quebec Automobile Insurance Act or any other social legislation.

d) *Disability pensions from a private plan (TPP, CSSP)*

95% of the initial net monthly amount payable in relation to the disability in question by the Teacher's Pension Plan, the Civil Service Superannuation Plan or any other private plan. By net amount, we mean the amount of the pension stipulated under the Plan in question less any applicable federal and provincial taxes.

To calculate taxes, the following non-reimbursable tax credits are taken into account:

PROVINCIAL	FEDERAL
1. Basic amount	1. Personal basic amount
2. Amount for spouse	2. Amount for spouse
3. Amount for dependents	

e) *Income from any remunerative employment*

75% of the monthly income obtained from any remunerative employment except for the period during which a rehabilitation program approved by SSQ was in effect. *Remunerative employment* means any professional or commercial activity for which the participant receives a direct or indirect compensation, immediate or deferred, with deductions made for current expenses incurred in the exercise of the employee's duties in accordance with the standards established by the *ministère du Revenu du Québec*.

Investment returns are not considered as remunerative employment unless the participant engages in such activity to a significant extent. An *activity engaged into a significant extent* means an activity that generates an income greater than 20% of the initial disability pension. In such a case, only the amount in excess of 20% is considered to be an income from any remunerative employment.

However, assets held prior to the beginning of the disability as well as any investment returns they may generate, including any capital gain resulting from the sale of such assets, are not taken into consideration in the application of this provision.

Notwithstanding the percentage of *income from any remunerative employment* indicated in the first paragraph of this section, any person engaging in remunerative employment without notifying SSQ will have the amount of the monthly pension reduced by 100% of the income obtained from such employment instead of 75%, and this retroactively the date of beginning of employment.

f) *Maternity, paternity, adoption or parental benefits*

Maternity or paternity benefits payable monthly to the employee under any act or government plan.

Adoption or parental benefits payable monthly to the employee under any act or government plan.

Failing to receive amounts from the different income sources previously mentioned in 4.4 b), c) and d), the employee must prove that an application for benefits was submitted to the organizations in question.

However, the employee does not have to apply for a pension:

- when the payment of this pension entails the application of an actuarial reduction in this pension;
- or when they have a waiver of contributions under their retirement plan and have not contributed to the plan for at least 38 years.

4.5 Indexation of Disability Pension

On January 1 of each year following the beginning of payment of a disability pension, the amount of the payable pension is indexed according to the terms of the QPP, up to a maximum annual indexation of 3%.

4.6 Duration of Disability Pension

The pension is paid every month for the duration of the same total disability period but no later than the participant's 65th birthday.

4.7 Total Disability Period

Any continuous total disability period or successive total disability periods, according to the definition given in section 1.1.3.

4.8 Rehabilitation Employment

A disabled insured may, with the agreement of SSQ, perform rehabilitation work. The disability pension payable is reduced by 50% of the remuneration earned from this work. Different resources are also provided to assist with rehabilitation.

4.9 Exclusions

SSQ does not pay any benefits for a total disability:

a) resulting from a war or civil war, whether declared or not, in Canada or in a foreign country, provided the government of Canada has issued a travel warning for the country in question. This exclusion does not apply to the insured who is in a foreign country at the time a war or civil war breaks out and that a recommendation of the government of Canada is issued afterwards, provided the insured takes the necessary steps to leave the country as soon as possible;

b) resulting from active participation of the employee in a riot, insurrection or criminal act;

c) resulting from the employee's active service in the armed forces;

d) resulting from alcoholism or drug addiction, except while the employee is receiving treatment or medical care for rehabilitation;

e) if the disability began while the employee was not covered under this plan;

f) during which the employee is not under the regular care of a physician, except for a stable condition as attested by a physician to the satisfaction of SSQ.

5- ADDITIONAL PLAN 3 - LIFE INSURANCE

This plan provides for a minimum compulsory amount of $10,000 in Participant's Life Insurance coverage. However, participants have the right to opt out of this coverage, as described in section 1.3.4 b). In addition, employees can choose their life insurance coverage from among the choices described below.

5.1 Participant's Life Insurance

5.1.1 Coverage amount

Upon the death of the participant insured under this coverage, SSQ agrees to pay one of the following coverage amounts to the beneficiary, according to the amount chosen by the participant.

$10,000	$100,000	$200,000
$25,000	$125,000	$225,000
$50,000	$150,000	$250,000
$75,000	$175,000	

IMPORTANT

Coverage for amounts of $10,000, $25,000 and $50,000 are available without evidence of insurability if the employer receives the "Application/Request for Change" form within the 180 days following the participant's date of eligibility or the date of a recognized event (see section 1.5.1 b)). After this 180-day period, evidence of insurability is required.

Amounts greater than $50,000 are always subject to the acceptance of evidence of insurability by SSQ.

5.1.2 Reduction of coverage amount

Coverage amounts over $25,000 are reduced by 50% on the January 1 following or coinciding with the participant's 65th birthday.

5.1.3 Limitation in case of suicide

No benefits are payable in the case of suicide of the participant for any coverage amount in excess of $25,000 requested more than 180 days after the date of eligibility* if the death occurs within 12 months following the effective date of such coverage amounts.

* For a newly hired participant who signs a contract of employment after the date on which the individual becomes eligible (contract with retroactive effect), this 180-day period begins on the date the employment contract is signed.

5.1.4 Accelerated benefit payment

Participants who have been granted a waiver of premiums and whose life expectancy is less than 12 months may submit a written request to SSQ to receive a disability benefit up to the lesser of $50,000 and 50% of the amount of life insurance they held. The amount of life insurance is determined by immediately considering any reduction in coverage provided for in the contract that is due to occur during the 24-month period following the date of the participant's request.

Participants who wish to exercise this right must supply evidence, demonstrating to SSQ's satisfaction:

- that their life expectancy is less than 12 months at the date of the request;
- that the approval of the participant's beneficiary, if irrevocable.

At the time of the participant's death, the amount otherwise payable by SSQ to the designated beneficiary is reduced by the amount of the disability pension paid to the participant, plus accrued interest.

Notwithstanding the above, if the participant has not been granted a waiver of premiums yet, SSQ agrees to apply the provisions of this section if a subrogation duly signed by the participant and, if any, by their beneficiary, is submitted to SSQ.

If SSQ is no longer the insurer on the date of the participant's death, the insurer at the time of the death is responsible for paying 100% of the benefit, which means that the amounts already paid by SSQ, including interest, will have to be reimbursed to SSQ.

5.2 Dependent's Basic Life Insurance

This coverage provides payment of the following amounts to the participant:

- $10,000 for the death of the spouse;
- $5,000 for the death of a dependent child aged 24 hours or over.

In the case of participants with Single-Parent status, the amount payable upon the death of the dependent child aged 24 hours or more is $5,000 plus: $10,000 divided by the number of dependent children (including the deceased child) in the family on the date of the dependent child's death.

5.3 Spouse's Optional Life Insurance

5.3.1 Coverage amount

In addition to the coverage amount stipulated in section 5.2, the participant may request from 1 to 10 units of $10,000 in Spouse's Optional Life Insurance. Coverage amounts for Spouse's Optional Life Insurance are always subject to the acceptance of evidence of insurability by SSQ.

5.3.2 Reduction of coverage amount

The amount of Spouse's Optional Life Insurance coverage is reduced by 50% on the January 1 following or coinciding with the participant's 65th birthday.

5.3.3 Limitation in case of suicide

In the case of suicide of the spouse, no benefits are payable for coverage amounts under Spouse's Optional Life Insurance if the death occurs within 12 months following the effective date of such amounts of coverage.

5.3.4 Accelerated benefit payment

If their spouse's life expectancy is less than 12 months, the participant may submit a written request to SSQ to receive a disability benefit up to the lesser of $50,000 and 50% of the amount of life insurance (basic and optional) held by the spouse. The amount of life insurance is determined by immediately considering any reduction in coverage provided for in the contract that is due to occur during the 24-month period following the date of the participant's request.

Participants who wish to exercise this right must supply evidence, demonstrating to SSQ's satisfaction that their spouse's life expectancy is less than 12 months at the date of the request.

At the time of the participant spouse's death, the amount otherwise payable by SSQ to the participant is reduced by the amount of the disability pension paid to the participant, plus accrued interest.

If SSQ is no longer the insurer on the date of the participant's spouse's death, the insurer at the time of the death is responsible for paying 100% of the benefit, which means that the amounts already paid by SSQ, including interest, will have to be reimbursed to SSQ.

5.4 Beneficiary

When a participant completes the "Application/Request for Change" form and chooses to participate in Additional Plan 3 - Life insurance, it is important to specifically designate a beneficiary in case of death.

If the participant does not designate a specific beneficiary, any amount payable at the time of death will be paid to the participant's assigns.

As for the amount payable at the death of an insured spouse or dependent child, this amount is always payable to the participant, if the participant is still alive.

6 - HOW TO SUBMIT A CLAIM

6.1 Hospital Expenses

For hospital expenses incurred in Quebec, insureds present their SSQ card at the hospital.

6.2 Prescription Drug Expenses

There are two ways to forward your prescription drug claims to SSQ:

6.2.1 Direct payment card

This payment method uses an electronic claims system to send benefit claims directly from the pharmacy to SSQ. Upon presentation of your SSQ insurance card, the pharmacist will be able to immediately validate whether the drug is eligible for reimbursement. If so, the insured will only have to pay the portion of the cost of the drug that is not reimbursed by the health insurance plan, because SSQ pays the insured portion directly to the pharmacist.

Once the insured's card has been presented to the pharmacist, it does not need to be presented for future purchases because the information will be kept in the pharmacist's files. However, insureds who change pharmacies will need to present their card to the new pharmacist.

Coordination of benefits at the pharmacy

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

6.2.2 By mail

If an insured is unable to use the SSQ card (lost, non-participating pharmacist, etc.), they can submit their claim by mail using the health care claim form. This form is attached to the claim statement from the last benefit payment. A claim form can also be printed by accessing the SSQ's website at **ssq.ca** and clicking on the "Individuals" link and on "To Submit a Claim". A personalized claim form is also available on the **ACCESS | Plan Members** website.

The pharmacist's invoice must be duly paid and show the insured's name, the patient's name, the number and date of the medical prescription, the physician's name, the drug name and quantity.

Drugs provided by a physician (or a nurse) in remote regions, where this practice is permitted by law, are also covered upon submission of receipts indicating the name and quantity of the drug.

It is recommended to send the original paid invoices **every 3 months**. Receipts and invoices will not be returned. Participants must therefore keep copies of the invoices sent to SSQ. **To be eligible for reimbursement, all receipts and invoices, including prescription drug expenses, must be presented within 12 months of the dates they were incurred.** Using the SSQ card for prescription drug purchases ensures that receipts and invoices are submitted on time.

6.3 Other Health Insurance Expenses

The insured must file claims for all other eligible expenses directly with SSQ.

It is recommended to send the original paid invoices **every 3 months.** Receipts and invoices will not be returned. Participants must therefore keep copies of the invoices sent to SSQ. **To be eligible for reimbursement, all receipts and invoices, including prescription drug expenses, must be presented within 12 months of the dates they were incurred.**

Insureds must submit their claims to SSQ using the claim form provided. This form is attached to the certificate or the claim statement from the last benefit payment. A claim form can also be printed by accessing the SSQ's website at **ssq.ca** and clicking on the "Individuals" link and on "To Submit a Claim". A personalized claim form is also available on the **ACCESS | Plan Members** website.

Some expenses may be claimed directly online via **ACCESS | Plan Members** website or using SSQ Mobile Services. These services are described below in sections 6.9 and 6.10. In both cases, participants must keep the original paid invoices for 12 months after the date expenses are incurred.

Direct Deposit of Health Insurance Benefits

Direct Deposit enables the insured to obtain reimbursement of claims more quickly and eliminates any risk of loss or theft of benefit cheques.

Insureds can apply for Direct Deposit by registering to use SSQ secure transactional site on **ACCESS | Plan Members.** To do so, insureds must have their SSQ Card on hand, as well as a personal cheque showing their bank account number. For more details on how to register and on our internet services, go to section 6.9.

Insureds who wish to apply for Direct Deposit but do not have internet access, or who require assistance, can contact SSQ Customer Service at the numbers indicated on the back of this booklet.

6.4 Dental Care Insurance Fees

To have their claims electronically transmitted to SSQ, insureds must present their SSQ insurance card to their dentist. That way, they only have to pay the amount not reimbursed by SSQ.

If the dentist does not offer an electronic claim transmission system, insureds must complete the "Benefit Claim for Dental Care" form, sign it and return it to SSQ. This form is available from the employer.

It is recommended to send the original paid invoices **every 3 months.** Receipts and invoices will not be returned. Participants must therefore keep copies of the invoices sent to SSQ. **To be eligible for reimbursement, all receipts and invoices must be presented within 12 months of the dates they were incurred.**

6.5 Hospital or Medical Expenses Related to a Workplace or Automobile Accident

In the event of a work or automobile accident, all resulting hospital and medical expenses are payable by the *Commission de la santé et de la sécurité du Travail* (CSST) or the *Société de l'assurance automobile du Québec* (SAAQ). These invoices must be submitted to the CSST or the SAAQ and not to SSQ.

6.6 Life Insurance

Life Insurance claim forms are available directly from SSQ. These claims must be submitted within 90 days following the event.

6.7 Long Term Disability Insurance

Any claim for long term disability insurance benefits must be submitted to SSQ in writing, along with satisfactory evidence as to the cause and duration of total disability, including a medical report, within the 90 days prior to the date on which the insured is entitled to long term disability benefits.

The insured must file such a benefit claim even if they are receiving disability benefits under another plan (e.g., CSST, QPP, etc.).

6.8 Where to Send Benefit Claims

The insured must indicate the contract number on any benefit claim or correspondence and send these to SSQ at the following address:

SSQ, P.O. Box 10500, Stn. Sainte-Foy, Quebec QC G1V 4H6

6.9 SSQ On-line Services

ACCESS | Plan Members

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

- submit a claim online (for some types of claims only);
- register for Direct Deposit of Health, Dental Care and Disability Insurance benefits;
- consult electronic claim statements on-line;
- print personalized Health Insurance Claim coupons;
- print Dental Care Insurance claim forms;
- order tax receipts for medical expenses incurred;
- print a temporary SSQ card if the existing card has been lost or misplaced;
- inform SSQ of a change of 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 as part of their insurance file;
- view the balance of their counter for the coverage involved.

To register for Access and take advantage of SSQ's online services, insureds can simply visit SSQ's website at **ssq.ca** and click on the **ACCESS | Plan Members** link in the group insurance section. Online instructions will explain how to register.

If they require assistance, insureds can contact SSQ Customer Service, Monday through Friday, from 8:30 a.m. to 4:30 p.m., at one of the numbers indicated on the back of this booklet.

6.10 SSQ's Mobile Services

A participant who has a mobile device can download SSQ's free Mobile Services application in order to:

- submit a group insurance claim;
- consult the history of recent payments;
- obtain an electronic version of the SSQ insurance card;
- contact SSQ's Customer Service.

For more information regarding SSQ's Mobile Services, the participant can visit SSQ's website at **ssq.ca**.

6.11 Personal Information and Insurance file

Notice of new file

To maintain the confidentiality of information concerning each person it insures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and information 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 or underwriting, in addition to any other persons the insured person may authorize. SSQ keeps these insurance files in its offices.

All participants have the right to consult the information contained in their file and, if necessary, have any errors or inaccuracies corrected, free of charge, making a written request to the attention of SSQ's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 boulevard Laurier, 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 communicate personal information to its reinsurers, legal agents and service providers, but only when it is required as part of the tasks they are assigned. The legal agents and service providers of SSQ must comply with SSQ's Personal Information Protection Policy.

By enrolling in a group insurance plan, and when making a benefit claim, participants consent to having their personal information on file used for the purposes described above by the insurer, its legal agents and service providers. It is understood that refusing this consent will compromise the management of their insurance and the quality of service SSQ can offer.

For more information, please refer to the Personal Information Protection Policy Statement on SSQ's website at **ssq.ca.**

An electronic version of this group insurance booklet is also available online on SSQ's Web site at **ssq.ca**. You can consult the booklet by clicking on the **ACCESS | Plan Members** link in the group insurance section of the Web site.

Please refer to the online booklet since it will be updated periodically to reflect any changes made to your insurance plan.

The current year's premium rates are available in the document entitled "Your Group Insurance Plan At a Glance", a copy of which can be obtained from your employer or via the **ACCESS | Plan Members** Web site.

CONTACT US

SSQ Head Office

2525 Laurier Boulevard
P.O. Box 10500, Station Sainte-Foy
Quebec (Quebec) G1V 4H6

1-888-651-8181

ssq.ca

Please keep this booklet for future reference.

SSQ Financial Group

Values in the right place

BV3467A (2015-09)