AUGUST
2008

GROUP INSURANCE PLAN

FOR
EMPLOYEE MEMBERS
OF THE

SSQ Financial Group

Please keep this booklet for future reference.

This plan is intended for all employees covered under the APTS collective agreement.

This booklet contains the main provisions and conditions of your group insurance plan.

The coverage provided under your insurance plan was determined by taking into consideration your needs as well as the benefits that are provided under various government plans.

The APTS and SSQ recommend that you read this booklet in order to become familiar with the coverage and benefits you are entitled to under your insurance plan as well as the administrative provisions governing your participation in the plan.

In the present booklet, SSQ designates SSQ, Life Insurance Company Inc.

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

Cette brochure est disponible en français.

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YOUR PLAN AT A GLANCE

The Schedule of Insurance below provides details about reimbursement provisions for each insurance benefit. The amounts indicated for eligible expenses are maximum amounts. Refer to section 2.2 for details about conditions for eligibility of these expenses.

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Prescription drugs with SSQ Card (deferred payment) (2.3.1)	80% of first $4,250 in eligible expenses per certificate and 100% of eligible expenses in excess of this per calendar year (RAMQ List)	80% of first $3,750 in eligible expenses per certificate and 100% of eligible expenses in excess of this per calendar year (Expanded List)	80% of first $3,750 in eligible expenses per certificate and 100% of eligible expenses in excess of this per calendar year (Expanded List)	Yes
Transportation by ambulance (2.3.2)	80% No maximum	80% No maximum	80% No maximum	No
Transportation and accommodation in Quebec (2.3.3)	80% Maximum reimbursement of $1,000 / calendar year / insured	80% Maximum reimbursement of $1,000 / calendar year / insured	80% Maximum reimbursement of $1,000 / calendar year / insured	Yes
Orthopaedic devices (corsets, medicated dressings, crutches, splints, casts, trusses, etc.) (2.3.4)	80% No maximum	80% No maximum	80% No maximum	Yes

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HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Therapeutic devices, respirators, insulin pumps and insulin pump accessories (2.3.5)	80% Maximum reimbursement of $10,000 / lifetime / insured for all these devices	80% Maximum reimbursement of $10,000 / lifetime / insured for all these devices	80% Maximum reimbursement of $10,000 / 24 months / insured for all these devices	Yes
Transcutaneous electrical nerve stimulator (TENS) (2.3.6)	Not covered	80% Eligible expenses of $700 / 60 months / insured		
Post-surgical brassieres (2.3.7)	80% Maximum reimbursement of $200 / lifetime / insured	80% Maximum reimbursement of $200 / lifetime / insured	80% Maximum reimbursement of $200 / lifetime / insured	Yes
Travel insurance with assistance [1] (2.3.8)	Not covered	100% $5,000,000 / trip / insured	100% $5,000,000 / trip / insured	According to the indications of the assistance service
Trip cancellation insurance (2.3.9)	Not covered	100% $5,000 / trip / insured	100% $5,000 / trip / insured	No

[1] Before leaving on a trip, if you know you have an illness or if your state of health is not stable, your must contact SSQ's Travel Assistance Service at 1-800-465-2928 to confirm your eligibility to travel under the provisions of your insurance coverage.

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HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Hospital expenses in Canada (2.3.10)	Not covered	100% of cost of semi-private room No limit on days	100% of cost of semi-private room No limit on days	No
Professional fees in case of accident to natural teeth (2.3.11)	Not covered	80% Care received within 12 months following the accident	80% Care received within 12 months following the accident	No
Non-motorized wheelchair and hospital bed (2.3.12)	Not covered	80% Temporary use only	80% Temporary use only	Yes
Artificial limbs and external prosthesis (2.3.13)	Not covered	80% Maximum reimbursement of $5,000 / lifetime / insured for all these articles	80% Maximum reimbursement of $5,000 / lifetime / insured for all these articles	No
Support stockings (2.3.14)	Not covered	80% Maximum reimbursement of $150 / calendar year / insured 20 mm HG or over	80% Maximum reimbursement of $150 / calendar year / insured 20 mm HG or over	Yes
Blood glucose monitor (2.3.15)	Not covered	80% $300 of eligible expenses / 60 months / insured	80% $300 of eligible expenses / 60 months / insured	Yes

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HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Esthetic surgery following an accident (2.3.16)	Not covered	75% Maximum reimbursement of $10,000 / lifetime / insured Expenses incurred within 36 months following the accident and treatments begun within 12 months following the accident	75% Maximum reimbursement of $10,000 / lifetime / insured Expenses incurred within 36 months following the accident and treatments begun within 12 months following the accident	Yes
Sclerosing injections (2.3.17)	Not covered	75% $20 of eligible expenses / treatment for the injected substance and $15 for professional fees Maximum reimbursement of $300 / calendar year / insured	75% $20 of eligible expenses / treatment for the injected substance and $15 for professional fees Maximum reimbursement of $300 / calendar year / insured	Yes
Nurse and nursing assistant (in exclusive and continuous attendance over the insured at the insured's home) **(2.3.18)**	Not covered	75% $300 of eligible expenses / day / insured Maximum reimbursement of $10,000 / calendar year / insured for all these professionals	75% $300 of eligible expenses / day / insured Maximum reimbursement of $10,000 / calendar year / insured for all these professionals	Yes

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HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Orthopaedic shoes (2.3.19)	Not covered	80% Maximum reimbursement of $250 / calendar year / insured for all these articles	80% Maximum reimbursement of 2 pairs / calendar year / insured	Yes
Foot orthoses (2.3.20)			80% Maximum reimbursement of $250 / calendar year / insured	
Occupational therapist, speech therapist and audiologist (2.3.21)	Not covered	75% Maximum reimbursement of $500 / calendar year / insured for all these professionals	75% No maximum	No
Physiotherapist and physical rehabilitation therapist (2.3.22)			75% Maximum reimbursement of $1,000 / calendar year / insured for all these professionals	
Osteopath (2.3.23)		Not covered		

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HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Chiropractor, acupuncturist or podiatrist (2.3.24)	Not covered	75% Maximum reimbursement of $400 / calendar year / insured for all these professionals X-rays by a chiropractor: $35 / calendar year / insured	75% Maximum reimbursement of $750 / calendar year / insured for all these professionals X-rays by a chiropractor: $35 / calendar year / insured	No
Dietitian (2.3.25)		75% Maximum reimbursement of $500 / calendar year / insured for all these professionals		
Psychologist and social worker (2.3.26)			75% Maximum reimbursement of $1,000 / calendar year / insured for all these professionals	
Psychiatrist, psychoanalyst, career counsellor and nurse specialized in psychotherapy (2.3.27)		Not covered		

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC HEALTH INSURANCE**	**INTERMEDIATE HEALTH INSURANCE (minimum participation of 48 months)**	**SUPERIOR HEALTH INSURANCE (minimum participation of 48 months)**	**MEDICAL PRESCRIPTION**
Massage therapist, kinesitherapist and orthotherapist (2.3.28)	Not covered	Not covered	75% Maximum reimbursement of $400 / calendar year / insured for all these professionals	No
Eye care: eye examination, eye glasses, contact lenses and laser eye surgery (2.3.29)			80% Maximum reimbursement of $200 / 24 months / insured for all these treatments and articles	
Hearing aid (2.3.30)			80% Eligible expenses of $600 / 48 months / insured	

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DENTAL CARE INSURANCE PLAN (optional) **Minimum participation of 48 months**			
COVERAGE	**REIMBURSEMENT LIMITATIONS**	**PERCENTAGE OF REIMBURSEMENT**	**MEDICAL PRESCRIPTION**
• **Preventive Dental Care** • Clinical examination • X-Rays • Tests and laboratory examinations • Biopsy, diagnostic model • Polishing, scaling • Space maintainer	Maximum reimbursement of $1,000/ calendar year / insured, for all coverage (subject to provisions of section 3.4)	80%	No
• **Basic Dental Care** • Amalgam or composite restorations • Root canal treatments (endodontics) • treatment of infection, surgery, splinting (periodontics) • Removal of teeth, and other surgery			
• **Major Restorative and Prosthetic Services** • Crown, cast metal post, prefabricated post • Removable dentures (partial and complete) • Fixed bridge [2] • Dental implants [3]		50%	

[2] Expenses incurred for fixed bridges are eligible up to a maximum of the cost of the limitations applying to the equivalent removable dentures.

[3] Expenses for implants (including expenses incurred for dentures attached to implants) are eligible up to a maximum of the cost and limitations of a crown, only at the time of final insertion of crown implant. Expenses incurred for additional procedures or treatments related to implants (surgery, graft, etc.) are not eligible.

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COMPLEMENTARY PLAN I: LIFE INSURANCE AND LONG TERM DISABILITY INSURANCE (compulsory)	
COVERAGE	**DESCRIPTION**
Participant's Basic Life Insurance	1 times the gross annual salary.
Participant's Optional Life Insurance (optional)	1, 2 or 3 times the gross annual salary.
Spouse's and Dependent Children's Life Insurance	$5,000 upon the death of the spouse; $2,000 upon the death of a dependent child aged 24 hours or older.
Spouse's Optional Life Insurance (optional)	1 to 10 units of $10,000.
Participant's Accidental Dismemberment Insurance	$15,000 to $60,000, depending on the loss.
Participant's Long Term Disability Insurance	
• Benefit payments	72% of net salary.
• Duration	For as long as total disability lasts, up to but no longer than age 60.
• Start date of benefit payments	As of the 105th week of disability.
• Indexation	After 12 months of benefits from SSQ, January 1 of each year, according to the RRQ (annual maximum: 3%).

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1. GENERAL INFORMATION

1.1 DEFINITIONS

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

Business partner: an individual with whom the insured is associated for business purposes as part of a corporation comprised of 4 shareholders or fewer, or a commercial or non-commercial corporation comprised of 4 partners or fewer.

Close relative: person whose relationship to another is one of the following: spouse, son, daughter, father, mother, brother, sister. Depending on the context, it can also designate a friend in cases where a participant has no close relatives.

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

Dependent: the participant's spouse or dependent child, as defined below:

a) Spouse:

   i) person who is related to the participant through a marriage or civil union that is legally recognized in Quebec; or

   ii) person who has been designated in writing as the spouse by the participant to SSQ, and who is presented publicly as the spouse and who lives with the participant on a regular basis:

   - if a child was born of the union; or
   - if no child was born of the union, who has lived with the participant on a regular basis for at least 1 year;

   The person loses the status of spouse if one of these events occurs:

   - dissolution of the marriage by divorce or annulment;
   - annulment of the civil union;
   - separation for more than 3 months in the case of a de facto union;

- designation in writing of another spouse by the participant.

If there are two spouses, only one can be recognized as such for all coverage under the same plan, the order of priority of which is determined as follows:

- the eligible spouse who was the last person to be designated as such by written notice of the participant to SSQ, subject to the approval of any evidence of insurability required;
- the person who is related to the participant through a marriage or civil union.

b) Dependent child: any unmarried child of the participant, of the spouse or both, or of whom the participant or the spouse exercises parental authority or would exercise such authority if the child was a minor, including a legally adopted child or for whom legal adoption procedures have been undertaken or a placement of order has been issued, in compliance with the adoption procedure. The child must reside or be domiciled in Canada and depend on the participant or the spouse for support. Also, to be considered a dependent child under this plan, the child must be:

i) under age 18; or

ii) aged 18 or over, but under age 26, studying full time in a recognized educational institution, in which case evidence deemed satisfactory by SSQ must be submitted; or

iii) aged 18 or over, suffering from a total disability or functional deficiency, as defined under the regulation respecting the government's Public Prescription Drug Insurance Plan (R.S.Q. c. A-29.01, r.2) when considered a dependent child according to the previous conditions and remained totally disabled without interruption ever since.

Sabbatical leave from school

Despite the preceding, a child who takes a sabbatical leave from school may maintain his or her dependent child status. A written request specifying the date the sabbatical leave will begin must be submitted to SSQ and be approved before the beginning of the leave. This continuation of dependent child status cannot last more than 12 months and must end at the beginning of a school year (September) or the winter term (January), but it cannot continue if the child ceases to be eligible for the Quebec Health Insurance Plan (Régime d'assurance maladie du Québec). Eligible expenses for

such a leave cannot exceed $1,000,000. A sabbatical leave is granted only once per lifetime per dependent child.

Employee: any employee subject to the collective agreement governing this plan. It also designates employees liberated for union activities according to the terms of the collective agreement and employees of APTS.

Employer: any establishment represented by an employer's association of the Health and Social Services sector and governed by a collective agreement, or any employer or category of employer accepted by the APTS.

Family member: person who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, father-in-law, mother-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent or grandchild.

Healthy tooth: tooth that has not been affected by any pathology, either in the substance itself or in the adjacent structures, or a tooth that has been treated or repaired and has recovered its normal function.

Hospital: a hospital centre, within the meaning of the Act and regulations respecting health services and social services (R.S.Q. ch. S-4.2 and ch. S-5) excluding any part of the centre that is reserved for long term care. "Hospital" also means any establishment outside Quebec that complies with the same standards.

Host at destination: an individual at whose principal residence the insured is planning to stay for at least part of the trip.

Illness: deterioration of health or bodily disorder documented by a physician as well as any surgical intervention related to family planning. Pregnancy is not considered an illness, except in the case of pathological complications.

Insured: any person who is granted insurance, either as a participant or as a dependent under this plan.

Net salary: salary after deduction of federal and provincial taxes, and contributions to Employment Insurance (EI), the Quebec Parental Insurance Plan (RPIP), the Quebec Pension Plan (QPP), and the Canada Pension Plan (CPP).

Participant: any employee insured under this plan.

Salary: basic salary to which the participant is entitled, including bonuses and supplemental income, where applicable.

Total disability:

During the first 48 months of a total disability period, a state of incapacity resulting from an accident or illness, complications of

a pregnancy, tubal ligation, vasectomy, or similar cases related to family planning, or donation of organs or bone marrow, requiring medical care and making the participant totally unable to carry out the normal duties of their employment or of any other comparable employment with similar remuneration offered to the individual by the employer.

Afterwards, "total disability" is a state of incapacity resulting from an illness, accident, complication of pregnancy, tubal ligation, vasectomy or similar cases related to family planning, donation of organs or bone marrow, making the participant totally unable to carry out any remunerative employment or perform any work entitling to a profit or salary and for which the employee is reasonably prepared as a result of education, training and experience, regardless of the availability of employment.

Total disability period:

During the first 104 weeks of total disability, any continuous period of total disability or consecutive periods of total disability separated by less than **15 days** of effective full-time work or availability for full-time work, unless the participant demonstrates to the satisfaction of the employer or employer's representative that a subsequent period is due to an illness or an accident completely unrelated to the cause of the preceding disability.

During the following 52 weeks, any continuous period of total disability or consecutive periods of total disability separated by less than **90 days** of effective full-time work or availability for full-time work, unless the participant demonstrates to the satisfaction of the employer or employer's representative that a subsequent period is due to an illness or an accident completely unrelated to the cause of the preceding disability.

Afterwards, any continuous period of total disability or consecutive periods of total disability separated by less than **6 months** of effective full-time work or availability for full-time work. Any period of total disability resulting from an illness or an accident completely unrelated to the cause of the preceding disability is considered as a new period of total disability, except if this new disability occurs during a period of total disability.

Any period of rehabilitation during the elimination period for the Long Term Disability Insurance coverage will not have the effect of interrupting the period of total disability.

Restrictions: The following periods are not considered total disability periods under this plan:

a) a period of disability resulting from an illness, injury or dismemberment self-inflicted by the participant, whether or not the individual was of sound mind at that time;

b) a period of disability resulting from alcoholism or drug abuse during which the participant was not receiving medical treatments or care for rehabilitation purposes;

c) a period of disability resulting from active participation in a riot, insurrection or criminal act;

d) a period of disability resulting from a war, whether declared or not;

e) a period during which the participant benefits from a preventative withdrawal related to a pregnancy or breastfeeding and approved by the CSST.

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

Travel expenses paid in advance: expenses incurred by the insured to purchase the following:

a) a trip package, including tickets from a public carrier, rental of motor vehicles from an accredited firm and hotel room reservations;

b) travel arrangements usually included in a trip package;

c) registration fees for a commercial activity.

Trip: for the purposes of Trip Cancellation Insurance, a trip made by an insured from the usual place of residence to temporarily visit a place at least 200 kilometres away. Also, to be considered eligible, the trip must have been made as a tourist or for pleasure or for a commercial activity, which entails the absence of the insured from his/her place of residence for a period of at least 2 consecutive nights. To be considered a trip, a cruise must last at least 2 consecutive nights and be operated under the responsibility of an accredited firm.

1.2 ELIGIBILTY

1) Employee

a) Any employee is eligible for insurance after completing one of the following service periods, whether the employee has completed the probationary period or not:

i) after one (1) month of continuous service for employees who have a permanent position and who are working full-time or at 70% or more of full-time.

ii) after three (3) months of continuous service for an employee who does not have a permanent position but is working full-time or at 70% or more of full-

time, or for an employee working part-time or less than 70% of full-time.

b) Employees who are moved to another job position under the employment security plan of their collective agreement, their eligibility for insurance with their new employer is determined according to the duration of their employment with their previous employer. Employees who have quit their job for 30 days or less for a definitive reason and who return to the same employer or begin to work for a new employer are exempted from the 1-month or 3-month period mentioned above, provided this plan is in force with the new employer. The employee's duration of employment, both outside and inside the bargaining unit, is also used for the purposes of this paragraph.

2) Dependents

Any person who is a dependent of the employee is eligible for coverage on the latest of the following dates:

a) the employee's date of eligibility;

b) the date on which such person becomes a dependent.

3) Retirees who are rehired

Retirees who are rehired are not eligible for this group insurance plan.

1.3 PARTICIPATION

1) **Employee**

a) Health Insurance Plan

Participation in the Health Insurance Plan is compulsory for all eligible employees, subject to the right of exemption described in section 1.3.4). However, eligible employees must choose to participate in one the following three plans:

- Basic Health Insurance Plan
- Intermediate Health Insurance Plan
- Superior Health Insurance Plan

Employees must maintain their participation in the Intermediate or Superior Plan for at least 48 months before they may be allowed to change their choice to a lower coverage option.

Employees aged 65 or over

Regardless of the minimum duration of participation established for the plan chosen, insureds aged 65 or over

may decide to be insured under the Public Prescription Drug Insurance Plan administered by the *Régie de l'assurance maladie du Québec* (RAMQ). Employees who choose RAMQ coverage may exercise their right of exemption, but may not subsequently resume participation in the group plan. The choice of becoming insured with the RAMQ can also be made by a spouse aged 65 or over.

b) Dental Care Insurance Plan

Participation in the Dental Care Insurance Plan is optional for eligible employees who participate in or are exempted from the Health Insurance Plan. However, the minimum duration of participation in this plan is 48 consecutive months. For transfers from another insurance contract, this 48-month period begins on the initial date of application for the dental insurance plan the employee of the Health and Social Services sector was participating in.

c) Complementary Plan I

Participation in Complementary Plan I is compulsory for employees who participate in or are exempted from the Health Insurance Plan, subject to the following exceptions:

i) employees may be entitled to a waiver privilege for Participant's Basic Life Insurance (see section 1.6); however, those who do so are not entitled to Participant's Optional Life Insurance;

ii) participation in Participant's Optional Life Insurance is not compulsory.

d) Specific provisions for employees working 25% of full-time or less

i) New eligible employee

New eligible employees working 25% of full-time or less must confirm their wish for coverage by sending a written notice to their employer within 10 days of receiving notice from the latter informing them of the percentage of time they have worked in relation to full-time during the first three months of employment. They must choose one of the following two options subject to the provisions for the right of exemption:

- participate in the Health Insurance Plan only and choose either the Basic Insurance Plan, the Intermediate Insurance Plan or the Superior Insurance Plan; or

- participate in one of the Health Insurance Plans, in the Complementary Plan I and in the Dental Care Insurance Plan (optional) subject to the condition of participating in the Life Insurance and Short Term Disability Insurance coverage provided for under the collective agreement.

New eligible employees who do not submit a written request to their employer within 10 days as specified above will automatically be registered for the Basic Health Insurance Plan with an Individual coverage status.

Participants working 25% of full-time or less who participate only in the Health Insurance Plan or who are exempted from it may choose to participate in the other benefits provided for under the plan as of January 1 of each year by making a written request to their employer before November 30 of the preceding year, as long as they participate in the Life Insurance and Short Term Disability Insurance benefits provided for under their collective agreement.

ii) Change in percentage of time worked

Decrease to 25% of full-time or less

Participants whose percentage of time worked decreases to 25% of full-time or less during the reference period (12 complete months ending on October 31 of the preceding year) must submit a written request to their employer within 10 days following the date on which they received a notice from the latter informing them of the percentage of time they have worked during the reference period. They must choose one of the following three options subject to any provisions related to the right of exemption:

- participate in Basic Health Insurance Plan only; or
- maintain participation only in the health plan held before the change in percentage of time worked; or
- maintain participation in all plans held before the change in percentage of time worked, provided the Life Insurance and Short Term Disability Insurance coverage provided for under the collective agreement are also maintained.

Participants who do not submit a written request to their employer within the above-mentioned 10-day deadline shall maintain coverage only in the health plan held before the change in percentage of time worked.

Participants working 25% of full-time or less who participate only in the Health Insurance Plan or who are exempted from it may choose to participate in the other benefits provided for under the plan as of January 1 of each year by making a written request to their employer before November 30 of the preceding year, as long as they participate in the Life Insurance and Short Term Disability Insurance coverage provided for under their collective agreement. Participants who have chosen to participate only in the Basic Health Insurance Plan, and who held the Intermediate Plan or Superior Plan, or the Dental Care Insurance Plan, before the change in the percentage of full-time worked, must continue participation in these plans until the minimum duration of 48 months has elapsed. The minimum duration of participation required in the Basic Health Insurance Plan is included in this 48-month period.

Increase to more than 25% of full-time

Participants who participate in the Health Insurance Plan only or are exempted from it and whose status changes because their percentage of time worked has increased to more than 25% of full-time are subject, as of the following January 1, to all of the rules of participation applicable to employees working more than 25% of full-time.

Participants who have chosen to participate in the Basic Health Insurance Plan only, and who held the Intermediate Plan or Superior Plan, or the Dental Care Insurance Plan, before the change in the percentage of full-time worked, must continue participation in these plans until the minimum duration of 48 months has elapsed. The minimum duration of participation in the Basic Health Insurance Plan is included in this 48-month period.

iii) General rules

Participants working 25% of full-time or less who participate in the Health Insurance Plan, Complementary Plan I and Dental Care Insurance

Plan (optional) are subject to the same rules of participation, depending on the plan concerned, as those who work more than 25% of full-time and must maintain participation in these plans for as long as they are working 25% of full-time or less.

2) **Dependents**

a) Health Insurance Plan

All participants must insure their dependents under the Health Insurance Plan subject to the right of exemption and to the provisions applicable to spouses aged 65 and over. The choice participants make to have the Basic Health Insurance Plan, Intermediate Health Insurance Plan or Superior Health Insurance Plan also applies to their dependents.

b) Dental Care Insurance Plan

Participation of dependents in the Dental Care Insurance Plan is optional, subject to the rules stipulated in section 1.3.3).

c) Complementary Plan I

Participation in Spouse's and Dependent Children's Life Insurance is compulsory for dependents insured under the Health Insurance Plan. Also, participants who are exempted from health insurance who choose the Individual coverage status cannot participate in Spouse's or Dependent Children's Life Insurance.

Participants who participate only in the Health Insurance Plan because they work 25% of full-time or less or because they are temporarily absent from work cannot participate in Spouse's or Dependent Children's Life Insurance, regardless of their coverage status.

Participation in Spouse's Optional Life Insurance is not compulsory.

3) **Coverage status**

Participants must select a coverage status for the Health Insurance Plan and for the Dental Care Insurance Plan. The types of coverage status available are as follows:

Coverage status	Individuals covered
Individual - I	The participant
Single-Parent - S-P	The participant and dependent children
Family - F	The participant, spouse and dependent children

The participant's coverage status under the Health Insurance Plan determines coverage status eligibility for the Dental Care Insurance Plan. The possible combinations are as follows:

Plan	Combinations					
	1	2	3	4	5	6
Health Insurance	I	S-P	S-P	F	F	F
Dental Care Insurance	I	S-P	I	F	S-P	I

Participants who are exempted from the Health Insurance Plan can obtain Individual, Single-Parent or Family coverage status for the Dental Care Insurance Plan.

4) **Right of exemption**

Eligible employees or participants may refuse or cease to participate in the Health Insurance Plan. To be entitled to the exemption, they must make a request to SSQ through their employer and establish that they and their dependents, if any, are insured under another group insurance plan with prescription drug insurance coverage. Also, any person aged 65 or over who is insured under the Public Prescription Drug Insurance Plan administered by the RAMQ may be exempted from participation in health insurance coverage. The right of exemption also allows participants to cease participation in the Intermediate Health Insurance Plan or Superior Health Insurance Plan even if the 48-month minimal duration of participation has not elapsed.

To be exempted from participation in the Dental Care Insurance Plan, eligible employees and participants must make a request to SSQ through their employer and establish that they and their dependents, if any, are covered by a compulsory public sector Dental Care Insurance Plan which does not allow exemptions from coverage. The right of exemption also allows participants to cease participation in the Dental Care Insurance Plan even if the 48-month minimal duration of participation is not completed.

a) <u>Start of exemption</u>

i) The exemption of new eligible employees begins on their date of eligibility, provided SSQ receives the duly completed written request within 30 days after this date. Otherwise, it begins on the first day of the pay period that follows the date SSQ receives the request.

ii) The exemption of participants begins on the date of the event that allows the exemption, provided SSQ

receives the duly completed request within 30 days following this event. Otherwise, it begins on the first day of the pay period that follows the date SSQ receives the request.

b) End of exemption

Participants who are exempted from participating in the Health Insurance Plan or Dental Care Insurance Plan may participate at a later date, provided they establish to the satisfaction of SSQ:

i) that they and their dependents, if any, were previously insured under this insurance plan or under another similar group insurance plan; and

ii) that it has become impossible for them, and their dependents, if any, to continue to be insured under the plan that allowed the exemption.

If the request to terminate exemption is received by SSQ within 30 days following the date of end of insurance permitting the exemption:

The insurance becomes effective on the date of termination of the plan that allowed the exemption.

Participants who held the Intermediate or Superior Health Insurance Plan or the Dental Care Insurance Plan before the beginning of the exemption must resume participation in those same plans if the minimum 48-month duration of participation was not completed. The exemption period is included as part of this 48-month period.

For participants who have a waiver of premiums for the Health Insurance Plan at the time they make an application request following the termination of an exemption, the Health Insurance Plan they are granted cannot be superior to the one held before the exemption; if the exemption began before January 1, 2008, or if it began upon their eligibility for coverage, they must choose between the Basic Health Insurance Plan and the Intermediate Health Insurance Plan.

However, if the request to terminate the exemption is received by SSQ over 30 days after the date of end of insurance permitting the exemption:

- *Health Insurance Plan*

  The **Basic Health Insurance Plan** is granted according to the coverage status requested on the first day of the pay period that coincides with or follows the date SSQ receives the request.

For participants who choose either the Intermediate or the Superior Health Insurance Plan, the plan will come into force on January 1 following the date SSQ receives the request, unless they are disabled on this date, in which case it will come into force on January 1 following the date of their effective return to work.

Participants who were enrolled in the Intermediate or Superior Health Insurance Plan before the start of the exemption must continue to participate in these plans if the minimum 48-month duration of participation period has not been completed. The plan in question will come into force on January 1 following the date SSQ receives the request, unless the person is disabled on this date, in which case it will come into force on January 1 following the date of the person's effective return to work. Any 48-month minimum duration of participation period already underway will begin again as of the effective date.

- *Dental Care Insurance Plan*

  The insurance will come into force on January 1 following the date SSQ receives the request, unless the person is disabled on this date, in which case it will come into force on January 1 following the date of the person's effective return to work. The gradual reimbursement limits indicated in section 1.5.4) a) apply. Any 48-month minimum duration of participation period already underway will begin again as of the effective date.

1.4 APPLICATION

1) Applications for insurance must be completed by employees and sent to SSQ by the employer within 30 days following the eligibility date of the person requesting the insurance. The application form is available from the employer's Human Resources department.

2) All applications for insurance must indicate the choice of Health Insurance Plan and participation in the Dental Care Insurance Plan, if applicable, as well as the coverage status desired by the employee. Subject to the participation rules concerning dependents, a participant's insurance automatically includes coverage for dependent children, or a spouse and dependent children, depending on whether the participant chooses the Single-Parent or Family coverage status.

3) As for the Health Insurance Plan, employees who neglect to or refuse to complete their application form within the required deadline are automatically registered for the **Basic Health Insurance Plan** with an Individual coverage status.

1.5 WHEN THE INSURANCE COMES INTO FORCE

1) **Employee**

a) **Health Insurance Plan**

Coverage for employees under the Health Insurance Plan comes into force on:

i) the date the employee becomes eligible for newly eligible employees; or

ii) the termination date of the insurance that allowed the exemption.

However, if SSQ receives the application for insurance or request to terminate an exemption more than 30 days after the eligibility date or the termination of the insurance that allowed the exemption, the **Basic Health Insurance Plan** is granted, on the eligibility date in the case of applications, or on the first day of the pay period which coincides with or follows the date SSQ receives the request in the case of exemption terminations. The rules for increasing coverage specified in section 1.8.1) apply.

b) **Dental Care Insurance Plan**

Coverage for employees under the Dental Care Insurance Plan comes into force on the latest of the following dates:

i) the date they become eligible in the case of newly eligible employees who are at work or capable of working on that date; otherwise the insurance becomes effective on the date of their effective return to work;

ii) the date they add their spouse or child to their list of dependents, provided the request for a Single-Parent or Family coverage status is given to SSQ within 30 days following the beginning of eligibility of said dependents and that the employees are at work or capable of working on that date; otherwise the insurance becomes effective on the date of their effective return to work;

iii) the date of termination of the insurance that allowed the exemption, provided the request is given to SSQ within 30 days following this date;

iv) on January 1, in the case of employees whose percentage of time worked has increased to more than 25% of full-time during the period of reference (period of 12 complete months ending on October 31 of the previous year) and who wish to participate in this insurance or who must complete the minimum duration of participation period of 48 months, provided they are at work or capable of working on that date, otherwise the insurance becomes effective on the date of their effective return to work. The rules stipulated in section 1.5.4) a) apply;

v) on January 1, if the application form was given to SSQ before the required deadline for employees working 25% of full-time or less who wish to participate in insurance or who must complete the 48-month minimum duration of participation period, provided they are at work or capable of working on that date, otherwise the insurance becomes effective on the date of their effective return to work. The rules stipulated in section 1.5.4) a) apply.

However, if the application or request to terminate an exemption is received by SSQ more than 30 days after the eligibility date or the end date of the insurance that allowed the exemption, the insurance becomes effective on January 1 following the date SSQ receives the request, except for insureds who are disabled on this date, in which case the insurance becomes effective on January 1 following the date of their effective return to work. The rules stipulated in section 1.5.4) a) apply.

c) **Complementary Plan I**

Coverage for employees under Complementary Plan I becomes effective on the latest of the following dates:

i) the date the employee becomes eligible in the case of newly eligible employees who are at work or capable of working on that date; otherwise the insurance becomes effective on the date of their effective return to work;

ii) on January 1, in the case of employees whose percentage of time worked has increased to more than 25% of full-time during the period of reference (period of 12 complete months ending on October 31 of the previous year) and who are at work or capable

of working on that date; otherwise the insurance becomes effective on the date of their effective return to work;

iii) on January 1, if the application form is given to SSQ within the required deadline in the case of employees working 25% of full-time or less and who are at work or capable of working on that date; otherwise the insurance becomes effective on the date of their effective return to work;

iv) on the first day of the pay period that follows the date the employer receives SSQ's notice of acceptance of the evidence of insurability, in all cases where such evidence is required and accepted.

2) **Dependents**

a) **Health Insurance Plan**

Dependents are not eligible for coverage until employees are insured. Subject to this requirement, the Health Insurance Plan comes into force on the latest of the following dates:

i) the date the dependent becomes eligible;

ii) the termination date of the insurance that allowed the exemption.

However, if the application for insurance or request to terminate an exemption is received by SSQ more than 30 days after the eligibility date or the end date of the insurance that allowed the exemption, the insurance becomes effective on the first day of the pay period following the date SSQ receives the request.

b) **Dental Care Insurance Plan**

Dependents are not eligible for coverage until employees are insured. Subject to this requirement, the Dental Care Insurance Plan comes into force on the latest of the following dates:

i) the date the dependent becomes eligible;

ii) the date the spouse or dependent child is added to the contract or the end date of the insurance that allowed the exemption;

iii) the date the employee's insurance becomes effective, in the case of employees whose percentage of time worked has increased to more than 25% of full-time during the period of reference (12-month period ending on October 31 of the previous year) and who wish to participate in this insurance;

iv) the date the employee's insurance becomes effective, in the case of employees working 25% of full-time or less and who wish to participate in this insurance.

However, if the application for insurance or request to terminate an exemption is received by SSQ more than 30 days after the eligibility date or the end date of the insurance that allowed the exemption, the insurance becomes effective on January 1 following the date SSQ receives the request, except for employees who are disabled on this date, in which case the insurance becomes effective on January 1 following the date of their effective return to work.

c) **Complementary Plan I**

Dependents are never eligible for coverage before employees are insured. Subject to this requirement, Spouse's Optional Life Insurance under Complementary Plan I becomes effective on the first day of the pay period that follows the date the employer receives SSQ's acceptance of the application for Spouse's Optional Life Insurance.

Spouse's and Dependent Children's Life Insurance comes into force on the effective date of the Single-Parent or Family coverage status for Health Insurance whether or not the eligible employee or the participant is capable of working.

3) **Evidence of insurability for Life Insurance**

Participants who exercise their right to exemption from Basic Life Insurance but who subsequently wish to participate in this insurance must make a request to SSQ and provide the required evidence of insurability.

Participant's Optional Life Insurance and Spouse's Optional Life Insurance is always subject to the presentation of evidence of insurability deemed satisfactory by SSQ.

4) **Particularities concerning the Dental Care Insurance Plan**

a) **Late applications**

For applications or requests to terminate exemptions that are made more than 30 days after the eligibility date or the end date of the insurance that allowed the exemption, the Dental Care Insurance Plan becomes effective on January 1 following the date SSQ receives the request, except for those who are disabled on this date, in which case the insurance becomes effective on January 1 following the date of their effective return to

work. The following reimbursement limits apply to all dental care expenses:

i) $600 per insured for expenses incurred during the first calendar year of insurance for the participant;

ii) $800 per insured for expenses incurred during the second calendar year of insurance for the participant;

iii) $1,000 per insured for expenses incurred per calendar year thereafter.

b) **Employees working 25% of full-time or less**

The gradual reimbursement limitations indicated in the previous paragraph also apply to employees working 25% of full-time or less who begin participation in the Dental Care Insurance Plan on January 1 of a given year.

1.6 RIGHT TO WAIVE PARTICIPANT'S BASIC LIFE INSURANCE

All eligible employees and participants may waive Participant's Basic Life Insurance under the Complementary Plan I provided they hold a minimum of $25,000 in **Individual coverage**. To do so, they must complete the "Request to Waiver Participant's Basic Life Insurance Plan" form usually available through their employer's human resources department and provide proof of this coverage. The waiver will apply as of the first day of the pay period following SSQ's acceptance of the request. On this date, eligible employees and participants may no longer participate in Participant's Optional Life Insurance.

1.7 CHANGE OF COVERAGE STATUS

1) **Increase**

Participants with Individual or Single-Parent coverage may choose to insure their spouse or dependent children, if applicable, without submitting evidence of insurability, as soon as they become eligible for insurance or as soon as they cease to be insured under another group prescription drug insurance or dental care insurance plan, provided the application is submitted to SSQ within 30 days following the date of eligibility of the dependents or the end of their previous insurance.

After this 30-day period, the new coverage status for the Health Insurance Plan becomes effective on the first day of the pay period that coincides with or follows the date

SSQ receives the application. As for Dental Care Insurance, the new coverage status will come into force on January 1 following the date of the application for insurance, except for insureds who are disabled on this date, in which case it will come into force on January 1 following the date of their effective return to work.

2) **Decrease**

Participants insured under a Family or Single-Parent coverage status remain insured under this status for as long as they have eligible dependents. However, please note that participants may change their coverage status to Individual or Single-Parent, as the case may be, only on the first day of the pay period following the date the employer receives a written notice to such effect.

1.8 CHANGE OF HEALTH INSURANCE PLAN

1) **Increase**

Employees who choose the Basic or Intermediate Health Insurance Plan may change to a higher level plan on January 1 of each year. To do so, they must duly complete the "Application / Request for Change" form and submit it to their employer's plan administrator. The change will come into force on January 1 following the date SSQ receives the form. Despite the preceding, employees who are on disability leave cannot increase their health insurance coverage.

2) **Decrease**

Employees who choose the Intermediate or Superior Health Insurance Plan may change to a lower level plan, **provided they have been covered under the plan they currently hold for at least 48 months**. To do so, they must duly complete the "Application / Request for Change" form and submit it to their employer's plan administrator. The effective date of this change is the first day of the pay period that follows the date the employer receives the form.

In the case of participants who were exempted from insurance, who held only the Basic Health Insurance Plan due to a temporary absence from work, or who decreased their percentage of time worked to 25% of full-time or less, the duration of these periods is included in the 48-month minimum duration of participation period for the Intermediate Health Insurance Plan and Superior Health Insurance Plan.

1.9 WAIVER OF PREMIUMS IN THE EVENT OF TOTAL DISABILITY

1) **Participant**

a) Health Insurance and Dental Care Insurance Plans

Participation in the Health Insurance Plan, and in the Dental Care Insurance Plan if applicable, is maintained without payment of premiums as of the 6th working day after the beginning of total disability for employees working full-time or 70% of full-time or more (for all other employees, participation is maintained as of the 8th day following the first day of total disability where the person would otherwise have reported to work). The period of total disability cannot exceed 3 years, and in no case may it continue after the participant reaches age 71 or after the termination of the contract.

For participants who are receiving full compensation under the *Act respecting industrial accidents and occupational diseases* and whose disability entitling them to such compensation occurred before their 62nd birthday, the waiver of premiums ends at the latest on the day they reach age 65. For participants receiving full compensation under the Act whose disability entitling them to such compensation occurred after their 62nd birthday, the waiver of premiums lasts for a maximum of 3 years and may in no case continue after the participant reaches age 71 or after the termination of the contract.

b) Complementary Plan I

Participation in Complementary Plan I is maintained without payment of premiums as of the 6th working day after the beginning of total disability for employees working full-time or 70% of full-time or more (for all other employees, participation is maintained as of the 8th day following the first day of total disability where the person would otherwise have reported to work) for as long as the participant remains totally disabled, whether or not the contract is still in force. Coverage continues without payment of premiums until age 60 for Long Term Disability Insurance and until age 65 for all other benefits. However, a participant who becomes totally disabled after their 62nd birthday maintains participation in Participant's Basic Life Insurance, Participant's Optional Life Insurance, Accidental Dismemberment Insurance, Spouse's & Dependent Children's Basic Life Insurance and Spouse's Optional Life Insurance coverage without payment of premiums for a maximum period of 3 years or until reaching age 71.

2) **Employer**

The employer's contribution is waived after the first 104 weeks of disability insurance benefits stipulated under the collective agreement.

3) **Warning** – Regardless of the above provisions, the waiver of premiums does not apply to participants who are benefiting from a preventative withdrawal related to pregnancy or breastfeeding and approved by the CSST; it also does not apply to a temporary assignment in the case of participants who are receiving the salary they received before their total disability began. For employees working part-time and those who do not have a permanent position, the salary is established based on what appears in section 3.3.3).

1.10 TEMPORARY ABSENCES FROM WORK

Participants who do not take advantage of the provisions allowing them to maintain insurance at the beginning of their temporary absence from work may not do so at a later date within the same period of absence.

1) **During unpaid leave of 28 days or less or paid leave**

Participation in all plans is maintained; the participant and the employer must pay their respective premiums.

2) **During an unpaid leave of more than 28 days**

The participant must submit a written request to the employer before the beginning of the leave and choose one of the following three options:

- participate in the Basic Health Insurance Plan only; or
- maintain participation only in the Health Insurance Plan held before the beginning of the leave; or
- maintain participation in all coverage held before the beginning of the leave. In this case, participants must personally pay the total premiums to their employer.

Participants who do not submit a written request to their employer before the beginning of their leave can only maintain participation in the Health Insurance Plan they held before the leave started.

Both the participant and the employer must maintain payment of their respective portion of the health insurance premium in the case of a leave for family or parental obligations stipulated by law. Any additional premium amounts required for maintaining participation in the Intermediate Health Insurance Plan or Superior Health Insurance Plan must be paid by the participant.

3) **During a period of absence due to dismissal**

a) Dismissed participants who challenge their dismissal through a grievance or appeal to arbitration under the Labour Code may maintain participation in the plans held before the dismissal, except for the Long Term Disability Insurance coverage under the Complementary Plan I, by paying the total amount of premiums owed directly to SSQ until the final decision has been made. Participants who do not maintain participation in all of their coverage previously held must participate in the Basic Health Insurance Plan and pay the total amount of premiums owed directly to SSQ.

b) Participation in Long Term Disability Insurance coverage under the Complementary Plan I cannot be maintained until the final decision on the grievance or appeal to arbitration has been made. If the decision is in favour of the employee, this coverage is reinstated retroactively on the date of the dismissal, making any total disability that began during this period eligible for benefits. In this case, the elimination period begins on the first day of the total disability in question. Premiums must then be paid retroactively to the date of dismissal, for the period ending on the date of the decision or on the date of return to work, if later.

4) **During a period of absence due to suspension**

a) Participants who are suspended for a period of 28 days or less maintain participation in all of their coverage during the suspension. The employer and the participant must continue to pay their respective premiums.

b) Participants who are suspended for a period of more than 28 days are subject to the same rules that apply to participants who take unpaid leave for more than 28 days.

5) **During a strike, lock-out or concerted cessation of work**

Participation in insurance is maintained for a minimum period of 30 days for the Health Insurance Plan held only. The participant and the employer must pay their respective premiums.

6) **During a leave with deferred payment plan**

a) Participants who are in a leave with a deferred payment plan must maintain participation in all plans held before the start of their period of contribution to such payment plan. Premiums and benefits under Complementary Plan I for Participant's Life Insurance

and Long Term Disability Insurance are based on the reduced salary, except for participants who choose to maintain participation based on the salary they would be receiving if they were not participating in the leave with deferred payment plan, in which case SSQ must be informed before the beginning of the period of contribution to the deferred payment plan.

b) During the leave period, the provisions stipulated for the leave without pay of more than 28 days are applicable. However, for participants who maintain their coverage under the Complementary Plan I, premiums and benefits for Participant's Life Insurance and Long Term Disability Insurance are based on the same salary as used for the period of contribution.

7) **During a progressive retirement program**

a) Participation in all plans is maintained; the participant and the employer must pay their respective premiums.

b) For the Complementary Plan I, premiums and benefits for Life Insurance and Long Term Disability Insurance are based on the salary paid to the participant by the employer for the time effectively worked. SSQ must be informed of this salary before the beginning of the program. Participants who wish to cease participation in Long Term Disability Insurance must submit a request to SSQ before the beginning of the progressive retirement program. In addition, the following provisions apply:

i) If the agreement concerning the program has a duration of 24 months or less, participation in Long Term Disability Insurance ceases as soon as the agreement comes into force.

ii) If the agreement concerning the program has a duration of more than 24 months, participation in Long Term Disability Insurance ceases no later than 24 months before the planned end date of the agreement. Participants who become totally disabled before this date while the insurance was still in force continue to receive the benefits planned under the coverage after the insurance ends, until their 60th birthday.

c) Subject to the provisions hereafter, participation in insurance and the right to benefits cease no later than the end date of the agreement concerning the progressive retirement program.

1.11 TERMINATION OF INSURANCE

1) **Participant**

a) **Health Insurance Plan**

Health insurance coverage ends for all participants at 23:59:59 p.m. on the earliest of the following dates:

i) the termination date of the contract;

ii) the date on which the participant ceases to be eligible;

iii) the end of the pay period during which the participant obtains an exemption from participating in the insurance;

iv) the end date of the waiver of premiums, unless the participant remains eligible for insurance and resumes payment of premiums;

v) the due date of any premiums that have not been paid;

vi) the date of retirement.

b) **Dental Care Insurance Plan**

Dental care insurance coverage ends for all participants at 23:59:59 p.m. on the earliest of the following dates:

i) the termination date of the contract;

ii) the end of the pay period during which participation in the plan ends, provided the 48-month minimum duration of participation period is completed;

iii) the date on which the participant ceases to be eligible;

iv) the end of the pay period during which the participant obtains an exemption from participating in the insurance;

v) the end date of the waiver of premiums, unless the participant remains eligible for insurance, decides to participate in it and resumes payment of premiums;

vi) the due date of any premiums that have not been paid;

vii) the date of retirement.

c) **Complementary Plan I**

Coverage under the Complementary Plan I ends for all participants at 23:59:59 p.m. on the earliest of the following dates:

i) the termination date of the contract, subject to the provisions regarding waiver of premiums;

ii) the date the participant no longer meets the eligibility conditions, subject to the provisions for extension contained in the life insurance conversion privilege;

iii) the date the participant reaches age 58 in the case of Long Term Disability Insurance;

iv) the date the participant reaches age 65 in the case of Accidental Dismemberment Insurance;

v) the end of the pay period during which the employer is informed of the participant's intention to cease participation in Participant's Optional Life Insurance;

vi) the first day of the pay period following SSQ's acceptance of the refusal for Participant's Basic Life Insurance; all Participant's Optional Life Insurance ends no later than this date;

vii) the due date of any unpaid premiums for the participant;

viii) the date of retirement.

2) **Dependents**

Coverage for all dependents ends at 23:59:59 p.m. on the earliest of the following dates:

a) the date the participant's insurance ends;

b) the date they no longer meet the definition of dependent;

c) for any given plan, the end of the pay period during which the participant obtains an exemption from participation for the dependent;

d) for any one category of dependents and any given plan, the date the participant whose coverage status is Single-Parent or Family changes to Individual or Single-Parent status;

e) the due date of any unpaid premiums for the dependent;

f) the end of the pay period during which the employer is informed of the participant's intention to cease participation in Spouse's Optional Life Insurance;

g) for Spouse's and Dependent Children's Life Insurance, the first day of the pay period during which participants who are working 25% of full-time or less or who are temporarily absent from work are only enrolled in the Health Insurance Plan.

1.12 CONVERSION PRIVILEGE

1) **Life Insurance**

Participants who cease to be eligible for life insurance before age 65 are entitled to convert the amount of insurance held to an equivalent individual plan (maximum of $200,000), at the rates and conditions in effect at SSQ and without a medical examination, provided they send a written request to SSQ **within 31 days of the end of their eligibility.**

Dependents are entitled to convert the amount of their insurance at the rates and conditions that apply to the participant, if their life insurance has ended due to one of the following events:

a) they cease to meet the definition of dependent;

b) the death of the participant;

c) the end of the participant's eligibility.

2) **Health Insurance and Dental Care Insurance**

Participants who cease to be eligible for Health Insurance or Dental Care Insurance are entitled to convert the coverage held to an individual plan with similar coverage, but without prescription drug coverage, for them and their dependents, if applicable, at the rates and conditions in effect at SSQ and without a medical examination, provided they send a written request to SSQ **within 31 days of the end of their eligibility.**

Spouses and dependent children are entitled to convert the amount of their insurance at the rates and conditions that apply to the participant, if their insurance has ended due to one of the following events:

a) they no longer meet the definition of dependent;

b) the death of the participant;

c) the end of the participant's eligibility.

1.13 BENEFIT CLAIMS

1) All benefit claims and supporting documents must be submitted to SSQ by the participants, at their expense and to the satisfaction of SSQ, within the following deadlines:

a) For the Health Insurance Plan and the Dental Care Insurance Plan: no later than 12 months after the date of the event entitling the insured to benefits.

b) For Accidental Dismemberment Insurance coverage and Life Insurance coverage: no later than 3 years after the event entitling the insured to benefits.

c) For Long Term Disability Insurance coverage: no later than 3 months before the beginning of benefits payable by SSQ.

2) Participants must provide the necessary evidence establishing their entitlement to benefits and the amount of such benefits, or have someone else provide them at their expense. Also, at any time during a period of total disability and while a benefit claim is being processed, SSQ may require that the person suffering the accident or illness making a benefit claim or requesting a waiver of premiums be examined by a physician chosen and hired by SSQ.

2. HEALTH INSURANCE PLAN

2.1 INSURANCE

Insureds who incur eligible expenses while they are covered under the Basic, Intermediate or Superior Health Insurance Plan are entitled to have all or part of these eligible expenses reimbursed by SSQ to the participant, subject to the provisions of the group insurance plan and applicable legislation.

2.2 CONDITIONS FOR ELIGIBILITY OF EXPENSES

1) **Medical necessity** - Expenses covered under the Health Insurance Plan apply to supplies, treatments or services necessary for the treatment of the insured person following an illness, accident, pregnancy, complication of pregnancy, surgery related to family planning, donation of organs or bone marrow, and unless otherwise specified, prescribed by a physician. The supplies must have been purchased and the treatments or services must have been received when the insurance was in force provided for reimbursement.

2) **Complement to public insurance** - For the purpose of the Health Insurance Plan, all insureds are considered to be covered under the public health and hospitalization plans of their province of residence in Canada. In no case may the amounts paid by SSQ be superior to those that would have been paid if the person was covered by these public insurance plans.

3) **Date the expenses were incurred** - Expenses must have been incurred while the person was insured under the contract. Expenses are considered to have been incurred on the date the services were provided.

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

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

2.3 DESCRIPTION OF ELIGIBLE EXPENSES

When insureds incur the expenses described below as eligible under their Health Insurance Plan, SSQ reimburses these expenses, subject to the provisions of this insurance and any limitations indicated in the "Your Plan at a Glance" table.

1) **Prescription Drugs**

Expenses incurred for prescription drugs bearing a valid DIN (Drug Identification Number) issued by the federal government, prescribed by someone legally authorized to do so, available only in pharmacy and sold by a pharmacist or a health professional in accordance with article 37 of the *Pharmacy Act*, upon submission of suitably itemized and fully paid invoices.

- Expanded list (Intermediate and Superior Health Insurance Plan)

  Prescription drugs appearing on this list are those listed in the current edition of the Association québécoise des pharmaciens propriétaires (AQPP) and whose use complies with indications approved by government authorities or, failing such authorities, with indications provided by the manufacturer.

- RAMQ list (Basic Health Insurance Plan)

  Prescription drugs appearing on this list are those covered by the Public Prescription Drug Insurance Plan, administered by the Régie de l'assurance maladie du Québec (RAMQ) subject to the conditions that are determined.

Some of these prescription drugs, commonly called "**exception drugs**" in the RAMQ list, are only covered in cases determined by the regulation applicable to the Public Prescription Drug Insurance Plan, in accordance with the conditions and therapeutic indications specified therein. These exception drugs require prior authorization from SSQ.

The **smoking cessation products** covered by SSQ are the same as those covered by the RAMQ. The amount of eligible expenses is determined each year by the RAMQ.

Expenses incurred for the following are also eligible:

- **Syringes, needles, lancets** and **test strips** for the treatment of diabetes;
- **Intrauterine contraceptive devices**, up to one intrauterine contraceptive device per 24 months, per insured;
- Multivitamins clearly identified by the manufacturer as **prenatal vitamins**;

- Drugs used for treating **infertility.** The maximum reimbursement for this type of medication is $1,500 per calendar year, per insured.

a) <u>Exclusions, limitations and restrictions related to prescription drugs</u>

In addition to the exclusions, limitations and restrictions described in section 2.4 which apply to the Health Insurance Plan, the exclusion of the following products applies to prescription drugs, whether or not the products in question are considered prescription drugs:

i) products used for esthetic or cosmetic purposes or for body hygiene (for example, products to compensate hair loss);

ii) substances or drugs used or administered on a preventive basis;

iii) drugs of experimental nature or obtained under a federal emergency drug program;

iv) homeopathic or natural products;

v) smoking cessation products, except those covered under the Public Prescription Drug Insurance Plan;

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

vii) sun screens and self-tan lotions; however, sunscreens meeting the conditions provided under this coverage and required for treating an illness may be eligible; the only evidence accepted is a complete medical report describing to SSQ's satisfaction all the conditions justifying the prescription of the product not otherwise covered;

viii) drugs used for artificial insemination or in vitro fertilization;

ix) growth hormones that cannot be included in the Public Prescription Drug Insurance Plan, according to the predetermined inclusion criteria, because of their diagnostic characteristics;

x) drugs provided during hospitalization or by a hospital pharmacy department or administered in hospital;

xi) drugs used for treating erectile dysfunction and that are only administered by mouth.

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

b) Deferred payment

Insureds can use the electronic claim transmission service. To use this service, follow the instructions in section 5.1.2.a).

2) **Transportation by ambulance**

When justified by the person's state of health, expenses for terrestrial transportation by ambulance, to or from the nearest hospital offering appropriate care, including the cost of the oxygen therapy received immediately before and during transportation.

Transportation by airplane (or helicopter, if not covered by a third party), boat or train is also covered when such means of transportation is required for part of the trip if the insured must be bedridden and takes the equivalent of two seats. Medical necessity must be established to SSQ's satisfaction in such cases.

3) **Transportation and accommodation in Quebec**

Expenses for transportation and lodging in Quebec for consultation with a medical specialist not available in the insured's area of residence or to receive specialized treatment not available in the insured's area of residence. A report signed by the insured's attending physician must be provided to SSQ. This report must demonstrate the necessity of the consultation, examination or specialized treatment and stipulate the location where it was provided. This location must be the nearest possible available location to the insured's area of residence.

- Eligible transportation expenses are those incurred for the following:
  - Transportation for a distance of at least 400 kilometres (round trip) from the insured's area of residence by the most direct route. These expenses cannot exceed the average cost of the most economical method of public transportation, regardless of whether public or private transportation was used. In the case of a private vehicle, receipts for the purchase of gasoline must be enclosed with the benefit claim;

- Accommodation in a commercial establishment, up to an eligible expense of $60 per day, following a trip of at least 400 kilometres (round trip) from the insured's place of residence, by the most direct route. The necessity of this accommodation must be established to SSQ's satisfaction. Documents justifying the accommodation expenses must be enclosed with the benefit claim.

- For insured children under age 18, transportation expenses for a parent accompanying the child are also eligible when the child is to be receiving the treatment.
- The maximum reimbursement stipulated under this coverage is $1,000 per calendar year, per insured; this maximum includes expenses incurred by a parent accompanying a child.

4) **Orthopaedic devices**

Expenses for repairing, renting or purchasing, if more economical and upon agreement with SSQ, corsets, medicated dressings, crutches, splints, casts, trusses and other orthopaedic devices.

5) **Therapeutic devices**

Expenses for repairing, renting or purchasing, if more economical and upon agreement with SSQ.

For example, the following devices are eligible:

- aerosol therapy devices, namely devices required for treating, among others, acute emphysema, chronic bronchitis or chronic asthma (e.g.: nebulizer or compressor);
- fracture consolidation stimulators; (e.g.: bone stimulator);
- respiratory monitors in case of respiratory arrhythmia (e.g.: apnea monitor);
- intermittent positive pressure respirators (e.g.: volumetric ventilator);
- insulin pump and accessories;
- burn treatment garments (e.g.: Jobst);
- expenses for purchasing diapers for incontinence, probes, catheters and other similar hygienic items required following a total and irrecoverable loss of the bladder or intestinal function.

Transcutaneous electrical nerve stimulators, monitoring devices (such as a stethoscope, sphygmomanometer or other similar devices) as well as domestic devices (such as

a whirlpool bath, air purifier, humidifier, air conditioner or other devices of similar nature) are not eligible under this coverage.

6) **Transcutaneous electrical nerve stimulator (TENS)**

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

7) **Surgical brassieres**

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

8) **Travel Insurance with Assistance**

See section 2.5.

9) **Trip Cancellation Insurance**

See section 2.6.

10) **Hospital expenses in Canada**

Expenses incurred for a hospital room for short-term hospitalization care in Canada, up to the difference between the cost of a room and that of a room with two beds (semi-private room) with no limitation as to the number of days. Expenses related to the financial contribution for lodging (long term care) and administrative expenses charged by the hospital are not covered.

11) **Professional fees in case of accident to natural teeth**

The professional fees of a dental surgeon, a specialist or a denturist, to repair damage caused to natural and healthy teeth resulting from an accident that occurred while the insurance was in force (teeth broken while eating are not covered). Services must be incurred within 36 months following the date of the accident and must begin within 12 months following the date of the accident.

Expenses are eligible up to the amounts and procedures listed in the fee guide of the Association des chirurgiens dentistes du Québec (ACDQ) of the year the services were incurred.

Expenses for implants (including expenses incurred for dentures attached to implants) are eligible up to a maximum of the cost and limitations of a crown, only at the time of final insertion of crown implant. Expenses incurred for additional procedures or treatments related to implants (surgery, graft, etc.) are not eligible.

12) **Non-motorized wheelchair and hospital bed**

Expenses for renting a non-motorized wheelchair or non-electrical hospital bed of the type generally used in hospital, for temporary use only.

13) **Artificial limbs or external prostheses**

Expenses for purchasing artificial limbs or external prostheses, excluding dentures, wigs, hearing aids, eyeglasses and contact lenses.

14) **Support stockings**

Expenses for purchasing support stockings (20 mm Hg or more) sold in a pharmacy or medical facility, in cases of insufficiency of the circulatory or lymphatic system.

15) **Blood glucose monitor**

Expenses for purchasing or repairing a blood glucose monitor.

16) **Esthetic surgery following an accident**

Expenses for esthetic surgery required to repair esthetic damage resulting from an accident that occurred while the insurance was in force. Expenses must be incurred within 36 months of the date of the accident and the treatment must have begun within the 12 months following the date of the said accident.

17) **Sclerosing injections**

Expenses incurred for the treatment of varicose for medical purposes only (not esthetic), for sclerosing injections administered by a physician.

18) **Nurse and nursing assistant**

Expenses for professional services of a nurse or nursing assistant, in continuous and exclusive attendance on the insured at the individual's home.

19) **Orthopaedic shoes**

Expenses for purchasing orthopaedic shoes from a specialized orthopaedic laboratory holding a license from legal authorities. These orthopaedic shoes must have been designed and made from a cast. Expenses incurred for prefabricated open, flared, straight shoes as well as those needed to maintain so-called Denis Browne splints when such shoes are required to compensate for a foot defect are also eligible. Expenses incurred for deep shoes or for sandals of any type are not covered.

20) **Podiatric orthoses**

Expenses for purchasing podiatric orthoses from a specialized orthopaedic laboratory holding a license from legal authorities. Eligible expenses are limited to the amounts provided in the price list of the Association nationale des orthésistes du pied.

21) **Occupational therapist, speech therapist and audiologist**

Expenses for professional services in a private clinic by an occupational therapist, speech therapist or audiologist.

22) **Physiotherapist and physical rehabilitation therapist**

Expenses for professional services in a private clinic by a physiotherapist or a physical rehabilitation therapist.

23) **Osteopath**

Expenses for professional services in a private clinic by an osteopath.

24) **Chiropractor, acupuncturist or podiatrist**

Expenses for professional services in a private clinic by a chiropractor, acupuncturist or podiatrist.

Expenses for X-rays taken by a chiropractor are limited to a maximum reimbursement of $35 per insured, per calendar year.

25) **Dietitian**

Expenses for professional services in a private clinic by a dietitian.

26) **Psychologist and social worker**

Expenses for professional services in a private clinic by a psychologist or a social worker.

27) **Psychiatrist, psychoanalyst, career counsellor and nurse specialized in psychotherapy**

Expenses for professional services in a private clinic by a psychiatrist, psychoanalyst, career counsellor or a nurse specialized in psychotherapy.

28) **Massage therapist, kinesitherapist and orthotherapist**

Expenses for professional services in a private clinic by a massage therapist, kinesitherapist or orthotherapist.

29) **Eye care**

Expenses for eye examination and the purchase of glasses or contact lenses including expenses for adjustment, replacement or repair, for correction of vision, on prescription of an ophthalmologist or optometrist. Also, expenses for laser eye surgery to correct myopia, hypermetropia, astigmatism or presbyopia.

30) **Hearing aid**

Expenses for the purchase, adjustment or repair of a hearing aid.

2.4 EXCLUSIONS, LIMITATIONS AND RESTRICTIONS

1) The Health Insurance Plan provides no reimbursement for the following:
   a) services or supplies that do not comply with ordinary and reasonable standards of the common practice of the health professions involved;
   b) expenses incurred for supplies, treatments or services which the insured would not be required to pay in the absence of this plan;
   c) expenses incurred for medical examinations requested by a third party (insurance, school, work) or for a health trip;
   d) products, devices or services used for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the competent authorities or, failing such authorities, with the indications given by the manufacturer;
   e) expenses incurred for esthetic treatments, except if specified otherwise;
   f) expenses incurred as the result of voluntary mutilation, regardless of the insured's state of mind;
   g) financial contribution charged to persons eligible for free prescription drug coverage under a government insurance plan;
   h) expenses incurred for services, products or examinations or care provided in a group;
   i) smoking cessation services or products, unless specified otherwise;
   j) vaccines or care of a preventive nature;
   k) expenses related to artificial insemination or the treatment of infertility, unless specified otherwise;
   l) expenses for purchasing contraceptives other than oral (unless specified otherwise);
   m) expenses resulting from active participation in a riot, an insurrection, criminal acts, or resulting directly or indirectly from a war or civil war in Canada, whether declared or not;
   n) expenses resulting directly or indirectly from a war in a foreign country where the insured is traveling, insofar as the government of Canada has issued a recommendation not to travel to the said country; this exclusion does not apply to the insured present in a foreign country when a war or civil war breaks out and that the government

of Canada then issues a recommendation, as long as the insured takes requisite measures to leave the country in question as soon as possible.

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

2.5 TRAVEL INSURANCE AND TRAVEL ASSISTANCE

1) Subject to the provisions of this travel insurance and to any limitations indicated in the "Your Plan at a Glance" schedule of insurance, SSQ covers expenses incurred by insureds outside their province of residence **following a death, an accident or a sudden and unexpected illness** requiring emergency care while the insured is temporarily outside his or her province of residence. Also, expenses incurred must be usual, reasonable and necessary and must apply to supplies or services prescribed by a physician that are necessary for the treatment of an illness or injury.

2) To be covered by travel insurance, insureds must be eligible for benefits under the government health insurance and hospitalization insurance programs of their province of residence in Canada throughout their stay outside their province of residence.

3) **Warning**

IMPORTANT

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

For the consequences of a known illness or infection to be covered, this illness or infection must be under control before the person's departure.

If the illness or infection:

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

It is recommended that the insured contract SSQ's Travel Assistance Service a few weeks before departure. The assistance service will provide more details on the meaning of "sudden and unexpected illness" as well as confirmation as to whether the coverage applies to a specific situation. SSQ's Travel Assistance Service can also provide useful advice on health issues to those travelling elsewhere than to the United States and Western Europe. Insureds must provide their contract number when they call. Telephone numbers to reach SSQ's Travel Assistance Service may vary depending on the origin of the call. They are:

A) Canada – United States 1-800-465-2928

B) Elsewhere in the world (collect call) 514-286-8412

Neither SSQ nor the Travel Assistance Service are responsible for the availability and quality of the medical and hospital care provided, nor for the possibility of obtaining such care.

Some of the services described may not be available in certain countries. Services provided may be modified by SSQ without notice.

4) **Eligible travel insurance expenses**

The following expenses are eligible:

a) Expenses for hospitalization in a hospital where the insured receives curative treatment. SSQ only reimburses the amount incurred that exceeds the amount of benefits payable under government health insurance and hospital insurance plans.

b) Professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care; SSQ only reimburses the amount incurred that exceeds the amount of benefits payable under the Plan in question.

c) The cost of transportation from the location where the illness or injury occurred to the nearest hospital by a licensed ambulance service.

d) Expenses incurred for drugs that can only be obtained by prescription.

e) Fees for a nurse for private nursing given exclusively in a hospital, up to a maximum reimbursement of $5,000. The nurse cannot be related to the insured nor be a travel companion.

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

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

h) Expenses for laboratory tests and X-rays.

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

j) Professional fees of a dental surgeon for accidental injury to natural teeth, up to a maximum reimbursement of $1,000 per stay; expenses must be incurred for an accident which occurred outside the insured's province of residence and the person must be insured by the Health Insurance Plan at the time the expenses are incurred.

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

l) The cost of economy class return air travel for a medical escort, when it is requested by the air carrier or the

insured's attending physician. These expenses must be agreed upon beforehand with SSQ's Travel Assistance Service; the medical escort must not be a close relative of the insured nor be a travel companion.

m) The cost of returning the insured's personal or rented vehicle, by means of a commercial agency, to the residence or the proper and nearest car rental agency, if the insured is unable to do so due to illness or accident, up to a maximum reimbursement of $1,000. The insured must present a certificate from the attending physician indicating that they are unable to return the vehicle; the insured's travel companions, if applicable, must also be unable to return the vehicle. These expenses must be agreed upon beforehand with SSQ's Travel Assistance Service.

n) In the event of death of the insured outside the province of residence, expenses incurred for the preparation and return of the insured's body by the most direct route to the residence, excluding expenses incurred for a coffin or casket, up to a maximum reimbursement of $5,000. These expenses must be agreed upon beforehand with SSQ's Travel Assistance Service.

o) The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home due to hospitalization of the insured, a family member or a travel companion of a minimum duration of 24 hours, up to a maximum reimbursement of $200 per day and of $1,600 per stay for all the individuals insured under this coverage.

p) The cost of return, economy-class transportation expenses of only one close relative, by the most direct route by plane, bus or train in order to visit the hospital where the insured is staying for at least seven (7) days, or to identify the body of the deceased insured before the remains are returned. These expenses must be agreed upon beforehand with SSQ's Travel Assistance Service and the insured must present a document from the attending physician certifying in writing that the visit was necessary. Reimbursable expenses, including transportation costs incurred in order to identify the body of an insured who died overseas prior to return, cannot exceed the following amounts:

   i) Transportation: $2,500 per trip for all insured family members;

   ii) Accommodation and meals: $200 per day for all insured family members, up to a maximum of $1,600 per stay.

5) **Travel Assistance**

The Travel Assistance Service is the intermediary between SSQ and the insured when prior authorization is required to benefit from the services available under this travel insurance.

The Travel Assistance Service offers the following services. These services are not available in all countries and may be modified by SSQ without notice:

a) Directing the insured to an appropriate clinic or hospital.

b) Verifying the medical insurance coverage to avoid, if possible, the insured having to make a money deposit.

c) Ensuring the proper follow-up of the insured's medical file.

d) Coordinating the return and transport of the insured as soon as medically possible.

e) Provide emergency assistance and coordinate claims.

f) If necessary, take steps for the transportation of a family member to the insured's bedside or for the coordination of the return of the deceased individual or identification of this individual.

g) If necessary, take steps for the return home of the spouse and dependents (return expenses not included).

h) If necessary, coordinate the return of the insured's personal vehicle if the insured is unable to do so because of illness or accident.

i) If necessary, communicate with the insured's family or employer.

j) Act as an interpreter for emergency calls.

k) Recommend a lawyer in case of serious accident. Legal fees are not covered.

l) If necessary, guarantee the payment of incurred hospital expenses.

m) Submit benefit claims to the RAMQ on behalf of the insured, if the latter agrees.

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

In addition to the exclusions, limitations and restrictions described in section 2.4 which apply to the Health Insurance Plan, the exclusion of the following expenses applies to travel insurance:

a) expenses incurred after the insured has refused to be repatriated to his or her province of residence upon

request from SSQ or from SSQ's Travel Assistance Service;

b) expenses incurred outside the insured's province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health, except for expenses required immediately following an emergency situation resulting from an accident or sudden illness; the fact that the quality of services offered in the insured's province of residence are inferior to those rendered outside the province are not considered to represent a danger to the insured's life or health;

c) expenses incurred in a region where the government of Canada has issued a recommendation not to travel; this exclusion does not apply if the insured is already present in said region at the time the government of Canada issues its recommendation, provided the insured then takes the necessary measures to conform with this recommendation as soon as possible;

d) expenses payable under any public plan;

e) expenses incurred for non emergency surgery or treatment;

f) in the case of a trip taken for the purposes of obtaining a consultation or receiving medical treatment or care, expenses incurred following the medical condition for which the trip was taken, regardless of whether the trip is taken upon a physician's recommendation or not;

g) expenses incurred in a chronic care hospital;

h) expenses incurred in an extended care home or thermal spa;

i) expenses incurred following an illness or a death resulting from participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, *bungee* jumping, skydiving, parachuting and any other similar activity, all extreme or combat sports, any motorized vehicle competition and any sporting or underwater activities for which the insured is receiving compensation;

j) expenses related to an event whose risk of occurring could reasonably have been predicted for the planned duration of the trip or soon after due to the state the insured was in at the beginning of the trip; this includes events such as a pregnancy, miscarriage, childbirth and their related complications occurring within the 2 months preceding the expected normal date of delivery or after;

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

2.6 TRIP CANCELLATION INSURANCE

1) **Reasons for cancelling the trip that may require eligible expenses**

For trip cancellation expenses to be eligible, the trip must be cancelled, extended or interrupted for one of the following reasons:

a) An illness or accident suffered by the insured or a travel companion, business associate or family member; the illness or accident must prevent the person from carrying out his or her regular functions and be reasonably serious to justify the cancellation or the interruption of the insured's trip or to force its interruption.

b) The death of the insured, of the spouse or of a child of the insured or of the spouse, or of a travel companion or business partner.

c) The death of a family member or of one of the following individuals: the insured; the insured's spouse; a child of the insured; the insured's travel companion. However, the funeral must take place during the planned trip or within 14 days before departure.

d) The death, illness or accident of an individual of whom the insured is the legal guardian.

e) Regardless of any other provision of this contract, suicide or attempted suicide of a travel companion or family member of the insured.

f) The death of an individual of whom the insured is the testamentary executor.

g) The death or emergency hospitalisation of the host at destination.

h) If the insured or a travel companion must report for jury duty or receives a subpoena to appear as a witness in a trial to be heard during the travelling period, provided the individual concerned has undertaken the necessary steps to have the trial postponed. Such an appointment is not considered an eligible cause for cancellation or interruption of a trip when the person appointed is filing suit or the defendant in the trial or when the person has been appointed as part of his or her duties as a police officer.

i) The quarantine of the insured, provided it terminates 7 days or less before the scheduled date of departure, or occurs during the time of the trip.

j) Hijacking of the airplane on which the insured is travelling.

k) Damage rendering uninhabitable the principal residence of the insured or the host at destination. The residence must still be uninhabitable 7 days or less before the scheduled date of departure, or the damage must occur during the trip.

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

m) Regardless of any other provisions in this contract, terrorism, war, whether declared or not, an epidemic in the area where the insured must go or must depart, provided the government of Canada issues a recommendation not to enter or leave this area. The advisory must be in force for the period of the trip and have been issued after finalization of travel arrangements or while the insured is already in this area.

n) Delay of the transportation used by the insured to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report.

o) Weather conditions such that:

- the departure of the public 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;

or

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

p) Damage occurring to the location where a professional or commercial activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity.

q) Death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation.

2) **Expenses eligible for Trip Cancellation Insurance**

Subject to the provisions of this travel insurance and to any limitations indicated in the "Your Plan at a Glance" table, SSQ reimburses eligible Trip Cancellation Insurance expenses under the APTS Group Insurance Plan when an insured must cancel, extend or interrupt a trip due to one of the above-mentioned reasons for cancelling a trip that are eligible for reimbursement. Only prepaid travel expenses can be eligible under Trip Cancellation Insurance. **Also, at the time the travel arrangements were finalized, the insured must not have been aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned trip.**

In the event of cancellation prior to departure

a) The non-refundable portion of prepaid travel expenses.

b) Additional expenses incurred by the insured if the travel companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation insurance and the insured decides to proceed with the trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel.

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

In the event of cancellation prior to departure, the trip must be cancelled through the travel agent or carrier within 48 hours of the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

In the event of missed departure or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination. Departure must be missed due to a delay in the means of transportation used by the insured, subject to the conditions specified in the eligible reasons for cancelling a trip. In the event of interruption of a trip, the interruption must be due to an illness or accident suffered by the insured or travel companion, subject to the conditions specified under the eligible reasons for cancelling a trip.

If the return is earlier or later than planned

a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure. These expenses must be agreed upon beforehand with SSQ's Travel Assistance Service.

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

Restriction

If the return is delayed by more than 7 days, the expenses incurred are eligible, provided the insured or the travel companion was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

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

If round trip transportation is needed

The cost of transportation by the most economical means, following approval by SSQ's Travel Assistance Service, for the insured to return to the province of residence and then back to the trip destination, provided the return is due to one of the following reasons:

a) Death or hospitalization of a member of the insured's family, a person for whom the insured is the legal

guardian or a person for whom the insured is the testamentary executor.

b) A disaster that has made the principal residence of the insured uninhabitable or has caused significant damage to the insured's business establishment.

3) **Exclusions, limitations and restrictions applying to Trip Cancellation Insurance**

In addition to the exclusions, limitations and restrictions described in section 2.4 which apply to the Health Insurance Plan, the exclusion of the following expenses applies to Trip Cancellation Insurance.

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

a) a war, whether declared or not, an epidemic or an act of war or terrorism, provided this exclusion does not apply to insureds who are already in the location where the war or epidemic breaks out or where the act of war or terrorism occurs, provided they then take the necessary measures to leave this location as soon as the government of Canada issues a travel warning to that effect; this exclusion also does not apply to insureds whose travel plans were finalized on or before the day the government advisory was issued;

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

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

d) intentional self-inflicted injury by the insured or travel companion; suicide or attempted suicide, whether the individual is sane or insane;

e) participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, *bungee* jumping, skydiving, parachuting and any other similar activity, all extreme or combat sports, any motorized vehicle competition and any sporting or underwater activities for which the insured is receiving compensation;

f) in the event that a trip 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;

g) 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;

If notice of cancellation of a trip prior to departure is not provided within the time specified, SSQ's liability is limited to the cancellation expenses 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 any adult accompanying the insured on the planned trip 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, and SSQ's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

2.7 COORDINATION OF TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE BENEFITS

If an insured is entitled to similar benefits under an individual group contract purchased from an insurer, the benefits payable under this coverage are reduced by the benefits payable under any other contract. However, if the insured is entitled to similar benefits under other provisions of the APTS Group Insurance Plan, the benefits are payable under Travel Insurance and Trip Cancellation Insurance before they are payable under any other coverage of this plan. The current provisions for coordination of benefits do not in any way limit the scope of their health insurance coverage when benefits are not payable under Travel Insurance or Trip Cancellation Insurance.

3. DENTAL CARE INSURANCE PLAN

3.1 INSURANCE

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

3.2 CONDITIONS FOR ELIGIBILITY OF EXPENSES

1) **Rates in force for the year the expenses were incurred** – Eligible expenses under this plan are limited to the rates suggested in the fee guide of the association of dental surgeons of the insured's province of residence for the year during which the expenses were incurred. Eligible laboratory expenses are limited to 50% of the fees detailed in the fee guide for the orodental act in question. Also, the services must have been provided when the contract was in force.

2) **Professional Health Services** – To be eligible, expenses must be for fees payable by the insured for services provided by a legally recognized dental surgeon or by a legally authorized denturist. Also, the person providing the care and the insured cannot be living in the same home or be closely related.

3) **Individuals insured under a public plan** – For the purposes of applying dental care insurance coverage, all insureds are considered to be covered under the Public Health Insurance Plan of their province of residence. In no case may the amounts paid by SSQ exceed those that would have been paid if the person was covered under a public plan.

3.3 DESCRIPTION OF ELIGIBLE EXPENSES

All dental procedures listed below are taken from the fee guide of the *Association des chirurgiens dentistes du Québec (ACDQ)*.

1) **PREVENTIVE DENTAL CARE REIMBURSABLE AT 80%**

   a) **Diagnostic**

      i) **Clinical oral examination**

         - recall or periodic oral examination: one examination per period of 6 months
         - dental examination for children under age 10, if not covered under the RAMQ plan: one examination per period of 12 months

- complete oral examination: one examination per period of 36 months
- emergency examination: 2 examinations per calendar year
- specific oral examination: 2 examinations per calendar year
- complete periodontal examination: one examination per period of 36 months

ii) **X-ray**

Intraoral films

- periapical film
- occlusal film
- bitewing film
- soft-tissue film

Extraoral films

- extraoral film
- sinus examination
- sialography
- use of radiopaque dyes to demonstrate lesions
- temporomandibular joint
- panoramic film: one film per period of 36 months
- cephalometric film
- duplicate radiograph: 2 times per calendar year

iii) **Tests and laboratory analyses**

- pulpal tests: 3 times per period of 12 months
- bacterial culture to determine pathological agents

iv) **Biopsy of soft tissue and hard tissue**

v) **Cytological tests**

- cytological smear from the oral cavity
- vital staining of oral mucosal tissues (for diagnosis)

vi) **Diagnostic models**

- unmounted
- mounted
- mounted, using adjustable articulator and face bow
- diagnostic wax-up

(excluded if associated with restoration treatment)

b) **Preventive services and space maintainers**

i) **Preventive services**

- polishing of coronal portion of teeth: one visit per period of 6 months
- topical application of fluoride: once per period of 6 months (only children under age 14 are covered for this service)
- nutritional counselling: once per lifetime
- oral hygiene instructions: once per lifetime
- oral hygiene reinstruction: once per lifetime
- plaque control program: 5 times per calendar year
- finishing restorations
- pit and fissure sealants, only on occlusal surfaces of premolar and permanent molar teeth for children under age 14: once per period of 36 months for the same tooth
- interproximal discing: 2 times per calendar year (only children under age 14 are covered for this service)
- prophylactic odontotomy (included as part of pit and fissure sealants if done on the same visit; only children under age 14 are covered for this service)
- scaling: once per period of 6 months

ii) **Control of oral habits ***

- myofunctional evaluation: one visit per period of 24 months
- motivation of patient: one visit per lifetime
- fixed and removable devices: once per period of 24 months
- myofunctional therapy: 5 visits per lifetime

* **Only children under age 14 are covered for these services.**

iii) **Space maintainers ***

- prefabricated, band type
- soldered lingual arch (unilateral)
- soldered lingual arch (bilateral)
- partial fixed - pontics tied to a lingual arch to replace missing incisors
- removable lingual arch - ellis arc
- steel crown or band
  - with unilateral attachment
  - with intra-alveolar attachment
- removable acrylic alveolar appliance
- appliance with acid link

* **Once per period of 24 months for a given replaced tooth, only children under age 14 are insured for these services.**

2) **BASIC DENTAL CARE REIMBURSABLE AT 80%**

a) **Minor restorative services**

- treatments for caries, trauma, pain control
- bonding/cementation of broken tooth chip: twice per calendar year
- unglued amalgam restoration *
- glued amalgam restoration *
- composite restoration* (the equivalent of bonded amalgam is reimbursed when composite restoration is claimed for molars)
- laboratory processed veneer for anteriors and premolars: once per period of 48 months, per tooth. An X-ray is required to confirm the non-esthetic nature of the procedure
- chairside veneer application: once per period of 12 months, per tooth. An X-ray is required to confirm the non-esthetic nature of the procedure
- retentive pins

* **The same surface or class on the same tooth is eligible for reimbursement once per period of 12 months, regardless of the treating dentist and the material used.**

b) **Endodontics**

i) **Endodontic emergency**

- pulpotomy
- pulpectomy
- open and drain (separate emergency procedure)
- opening through metal or porcelain crown

ii) **Endodontic traumatism**
- relieving traumatic occlusion (as a separate procedure)
- reimplantation of avulsed tooth
- repositioning of traumatically displaced tooth

iii) **General endodontic treatment**
- preparation of tooth for treatment
- root canal treatment
- additional root canal

iv) **Apexification**

v) **Endodontic surgery**
- apicoectomy
- retrofilling (separate procedure from root canal)
- root amputation
- hemisection
- intentional reimplantation
- perforation repair

c) **Periodontics**
- treatment of acute infection and other injuries
- application of desensitizing agent
- periodontal surgery (except periodontal surgery following the guided method)
- gingival curettage and root planning: one treatment per calendar year per tooth
- splinting (excluding Maryland type)
- occlusion
  - minor equilibration: 3 times per calendar year
  - major equilibration: once per calendar year
- periodontal appliances: once per period of 48 months
  - repairs: once per period of 12 months
  - reline
- periodontal pocket irrigation

d) **Oral surgery**
- removal of erupted teeth (uncomplicated)
- complex surgical removals, erupted teeth, impacted tooth and roots
- surgical exposure of tooth with bone tissue coverage: once per lifetime per tooth
- surgical exposure of tooth, including orthodontic attachment: once per lifetime per tooth

- transplantation of tooth, including splinting: once per lifetime per tooth
- surgical repositioning of tooth: once per lifetime per tooth
- enucleation of an unerupted tooth and follicle: once per lifetime per tooth
- alveolectomy
- alveoloplasty
- osteoplasty
- tuberoplasty
- removal of hyperplasic tissue
- removal of excess mucosa
- extension of mucous folds
- surgical excision (cyst & tumour)
- incision and drainage
- reduction of fracture
- frenectomy
- dislocation of mandible
- treatment of salivary glands
- recovery of dental root or foreign body from antrum
- antrum lavage
- closure of oro-antral fistula
- hemorrhage control
- post-surgical treatment
- repair of soft tissue laceration
- through & through laceration

e) **General Services**

Local anesthesia

3) **MAJOR RESTORATIVE AND PROSTHETIC SERVICES REIMBURSABLE AT 50%**

a) **Major restoration and fixed prosthodontics**

i) **Individual crown**

- acrylic processed
- transitional (when insertion is done by a different dentist who is not a partner of the dentist who performed the insertion of the permanent crown)
- porcelain

- porcelain, metal
- precious metal or not (full crown)
- porcelain, ceramic, resin, precious metal or not (¾ crown)
- coping, precious metal or not: once per period of 48 months

ii) **Preformed crown**

- stainless steel: once per period of 12 months
- plastic or other similar material: once per period of 12 months

iii) **Additional acts – crown**

- supplement for preparation of crown under existing denture clasp: once per period of 48 months
- crown or veneer repair, chairside
- porcelain or ceramic repair, individual crown or veneer, indirect, excluding recementation, if necessary
- recementation of crown, veneer, post and supplement for acid etch technique: twice per calendar year
- removal of crown or post

iv) **Cast post**

v) **Prefabricated post**

vi) **Reconstruction of tooth in preparation for crown**

b) **Removable dentures**

i) **Complete dentures**

- complete dentures
- immediate dentures
- immediate transitional dentures
- overdenture

ii) **Partial dentures**

- immediate or permanent partial dentures only
- partial dentures with cast
- partial dentures with precision attachments
- semi-precision cast partial dentures
- hybrid partial dentures
- remake of partial dentures: once per period of 48 months

- adjustment of dentures
- analysis for the fabrication of a denture: once per period of 48 months

iii) **Supplement for restorations done under the clasp of partial dentures**

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

- repairs with or without impression
- structure additions to partial dentures
- rebase, reline
- resetting of teeth
- therapeutic tissue conditioning
- obturator, palatal
- remount and equilibration of complete or partial dentures: once per period of 48 months

d) **Fixed Bridges**

Expenses incurred for fixed bridges may be eligible up to a maximum of the cost of the limitations applying to the equivalent removable dentures.

e) **Implant**

Expenses for implants (including dentures attached to implants) are eligible up to a maximum of the cost and limitations of a crown, only at the time of final insertion of crown implant.

Exclusion:

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

3.4 MAXIMUM REIMBURSEMENT

The maximum reimbursement is $1,000 per calendar year, per insured. However, for the year during which the eligible employee or the participant applies for insurance, the maximum reimbursement applicable between the date of application and December 31 is determined as follows, depending on the month of application:

- January, February or March $1,000
- April, May or June $800
- July, August or September $600
- October, November or December $400

For those who apply for insurance outside normal deadline provisions, the maximum reimbursement amount is increased gradually over 3 years, as described in section 1.5 4) a).

3.5 MINIMAL DURATION OF PARTICIPATION AND COVERAGE STATUS

Employees or participants who wish to apply for the Dental Care Insurance Plan must maintain their participation for a minimum duration of 48 months.

In the case of participants who were exempted from insurance or who terminated their participation and maintained their Basic Health Insurance Plan due to a temporary absence from work, or who decreased their percentage of time worked to 25% of full-time or less, the duration of these periods is included in the 48-month minimum duration of participation period in the Dental Care Insurance Plan.

3.6 EXCLUSIONS, LIMITATIONS AND RESTRICTIONS

1) The SSQ Dental Care Insurance Plan does not provide for reimbursement in the following cases:
   a) services or supplies that do not comply with ordinary and reasonable standards of dentistry;
   b) expenses the insured would not have had to pay had the individual not been insured, which the insured would not have been required to pay had he or she been availed of any public insurance or social security plan, or government program to which eligible;
   c) expenses paid under a public insurance or social security plan, social or a government program, under a law or regulation or decree adopted with regard to these laws, plans or programs including expenses that would have been payable if the provider of the supplies, treatments or services had chosen to participate in said plan or program;
   d) expenses incurred for esthetic purposes; x-rays may be required to confirm the non-esthetic nature of the treatments;
   e) expenses relating to treat an illness or injury that was self-inflicted by the insured or resulting from active participation in a riot, insurrection or criminal act;
   f) expenses incurred for a third party;
   g) expenses for prescription drugs, products, devices, services or supplies used for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the competent authorities or, failing such authorities, with the indications given by the manufacturer;

h) expenses incurred for filling out benefit claims, for a missed appointment or for advice given by telephone.

2) Insureds who change dentists or denturists during their treatment, or who must be transferred to another dentist or denturist, or if there is more than one dentist or denturist participating in the same treatment, the amount of benefits payable by SSQ is limited to the amount that would have been payable if the services had been provided by a single dentist or denturist.

3) Replacement treatments of cast posts, prefabricated posts, crowns, removable dentures and fixed bridges are not eligible for reimbursement when the insertion occurs less than 48 months after the previous insertion. However, a permanent removable denture, partial or complete, may be eligible for reimbursement if it replaces a transitional removable denture (partial or complete) and if replacement occurs within 6 months following the date of insertion of the transitional denture.

4) When the word "sextant" or "quadrant" is used in the description of a treatment, the code or codes for insured services corresponding to such treatment are limited to 6 different sextants per calendar year, per insured or 4 different quadrants per calendar year, per insured.

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

3.7 PRIOR ASSESSMENT

When the cost of a treatment exceeds $800 or the scheduled services are for removable dentures, fixed bridges or implants with crown implants, insureds who wish to be informed beforehand of the amount that will be reimbursable by the insurance **must** provide SSQ with an assessment of the treatment before it is carried out. The assessment must include the results of the dental examination, the services required and the fees of the dentist. Preoperative X-rays, periodontal charts, photographs, diagnostic casts and any other supporting documents can be required for the analysis and the authorization of some other care.

4. COMPLEMENTARY PLAN I - LIFE INSURANCE - ACCIDENTAL DISMEMBERMENT INSURANCE - LONG TERM DISABILITY INSURANCE

4.1 LIFE INSURANCE

No changes may be made to Participant's Basic or Optional Life Insurance or to Spouse's Optional Life Insurance while the participant is on total disability.

For participants who are not full-time employees, the salary used to determine the amount of Participant's Basic and Optional Life Insurance is calculated in proportion to the time effectively worked compared with the time worked on a full-time basis during the 12 months preceding death.

1) **Participant's Basic Life Insurance**

   Upon the death of the participant, SSQ pays an amount of life insurance corresponding to one times the annual salary. This amount is paid to the persons designated as beneficiaries in the most recent valid beneficiary designation received from the participant.

2) **Participant's Optional Life Insurance**

   In addition to the amount of Basic Life Insurance coverage mentioned in the preceding section, the participant may choose to have an additional amount of life insurance equal to 1, 2 or 3 times the annual salary.

   Evidence of insurability deemed satisfactory by SSQ is required at the time of application or request for increase in the amount of insurance.

   Rating takes the participant's age, gender and smoking habits into account. To take advantage of the lower rates offered to non-smokers, participants must provide SSQ with a duly completed and signed non-smoker's statement, using the "Application / Request for Change" form. If no such declaration is received, the premium rates for a smoker apply.

   Limitations in case of suicide – Participants who commit suicide within 12 months following the coming into force of the Optional Life Insurance they requested more than 30 days following their date of eligibility, no insurance amount is payable. In this case, SSQ only reimburses the premiums paid for these amounts.

3) **Accelerated benefit payment due to short life expectancy (Participant's Basic Life Insurance)**

Totally disabled participants who choose to maintain their Basic Life Insurance without payment of premiums and who are able to medically prove that their life expectancy is less than 12 months may make a written request to SSQ's Head Office, to receive the lesser of $25,000 and of 50% of the life insurance amount for which they would have been covered 24 months after the date the anticipated benefit payment request is received, including any reductions stipulated in the insurance.

Participants making accelerated benefit payment requests must provide SSQ with evidence showing:

a) that their life expectancy is less than 12 months at the date of the request;

b) that any beneficiary that would normally have been designated for the Basic Life Insurance has accepted that this request be made.

Upon the death of the participant, the remaining amount of Basic Life Insurance coverage is payable by SSQ. This remaining amount is calculated by subtracting the amount of accelerated benefit payments with accrued interest from the amount of insurance that would have been payable if the accelerated benefit payment request had not been made.

4) **Beneficiary**

At any time, in compliance with applicable legislation, participants have the right to designate a beneficiary of the insurance amounts payable upon their death, or to change the designated beneficiary, by providing written notice of such to SSQ.

If there is no designated beneficiary upon the death of the participant, benefits are payable to the executors or administrators of the participant's estate or assignees. If there is more than one beneficiary and no indication on how to divide the benefits, the amount of insurance is divided equally between the beneficiaries.

5) **Spouse's and Dependent Children's Life Insurance**

This insurance covers dependents aged 24 hours and over who are insured under the Health Insurance Plan. A change in coverage status for the Health Insurance Plan may change the coverage held under this insurance, whether or not the participant is capable of working.

If the participant has a Single-Parent status under the Health Insurance Plan, an amount of $2,000 is payable by SSQ upon the death of each dependent child aged 24 hours or more.

If the participant has a Family coverage status under the Health Insurance Plan, the amount of insurance that is payable by SSQ is $5,000 upon the death of the insured spouse and $2,000 upon the death of each insured dependent child aged 24 hours or more.

6) **Spouse's Optional Life Insurance**

Participants can opt for an additional amount of insurance for their spouse. The amount they choose must be a multiple of $10,000 and cannot exceed $100,000.

Evidence of insurability deemed satisfactory by SSQ is required at the time of application or request for increase in the amount of insurance.

Rating takes the participant's age and the spouse's gender and smoking habits into account. To take advantage of the lower rates offered to non-smokers, participants must provide SSQ with a non-smoker's statement duly completed and signed by the spouse, using the "Application / Request for Change" form. If no such declaration is received, the premium rates for a smoker apply.

4.2 PARTICIPANT'S ACCIDENTAL DISMEMBERMENT INSURANCE

1) **Insurance**

Participants who sustain, before age 65, one of the losses indicated in the table below as a result of an accident and if such a loss occurs within 365 days of the said accident, the amounts of Accidental Dismemberment Insurance payable are those that appear in the table. However, the amount of insurance benefits cannot exceed $60,000 for all losses relating to the same accident.

Accidental loss	Amount
• of both hands or both feet or sight in both eyes	$60,000
• of one hand and one foot	$60,000
• of one hand or one foot and sight in one eye	$60,000
• of hearing in both ears and of speech	$60,000
• quadriplegia	$60,000
• paraplegia	$60,000
• hemiplegia	$60,000
• of one leg or one arm	$45,000
• of one hand or one foot or sight in one eye or hearing in both ears or of speech	$30,000
• of the thumb and index finger of the same hand	$15,000
• of hearing in one ear	$15,000

2) **Definitions**

The following definitions apply to losses included as part of this coverage:

Loss means the total, permanent and irrecoverable loss of use of a limb, sight, hearing or speech.

Loss of an arm means amputation at or above the elbow.

Loss of a leg means amputation at or above the knee.

Loss of a hand means amputation at or above the wrist without loss of the arm.

Loss of a foot means amputation at or above the ankle without loss of the leg.

Loss of a finger means amputation at or above the joint linking the finger to the hand, without loss of the hand or arm.

3) **Exclusions, limitations and restrictions for Participant's Accidental Dismemberment Insurance**

No amount of insurance is payable under Participant's Accidental Dismemberment Insurance for losses that are directly or indirectly, totally or partially due to one of the following causes:

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

b) active participation in a criminal act;

c) active participation in a war, civil war, riot or insurrection, active service in the armed forces of any country, whether the hostilities are declared or not;

d) injuries exhibiting no visible external wound or contusion on the body (except in the case of drowning and internal injuries revealed by surgery or autopsy);

e) poisoning or intoxication;

f) travel or flight in any type of aircraft when the insured performs any duty as a crew member.

4.3 LONG TERM DISABILITY INSURANCE

1) **Insurance**

For participants who are totally disabled at the end of the elimination period for Long Term Disability Insurance coverage and provided they became totally disabled while they were insured under this coverage, SSQ agrees to pay monthly benefits in accordance with the provisions of this plan.

2) **Elimination period**

For participants who have a permanent position and are working full-time or at 70% or more of full-time, the elimination period is 5 working days plus 104 weeks. For all other participants, the elimination period is 7 calendar days of disability plus 104 weeks and begins on the first day they would normally have returned to work if they had not been totally disabled.

3) **Amount of benefits**

The initial amount of monthly benefits equals to 72% of the net monthly salary. The first payment of the monthly benefit is made one month after the end of the elimination period and once a month afterwards, for as long as the total disability lasts. These benefits are non-taxable.

For the means of this coverage, net salary is defined as the salary the participant would have received at the 105th week of total disability had the individual not been disabled, less provincial and federal income taxes, contributions to employment insurance (EI), to the Quebec Parental Insurance Plan (QPIP), to the Régime des Rentes du Québec (RRQ) and to the Canada Pension Plan (CPP).

For participants who are not full-time employees, the salary used to determine the amount of benefits payable by SSQ under this coverage is calculated in proportion to the time effectively worked compared with the time worked on a full-time basis during the 52 weeks preceding the beginning of the total disability. From these 52 weeks are excluded those during which periods of sick leave, maternity or adoption leave, preventative withdrawal, annual leave or leave without pay provided for in the collective agreement were granted. However, calculations must be made using a minimum of 12 weeks. Therefore, SSQ may take into account time effectively worked before the period of 52 weeks until this 12-week minimum is reached. If less than 12 weeks between the employee's most recent employment date and the beginning of the disability meet the above definition, the calculations are made based on the entire period.

4) **Duration of benefit payments**

When the elimination period expires, benefits are paid monthly for as long as the total disability lasts, until the last day of the month during which the person reaches age 60.

5) **Reduction of benefits**

Monthly benefits payable by SSQ are reduced by any **disability benefits** payable under *Quebec's Automobile Insurance Act*, the *Act Respecting Industrial Accidents and Occupational Diseases*, the Régime des rentes du Québec, the Canada Pension Plan, the Canadian Forces' group insurance plan, an employer's retirement plan or any other social legislation. They are also reduced by **85% of the gross retirement pension** the employee receives under an employer's retirement plan. This reduction also applies to persons who are not receiving the above-mentioned pension but could receive it without actuarial reduction if they ceased to benefit from a waiver of contributions due to disability stipulated under the employer's retirement plan. The employer's retirement plan may, for example, be the Government and Public Employees Retirement Plan (RREGOP), the Teachers' Pension Plan (TPP), or the Civil Service Superannuation Plan (CSSP). Participants must

provide proof that they are not eligible for benefits under any of the above-mentioned legislation or plans.

Calculation of the disability benefits payable by SSQ does not take into account the indexation of the above-mentioned sources of disability income.

6) **Coordination of benefits**

If income from all sources received by the participant and benefits payable under this coverage exceed 100% of the net salary, the benefits payable by SSQ are reduced so that the total income received by the participant is equal to 100% of the net salary. Income from any source means:

a) all benefits indicated in the "Reduction of benefits" section;

b) any income from an insurance plan under which the participant is insured as a member of an association;

c) any reimbursement of salary loss obtained because the loss was legally the responsibility of a third party or because it was otherwise compensated under another insurance plan, or because the loss would not have been incurred in the absence of this contract.

For the purposes of coordinating benefits, the above-mentioned sources of income are not indexed.

7) **Indexation of benefits**

When SSQ has paid Long Term Disability Insurance benefits for 12 full months, whether consecutive or not, for a same disability period, they are indexed on January 1 of each subsequent year according to the same terms as those of the Quebec Pension Plan, up to a maximum annual adjustment of 3%.

8) **Rehabilitation employment**

With the consent of SSQ, totally disabled participants may perform work that promotes rehabilitation. The benefits payable by SSQ during the rehabilitation period are reduced by 50% of the gross income earned from such work. In addition, benefits are limited so that the sum of these benefits and the income earned from rehabilitation employment cannot be higher than the monthly net salary of the participant at the beginning of payment of total disability benefits of the employer's plan.

9) **Exclusions, limitations and restrictions**

a) The following periods of total disability are not covered under Long Term Disability Insurance:

i) periods during which the participant does not follow the recommendations of the attending physician,

except in the case that the participant's condition is deemed stable and is attested by a physician to the satisfaction of SSQ;

ii) periods during which the participants hold a position or does work that could provide a salary or any profit whatsoever, except for the case provided for in the "Rehabilitation Employment" section of this coverage.

iii) periods of disability resulting from esthetic treatments;

iv) periods excluded in the restrictions stated in the definition of "total disability period."

b) Participants who fail to provide SSQ with additional evidence that SSQ requires or who refuse to submit to a medical examination requested by SSQ within 31 days following the request lose their entitlement to total disability benefits until SSQ receives the required documents. Participants who do not submit to a request by SSQ within 6 months lose their entitlement to benefits retroactively to the date SSQ made the initial request.

10) **Extension**

The waiver of premiums and the insurance of this coverage continue until the end of the same total disability period, except during any period of return to work, whether or not the contract or this coverage remain in force.

11) **Total disability beginning during a period of temporary interruption of work**

Total disability periods beginning during a temporary interruption of work stipulated in the collective agreement are treated according to the following provisions:

a) for participants who maintained participation in Long Term Disability Insurance, the total disability period is recognized and the elimination period begins on the **planned date of return to work** of the participant; benefits are payable as of the end of the elimination period, as long as the person is still totally disabled on this date;

b) for participants who did not maintain participation in Long Term Disability Insurance, the total disability period is not recognized; therefore, they are not entitled to Long Term Disability Insurance benefits, neither during their interruption of work nor afterwards.

5. HOW TO SUBMIT A BENEFIT CLAIM AND OTHER INFORMATION

5.1 HOSPITAL AND MEDICAL EXPENSES

5.1.1 Hospital expenses

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

5.1.2 Drugs

a) Filing a claim using the deferred payment card

For prescribed drugs, insureds show their SSQ Card to their pharmacist. **The prescription is payable in full** to the pharmacist. The receipt delivered to the insured will indicate the cost of the drug purchased and whether it is eligible for reimbursement or not. If the drug is eligible, there will be no other procedure to follow since the claim will have been electronically forwarded directly to SSQ.

Reimbursement from SSQ is made on the first of the following events:

- when the total of eligible expenses reaches $75;
- when 15 days have elapsed since the first eligible claim was submitted;
- when a claim is made for expenses incurred under another health insurance benefit (e.g.: physiotherapist expenses).

However, insureds who register for Direct Deposit of benefits will receive their reimbursements faster because there will be no postal delays. In addition, insureds who also register for Electronic Claim Statements will receive their reimbursement shortly after their claim is processed, even when none of the above-mentioned conditions is met.

First use

For participants who have Single-Parent or Family coverage and who are using the card for one of their dependents for the first time, the pharmacist must complete the file by registering the first name and date of birth of the insured person. SSQ recommends that the participant provide the pharmacist with this information, if not already recorded in the file. This information will remain confidential. Proof of age may be required by the pharmacist, which can be done by

presenting the card of the Régie de l'assurance maladie du Québec (RAMQ).

Dependent children aged 18 to 25 inclusively, studying full-time

Drug expenses for dependent children aged 18 to 25 inclusively are covered upon presentation of a statement of school attendance. The deferred payment method eliminates the need to complete the statement on the back of the claim stub each time a claim is submitted.

However, this statement must be presented to SSQ once every school year (September 1 to August 31) for the insured's claim to be processed directly in the pharmacy. Therefore, SSQ recommends that participants who have dependent children aged 18 to 25 submit a statement of school attendance. This declaration can be done in writing or verbally.

If SSQ does not receive this information before September 1, a message will appear on the receipt issued by the pharmacist when the drug is purchased.

b) Filing a claim by mail

If the pharmacist does not have an agreement with the service provider or if the benefit claim for a specific category of drugs (magistral prescription or drugs used to treat infertility) cannot be sent to SSQ electronically, benefits will be payable upon presentation of a suitably itemized receipt to SSQ. The receipt must be sent to the address indicated in section **5.1.3.**

In such a case, the pharmacy receipt must indicate the name of the insured, the number and date of the medical prescription, the name of the physician and the name and quantity of the drug.

Drugs supplied by a physician where this practice is legally authorized are also reimbursable, upon presentation of receipts indicating the name and quantity of the drugs.

5.1.3 Other expenses

Participants must claim all other expenses directly from SSQ.

Participants must keep copies of the invoices they send to SSQ (invoices are not returned) and must send only originals of suitably itemized and paid invoices along with the **claim stub**, attached to the certificate or to the invoice statement from the last benefit payment. You can also print a personalized claim form from our Access | Service for

plan members site at **www.ssq.ca**. **Invoices submitted more than 12 months after the date the expenses were incurred are not reimbursed.**

All correspondence must be sent to the following address:

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

5.2 HOSPITAL OR MEDICAL EXPENSES RESULTING FROM A WORK OR AUTOMOBILE ACCIDENT

Medical or hospital expenses resulting from a work or automobile accident may be reimbursed by the CSST or the SAAQ. Invoices should thus be submitted to the CSST or the SAAQ and not SSQ.

5.3 DENTAL CARE INSURANCE

Insureds show their SSQ card to their dentist and pay the portion of the insured expenses that is not reimbursable by SSQ. In the case of dentists who do not offer an electronic claim transmission system, insureds must have the "Benefit claim for dental care" form (FDEN121A) filed by their dentist, and complete, sign and return this document to SSQ, according to the procedure described in section **5.1.3**.

5.4 PARTICIPANT'S, SPOUSE'S AND DEPENDENT CHILDREN'S LIFE INSURANCE

Life Insurance claim forms are available directly from SSQ.

5.5 LONG TERM DISABILITY INSURANCE

Claims for Long Term Disability Insurance must be submitted 3 months before the beginning of benefits payable by SSQ.

5.6 DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENTS

Participants can apply for Direct Deposit of benefits by completing the appropriate form. This form is available from SSQ or at our Web site at **www.ssq.ca**. Direct Deposit enables you to obtain reimbursement of your claims more quickly and eliminates any risk of loss or theft of your benefit cheques.

Electronic Claim Statements provide you with the same information as your paper statements, but much faster.

To register for these services, consult section **5.10** " SSQ On-line services ".

5.7 TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE

5.7.1 Travel Insurance

Hospital and medical expenses payable under the Travel Insurance benefit are reimbursed only after government agencies have completed their analysis of the claim and paid benefits, where applicable.

All expenses eligible for reimbursement under this coverage may be submitted directly to SSQ upon presentation of supporting evidence deemed satisfactory by SSQ (e.g., invoices, receipts, prescriptions).

5.7.2 Trip Cancellation Insurance

When submitting a claim for Trip Cancellation Insurance, insureds must include the following documents:

a) Any unused travel tickets.

b) Official receipts for additional transportation expenses

c) Receipts for travel arrangements. The receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation.

d) Written proof that a reimbursement of travel expenses has been requested from the travel agent or accredited firm, along with the reply received from the travel agent or accredited firm.

e) Official documents certifying the reason for cancellation. When the cancellation is due to medical reasons, insureds must provide a medical certificate issued by a legally authorized physician practicing where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip.

f) Official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure.

g) Official report issued by the appropriate authorities pertaining to weather conditions.

h) Written proof issued by the official organizer of a commercial activity to the effect that an event has been cancelled, indicating the specific reasons for the cancellation.

i) Any other report required by SSQ in support of the insured's claim.

5.8 CHANGE OF ADDRESS

Participants must inform SSQ of any change of address.

5.9 FILE AND PERSONAL INFORMATION

Notice of new file

To maintain the confidentiality of information concerning each person it ensures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and information about any insurance claims made.

Except for certain exceptions provided for under applicable legislation, access to your file is restricted to those employees, legal agents and service providers who must consult your file for the purpose of contract management, underwriting, claims adjudication and claims audit purposes, in addition to any other person you may authorize. SSQ archives these insurance files in its offices.

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

Legal agents and service providers

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

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

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

5.10 SSQ ON-LINE SERVICES

Access | Service for plan members

This handy on-line service gives you fast, secure and confidential access to your insurance file at any time. Here are just a few of the operations you'll be able to carry out:

- Register for Direct Deposit of your Health, Dental Care and Disability Insurance benefits;
- View your electronic claim statements on line;
- Print personalized Health Insurance Claim coupons;
- Print Dental Care Insurance claim forms;
- Order tax receipts for medical expenses incurred;
- Print a temporary SSQ Card if you lose or misplace your existing card;
- Change your address on line;
- Print the form required for exception drug claims;
- Submit a declaration of school attendance;
- View and make changes to the designated beneficiary of your Life Insurance coverage;
- View the coverage included as part of your file;
- View the balance of your counter for the coverage involved.

To register for **Access** to be able to take advantage of our on-line services, visit our Web site at **www.ssq.ca**. Click on the **Access | Service for plan members** link in the Group Insurance area of the site and then follow the instructions designed to guide you through the registration process smoothly and easily.

If you need any assistance, contact SSQ Customer Service from 8:30 a.m. to 4:30 p.m. Monday to Friday, at the number provided on the back of this booklet.

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

1 888 651-8181

For more information about your group insurance plan, please consult your insurance booklet, or the **Access | service for plan members** Web site at **www.ssq.ca** or your collective agreement.

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