CONTRACT
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January 1, 2021

alter ego

THE *CSQ* ADVANTAGE

YOUR GROUP INSURANCE PLAN

REFLECTING MY REALITY

The new Centrale des syndicats du Québec (CSQ) group insurance plan: well thought-out and designed to meet its members' genuine interests.

CSQ
Centrale des syndicats du Québec

In partnership with
SSQ insurance

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

This booklet is provided for information purposes only and in no way affects the provisions and conditions of the group insurance contract applicable as of January 1, 2021.

Cette brochure est disponible en français.

Table of Contents

SCHEDULE OF BENEFITS

Health Insurance (compulsory participation, with right of exemption)

Refer to the Health Insurance Plan section for details pertaining to the benefit, including applicable exclusions, restrictions and limitations.

For each type of eligible expenses, the percentage of reimbursement and the applicable maximum, where applicable, are shown in the table below.

Maximum amounts indicated in the table below apply per insured person, except for the annual out-of-pocket for prescription drugs that applies per certificate.

To be considered eligible, all expenses identified by an asterisk (*) in the table must be incurred on the attending physician's recommendation.

If no amount is indicated, customary and reasonable expenses apply.

Compulsory Basic Plan	Reimbursement Parameters
Prescription drugs* and eligible pharmaceutical services - direct payment card [(1)]	80% of eligible expenses (100% if the annual out-of-pocket exceeds $970 / certificate)
	Regular list Drugs available on prescription only
Sclerosing injections	The percentage of reimbursement for prescription drugs applies Maximum reimbursement of $35 / day
Accidental dismemberment	$25,000 or $50,000 depending on the loss

[(1)] Reimbursement of drugs with mandatory generic substitution

All eligible prescription drugs expenses are reimbursed at 80%. If you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. Besides, the amount taken into account in the calculation of the annual out-of-pocket maximum will be based on the lowest cost generic equivalent.

It is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons by submitting the appropriate form duly completed by the attending physician. All professional fees required to complete the form are at the expense of the insured and SSQ must approve the request.

Optional Complementary Package 1	Reimbursement Parameters
Ambulance and transportation by plane	80%
Hospital expenses in Canada	100% Semi-private room
Professional fees following an accident to natural teeth	80% Within 24 months of the accident
Psychological care	80 % Maximum reimbursement of $1,000 / calendar year
Transportation by plane or by train of a bedridden insured*	80%
Travel Insurance with Assistance	100% Maximum reimbursement of $5,000,000 / trip
Trip Cancellation Insurance	100% Maximum reimbursement of $5,000 / trip

<table>
<tr><th>Optional Complementary Package 2</th><th colspan="2">Reimbursement Parameters</th></tr>
<tr><td>Audiology</td><td rowspan="8">80%
Combined maximum reimbursement of $1,000 per insured, per calendar year for all of these professionals</td><td rowspan="11">80%
Combined maximum reimbursement of $2,000 per insured, per calendar year for all of these professionals if Optional Complementary Packages 2 and 3 are chosen</td></tr>
<tr><td>Chiropractic (including X-rays)</td></tr>
<tr><td>Eye examinations</td></tr>
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<tr><th>Optional Complementary Package 3</th></tr>
<tr><td>Acupuncture</td><td rowspan="5">80%
Combined maximum reimbursement of $1,000 per insured, per calendar year for all of these professionals</td></tr>
<tr><td>Dietetics</td></tr>
<tr><td>Homeopathy (including homeopathic remedies)</td></tr>
<tr><td>Massage therapy, kinesitherapy and orthotherapy</td></tr>
<tr><td>Naturopathy</td></tr>
<tr><td>Osteopathy</td></tr>
</table>

Optional Complementary Package 4	Reimbursement Parameters
Artificial limbs and external prosthesis*	80%
Blood glucose monitor*	80% Maximum reimbursement of $240 / 36 months
Breast prostheses*	80% For mastectomy
Capillary prosthesis*	80% Lifetime maximum reimbursement of $300
Coagulometer*	80% Maximum of 1 device / 60 months
Deep shoes*	80%
Detoxification treatment*	80% Maximum reimbursement of $64 / day, up to 30 days / calendar year
Foot orthoses*	80%
Hearing aid (including fees of a hearing aid practitioner)	80% Maximum reimbursement of $560 / 48 months
Insulin pump and accessories*	80%
Intraocular lenses*	80%
Medium or full compression support stockings*	80% Maximum of 3 pairs / calendar year
Nursing care*	80% Maximum reimbursement of $240 / day, up to $5,000 / calendar year
Orthopaedic devices*	80%
Orthopaedic shoes*	80%

Ostomy appliances*	80%
Post-surgical brassieres*	80% Lifetime maximum reimbursement of $200 For mastectomy or breast reduction
Respirator and oxygen*	80%
Therapeutic devices*	80%
Transcutaneous electrical nerve stimulator*	80% Maximum reimbursement of $800 / 60 months
Transportation and accommodation expenses in Quebec*	80% Maximum reimbursement of $1,000 / calendar year
Wheelchair, walker or hospital bed (temporary use only)*	80%

Dental Care Insurance (optional participation)

Refer to the Dental Care Insurance Plan section for details pertaining to the benefit, including applicable exclusions and restrictions.

Coverage	• Preventive Dental Care • Minor Restorative Dental Care • Major Restorative Dental Care
Deductible	$50 annual deductible per certificate covers both Minor Restorative Dental Care and Major Restorative Dental Care coverage
Percentage of reimbursement	• Preventive Dental Care: 80% • Minor Restorative Dental Care: 80% • Major Restorative Dental Care: 50%
Progressive maximum reimbursement	• 1st calendar year during which coverage starts: $600 / insured person • 2nd calendar year: $800 / insured person • 3rd calendar year and thereafter: $1,000 / insured person

Short Term Disability Insurance (compulsory participation, with waiver privilege)

Refer to the Short Term Disability Insurance Plan section for details pertaining to the benefit, including applicable exclusions.

The Short Term Disability Insurance Plan is applicable to participants whose collective agreement does not include a Short Term Disability Insurance Plan.

Types of plans	• Disability insurance plan for the employer • Disability insurance plan for the employee
Pension	• Disability insurance plan for the employer: 60% to 100% of the weekly salary • Disability insurance plan for the employee: 60% to 75% of the weekly salary
Pension tax status	• Disability insurance plan for the employer: taxable pension • Disability insurance plan for the employee: non-taxable pension
Elimination period	Accident/Hospitalization: 0 to 365 days Illness: 7 to 365 days
Maximum pension period	52 weeks or 104 weeks or payable until the participant reaches age 70

Long Term Disability Insurance (compulsory participation, with waiver privilege and right of exemption)

Refer to the Long Term Disability Insurance Plan section for details pertaining to the benefit, including applicable exclusions.

Pension	• 65% of the first $20,000 of the gross annual salary • 50% of the next $20,000 • 45% of the amount in excess
Pension tax status	Non-taxable pension
Elimination period Accident/ Hospitalization/ Illness	104 weeks
Maximum pension period	Payable until the participant reaches age 65

Life Insurance

Refer to the Life Insurance Plan section for details pertaining to the benefit, including applicable limitations.

Compulsory participation, with right to opt out

Participant's Basic Life Insurance	
Sum insured	$10,000 or $25,000, at the participant's choice

Optional participation

Participant's Optional Life Insurance	
Sum insured available	1 to 9 units of $25,000, with evidence of insurability, except for the first two units of $25,000 if the participant chooses a coverage amount of $25,000 under Basic Life Insurance and requests it within 180 days of the eligibility date
Reduction of the sum insured	On January 1 coinciding with or following the participant's 65th birthday, the sum insured is reduced by 50%
Dependents' Basic Life Insurance	
Option 1	Option 2
Spouse: $10,000	Spouse: $20,000
Child (aged 24 hours or older): $5,000	Child (aged 24 hours or older): $10,000
Spouse's Optional Life Insurance (subject to participation in Option 2 under Dependents' Basic Life Insurance)	
Sum insured available	1 to 10 units of $10,000, with evidence of insurability
Reduction of the sum insured	On January 1 coinciding with or following the participant's 65th birthday, the sum insured is reduced by 50%

1- GENERAL INFORMATION

1.1 Definitions

1.1.1 Accident

A fortuitous event due to a sudden and unforeseen external cause and resulting in bodily injury, as diagnosed by a physician.

1.1.2 Accident (for the purposes of Travel Insurance with Assistance and Trip Cancellation Insurance benefits)

An unintentional, sudden, accidental and unforeseeable event caused exclusively by an external cause and resulting, in bodily injury, directly and independently of any other cause.

1.1.3 Annual earnings (for insurance purposes)

For the purposes of Short Term Disability Insurance:

The remuneration, in current money calculated on an annual basis, according to the collective agreement applicable, including premiums for any regional disparity and retroactive salary adjustment but excluding any bonus, overtime pay and severance pay. This remuneration is based on the annual salary payable at the beginning of disability.

For any part-time employee, the salary is calculated in proportion to the time worked compared to the regular working week of a full-time employee.

However, for a part-time teacher, the salary is calculated in proportion to the teaching workload carried out compared to the individual workload of a full-time teacher.

For **support staff of school boards or school service centres working in the adult education sector**, this definition is replaced by the one given in section 1.14.3 d) of this booklet.

For the purposes of Long Term Disability Insurance:

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 the pension 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.

The annual earnings used for contribution of premium purposes is the one given above, while the annual earnings used to establish the pension 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 1.14.2 b).

For **support personnel of a school board or a school service centre working in the adult education sector**, this definition is replaced by the one given in section 1.14.3 d).

1.1.4 Business partner

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

1.1.5 Collective agreement

The collective agreement, as defined in the Labour Code. Also refers to the National Agreement. By extension, it also means any decree in lieu thereof.

1.1.6 Commercial or professional activity

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

1.1.7 Customary and reasonable expenses

Expenses generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration, that requires the same skill and is performed by a provider of similar training and experience.

1.1.8 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.

1.1.9 Dependent child

- A child of the employee, of the spouse, or of both;

- A child 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 under the age of 18;

b) be under the age of 26 and attend a recognized educational institution as a duly registered full-time student, subject to proof of registration deemed satisfactory by SSQ;

   A dependent child who is between the ages of 18 and 25 inclusive, who takes a sabbatical school leave, 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);

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 Public Prescription Drug Insurance Plan, is also considered to be totally disabled.

1.1.10 Employee

<u>For the purposes of all plans, except for the Short Term Disability Insurance Plan</u>:

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 are part of any group acknowledged by the policyholder.

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

<u>For the purposes of the Short Term Disability Insurance Plan</u>:

Any individual who belongs to one of the following categories:

- members of certain unions affiliated to the CSQ;
- personnel and individuals on union leaves of the CSQ;

- personnel and individuals on union leaves of certain unions or federations affiliated to the CSQ;
- personnel of any other institutions accepted by the CSQ.

1.1.11 Employer

For the sole purposes of Short Term Disability Insurance, the Centrale des syndicats du Québec (CSQ) or one of its unions or federations that are affiliated or under an agreement for technical services, as well as any other establishment accepted by the policyholder.

1.1.12 Evidence of insurablity

Proof deemed satisfactory by SSQ to determine if an insured or dependent are eligible for insurance depending on the state of health and life habits.

1.1.13 Good and stable state of health

State of health allowing the insured to carry out usual daily activities while not experiencing any symptoms that may reasonably suggest that any complications may arise or that medical care may be required during a trip outside the province of residence.

1.1.14 Family member

A spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, grandparent, grandchild, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law or daughter-in-law.

1.1.15 Hospital

Any establishment considered a hospital under the acts and regulations respecting health services and social services (R.S.Q., ch. S-4.2); outside the province of Quebec, the term means any establishment meeting the same standards.

1.1.16 Host at destination

An individual providing accommodations at his/her main residence where the insured person is planning to stay for at least part of the trip.

1.1.17 Illness

A deterioration of physical or mental health or bodily disorder, as diagnosed by a physician.

1.1.18 Insured

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

1.1.19 National agreement

All the clauses negotiated and agreed at the national level in accordance with the Act respecting the process of negotiation of the collective agreements in the public and parapublic sectors (R.S.Q., c. R-8.2). By extension, it also means any decree in lieu thereof.

1.1.20 Participant

Any employee participating in the group insurance plan.

1.1.21 Physician

An individual who is legally authorized to practise medicine.

1.1.22 Point of departure

The first location where the insured person leaves for the planned trip (airport, bus station, port, train station).

1.1.23 Policyholder

La Centrale des syndicats du Québec (CSQ).

1.1.24 Premium period

Period for which premiums are payable, as agreed by SSQ and the Policyholder.

1.1.25 Prepaid travel expenses

Refers to the following:

- Expenses incurred by the insured to purchase a trip, including tickets from a public carrier, rental of motor vehicles or accommodation from a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services;
- Amounts paid by the insured for travel arrangements usually included in a package trip;
- Amounts paid by the insured in relation to registration fees for a commercial activity.

1.1.26 Spouse

The person who so became following a marriage or civil union legally contracted 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 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 seperation for more than 3 months in the case of a marriage or civil union or de facto separation for more than 3 months in the case of a common law union.

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 the employer in writing of any change related to the spouse so that the insurance file may be corrected if necessary.

1.1.27 SSQ

SSQ, Life Insurance Company Inc., the Insurer.

1.1.28 Total disability

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.

1.1.29 Total disability period

Successive disability periods of the same nature: 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).

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

- **school boards or school service centres teachers:** period of 35 consecutive days;
- **school boards or school service centres support personnel:** period of 32 consecutive days;
- **school boards or school service centres 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.

Successive disability periods of a different nature: 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 part of the same period if both periods are not separated by one day of full-time effective work or availability for such work. In the case of a full-time return to work of at least one day of effective work or availability for such work, a period of total disability completely unrelated to the cause of the preceding disability is considered as a new period of total disability.

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

1.1.30 Travel companion

The person with whom the insured person shares the room or apartment at the destination, or whose travel expenses were paid along with those of the insured person. Also includes the person with whom the insured person travels during the whole duration of the trip in the case of a two-person trip.

1.1.31 Trip (for the purposes of Trip Cancellation Insurance benefit)

Travel for leisure or a commercial activity, which entails the absence of the insured person from the place of residence for at least two consecutive nights and requiring travel of at least 400 kilometres (round trip) from the place of residence. A cruise lasting at least two consecutive nights, under the responsibility of an accredited firm, is also considered to be a trip.

1.1.32 Waiting period

The period at the beginning of disability during which no pension is payable.

1.1.33 Weekly salary (for insurance purposes)

The weekly salary is equal to $1/52^{th}$ of the annual salary. However, for an employee whose annual salary is paid over a period that is less than 12 months, the weekly salary is determined by dividing the annual salary by the number of pay periods provided for the payment of the salary. The result is brought back on a weekly basis if the pay periods applicable are greater than one week.

For provisions applicable to **support staff of school boards or school service centres working in the adult education sector**, see section 1.14.3 e) of this booklet.

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 Insurance Compulsory Basic Plan.

For provisions applicable to **support staff of school boards or school service centres working in the adult education sector**, see section 1.14.3 b) of this booklet.

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 Particularities regarding the Short Term Disability Insurance Plan

a) *Eligibility*

Any employee who does not benefit from another disability insurance plan covering at least 104 weeks of disability is eligible for the Short Term Disability Insurance Plan from the date the individual becomes an employee.

Eligibility for this plan is determined according to the applicable collective agreement.

b) *Implementation of the plan*

In accordance with the rules of participation described in section 1.3.3, participation in this plan is compulsory for any eligible employee.

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*

In accordance with the rules of participation described in section 1.3.4, all eligible employees must participate in the plan.

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 the waiver privilege for insureds aged 65 and older described on page 18 or to the right of exemption as described in section 1.3.1 b).

All eligible employees must participate in the Compulsory Basic Plan only or combine participation to this plan with one or many of the following optional complementary packages:

– Optional Complementary Package 1

– Optional Complementary Package 2

– Optional Complementary Package 3

– Optional Complementary Package 4

Important

The minimum period of participation* is 24 months for each optional complementary package.

****Minimum period of participation***

The above-mentioned minimum period of participation of 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 Compulsory Basic Plan only (according to what is stipulated in sections 1.9.2 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 Alter ego 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 Alter ego Health Insurance Plan.

When employees turn 65, they are automatically registered for the Public Prescription Drug Insurance Plan of the RAMQ.

They can choose to:

- maintain all of their coverage under the Alter ego Health Insurance Plan, including prescription drugs, with no change in premiums, and they must contact the RAMQ in order to opt out of this plan;
- waive their coverage under the Alter ego Health Insurance Plan and maintain their participation in the Public Prescription Drug Insurance Plan of the RAMQ. In this case, the Alter ego Health Insurance Plan terminates permanently and they will not be able to modify their choice.

If employees wish to take advantage of their right to waive, they must send to SSQ, through their employer, the completed "Health Insurance Plan Waiver Privilege" form. The waiver becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

When the insured spouse turns 65:

The coverage is maintained under the Alter ego Health Insurance Plan, including prescription drugs, with no change in premiums.

IMPORTANT:

When employees or their spouse maintain coverage under the Alter ego Health Insurance Plan, because all Quebec residents who reach age 65 are automatically registered for the Public Prescription Drug Insurance Plan, themselves and their spouse, as the case may be, must contact the RAMQ in order to opt out of this plan to avoid paying premiums.

b) *Right of exemption*

Employees may refuse or cease to participate 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 one or many optional complementary packages can choose to be exempted even if the minimum period of participation of 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 60 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 60 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 60 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 premium period coinciding with or following the date the employer 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 60 days following the end of the eligibility to the group insurance plan having allowed the exemption:

  The employee may then choose the plan that meets their needs (Compulsory Basic Plan only or Compulsory Basic Plan combined with one or many optional complementary packages) with the required 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 60 days after the end of the eligibility to the group insurance plan having allowed the exemption:

  The insurance under the plan chosen becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request, according to the required coverage status (individual, single-parent or family).

1.3.2 Dental Care Plan

a) *Optional feature*

Participation in this plan is optional for all employees eligible to the Dental Care Plan.

b) *Minimum period of participation*

The minimum period of participation for all employees 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 a compulsory dental care coverage. Afterwards, if they wish to participate in the Dental Care Plan once again, a new minimum period of participation of 48 months will begin as of the date the coverage comes into force.

The minimum period 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 Compulsory Basic Plan only or the current Health Insurance Plan only (as stipulated in sections 1.9.2 and 1.11.1).

1.3.3 Short Term Disability Insurance Plan

a) *Compulsory feature*

Participation is compulsory for all employees who are eligible for the Short Term Disability Insurance Plan, subject to the waiver privilege described in section 1.3.3 b) hereinafter.

b) *Waiver privilege*

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

- be a rehired retiree and receive a retirement pension; or
- be actively at work and eligible for a retirement pension without actuarial reduction; or
- be actively at work and eligible for a retirement pension without actuarial reduction by the end of the disability pension payment that would be payable under the Disability Insurance Plan for the employer.

If employees wish to take advantage of the waiver privilege, they must send to SSQ, through their employer, the completed "Short Term Disability Insurance Plan for the Employees Waiver Privilege" form. The waiver becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

Important

If employees take advantage of the waiver privilege, they cannot reinstate their participation in the Short Term Disability Insurance Plan for the employees afterwards, with or without evidence of insurability.

However, when they are rehired, the waiver privilege is not renewed. If they have already taken advantage of the waiver privilege, they must complete another form and send it to the employer.

1.3.4 Long Term Disability Insurance Plan

a) *Compulsory feature*

Participation is compulsory for all employees who are eligible for the Long Term Disability Insurance Plan, subject to the waiver privilege described in section 1.3.4 b) hereinafter and the right of exemption described in section 1.3.4 c).

After a temporary absence from work during which participation in the Long Term Disability Insurance Plan has not been maintained, participants will be covered under this plan on the date of their return to work.

b) *Waiver privilege*

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

- participation in the Government and Public Employees Retirement Plan (RREGOP) with 33 years of service or more;
- age 53 or older;
- 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 the waiver privilege, they must send to SSQ, through their employer, the completed "Long Term Disability Insurance Plan Exemption or Waiver Privilege" form. The waiver becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

Important

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

However, when they are rehired, the waiver privilege is not renewed. If they have already taken advantage of the waiver privilege, they must complete another form and send it to the employer.

c) *Right of exemption*

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

- they are a member of a professional order with coverage under a Long Term Disability Insurance Plan offered by this professional order, as long as the coverage is equivalent to that provided by the Alter ego Long Term Disability Insurance Plan;
- they are on union leave with pay and eligible to the Long Term Disability Insurance Plan provided by the employer for which they perform union-related tasks.

If employees wish to take advantage of their right of exemption, they must send to SSQ, through their employer, the completed "Long Term Disability Insurance Plan Exemption or Waiver Privilege" form. The exemption becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

Employees exempted from participation in the Long Term Disability Insurance Plan who prove that they are no longer eligible for the plan having allowed the exemption may resume participation in the Long Term Disability Insurance Plan, without evidence of insurability. The end of the exemption becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.

1.3.5 Life Insurance Plan

a) *Compulsory feature with right to opt out*

Participation in Participant's Basic 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 1.3.5 c) hereinafter.

b) *Optional feature*

Participation in Participant's Basic Life Insurance for an amount exceeding $10,000 as well as participation in other life benefits is optional.

Upon enrolment, the participant can choose among the following coverage options:

- Participant's Basic Life Insurance (coverage amount of $25,000);
- Participant's Optional Life Insurance (subject to a coverage amount of $25,000 in Participant's Basic Life Insurance);
- Dependents' Basic Life Insurance (Option 1 or Option 2 as described in section 6.3);
- Spouse's Optional Life Insurance (subject to a coverage amount of $20,000 from Option 2 for the spouse in Dependents' Basic Life Insurance).

c) *Right to opt out*

Participants have a maximum of 180 days as of the date the $10,000 coverage in Participant's Basic Life Insurance automatically granted becomes effective to make a request to opt out by completing the "Application/Request for Change" form.

If the employer receives the request to opt out:

i) Within 60 days following the date the coverage amount became effective:

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

ii) After more than 60 days but 180 days or less after the coverage amount became effective:

Participant's Basic Life Insurance will be terminated on the first day of the premium period coinciding with or following the date the employer receives the request.

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

The minimum coverage amount of $10,000 in Participant's Basic Life Insurance remains in force and the right to opt out is no longer applicable.

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.

For newly hired participants who sign a contract of employment after the date on which the individual becomes eligible (contract with retroactive effect), the 60-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, Short Term Disability Insurance and Long Term Disability Insurance Plans

	Date the application for insurance is received by the employer	
Plan	**Within 60 days following the date of eligibility**	**More than 60 days after the date of eligibility**
Health Insurance	The chosen Health Insurance Plan (Compulsory Basic Plan or Compulsory Basic Plan combined with one or many optional complementary packages) will become effective on the date of eligibility, according to the required 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 Compulsory Basic Plan is granted with an individual coverage status as of the date of eligibility. a) For employees who requested a single-parent or family coverage status, the coverage status will be granted under the Compulsory Basic Plan as of the first day of the premium period coinciding with or following the date the employer receives the request; b) For employees who requested to be exempted from participation in the Health Insurance Plan, the exemption will become effective on the first day of the premium period coinciding with or following the date the employer receives the request; c) For employees who requested to participate in one or many optional complementary packages, the chosen plans will become effective on the first day of the premium period coinciding with or following the date the employer receives the request.

	Date the application for insurance is received by the employer	
Plan	**Within 60 days following the date of eligibility**	**More than 60 days after the date of eligibility**
Dental Care Insurance	The insurance will become effective on the date of eligibility, according to the required coverage status (individual, single-parent or family).	The insurance will become effective on the first day of the premium period coinciding with or following the date the employer receives the request, according to the required 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 Insurance Plan.**	
Short Term Disability Insurance	The insurance becomes effective on the date of eligibility.	
Long Term Disability Insurance	The insurance becomes effective on the date of eligibility.	

1.4.2 Date the Life Insurance Plan becomes effective

	Date the application for insurance is received by the employer		
Coverage	**Within 60 days following the date of eligibility**	**More than 60 days but 180 days or less after the date of eligibility**	**More than 180 days after the date of eligibility**
Participant's Basic Life Insurance	A $10,000 or $25,000 coverage amount, at the participant's choice, becomes effective on the date of eligibility, with a right to opt out.	A $10,000 coverage amount becomes effective on the date of eligibility. A $25,000 coverage amount, at the participant's choice, becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request.	A $10,000 coverage amount becomes effective on the date of eligibility. A $25,000 coverage amount is subject to the presentation of evidence of insurability. This amount becomes effective on the first day of the premium period coinciding with or following the date SSQ approves the required evidence of insurability.

	Date the application for insurance is received by the employer		
Coverage	**Within 60 days following the date of eligibility**	**More than 60 days but 180 days or less after the date of eligibility**	**More than 180 days after the date of eligibility**
Participant's Optional Life Insurance	Participants may choose a $25,000 or $50,000 coverage amount (1 or 2 units of $25,000) without evidence of insurability. This amount becomes effective on the date of eligibility. Coverage amounts greater than $50,000 (between 3 and 9 units of $25,000) are subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the premium period coinciding with or following the date SSQ approves the required evidence of insurability.	Participants may choose a $25,000 or $50,000 coverage amount (1 or 2 units of $25,000) without evidence of insurability. This amount becomes effective on the first day of the premium period coinciding with or following the date the employer receives the request. Coverage amounts greater than $50,000 (between 3 and 9 units of $25,000) are subject to the presentation of evidence of insurability. Any amount in excess of $50,000 becomes effective on the first day of the premium period coinciding with or following the date SSQ approves the required evidence of insurability.	Participants may request 1 to 9 units of $25,000. This insurance is subject to the presentation of evidence of insurability and becomes effective on the first day of the premium period coinciding with or following the date SSQ approves the required evidence of insurability.
Dependents' Basic Life Insurance (Option 1 or Option 2)	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 premium period coinciding with or following the date the employer receives the request.	The insurance becomes effective on the first day of the premium period coinciding with or following the date SSQ approves the required evidence of insurability.
	Note: Employees may participate in Dependents' Basic Life Insurance even if they opt out of Participant's Basic Life Insurance.		

	Date the application for insurance is received by the employer		
Coverage	**Within 60 days following the date of eligibility**	**More than 60 days but 180 days or less after the date of eligibility**	**More than 180 days after the date of eligibility**
Spouse's Optional Life Insurance	The insurance is available only if Dependents' Basic Life Insurance (coverage amount of $20,000 from Option 2 for the spouse) is in force. Participants may request 1 to 10 units of $10,000 in Spouse's Optional Life Insurance. This insurance is subject to the presentation of evidence of insurability and becomes effective on the first day of the premium period coinciding with or following the date the evidence of insurability is approved by SSQ.		

1.5 Change in Coverage Status

1.5.1 Increase in 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.

a) *Health Insurance Plan*

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 one of these events:

- marriage or civil union;
- 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, adoption or custody 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 Plan, if applicable.

Effective date of new coverage status

i) If the employer receives the "Application/Request for Change" form within 60 days following the event that allows the participant to increase the coverage status:

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

ii) If the employer receives the "Application/Request for Change" form more than 60 days following the event that allows the participant to increase the coverage status:

The new coverage status becomes effective on the first day of the premium period coinciding with or following the receipt of the request by the employer.

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.

b) Dental Care Plan

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 one of these events:

- marriage or civil union;
- 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, adoption or custody of a child;
- termination of the insurance of the spouse or dependent children;
- regular employment status obtained, according to the applicable collective agreement.

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 Dental Care Plan may be different than the one chosen for the Health Insurance Plan, if applicable.

Effective date of new coverage status

i) If the employer receives the "Application/Request for Change" form within 60 days following the event that allows the participant to increase the coverage status:

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

ii) If the employer receives the "Application/Request for Change" form more than 60 days following the event that allows the participant to increase the coverage status:

The new coverage status becomes effective on the first day of the premium period coinciding with or following the receipt of the request by the employer.

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 full-time.

1.5.2 Decrease in coverage status

a) *Health Insurance Plan*

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.

The decrease in coverage status can only be granted following one of these events:

- separation, divorce or death of the spouse;
- termination of eligibility or death of a dependent child;
- eligibility to the insurance of the spouse.

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 premium period coinciding with or 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 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 chosen plan (Compulsory Basic Plan or Compulsory Basic Plan combined with one or many optional complementary packages) must comply with the provided requirements of the law. Therefore, all insureds must be covered by the same Health Insurance Plan.

Important

Employees must make sure they inform the employer of any change regarding their dependents so SSQ can be notified. The coverage status they hold under the Health Insurance Plan (individual, single-parent or family) must correspond to their current family status, in accordance with the definition of "dependent" in section 1.1.8, to avoid paying unnecessary premiums.

b) Dental Care Plan

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.

The decrease in coverage status can only be granted following one of these events:

- separation, divorce or death of the spouse;
- termination of eligibility or death of a dependent child;
- eligibility to the insurance of the spouse;
- regular employment status obtained, according to the applicable collective agreement.

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 premium period coinciding with or following the receipt of the request by the employer.

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

1.6 Change in Coverage

1.6.1 Addition of coverage

The minimum period of participation is 24 months for each optional complementary package of the Health Insurance Plan and 48 months for the Dental Care Insurance Plan.

a) *Health Insurance Plan*

Participants can increase their coverage under the Health Insurance Plan by participating in one or many **optional complementary packages**.

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

Effective date of change requested

The change requested becomes effective on the first day of the premium period coinciding with or following the date the request is received by the employer.

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 full-time return to work, except if the coverage is chosen as part of the termination of an exemption.

b) *Dental Care Plan*

Participants can enrol in the Dental Care Plan at any time.

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

Effective date of change requested

The change requested becomes effective on the first day of the premium period coinciding with or following the date the request is received by the employer.

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 full-time return to work.

c) *Life Insurance Plan*

Participants may increase their coverage as follows:

- apply for Participant's Basic Life Insurance, if they were not covered;
- increase their coverage amount in Participant's Basic Life Insurance (from $10,000 to $25,000);
- apply for Participant's Optional Life Insurance, provided a $25,000 coverage amount for Participant's Basic Life Insurance is already in force;
- increase their coverage amount in Participant's Optional Life Insurance;
- apply for Dependents' Basic Life Insurance (Option 1 or Option 2);
- increase their coverage amount in Dependents' Basic Life Insurance (from Option 1 to Option 2);
- apply for Spouse's Optional Life Insurance, provided the $20,000 coverage amount from Option 2 for the spouse in Dependents' Basic Life Insurance is already in force;
- 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 change requested

i) <u>If the employer receives the request for change within 60 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, adoption or custody of a child;
- the termination of the spouse's or dependent children's insurance;
- the death of the spouse or a dependent child;
- the obtainment of regular employment status, according to the applicable collective agreement.

Coverage amounts of $10,000 or $25,000 for Participant's Basic Life Insurance, coverage amount of $50,000 for Participant's Optional Life Insurance and coverage amounts for Dependents' Basic Life Insurance provided for under options 1 and 2 are available without evidence of insurability and **the insurance becomes effective on the date of the event**.

Coverage amounts for Participant's Optional 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 premium period coinciding with or 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 premium period coinciding with or following the date the evidence of insurability is approved by SSQ.

ii) <u>If the employer receives the request for change more than 60 days but 180 days or less after the events described above</u>:

Coverage amounts of $10,000 or $25,000 for Participant's Basic Life Insurance, coverage amount of $50,000 for Participant's Optional Life Insurance and coverage amounts for Dependents' Basic Life Insurance provided for under options 1 and 2 are available without the requirement for evidence of insurability and **the insurance becomes effective on the first day of the premium period coinciding with or following the date the request is received by the employer.**

Coverage amounts for Participant's Optional 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 premium period coinciding with or 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 premium period coinciding with or following the date the evidence of insurability is approved by SSQ.

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

Evidence of insurability is required and the insurance becomes effective on the first day of the premium period coinciding with or 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 full-time return to work.

1.6.2 Decrease in coverage

a) *Health Insurance Plan*

The participant can decrease the coverage under the Health Insurance Plan by terminating participation in one or many optional complementary packages.

The participant must have completed the minimum period of participation of 24 months to the optional complementary packages before a decrease of the Health Insurance Plan can be granted. Once this minimum period is completed, the participant may choose to keep the selected optional complementary packages or not. Each package has its own minimum period of participation of 24 months.

The participant may also terminate participation in one or many optional complementary packages before the end of the 24-month period if a recognized life event occurs.

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

Recognized life events allowing the participant to terminate participation in a package before the end of the 24-month period

If the employer receives the request for change within 60 days following one of these events:

- 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, adoption or custody of a child;
- termination of eligibility or death of a dependent child;
- the termination of the spouse's insurance or death of the spouse;
- the obtainment of regular employment status, according to the applicable collective agreement.

The requested change becomes effective on the first day of the premium period coinciding with or following the date the request is received by the employer.

b) *Dental Care Plan*

The participant can terminate participation in the Dental Care Plan.

The participant must have completed the minimum period of participation of 48 months before the termination of participation can be granted.

The participant may also terminate participation in the plan before the end of the 48-month period if a recognized life event occurs.

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

Recognized life events allowing the participant to terminate participation in the plan before the end of the 48-month period

If the employer receives the request for change within 60 days following one of these events:

- 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, adoption or custody of a child;
- termination of eligibility or death of a dependent child;
- the termination of the spouse's insurance or death of the spouse;
- the obtainment of regular employment status, according to the applicable collective agreement.

The requested change becomes effective on the first day of the premium period coinciding with or following the date the request is received by the employer.

c) *Life Insurance Plan*

Participants may decrease their coverage as follows:

- terminate their Participant's Basic Life Insurance, subject to respecting the delay for receiving the request for opting out specified in section 1.3.5 c);
- reduce their coverage amount for Participant's Basic Life Insurance, subject to the minimum coverage amount of $10,000;
- terminate Participant's Optional Life Insurance;
- decrease the coverage amount of Participant's Optional Life Insurance;
- terminate Dependents' Basic Life Insurance and Spouse's Optional Life Insurance, if any;
- decrease the coverage amount of Dependents' Basic Life Insurance and terminate Spouse's Optional Life Insurance, if any;
- decrease the coverage amount of Dependents' Basic Life Insurance;
- 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 premium period coinciding with or 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 Dependents' Basic Life Insurance or Spouse's Optional Life Insurance, if any, within 60 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 in Participant's Basic Life Insurance: if the employer receives the request to opt out within 60 days following the effective date of this coverage amount, the insurance is terminated on the date upon which this amount became effective.

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 on which starts the premium period following the reception date of the request by the employer to terminate the participant's participation in the plan, subject to the minimum period of participation described in section 1.3.2 b);
- the date on which the waiver of premiums ends, unless the participant remains eligible for insurance and the applicable premiums are paid;
- the date on which starts the participant's mandatory dental care coverage through the spouse.

d) *Short Term Disability Insurance Plan*

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

- the date on which the participant is no longer an eligible employee for a reason other than retirement. However, for a participant whose annual premiums are payable over a 10-month period, who is insured for at least one day during the month of May or June of a given year and who ceases to be an employee in May, June, July or August of the same year, the insurance ends at 11:59 p.m. on August 31 of that year;
- the date the participant reaches age 70;
- the date the waiver privilege becomes effective according to the criteria described in section 1.3.3 b).

e) *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 waiver privilege becomes effective according to the criteria described in section 1.3.4 b).

f) *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 right to opt out of Participant's Basic Life Insurance becomes effective as described in section 1.3.5 c).

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 premium period coinciding with or following the date the employer receives a request to terminate the dependent's insurance;
- for the spouse's life insurance coverage: the date of the spouse's death if the employer or SSQ receives the death notification or pays the benefit within 60 days following the date of death; otherwise, the first day of the premium period coinciding with or following the date the employer receives the request or the date SSQ receives the death notification;
- for the dependent children life insurance coverage: the date of the dependent's death if the employer receives the request to terminate participation in the coverage within 60 days following the date of death; otherwise, the first day of the premium period coinciding with or 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 while insured under the policy 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 premium 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 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.

For total disability periods that began between January 1, 2006, and December 31, 2019, 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.

For total disability periods that began on January 1, 2020, or later, the participant's waiver of premiums continues until the **last** of the following dates for the Health Insurance and Dental Care Insurance Plans:

a) the date the participant becomes eligible to a retirement pension without actuarial reduction;

b) the date they were granted a 36-month waiver of premiums for the disability period underway, without exceeding their 65th birthday. However, if the participant receives a salary from the employer on the date of their 65th birthday, the waiver of premiums ends on the last day the participant receives the salary;

c) the date the total disability period ends;

d) the date this group insurance contract is terminated.

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 Québec (CSQ) - ASSUREQ. For more information, please consult section 9.

1.8.3 End of waiver – Short Term Disability Insurance Plan

The participant's waiver of premiums continues until the **first** of the following dates for the Short Term Disability Insurance Plan:

a) the participant's 70th birthday;

b) the date the total disability period ends; total disability is deemed to have ended on the date the participant fails to submit to SSQ satisfactory proof of total disability.

1.8.4 End of waiver – Long Term Disability Insurance and Life Insurance Plans

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.

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.

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 1.3.5;

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 Québec (CSQ) - ASSUREQ. For more information, please consult section 9.

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

The waiver of premiums is suspended 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 and Suspension Without Pay

1.9.1 Leave without pay and suspension without pay of 30 days or less

All of the participant's coverage is maintained and the applicable premiums continue to be paid to SSQ in the usual manner.

1.9.2 Leave without pay and suspension without pay of more than 30 days

1.9.2.1 Maintaining plans

a) During a leave without pay or a suspension without pay, participants must choose one of the following three options:

- maintain participation in all plans held before their leave without pay or suspension without pay;
- maintain participation in the Health Insurance Plan held before their leave without pay or suspension without pay only;
- maintain participation in the Health Insurance Compulsory Basic Plan only.

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

c) All participants who are on leave without pay or suspended without pay and have chosen to maintain participation in the Health Insurance Plan held before or the Health Insurance Compulsory Basic Plan only will be granted the coverage they held before their leave without pay or suspension without pay upon the date they return to work.

1.9.2.2 Disability during a leave without pay or suspension without pay

- If a disability occurs during the leave without pay or suspension without pay and that all coverage has been maintained, the disability is considered to have begun on the day the participant was scheduled to return to work.
- If participants only maintained coverage under the Health Insurance Plan held or the Compulsory Basic Plan, no disability occurring during the leave without pay or suspension without pay is recognized. Only the Health Insurance Plan held or the Compulsory Basic Plan is maintained until the date of return to work. On this date, participants will be granted the plans held before the leave or suspension. For the purposes of waiver of premiums of the Health Insurance Plan held or the Compulsory Basic Plan, total disability will be considered to have begun on the date participants were scheduled to return to work.

1.10 Other Leaves

	Types of leaves	
Plan	- Part-time leave without pay - Progressive retirement - Deferred pay leave	- Pay leave related to parental rights (maternity, paternity or adoption leave) - Preventive withdrawal
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
Short 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 • For the deferred pay leave: the premium payable is in accordance with the provisions of the applicable collective agreement	• 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

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

The participant who returns to work after a full-time union leave with pay that was granted to work within the CSQ executive or one of its federations must inform SSQ in writing. The participant can benefit from the life insurance amount he/she held before the union leave or a higher amount. The total amount of life insurance cannot exceed the total amount he/she held during the union leave period.

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 following three options:

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

b) Subject to the provisions stipulated in section 1.11.4, the choice made applies for a period of 120 days or 90 days depending on the federation (see section 1.11.3) 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 or school service centres 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 or 90 days depending on the federation (see section 1.11.3) 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 1.14.1, 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 premium period coinciding with or immediately following the date they are rehired.

d) If, at the end of the 120-day period or 90-day period depending on the federation (see section 1.11.3), the participant has not been rehired, all coverage is terminated.

1.11.2 Particularities for teachers with school boards or school service centres

a) The provision described in paragraph 1.11.1 c) is replaced with the one described in section 1.14.1.

b) Teachers with school boards or school service centres 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 Particularities for the members of the Fédération du personnel de soutien scolaire

Subject to the provisions stipulated in section 1.11.4, the choice made in accordance with section 1.11.1 applies for a period of 90 days beginning on the date of the layoff or termination of the contract, provided employees make a request to the employer within 30 days following this date and pay the applicable premiums. **Employees of school boards or school service centres must indicate their choice on the individual invoice that SSQ sends to them.**

1.11.4 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, 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.

1.11.5 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 or 90-day period depending on the federation 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 or 90-day period and continue to pay the required premiums.

1.12 Dismissal and Non-Rehiring

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

- maintain coverage under all plans held, except the Short Term Disability Insurance Plan and 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 Insurance Plan held before the dismissal, non-rehiring or dismissal that has been contested by a grievance;
- maintain participation in the Health Insurance Compulsory Basic 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 dismissal that has been contested by a grievance.

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 Short Term Disability Insurance Plan and the Long Term Disability Insurance Plan cannot be reinstated as long as the final decision regarding the grievance is pending or as long as the parties do not come to an agreement before the arbitration decision.

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 Insurance Plan held or the Health Insurance Compulsory Basic Plan only, SSQ reinstates the plans to which they were participating immediately before the dismissal, non-rehiring or dismissal that has been contested by a grievance 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 Short Term Disability Insurance Plan and 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 of their intention to exercise their conversion privilege before their coverage under the Life Insurance Plan ends, or within 31 days following the date of termination.

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 Life Insurance Plan.

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 insurance under the Life Insurance Plan 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 in case of total disability.

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 Special Provisions for Certain Personnel Categories

1.14.1 Teachers with school boards or school service centres (Contract renewal)

New contract	In addition to the provisions of this group insurance contract, the following special provisions apply to teachers with a school board or school service centre who sign a new contract with the same school board or same school service centre with a new school board or new school service centre 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.
New contract becoming effective during the first 3 premium 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.

New contract becoming effective after the first 3 premium 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 premium periods of the school year must choose, for a 120-day period, between the Health Insurance Compulsory Basic Plan only, the Health Insurance Plan held 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 Compulsory Basic Plan only or the Health Insurance Plan held 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 Insurance Compulsory Basic Plan or the Health Insurance Plan held 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.
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.

1.14.2 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 1.1.3 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.

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 Insurance Compulsory Basic Plan.

1.14.3 School boards or school service centres support personnel in the adult education sector

a) *Employee*

The definition of "**employee**" given in section 1.1.10 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 of 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 1.1.3 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 the pension is also the one given above, without however being less than $14,400.

e) *Weekly salary*

The weekly salary is equal to $1/52^{th}$ of the annual salary.

f) Coverage under the Short Term Disability Insurance Plan

The waiting period is 112 days.

The short term disability insurance pension is equal to 66 2/3% of the average weekly salary. The pension is non-taxable.

The pension is paid on a weekly basis for as long as total disability lasts, including during the periods where salary is not usually paid, without exceeding 104 weeks as of the beginning of disability.

If disability occurred during a layoff, the disabled individual is entitled to the pension insofar as the individual would have maintained all benefits and been recalled, in accordance with the recall list, had there been no disability. The date of beginning of such disability will be the date on which the employee would normally return to work.

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 order relevant to the treatments, care or supplies in question or, failing the existence of such order, 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.

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 and the parameters described in the Schedule of Benefits.

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 Plan Structure

The Health Insurance Plan is made up of a compulsory component (Compulsory Basic Plan) and an optional component (Optional Complementary Packages 1, 2, 3 and 4). The four optional complementary packages provide the participant with additional coverage and benefits. The description of these benefits is presented in sections 2.3, 2.4. 2.5 and 2.6 hereinafter.

2.2 Expenses covered under the Compulsory Basic Plan

2.2.1 Prescription drugs and eligible pharmaceutical services

Any drugs available only on 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. The medical procedure is not covered.

Smoking cessation products covered under the Public Prescription Drug Insurance Plan (PPDIP) are also covered under this 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 plan are those 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 PPDIP are recognized as expenses covered under this benefit.

Some of these drugs, commonly called "exception drugs", require prior authorization from SSQ. For these drugs to be covered, their use must meet all of the following conditions:

- Comply with the specific clinical criteria and directions for use determined by the government authorities;
- Comply with the usage criteria suggested by the recognized appropriate medical and governmental authorities of the medical sector;
- Comply with the necessary, customary and reasonable standards of practice generally accepted in the health care sector, including the ratio between their cost and their effectiveness.

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 Public Prescription Drug Insurance Plan (PPDIP);
3) drugs used in the treatment of sexual dysfunction that are not covered under the Public Prescription Drug Insurance Plan (PPDIP);
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 PPDIP, 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 PPDIP.

2.2.2 Accidental Dismemberment (AD)

When a person insured under the Health Insurance 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 and accidental means, (the loss must occur within 365 days following the date of the accident, provided the person was covered by the Health Insurance 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, regardless of the state of mind of the insured;

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.

2.3 Expenses covered under the Optional Complementary Package 1

2.3.1 Ambulance and transportation by plane

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

2.3.2 Hospital expenses in Canada

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.

2.3.3 Professional fees following an accidental injury to natural teeth

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), 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 an external cause and resulting, directly and independently of any other cause, in bodily injuries. A "natural" tooth is one that has not been replaced. 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.

2.3.4 Psychological care

Expenses for professional psychotherapy services (the professional must hold a psychotherapist's permit issued by the board of directors of the Ordre professionel des psychologues du Québec) or for services provided by a psychologist, psychiatrist, social worker, career counsellor, psychoeducator, marriage or family therapist, nurse or psychotherapist.

2.3.5 Transportation by plane or by train of a bedridden insured

Expenses for transportation of a bedridden insured described below:

- 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.

2.3.6 Travel Insurance with Assistance

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.

To be eligible for this coverage, the insured persons must be eligible for benefits under the government health insurance and hospitalization insurance program of their province of residence in Canada for the entire duration of their stay outside their province of residence.

Important

Insured persons who already have a known disease or illness before the trip must ensure before departure that their state of health is good and stable. The known disease or illness must be under control prior to departure.

If the disease or illness:
- has worsened;
- has relapsed or recurred;
- is unstable;
- is in its terminal phase;
- is chronic and shows signs that degradation may occur or foreseeable complications may arise during the trip;

it is recommended to contact the travel assistance service before departure. The travel assistance service will provide the participant with details of what is meant by "sudden and unexpected illness," and can confirm whether the coverage applies in a specific situation. The telephone numbers for the service appear on the back of the card that came with the certificate issued by SSQ, as well as at the end of section **2.3.6.3**.

2.3.6.1 Eligible expenses

The following expenses are eligible for reimbursement:

a) **Hospitalization** in a hospital where the insured person actually received treatment. The expenses incurred are payable only if they are eligible for coverage under the hospital insurance plan of the insured person's province of residence, and only for the portion of expenses that exceeds the benefits reimbursed under this plan.

b) Professional fees of a **physician** for medical, surgical or anesthetic care other than fees for dental care. The expenses incurred are payable only if they are eligible for coverage under the health insurance plan of the insured person's province of residence, and only for the portion of expenses that exceeds the benefits reimbursed under this plan.

c) **Ambulance** transportation to the nearest hospital by a licensed ambulance carrier.

d) The **eligible prescription drugs** described in section 2.2.1.

e) Professional fees of a **private nurse** at a hospital, when medically necessary. This nurse must not be related to the insured person, nor be a travel companion of this person. Expenses are subject to a maximum reimbursement of $5,000 per insured person, per stay.

f) Professional fees for **health care professionals** deemed necessary by the travel assistance service.

g) The rental of a **wheelchair**, **hospital bed** or **breathing assistance apparatus**.

h) **Lab tests** or **medical imaging**.

i) Purchase of **trusses**, **corsets**, **crutches**, **braces**, **casts** or other **orthopaedic devices**.

j) Professional fees for a **dental surgeon** for accidental injury to natural teeth in an accident that occurred outside the insured person's province of residence,

up to a maximum reimbursement of $1,000 per accident. Eligible expenses must be incurred within 12 months of the accident and treatment may be obtained after the insured person's return to the province of residence. Only expenses incurred while this coverage is in force are eligible.

k) **Repatriation** of the insured person to the province of residence for immediate hospitalization and the cost of transporting the insured person to the nearest location where appropriate medical care is available. Expenses for transportation or repatriation must be previously approved by SSQ before being incurred, and benefits are limited to the cost of the most economical transport option, according to SSQ's evaluation, accounting for the insured person's state of health.

l) **Round-trip air travel** in economy class of a medical escort when required by the air carrier or by the insured person's attending physician. Prior authorization by SSQ is required. The medical escort must not be related to the insured person, nor be a travel companion of this person.

m) **Return of personal or rental vehicle** by means of a commercial agency, to the insured person's home or the nearest vehicle rental agency. The insured person must present a medical certificate stating that he or she is incapable of doing so due to an illness or accident. These expenses are eligible up to a maximum reimbursement of $2,000. Prior authorization by SSQ is required.

n) In the event of **death** of the insured person outside the province of residence, expenses incurred for the preparation and return of the remains, excluding the cost of the casket, by the most direct route to the insured person's residence in Canada, up to a maximum reimbursement of $10,000. Prior authorization by SSQ is required.

o) **Living expenses for accommodation and meals** in a commercial establishment, which the insured person must incur when obliged to postpone the return home due to hospitalization of at least 24 hours of the insured person, an accompanying close family member or a travel companion, up to a maximum reimbursement of $300 per day and $2,400 per stay abroad for all persons insured under this coverage.

p) **Living expenses for accommodation and meals** in a commercial establishment, as well as the cost of round-trip **transportation** for a close family member or friend, using the most economical means, in order to visit the insured person hospitalized for at least seven days, or to identify the deceased insured person, subject to the following maximum reimbursements for all insured persons under this plan:

- transportation: $2,500 per trip;
- accommodation and meals: $300 per day, up to a maximum of $2,400 for the whole duration of the stay.

Prior authorization by SSQ is required.

q) The following travel assistance services:

1) Directing the insured person to an appropriate clinic or hospital;
2) Verifying the insured person's health insurance coverage to avoid the insured having to pay for services out of pocket, wherever possible;
3) Ensuring the proper follow-up of the insured person's medical file;
4) Coordinating the insured person's return and transportation as soon as medically possible;
5) Providing emergency assistance and coordinating benefit claims;
6) If necessary, arranging the transportation of a family member to the insured's bedside, to identify the insured person's body if deceased and/or coordinate the repatriation of the deceased insured person's body;
7) If necessary, arranging for the return of insured dependents to their home (return expenses not included);
8) If necessary, coordinating the return of the insured person's personal vehicle if the insured is unable to do so due to illness or accident;
9) If necessary, contacting the insured person's family or employer;
10) Acting as an interpreter for emergency calls;
11) Recommending a lawyer in the case of a serious accident (legal fees are not covered);
12) If necessary, guaranteeing payment of incurred hospital expenses;
13) Submitting benefit claims to Régie de l'assurance maladie du Québec on behalf of the insured, if the latter agrees.

2.3.6.2 Limitations

If, due to a sudden accident or illness, the insured person requires extended medical care, treatments or surgery, and if medical proof reveals that after having received a diagnosis or an emergency treatment for this reason, the insured person could have returned to their province of residence, but chose to obtain these services, treatments or surgery outside their province of residence, SSQ does not reimburse the expenses incurred for these services, treatments or surgery nor any other related expenses.

SSQ reserves the right to repatriate the insured person to the province of residence if his or her medical condition allows it. Any refusal to be repatriated discharges SSQ from any liability for expenses subsequently incurred.

2.3.6.3 Exclusions

This coverage does not include the following:

a) expenses incurred after the insured person has returned to the province of residence. This exclusion does not however apply to the expenses described in paragraph j) of section 2.3.6.1;

b) expenses payable under a government plan or legislation;

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

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

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

f) expenses incurred in a hospital specialized in chronic care or in a chronic care ward of a publicly-funded hospital, or in a palliative care home or thermal spa facility;

g) expenses incurred in a location for which the Government of Canada issued an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the insured is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

   If it is impossible for the insured to comply with the advisory, the insured must contact the travel assistance service before the end of the 14-day deadline.

   This exclusion does not apply if the insured provides proof deemed satisfactory by the travel assistance service that reasons beyond his or her control prevented him or her from complying with the advisory within the aforementioned deadline.

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

a) active participation of the insured person in a riot or insurrection, or perpetration or attempted perpetration of a criminal act by the insured or the travel companion;

b) intentional self-inflicted injury by the insured person, suicide or attempted suicide, regardless of the state of mind of the person in question. However, in cases of suicide, only expenses incurred for the preparation and repatriation of the remains are covered, in accordance with the provisions of section 2.3.6.1 n);

c) abusive consumption of medications, drugs or alcohol and the ensuing consequences;

d) participation in any extreme or combat sports, gliding, hang-gliding, mountain climbing, parachuting, skydiving or any other similar activity, participation in any racing or speeding event regardless of the nature of these activities, participation in any sporting or underwater activity for which the insured person receives compensation;

e) pregnancy, miscarriage, childbirth or related complications occurring within the two months preceding the normal expected date of delivery.

Important

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

Some of the services described may not be available in certain countries. The services offered are subject to change by SSQ without prior notice.

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

A) CANADA – UNITED STATES 1-800-465-2928
B) ELSEWHERE IN THE WORLD, COLLECT CALL 514-286-8412

These telephone numbers appear on the back of the plastic-covered card issued by SSQ to the insured person. The insured person must have the certificate number handy when they call.

Note: The travel assistance services can serve as an intermediary between SSQ and the insured person when "prior authorization from SSQ" is required to obtain services.

2.3.6.4 Multiple coverage and coordination of benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not the participant has submitted a claim for such benefits.

If the participant is entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

If the participant and their spouse each have group health insurance coverage, each of them should first submit their own claims to their own group insurance plan.

If the participant and their spouse each have family coverage status for their group health insurance, claims for their dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If they are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If they share joint custody, claims for children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

Expenses eligible for reimbursement under the Travel Insurance with Assistance benefit will be reduced by the amount of any corresponding benefits payable under another insurance contract. If the participant is entitled to receive benefits under Travel Insurance with Assistance as well as under another benefit of the Health Insurance Plan, benefits shall only be payable under Travel Insurance with Assistance.

2.3.7 Trip Cancellation Insurance

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 made, was unaware of any event that could reasonably lead to the cancellation or interruption of the planned trip.**

2.3.7.1 Reasons for trip cancellation or interruption

To be eligible for this coverage, the trip must be cancelled or interrupted due to one of the following:

a) an illness or accident suffered by the insured person, a travel companion, a business partner or a family member of the insured that prevents the person from performing his or her usual activities and be serious enough to justify the cancellation or interruption of the insured's trip;

b) the death of the insured person, the spouse, a child of the insured person or of the spouse, a travel companion or a business partner;

c) the death of a member of the insured person's family or a member of the travel companion's family, provided the funeral takes place during the planned trip or within 14 days of the scheduled departure date;

d) the death or emergency hospitalization of the host at destination;

e) the insured person's or a travel companion's summons for jury duty or subpoena to testify at a hearing during the travel period, provided the person concerned is not part of the legal proceedings and has undertaken the necessary steps to have the hearing postponed. However, a summons or subpoena is not considered an eligible reason for cancellation or interruption of a trip if the insured person has been subpoenaed as part of his or her duties as police officer;

f) quarantine of the insured person, provided such quarantine ends seven days or more before the scheduled date of departure;

g) hijacking of the airplane on which the insured person is travelling;

h) damage rendering the main residence of the insured person or the host at destination uninhabitable. The residence must remain uninhabitable seven days or less before the scheduled date of departure; otherwise, the damage must occur during the trip;

i) transfer of the insured person, for the same employer, to a location more than 100 kilometres from the current residence, within thirty days preceding the scheduled date of departure;

j) **For trip cancellation**

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured plans to travel; or
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship.

The advisory must be issued after the insured has made the travel arrangements. The advisory must be in force on the scheduled date of departure.

For trip interruption

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured is on a trip; or
- to avoid all cruise ship travel when the insured is already on a cruise ship.

The advisory must be in force during the trip. The insured must comply with the advisory within 14 days following its issuance.

k) delay of the transportation used to reach the point of departure of the planned trip, provided such means of transportation provided for scheduled arrival at the point of departure at least three hours prior to the time of departure (or at least two hours if the distance to be covered is less than 100 kilometres). The delay must be caused by weather conditions, mechanical problems (except those affecting the insured's private automobile), a traffic accident or an emergency road closure (each of the latter two causes require confirmation by a police report);

l) weather conditions such that:

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

m) damage to the place of business or physical location where a commercial activity is to be held. The damage must prevent the planned activity from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity;

n) death, illness or accident of a person for whom the insured person is the legal guardian;

o) the suicide or attempted suicide of a member of the insured person's family or a member of the travel companion's family;

p) the death or a person for whom the insured person is the executor of the will;

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

2.3.7.2 Eligible expenses

a) **In the event of cancellation prior to departure**, eligible expenses are as follows:

i) the non-refundable, unusable, non-transferrable and irrecoverable portion of prepaid travel expenses. Any form of credit, compensation or indemnification (with or without restriction on use) offered by a travel provider, a travel agency, a public carrier, an accommodation facility or an agency is considered as a reimbursement of prepaid travel expenses;

ii) additional expenses incurred by the insured person if the travel companion must cancel for one of the reasons mentioned under section 2.3.7.1, and the insured person decides to proceed with the trip as initially planned. Expenses are covered up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel;

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

b) **In the event of missed departure (at the start or during the trip),** eligible expenses are as follows:

the additional cost requested by a scheduled public carrier (plane, bus, train) in economy class by the most direct route to the initially-planned travel destination.

c) **If the return is earlier or later than planned,** eligible expenses are as follows:

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

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

Restrictions

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

If travel expenses were not prepaid, the expenses incurred by the insured person are covered provided that prior to the scheduled date of departure, the insured person was not aware of any event that could reasonably lead to the interruption of the planned trip.

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

d) **If round-trip transportation is needed**, eligible expenses are as follows:

Expenses for transportation by the most economical means following approval by the travel assistance service for the insured person to return to the province of residence and then back to the trip destination, provided it is for one of the following situations:

i) the death or hospitalization of a member of the insured person's family, a person for whom the insured person is the legal guardian or a person for whom the insured is the testamentary executor;

ii) a disaster that has rendered the main residence of the insured person uninhabitable or has caused significant damage to the insured person's business establishment.

2.3.7.3 Maximum eligible expenses

Eligible expenses include only expenses that are payable by the insured person.

2.3.7.4 Exclusions

a) Trip Cancellation Insurance does not cover losses due to the following causes or to which such causes have contributed:

i) Active participation of the insured in a riot or insurrection, perpetration or attempted perpetration of a criminal act by the insured or the insured's travel companion or participation of the insured or the insured's travel companion in a criminal act;

ii) Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences;

iii) Intentional self-inflicted injury by the insured or travel companion, or suicide or attempted suicide by the insured, regardless of the state of mind of the person;

iv) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to;

v) The reason for which the trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician;

vi) In the event that the trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person;

vii) A cause which, beyond any possible doubt, does not prevent the insured from proceeding with the trip.

b) No expenses are payable if the insured made travel arrangements while a Government of Canada advisory was in effect recommending:

- to avoid all travel to a location where the insured plans to travel; or
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply:

- to any trip cancellation for an eligible reason for cancellation other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure; and
- to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure or during the insured's trip.

c) No trip interruption expenses are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending:

- to avoid all travel to a location where the insured plans to travel;
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory, if there is a change to the risk level of the advisory to a lower risk level during the insured's trip.

d) No trip interruption expenses caused by the following advisory are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending to avoid non-essential travel to a location where the insured plans to travel.

However, this exclusion does not apply to any trip interruption caused by the advisory, if there is a change to the risk level of the advisory to a higher risk level during the insured's trip.

e) No trip interruption expenses caused by one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel or to avoid non-essential travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

If it is impossible for the insured to comply with the advisory, the insured must contact the travel assistance service before the end of the 14-day deadline.

This exclusion does not apply if the insured provides proof deemed satisfactory by the travel assistance service that reasons beyond his or her control prevented him or her from complying with the advisory within the aforementioned deadline.

f) No trip interruption expenses for an eligible reason for interruption other than one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

If it is impossible for the insured to comply with the advisory, the insured must contact the travel assistance service before the end of the 14-day deadline.

This exclusion does not apply if the insured provides proof deemed satisfactory by the travel assistance service that reasons beyond his or her control prevented him or her from complying with the advisory within the aforementioned deadline.

2.3.7.5 Deadline to request cancellation

In the event of trip cancellation prior to departure due to a travel advisory issued by the Government of Canada, the insured must contact SSQ's travel assistance service for the procedure to follow either 72 hours before a deposit becomes due or 72 hours before the scheduled date of departure, whichever comes first.

In the event of trip cancellation prior to departure for any reason other than a travel advisory, the insured must contact SSQ's travel assistance service for the procedure to follow at the latest 48 hours following the event causing cancellation.

The telephone numbers to contact SSQ's travel assistance service are the following:

From Canada or the United States: 1-800-465-2928

From elsewhere in the world: 514-286-8412 (collect call)

The insured must provide the certificate number specified on the SSQ card when calling.

SSQ's liability is limited to the applicable cancellation costs stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and spouse provide proof deemed satisfactory by SSQ that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so. SSQ's liability is limited to the applicable cancellation costs stipulated in the travel insurance contract on this date.

2.3.7.6 Multiple coverage and coordination of benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not the participant has submitted a claim for such benefits.

If the participant is entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

If the participant and their spouse each have group health insurance coverage, each of them should first submit their own claims to their own group insurance plan.

If the participant and their spouse each have family coverage status for their group health insurance, claims for their dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If they are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If they share joint custody, claims for children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

Expenses eligible for reimbursement under the Trip Cancellation Insurance benefit will be reduced by the amount of any corresponding benefits payable under another insurance contract. If the participant is entitled to receive benefits under Trip Cancellation Insurance as well as under another benefit of the Health Insurance Plan, benefits shall only be payable under Trip Cancellation Insurance.

2.4 Expenses covered under the Optional Complementary Package 2

2.4.1 Chiropractic

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

2.4.2 Eye examinations

Expenses for eye examination by an optometrist or ophthalmologist.

2.4.3 Kinesiology

Expenses for treatments administered by a kinesiologist.

2.4.4 Physiotherapy and athletic therapy

Expenses for treatments administered by a physiotherapist or an athletic therapist.

2.4.5 Podiatry or podology

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.

2.4.6 Speech therapy, occupational therapy or audiology

Fees for services provided by a speech therapist, an occupational therapist or an audiologist.

2.5 Expenses covered under the Optional Complementary Package 3

2.5.1 Acupuncture

Expenses for treatments administered by an acupuncturist.

2.5.2 Dietetics

Expenses for consultation with a dietitian.

2.5.3 Homeopathy

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

2.5.4 Massage therapy, kinesitherapy and orthotherapy

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

2.5.5 Naturopathy

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.

2.5.6 Osteopathy

Expenses for treatments administered by an osteopath.

2.6 Expenses covered under the Optional Complementary Package 4

2.6.1 Artificial limbs and external prosthesis

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

2.6.2 Blood glucose monitor

Expenses for purchasing, adjusting, replacing or repairing a blood glucose monitor. Purchase of an intermittent blood glucose monitor requiring glucose sensors is also eligible. Prior approval by SSQ must be obtained for the glucose sensors.

2.6.3 Breast prosthesis

Expenses for the purchase of breast prosthesis if necessary because of a mastectomy (simple, double or partial).

2.6.4 Capillary prosthesis

Expenses for purchasing a first capillary prosthesis following chemotherapy.

2.6.5 Coagulometer

Expenses for the purchase of a coagulation self-monitoring device.

2.6.6 Deep shoes

Ready-made deep shoes. Shoes must be needed in order to use an orthosis designed to correct or compensate for a foot defect. Shoes must be obtained from a fully licensed specialized orthopaedic laboratory.

For the purposes of this insurance contract, sandals are not considered deep shoes.

2.6.7 Detoxification treatment

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.

2.6.8 Foot orthoses

Expenses for purchasing foot orthoses (arch supports, shoe lifts). 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 and be prescribed by a physician, a podiatrist or a specialized nurse practitioner.

2.6.9 Hearing aid

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

2.6.10 Insulin pump and accessories

Expenses for the purchase and repair of an insulin pump and expenses for the purchase of insulin pump accessories.

2.6.11 Intraocular lenses

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.

2.6.12 Medium or full compression support stockings

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

2.6.13 Nursing care

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.

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

2.6.14 Orthopaedic devices

Expenses for purchasing, renting or replacing trusses, corsets, casts, splints, crutches and other orthopaedic apparatus.

2.6.15 Orthopaedic shoes

Expenses for purchasing shoes designed and made-to-measure from a cast to correct a foot defect. 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.

2.6.16 Ostomy appliances

Expenses for purchasing the necessary products for ostomy. Only the portion of expenses in excess of what is paid by the government is reimbursed.

2.6.17 Post-surgical brassieres

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

2.6.18 Respirator and oxygen

Expenses for renting or purchasing, if more economical, a respirator (breathing assistance device). The oxygen is also included in the eligible expenses for this benefit.

2.6.19 Therapeutic devices

Expenses for renting or purchasing, if more economical, therapeutic devices. This coverage also includes expenses for adjusting, replacing or repairing and expenses for some accessories.

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;
- compression garments.

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, it is recommended to obtain prior authorization from SSQ before any expenses are incurred.

2.6.20 Transcutaneous electrical nerve stimulator

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

2.6.21 Transportation and accommodation expenses in Quebec

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.

COMMENT:

These expenses may be eligible for reimbursement in accordance with a program 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, CISSS or CIUSSS. These organizations are the "first payers" and only expenses that are not reimbursed by these organizations and eligible in accordance with the contract are reimbursed.

2.6.22 Wheelchair, walker or hospital bed

Expenses for renting or purchasing, if more economical, a non-motorized wheelchair, a walker, or a hospital bed, 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.

2.7 Exclusions and Limitations

2.7.1 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 Public Prescription Drug Insurance Plan.

Regardless of the above, all pharmaceutical supplies or services that are covered by the Public Prescription Drug Insurance Plan are not excluded.

2.7.2 Limitations

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.

2.7.3 Multiple coverage and coordination of benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not the participant has submitted a claim for such benefits.

If the participant is entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

If the participant and their spouse each have group health insurance coverage, each of them should first submit their own claims to their own group insurance plan.

If the participant and their spouse each have family coverage status for their group health insurance, claims for their dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If they are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If they share joint custody, claims for children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

3- DENTAL CARE INSURANCE PLAN

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 and Description of Dental Treatment Services* for the year 2021. 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 claims is available. In order to use this service, follow the steps described in section 8 of this booklet.

3.2 Shared Deductible – Minor Restorative Dental Care and Major Restorative Dental Care

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

3.3 Preventive Dental Care

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

3.3.1 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

3.3.2 X-rays

a) intraoral X-rays

b) extraoral 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.

3.3.3 Lab examinations, tests and diagnostic tests

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

3.3.4 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.*

3.3.5 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.*

3.3.6 Additional services

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

3.4 Minor Restorative Dental Care

The following eligible expenses **are reimbursed at 80%** and are subject to the shared deductible indicated in section 3.2:

3.4.1 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.

3.4.2 Endodontics

- endodontic emergency
- general endodontic treatments
- root canal therapy
- endodontic surgery

3.4.3 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 3.7 a) below)
- root planing under local anesthesia: once per tooth per 12-month period
- splint or ligation (for cast metal splint, refer to Major Restorative Dental Care)
- 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

3.4.4 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 3.7 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

3.5 Major Restorative Dental Care

The following eligible expenses **are covered at 50%** and are subject to the shared deductible indicated in section 3.2:

3.5.1 Removable prosthodontics (see section 3.7 b) below)

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

3.5.2 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)
- repairs with or without impression
- therapeutic tissue conditioning
- resetting of teeth
- obturator, palatal: once per 60-month period
- vertical dimension recuperation by addition of acrylic to existing prothesis

3.5.3 Fixed prosthodontics (see section 3.7 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

3.5.4 Repair of fixed prosthodontics

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

3.5.5 Implants

Expenses for implants (including implant-supported prosthesis) may be eligible up to a maximum of the cost and limitations applying to an equivalent crown, only at the time of final insertion of crown implant.

3.6 Maximum Reimbursement of Dental Care Expenses

All of the care described in sections **3.3, 3.4** and **3.5** 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 the Dental Care coverage starts.

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).*

3.7 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 calendar year, per insured

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, 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.

3.8 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, acts or complementary treatments related to implants (surgery, grafts, etc.) do not qualify as eligible expenses under the contract.

4- SHORT TERM DISABILITY INSURANCE PLAN

Depending on work conditions, this plan includes the following:

- a disability insurance plan for the employer: the employer pays the premiums and receives the pension if one employee becomes totally disabled;
- a disability insurance plan for the employee: the employee pays the premiums and receives the pension if he/she become totally disabled.

4.1 Determination of the Content of the Plan

For any eligible employee or participant, the choice indicated in the collective agreement, or the choice made by a bargaining unit, an employer or the union to which the participant belongs, constitutes the Short Term Disability Insurance Plan. This choice applies to the waiting period, the percentage of reimbursement and the maximum duration of the pension.

The premiums for the plan are paid by the employer or by the participants, depending on whether the Short Term Disability Insurance Plan is for the employer or for the employee as described above.

The choice of an employer, a bargaining unit or union that applies to the waiting period, the percentage of reimbursement and the maximum duration of the pension is irrevocable until January 1 that follows the expiration of a 24-month period after the date of this choice, unless there is a modification of the collective agreement to that effect.

However, when the premiums for the plan are paid by the participants, the choice of a bargaining unit or a union that applies to the percentage of reimbursement can be decreased at any time. This modification takes effect at the premium period coinciding with or following the date indicated on the written notice on the effective date of the modification.

4.2 Disability Pension

A participant who is insured under the Short Term Disability Insurance Plan is entitled to a short term disability insurance pension, according to the terms and conditions specified in this section, as indicated in the collective agreement, or as chosen by the employer, a bargaining unit or the union to which the participant belongs. The applicable provisions are those in force at the beginning of the total disability, and they will remain applicable until the end of the total disability.

When a participant becomes totally disabled and the period of total disability lasts beyond the waiting period, SSQ agrees to pay a weekly pension to the participant for as long as the same period of total disability lasts, without however exceeding

the participant's 70th birthday or the maximum duration of pension. When the premiums for the plan are paid by the employer, the weekly pension is paid to this employer instead of the insured.

4.2.1 Waiting period

The waiting period can vary from 0 to 365 days for a disability resulting from an accident and from 7 to 365 days for a disability resulting from an illness.

For a participant who receives annual salary over a period that is less than 12 months, if disability begins within a period during which payment of the salary by the employer is suspended, the waiting period will apply as of the first day of the period during which payment of the salary by the employer resumes.

4.2.2 Maximum duration of pension

The maximum duration of pension is 52 or 104 weeks, including the waiting period.

For a participant who receives annual salary over a period that is less than 12 months, payment of pension is suspended for the periods during which payment of the salary by the employer is normally suspended. However, these periods are included in the calculation of the maximum duration of pension.

The pension is payable for as long as the same period of total disability lasts, without exceeding the maximum duration of the pension and without exceeding the date the employee reaches age 70. Moreover, total disability is deemed to have ended on the date the participant fails to submit to SSQ satisfactory proof of total disability.

4.3 Amount of Disability Pension

When the pension is paid by the employer, the amount of the weekly pension can vary from 60% to 100% of the weekly salary payable at the beginning of total disability. **The pension is taxable.**

When premiums are paid by the participant, the amount of the weekly pension can vary from 60% to 75% of the weekly salary payable at the beginning of total disability. **The pension is non-taxable.**

The pension are calculated at 1/5th of the weekly salary for each day of total disability.

Important

Participants who would like to learn more about the content of their plan must contact the group insurance administrator of their establishment, the union or SSQ's Customer Service.

4.4 Reduction of Disability Pension

The amount of the weekly pension indicated in the preceding section is reduced by:

a) *Any salary paid by the employer*

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

b) *Retirement pensions*

- The initial gross amount on a weekly basis of any retirement pension payable by a retirement plan for employees of the public and parapublic sectors (RREGOP, PPMP, etc.) or by another private retirement plan, if the retirement pension payment began after the beginning of the disability.

  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 the Short Term Disability Insurance 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 gross amount on a weekly basis of any retirement pension paid by the Québec Pension Plan (QPP) or the Canada Pension Plan (CPP).

c) *Public or social legislation disability pension plan (QPP, CPP, CNESST, SAAQ, etc.)*

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

d) Disability pensions from a private plan

95% of the initial net amount on a weekly basis payable in relation to the disability in question by any 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) Maternity, paternity, adoption or parental benefits

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

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

Failing to receive amounts from the different income sources previously mentioned in section 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 40 years.

4.5 Rehabilitation Employment

The weekly benefits payable are reduced by 50% of any salary earned from a rehabilitation program approved by SSQ.

4.6 Exclusions

SSQ will not pay the pension for any period of 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, drug addiction or gaming addiction, except while the employee is receiving treatment or medical care for rehabilitation;

e) if the total disability began while the employee was not covered under the Short Term Disability Insurance 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;

g) during which the employee performs remunerative work, in accordance with the definition of disability, except within a rehabilitation program approved by SSQ;

h) during which the employee receives full or partial salary, unless the union (employer of the disabled individual) uses the benefits paid to finance its policy on salary continuation;

i) during which the employee receives payment of sick leaves, unless the union (employer of the individual) uses the benefits paid to finance its policy on sick leaves;

j) resulting from attempted suicide or self-inflicted mutilation, regardless of the state of mind of the employee.

5- LONG TERM DISABILITY INSURANCE PLAN

The Long Term Disability Insurance Plan 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 the Long Term Disability Insurance Plan that are in force on the date the disability begins apply until the end of this total disability period.

5.1 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 pension 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 the disability pension planned in the collective agreement or by the equivalent disability insurance plan.

5.2 Amount of Disability Pension

The monthly pension is determined by dividing the following annual amount by 12:

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

1) 65% of the first $20,000 of the gross annual salary;

2) 50% of the next $20,000 of the gross annual salary;

3) 45% of the amount in excess.

* 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.

5.3 Reduction of Disability Pension

The amount of the monthly pension as determined in section 5.2 is reduced by the following amounts:

a) *Any salary paid by the employer*

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

b) *Retirement pensions*

- 80% of the initial gross amount on a monthly basis of any retirement pension payable by a retirement plan for employees of the public and parapublic sectors (RREGOP, PPMP, 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 gross amount on a monthly basis of any retirement pension paid by the Québec Pension Plan (QPP) or the Canada Pension Plan (CPP).

c) *Public or social legislation disability pension plan (QPP, CPP, CNESST, SAAQ, etc.)*

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

d) *Disability pensions from a private plan*

95% of the initial net amount on a monthly basis payable in relation to the disability in question by any 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 gross 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.

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.

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.

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

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

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

Failing to receive amounts from the different income sources previously mentioned in section 5.3 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 40 years.

5.4 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%.

5.5 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.

5.6 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.

5.7 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, drug addiction or gaming 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 the Long Term Disability Insurance 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.

6- LIFE INSURANCE PLAN

This plan provides for a minimum compulsory coverage amount of $10,000 in Participant's Basic Life Insurance. However, participants have the right to opt out of this coverage, as described in section 1.3.5 c). In addition, employees can choose the content of their life insurance coverage among the benefits described below.

6.1 Participant's Basic Life Insurance

Coverage amount

At the time of the death of the participant insured under this coverage, SSQ agrees to pay to the beneficiary or beneficiaires an amount of $10,000 or $25,000, depending on to the amount chosen by the participant.

Upon the initial enrolment, coverage amounts of $10,000 and $25,000 are available without evidence of insurability if the employer receives the "Application/Request for Change" form within 180 days following the participant's date of eligibility. Upon a change of coverage, these amounts are available without evidence of insurability if the employer receives the form within 60 days following the date of a recognized event (see section 1.6.1 c)).

After the deadlines mentioned above, evidence of insurability is required to obtain the coverage amount of $10,000, if the participant used his right to opt out, and to obtain the coverage amount of $25,000.

6.2 Participant's Optional Life Insurance

6.2.1 Coverage amount

If the participant chooses a coverage amount of $25,000 in Participant's Basic Life Insurance provided for under section 6.1, the participant may request from 1 to 9 units of $25,000 in Participant's Optional Life Insurance.

The first $50,000 are available without evidence of insurability if requested within the deadlines. Coverage amounts over $50,000 are always subject to the acceptance of evidence of insurability by SSQ.

6.2.2 Reduction of coverage amount

Coverage amount under Participant's Optional Life Insurance is reduced by 50% on the January 1 coinciding with or following the participant's 65th birthday.

6.2.3 Limitation in case of suicide

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

6.2.4 Accelerated benefit payment

Participants whose life expectancy is less than 24 months may submit a written request to SSQ to receive a life insurance benefit up to the lesser of $100,000 and 50% of the amount of life insurance (basic and optional) 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 24 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 life insurance paid to the participant, plus accrued interest.

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.

6.3 Dependents' Basic Life Insurance

Coverage amount

This benefit offers three coverage options:

- coverage for the spouse only;
- coverage for dependent children only; or
- coverage for the spouse and dependent children.

The participant can choose between the following two options and, depending on the choice above, the amount indicated will apply to the spouse or dependent child or children, or to both:

Option 1: $10,000 for the spouse and $5,000 per dependent child aged 24 hours or more

Option 2: $20,000 for the spouse and $10,000 per dependent child aged 24 hours or more

The same option must be chosen for the spouse and dependent child or children.

6.4 Spouse's Optional Life Insurance

6.4.1 Coverage amount

If the participant chooses a coverage amount of $20,000 for the spouse under Dependents' Basic Life Insurance (Option 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.

6.4.2 Reduction of coverage amount

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

6.4.3 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.

6.4.4 Accelerated benefit payment

If their spouse's life expectancy is less than 24 months, the participant may submit a written request to SSQ to receive a life benefit up to 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 24 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 life insurance 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.

6.5 Beneficiary

When a participant completes the "Application/Request for Change" form and chooses to participate in the Life Insurance Plan, 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 estate.

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.

7- EMPLOYEE ASSISTANCE PROGRAM

7.1 Assistance Program

The Employee Assistance Program is offered to participants who are covered under the Short Term Disability Insurance Plan of the contract and their dependents.

This program aims to help insureds who are experiencing problematic situations.

The available services of the Employee Assistance Program include maximums applicable per calendar year and per family unit (the participant and the participant's spouse and dependent children). The covered services are as follows:

a) over the-phone counselling, up to a maximum of 3 hours, it being understood that legal and financial counselling is limited to only one of these 3 hours;

b) counselling with professionals, in their office or using secure internet connections, up to a maximum of 12 hours.

Insureds can have recourse to their own health care professional if the health care professional and the service provider come to an agreement on the different criteria to be met.

Important

The most recent description of the assistance program as well as the phone number to have access to those services can be found on SSQ's website at **ssq.ca**, via the group insurance section for individuals.

The certificate number will be required at the time of the call.

7.2 Specific Provisions Applicable at the Death of the Participant

In the event of the participant's death, the participant's spouse and dependent children remain entitled to services under the Employee Assistance Program for 3 months following the death, subject to any maximum provided for in this section.

7.3 Specific Provisions Applicable at the Termination of Insurance

At the termination of the participant's insurance, coverage is maintained for a 30-day period after the termination date when, at the date of termination, services are currently provided to an insured in accordance with this section. However, services are limited to a maximum of 2 hours per insured, up to the provided maximums.

8 - HOW TO SUBMIT A CLAIM

8.1 Prescription Drug Expenses

Most prescription drug expenses may be claimed directly online via the **Customer Centre** website.

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

8.1.1 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.

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.

8.1.2 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. The claim form can be printed by accessing the **Customer Centre** 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.

To be eligible for reimbursement, all receipts and invoices 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.

8.2 Other Health Insurance Expenses

Most health care insurance expenses may be claimed directly online via the **Customer Centre** website.

When an insured submits an online claim, all original documents (paid invoices, receipts and prescriptions) must be kept for a period of 12 months in order to be able to submit them to the Insurer upon request.

Insureds may also submit their claims to SSQ by mail using the health care claim form. This form can also be printed by accessing the **Customer Centre** website.

To be eligible for reimbursement, all receipts and invoices must be presented within 12 months of the dates they were 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 the **Customer Centre** website**.** 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 8.9.

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

8.3 Dental Care Insurance Expenses

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 on the **Customer Centre** website.

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).

To be eligible for reimbursement, all receipts and invoices must be presented within 12 months of the dates they were incurred.

8.4 Hospital or Medical Expenses Subject to a Social Legislation

Hospital or medical expenses subject to a social legislation are payable by the organization in question (CNESST, SAAQ, IVAC, etc.). These invoices must be submitted to these organizations and not to SSQ.

8.5 Short Term Disability Insurance

Any claim for short term disability insurance pension must be submitted in writing to the head office of SSQ within 90 days following the date of beginning of the participant's disability, along with satisfactory evidence indicating the cause and the duration of total disability, including a medical report. If the participant fails to submit the claim or required proof within the delay specified above, the participant will not be entitled to receive a pension for any period prior to the date the Insurer receives the claim or evidence.

Failing to submit a pension claim or to provide the evidence and information within the required period will not entail the rejection of the claim as long as the request, evidence and information are provided as soon as it is reasonably possible to do so within 12 months following the date of beginning of total disability, unless the participant can demonstrate, to SSQ's satisfaction, that there were legitimate reasons for not submitting the claim within the required period.

Any disability period beginning while the contract is in force must be notified during the 12 months period immediately following the termination date of the contract, when it is reasonably possible to do so.

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

When a claim is submitted, and periodically afterwards, SSQ reserves the right to have any totally disabled participant examined by a physician chosen and paid by SSQ.

8.6 Long Term Disability Insurance

Any claim for long term disability insurance pension 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 following to the date on which the insured is entitled to long term disability benefits. If the participant fails to submit the claim or required proof within the delay specified above, the participant will not be entitled to receive a pension for any period prior to the date the Insurer receives the claim or evidence.

The insured must file such a benefit claim even if they are receiving disability benefits under any other social legislation (e.g., CNESST, QPP, etc.).

When a claim is submitted, and periodically afterwards, SSQ reserves the right to have any totally disabled participant examined by a physician chosen and paid by SSQ.

8.7 Life Insurance

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

8.8 Where to Send Benefit Claims

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

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

8.9 SSQ's Online Services

Customer Centre

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

- 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 online;
- print Dental Care Insurance claim forms;
- consult or print tax receipts for medical expenses incurred;
- print a SSQ card;
- 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;
- print a proof of coverage for Travel Insurance benefits.

To register and take advantage of SSQ's online services, insureds can simply visit the **Customer Centre** website at **customer-centre.ssq.ca**. Online instructions will explain how to register.

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

8.10 SSQ's Mobile Services

Participants who have a mobile device can download SSQ's free Mobile Services application. The application enables them to carry out the same operations as they would on the **Customer Centre** website.

8.11 Personal Information and Insurance File

Notice of new file

To maintain the confidentiality of information concerning each person it insures, SSQ Insurance 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 Insurance, 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.**

9 - PLAN 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 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 or school service centres who retire during the months of May, June, July or August become eligible for the plans offered to retirees on the following September 1.*

This group insurance booklet is also available online on the Customer Centre website at **customer-centre.ssq.ca**.

CUSTOMER CENTRE

The key tool for your group insurance

- Submit a claim online and the reimbursement will be directly deposited in your account within 48 hours (for most of health care expenses).
- Never look for your insurance documents (statements, proof, card) again.
- Consult your claims easily.
- Always know the details of your insurance coverage.

Log in
customer-centre.ssq.ca

Keep this booklet for future reference.

QUESTIONS?

For questions about your group insurance plan:

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

1 888-CSQ-0006
(1-888-277-0006)

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