alter ego

THE CSQ ADVANTAGE

YOUR GROUP INSURANCE PLAN

REFLECTING MY REALITY

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SCHEDULE OF BENEFITS

Health Insurance (compulsory participation, with right of exemption)

Refer to the Health Insurance Plan section for details pertaining to the bene t, 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 certi cate.

To be considered eligible, all expenses identi ed 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 $987 / certi cate)
	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.

<table>
<tr><th>Optional Complementary Package 2</th><th colspan="2">Reimbursement Parameters</th></tr>
<tr><td>Audiology</td><td rowspan="9">80%
Combined maximum reimbursement of $1,000 per insured, per calendar year for all of these professionals</td><td rowspan="16">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>
<tr><td>Kinesiology</td></tr>
<tr><td>Occupational therapy</td></tr>
<tr><td>Physiotherapy and athletic therapy</td></tr>
<tr><td>Podiatry</td></tr>
<tr><td>Podology</td></tr>
<tr><td>Speech therapy</td></tr>
<tr><th colspan="2">Optional Complementary Package 3</th></tr>
<tr><td>Acupuncture</td><td rowspan="6">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
Arti cial 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%
Detoxi cation 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 bene t, including applicable exclusions and restrictions.

Coverage	• Preventive Dental Care • Minor Restorative Dental Care • Major Restorative Dental Care
Deductible	$50 annual deductible per certi cate 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 bene t, 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)

Life Insurance

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

<u>Compulsory participation, with right to opt out</u>

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

<u>Optional participation</u>

Participant's Optional Life Insurance	
Sum insured available	1 to 9 units of $25,000, with evidence of insurability, except for the rst 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	
<u>Option 1</u>	<u>Option 2</u>
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

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 de nition 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 de nition 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

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- personnel and individuals on union leaves of certain unions or federations af liated 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 af liated 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.

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 noti ed of the change, at which time the coverage of the person previously designated as spouse is terminated.

Please inform the emplo er in writing of an change related to the spouse so that the insurance le ma be corrected if necessar .

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;

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) *Eligibilit*

Any employee who does not bene t 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) *Eligibilit*

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.

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 rst 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*

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) *Compulsor 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 rst 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

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*

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 rst 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 rst 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 rst day of the premium period coinciding with or following the date the employer receives the request.

<table>
<tr><th></th><th colspan="2">Date the application for insurance is received by the employer</th></tr>
<tr><th>Plan</th><th>Within 60 days following the date of eligibility</th><th>More than 60 days after the date of eligibility</th></tr>
<tr><td rowspan="2">Dental Care Insurance</td><td>The insurance will become effective on the date of eligibility, according to the required coverage status (individual, single-parent or family).</td><td>The insurance will become effective on the rst 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).</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Short Term Disability Insurance</td><td colspan="2">The insurance becomes effective on the date of eligibility.</td></tr>
<tr><td>Long Term Disability Insurance</td><td colspan="2">The insurance becomes effective on the date of eligibility.</td></tr>
</table>

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 rst 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 rst 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**
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 rst 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 ouy89 0 Td(Participasasa0.606 0 /4 9.5 1n

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)

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

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

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

Evidence of insurability is required and the insurance becomes effective on the first day of the 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 rst 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.

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 Disabilit 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

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 60

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)

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.

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

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 le 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 nal 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 nal 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 nal 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 rst 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.

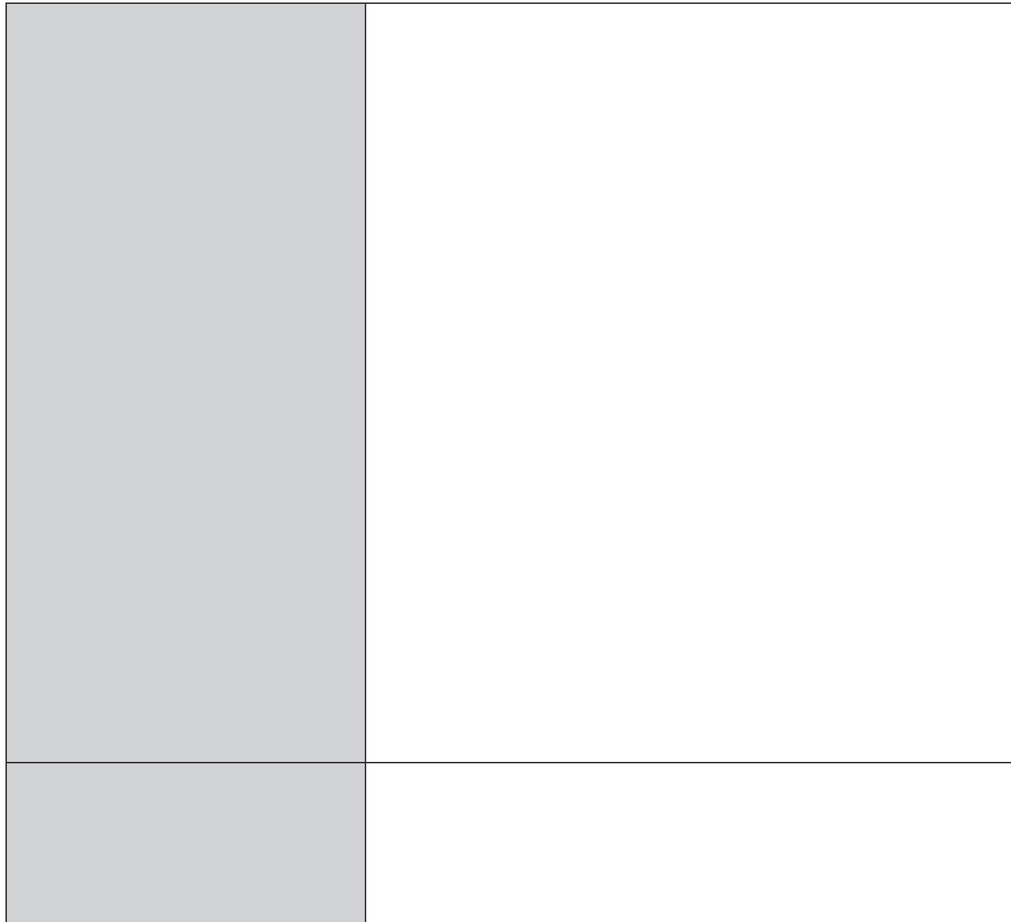
d) The premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the participant's age and employment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

e) The amount of life insurance

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.



b) *Annual earnings*

The de nition 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

f) Coverage under the Short Term Disabilit 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,

2- HEALTH INSURANCE PLAN

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

The only expenses covered are those incurred for treatments, care or supplies provided by a health professional who is a member in good standing of the professional 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 Bene ts.

The medical prescription, when required for the expenses incurred to be eligible for

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.

<u>Exclusions</u>

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 ight 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 ight instructor as provided in the collective agreement or in the individual employment contract.

Bene ciary

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

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 BĐ[illegible]

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

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

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-in icted 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

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 of cially 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 indemni cation (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)

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 signi cant 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-in icted 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.

2.5.2 Dietetics

Expenses for consultation with a dietitian.

2.5.3 Homeopathy

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 insuf ciency 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, ared 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 modi cations 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 bene t.

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

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 " rst 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 bene ts 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 veri cation 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;

- complete periodontal examination: 1 examination per 36-month period
- emergency examination: 2 examinations per calendar year
- speci c oral examination: 2 examinations per calendar year

3.3.2 X-rays

a) intraoral X-rays

b) extraoral X-rays

- extraoral lm
- sinus examination
- sialography
- radiopaque dyes
- temporomandibular joint
- panoramic lm: 1 lm per 36-month period
- cephalometric lm
- duplicate le 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
- uoride, 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
- nishing restorations
- pit and ssure 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

* *Onl 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
- xed or removable device: 1 device per 24-month period
- myofunctional therapy: 5 visits per lifetime

* *Onl 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

•

- 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

- 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 9.5 0 0month period≮Lang (fr-CA)/MCID 3846 /MCI0 9.5 108 279.303 Tm(•)ET

- abutment for bridge (except transitional)
- retentive bar: once per 60-month period

3.5.4 Repair of fixed prosthodontics

- removal, xed bridge
- recementation, xed bridge: twice per calendar year per abutment
- repairs, xed bridge
- other xed 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 nal 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 speci ed in the following table. The rst 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 rst calendar ear 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 modi cation 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 modi cation takes effect at the premium period coinciding with or following the date indicated on the written notice on the effective date of the modi cation.

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 speci ed 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

d)

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.

d) *Disabilit 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 an remunerative emplo ment*

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 emplo ment* 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 an remunerative emplo ment* indicated in the rst 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 signi cant extent. An *activit engaged into a signi cant 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) *Maternit , paternit , adoption or parental bene ts*

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

Adoption or parental gross bene ts 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 bene ts 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

d)

employee is receiving treatment or medical care for rehabilitation;

e)

Disability Insurance Plan;

f)

stable condition as attested by a physician to the satisct ion 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 bene ts described below.

6.1

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 bene t up to the lesser of $100,000 and 50% of the amount of life insurance (basic and optional) they held. The amount

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 bene ts 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 bene t 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 bene t, 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.

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 bene t 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 bene ts 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 Bene t Claims

The insured must indicate the certi cate number on any bene t 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 le at any time. Here are a few of the operations that can be carried out quickly, securely and con dentially:

- submit a claim online (for some types of claims only);
- register for Direct Deposit of Health, Dental Care and Disability Insurance bene ts;
- 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 bene ciary;
- view the coverage included as part of their insurance le;
- view the balance of their counter for the coverage involved;
- print a proof of coverage for Travel Insurance bene ts.

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

<u>Notice of new file</u>

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.

<u>Legal agents and service providers</u>

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 Ma , June, Jul or August become eligible for the plans offered to retirees on the following September 1.*

T a ce b e a a a ab e e e C e Ce e eb e a
c omer cen re q ca

CUSTOMER CENTRE