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SSQ insurance

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Group insurance

Your group insurance plan

Contract X9999
April 1, 2022

Alliance du personnel professionnel
et technique de la santé et des services sociaux

Members of the APTS

APTS

To the employees who are covered by the APTS collective agreement.

This booklet includes the main provisions and conditions of your group insurance plan.
Your insurance plan benefits were designed to meet your needs while taking into account the benefits provided for under the government group insurance plans.

The APTS and SSQ recommend that you read this booklet in order to know the coverage you have and the administrative procedures regarding your participation in the plan.

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

This booklet is published for information purposes only, and it does not change in any way the group insurance contract provisions and conditions.

Cette brochure existe aussi en français.

TABLE OF CONTENTS

EMPLOYEES' GROUP INSURANCE PLAN AT A GLANCE

1. INTRODUCTION

This section explains the reimbursement method used for each benefit. For a complete description of the applicable provisions, refer to the following: section 2 for Health Insurance Plan; section 3 for Dental Care Insurance Plan; section 4 for Complementary Plan I; section 5 for Retirees Life Insurance plan.

Unless otherwise specifically provided, indicated maximums apply to **each insured person**. In addition, reimbursement of eligible expenses under the Health Insurance Plan cannot exceed the customary and reasonable amounts normally charged in the area where services are rendered.

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC PLAN**	**INTERMEDIATE PLAN (Minimum of 24 months)**	**SUPERIOR PLAN (Minimum of 24 months)**	**MEDICAL PRESCRIPTION**
Prescription drugs				
Prescription drugs[1] and eligible pharmaceutical services, including fertility drugs (direct payment)	80% of eligible expenses and 100% when the out-of-pocket exceeds $850 / certificate / calendar year **RAMQ List**	80% of eligible expenses and 100% when the out-of-pocket exceeds $750 / certificate / calendar year **Standard List**	80% of eligible expenses and 100% when the out-of-pocket exceeds $750 / certificate / calendar year **Standard List**	Yes
Fertility drugs	Maximum reimbursement of $1,500 / calendar year	Maximum reimbursement of $1,500 / calendar year	Maximum reimbursement of $1,500 / calendar year	Yes
[1] **Reimbursement of brand-name drugs:** If you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons, by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by SSQ.				
Sclerosing injections	Not covered	75% $20 of eligible expenses / treatment for injected substance and $15 for professional fees Maximum reimbursement of $300/calendar year	75% $20 of eligible expenses / treatment for injected substance and $15 for professional fees Maximum reimbursement of $300/calendar year	Yes

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	BASIC PLAN	INTERMEDIATE PLAN (Minimum of 24 months)	SUPERIOR PLAN (Minimum of 24 months)	MEDICAL PRESCRIPTION
Hospitalization and transportation				
Hospitalization in Canada	Not covered	100% of cost of semi-private room	100% of cost of semi-private room	No
Transportation by ambulance	80%	80%	80%	
Transportation and accommodation in Quebec	80% Maximum reimbursement of $1,000 / calendar year	80% Maximum reimbursement of $1,000 / calendar year	80% Maximum reimbursement of $1,000 / calendar year	Yes
Health care professionals				
Audiologist, occupational therapist or speech therapist	Not covered	75% Combined maximum reimbursement of $500 / calendar year for all these practitioners	75%	No
Physiotherapist or physical rehabilitation therapist			75% Combined maximum reimbursement of $1,000 / calendar year for all these practitioners	
Osteopath		Not covered		
Massage therapist, kinesitherapist or orthotherapist			75% Combined maximum reimbursement of $400 / calendar year for all these practitioners	

<table>
<tr><th colspan="5">HEALTH INSURANCE PLAN (compulsory)</th></tr>
<tr><th>COVERAGE</th><th>BASIC PLAN</th><th>INTERMEDIATE PLAN
(Minimum of 24 months)</th><th>SUPERIOR PLAN
(Minimum of 24 months)</th><th>MEDICAL PRESCRIPTION</th></tr>
<tr><td colspan="5">Health care professionals (contd')</td></tr>
<tr><td>Chiropractor, acupuncturist or podiatrist</td><td rowspan="4">Not covered</td><td>75%
Combined maximum reimbursement of $400 / calendar year for all these practitioners
X-rays by a chiropractor: $35 / calendar year</td><td rowspan="2">75%
Combined maximum reimbursement of $750 / calendar year for all these practitioners
X-rays by a chiropractor: $35 / calendar year</td><td rowspan="3">No</td></tr>
<tr><td>Dietitian</td><td rowspan="2">75%
Combined maximum reimbursement of $1,000 / calendar year for all these practitioners</td></tr>
<tr><td>Psychologist or social worker</td><td rowspan="2">75%
Combined maximum reimbursement of $1,500 / calendar year for all these practitioners</td></tr>
<tr><td>Psychiatrist, psychoanalyst, career counsellor, psychotherapist, or nurse specialized in psychoeducation</td><td>Not covered</td></tr>
<tr><td>Nurse or nursing assistant</td><td>75%
Eligible expenses of $300 / day
Combined maximum reimbursement of $10,000 / calendar year for all these practitioners</td><td>75%
Eligible expenses of $300 / day
Combined maximum reimbursement of $10,000 / calendar year for all these practitioners</td><td>Yes</td></tr>
</table>

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC PLAN**	**INTERMEDIATE PLAN (Minimum of 24 months)**	**SUPERIOR PLAN (Minimum of 24 months)**	**MEDICAL PRESCRIPTION**
Vision care				
Eye examination	Not covered	Not covered	80% Maximum reimbursement of $50/ 24 months	No
Eye care (eyeglasses, contact lenses and laser eye surgery)			80% Combined maximum reimbursement of $200 / 24 months for all these items	Yes for laser eye surgery
Other medical care				
Hearing aid	Not covered	Not covered	80% Maximum eligible expenses of $600 / 48 months	No
Orthopaedic devices	80%	80%	80%	Yes
Therapeutic devices or breathing assistance device	80% Lifetime combined maximum reimbursement of $10,000 for all these items	80% Lifetime combined maximum reimbursement of $10,000 for all these items	80% Combined maximum reimbursement of $10,000 / 24 months for these items and the transcutaneous nerve stimulator	
Ostomy appliances	Not covered	80%	80%	

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC PLAN**	**INTERMEDIATE PLAN (Minimum of 24 months)**	**SUPERIOR PLAN (Minimum of 24 months)**	**MEDICAL PRESCRIPTION**
Other medical care (contd')				
Support stockings	Not covered	80% Maximum reimbursement of $150 / calendar year	80% Maximum reimbursement of $150 / calendar year	Yes
Orthopaedic shoes		80% Combined maximum reimbursement of $250 / calendar year for all these items and foot orthoses	80% Maximum reimbursement of 2 pairs / calendar year	
Esthetic surgery following an accident		75% Lifetime maximum reimbursement of $10,000	75% Lifetime maximum reimbursement of $10,000	
Non-motorized wheelchair and hospital bed		80%	80%	
Blood glucose monitor		80% Maximum eligible expenses of $300 / 60 months	80% Maximum eligible expenses of $300 / 60 months	
Professional fees in case of accident to natural teeth		80%	80%	No

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	BASIC PLAN	INTERMEDIATE PLAN (Minimum of 24 months)	SUPERIOR PLAN (Minimum of 24 months)	MEDICAL PRESCRIPTION
Other medical expenses (contd')				
Intraocular lens implants	Not covered	80%	80%	Yes
Transcutaneous electrical nerve stimulator (TENS)		80% Maximum eligible expenses of $700 / 60 months	80% Maximum reimbursement of de $10,000 / 24 months combined with therapeutic appliances and breathing assistance device	
Podiatric orthoses		80% Maximum reimbursement of $250 / calendar year combined with orthopaedic shoes	80% Maximum reimbursement of $250 / calendar year	
Insulin pump	80% Maximum eligible expenses of $7,500 / 60 months	80% Maximum eligible expenses of $7,500 / 60 months	80% Maximum eligible expenses of $7,500 / 60 months	
Insulin pump accessories	80% Purchase and maintenance expenses	80% Purchase and maintenance expenses	80% Purchase and maintenance expenses	
Wig	Not covered	80% Maximum reimbursement of $300 / 60 months	80% Maximum reimbursement of $300 / 60 months	

HEALTH INSURANCE PLAN (compulsory)				
COVERAGE	**BASIC PLAN**	**INTERMEDIATE PLAN (Minimum of 24 months)**	**SUPERIOR PLAN (Minimum of 24 months)**	**MEDICAL PRESCRIPTION**
Other medical expenses (contd')				
External prostheses or artificial limbs	Not covered	80% Combined maximum reimbursement of $30,000 / calendar year for all these items	80% Combined maximum reimbursement of $30,000 / calendar year for all these items	No
Breast prostheses		80%	80%	Yes
Surgical brassieres	80% Maximum reimbursement of $200 and only one brassiere / calendar year	80% Maximum reimbursement of $200 and only one brassiere / calendar year	80% Maximum reimbursement of $200 and only one brassiere / calendar year	
Travel				
Travel Insurance with assistance [1]	100% $5,000,000 / trip	100% $5,000,000 / trip	100% $5,000,000 / trip	Yes for some expenses, as confirmed by the travel assistance service
Trip Cancellation Insurance	100% $5,000 / trip	100% $5,000 / trip	100% $5,000 / trip	No

[1] Before departure, insureds whose state of health is not good and stable must contact the travel assistance service of SSQ at 1-800-465-2928 to know if their coverage may be limited in any way by their condition.

DENTAL CARE INSURANCE PLAN (optional) – Minimum participation period of 48 months			
COVERAGE	**PERCENTAGE OF REIMBURSEMENT**	**MAXIMUM REIMBURSEMENT**	**MEDICAL PRESCRIPTION**
Preventive dental care [2]	80%	Refer to section 3	No
• Clinical examination			
• X-rays			
• Tests and laboratory examinations			
• Preventive care (polishing, scaling, etc.)			
• Correction of oral habits			
• Space maintainers			
Basic dental care			
• Operative dentistry (restoration, veneer, etc.)			
• Periodontics (treatment of infections, surgery, splinting, etc.)			
• Oral surgery (tooth removals, trauma, etc.)			
Endodontics	80%	Maximum reimbursement of $1,000 / calendar year, subject to section 3 (refer specifically to 3.4)	
• Endodontics (root canal therapy)			
Major restorative treatments and prosthetic services	50%		
• Fixed prostheses (crown), removable prostheses (complete or partial)			
• Prostheses, complementary services			
• Fixed bridge [3]			
• Implant [4]			

[2] Once per period of 9 months for: recall or periodic examination, polishing, topical application of fluoride and scaling.

[3] Expenses incurred for fixed bridges may be considered eligible up to a maximum of the cost and limitations applicable to an equivalent removable prosthesis.

[4] Expenses for dentures attached to implants may be considered eligible up to a maximum of the cost and limitations applicable to an equivalent alternative treatment provided for in the contract, and payable only at the time of the final insertion of the dentures attached to the implants. Expenses incurred for additional procedures or treatments related to implants (surgery, graft, etc.) are not eligible.

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	1, 2 or 3 times the gross annual salary (evidence of insurability always required – participation in the Participant's Basic Life Insurance is also required)
Spouse and Dependent Children Life Insurance	$5,000 upon death of spouse $5,000 upon death of a dependent child of at least 24 hours Automatically granted to participants whose coverage status under Health Insurance Plan is Couple, Single-Parent or Family
Spouse Optional Life Insurance	1 to 10 units of $10,000 (evidence of insurability always required – participation in the Spouse and Dependent Children Life Insurance is also required)
Participant's Accidental Dismemberment Insurance	Depending on loss suffered: Between $15,000 $ and $60,000
Participant's Long Term Disability Insurance • Monthly benefit • Maximum duration • Beginning of benefit period • Cost-of-living adjustment	 • 72% of net salary • Up to age 65 (age 60 for disabilities that began before 2016) • After 104 weeks of total disability • After 12 months of benefit payment by SSQ, on January 1 of each year, in accordance with the Quebec Pension Plan index adjustment rate, subject to a yearly maximum of 3%
RETIREES LIFE INSURANCE PLAN (optional)	
COVERAGE	**DESCRIPTION**
Retired Participant's Life Insurance	1 to 20 units of $5,000
Retired Participant's Spouse and Dependent Children Life Insurance	$5,000 upon death of spouse $2,000 upon death of a dependent child of at least 24 hours
Retired Participant's Spouse Optional Life Insurance	1 to 10 units of $5,000 (evidence of insurability always required if new spouse)

2. INSURANCE EFFECTIVE DATE AND MODIFICATIONS IN COVERAGE

This section is an overview of the provisions applicable to each plan at the time coverage becomes effective and at the time of any change in coverage status or in other available options. For a complete description of the applicable provisions, refer to section 1.

Specific provisions for participants whose percentage of time worked is 25% or less of the full-time work schedule are given in part 4 of this Employees' Group Insurance Plan at a Glance section.

Plan	Circumstances	If the request is received	
		Within 30 days after the event	More than 30 days after the event
HEALTH INSURANCE (Compulsory)	**Application for insurance when becoming eligible and after exemption**	**When becoming eligible**: The chosen plan and coverage status become effective: • on the date of eligibility in the case of a newly eligible person; • on the date immediately following termination of the insurance that allowed the exemption. **Termination of exemption**: Refer to 1.3 4) b) for information on rules for choosing a health insurance plan. The same rules apply to dependents, except that their coverage cannot become effective before the participant's coverage.	**When becoming eligible**: The Basic Health Insurance Plan with the individual coverage status becomes effective on the eligibility date. **Termination of exemption**: The Basic Health Insurance Plan with the requested coverage status becomes effective on the first day of the pay period which coincides with or follows the date SSQ receives the application. Dependents coverage becomes effective on the first day of the pay period which coincides with or follows the date SSQ receives the application. Changing of coverage status is subject to the provisions on the next page.

Plan	Circumstances	If the request is received	
		Within 30 days after the event	More than 30 days after the event
HEALTH INSURANCE (Compulsory)	**Changing coverage status (Individual, Couple, Single-parent, Family)**		
	a) Increasing number of insureds	Changing coverage status in order to cover more individuals becomes possible as soon as the participant has a new spouse or new dependent children or as soon as the spouse's or dependent children's coverage terminates under a prescription drug group insurance plan. The new coverage status becomes effective on the date they become eligible or on the date their coverage terminates under the other group plan.	The new coverage status becomes effective on the first day of the pay period which coincides with or follows the date SSQ receives the request.
	b) Decreasing number of insureds	Participants with Couple, Single-parent or Family status cannot change their status unless there is a change in the eligibility of their spouse or dependent children. The new coverage status becomes effective on the first day of the pay period which coincides with or follows the date the employer receives the request.	

Plan	Circumstances	If the request is received	
		Within 30 days after the event	**More than 30 days after the event**
HEALTH INSURANCE (Compulsory)	**Changing health plans (Basic, Intermediate, Superior)**		
	a) Increasing coverage	Participants can have their coverage increased by changing from one plan to another at any time. Coverage under the new plan becomes effective on the first day of the pay period which coincides with or follows the date the employer receives the request. **Notice** – Coverage cannot be increased if the participant is totally disabled on the date the change would have become effective.	
	b) Decreasing coverage	Participants are allowed to have their coverage decreased by changing from one plan to another, **provided they have been participating for at least 24 months in the plan to be replaced**. Periods of exemption and periods when participants maintained their participation in the Basic Health Plan as provided for in case of temporary absence from work or reduction of time worked to 25% of full-time or less are included as part of the minimum participation period of 24 months of the Intermediary and Superior plans. The new coverage status becomes effective on the first day of the pay period which coincides with or follows the date the employer receives the request.	
	Starting exemption	Exemption begins on the date of eligibility or on the date of the event that allows the exemption.	Exemption begins on the first day of the pay period which coincides with or follows the date SSQ receives the request.

Plan	Circumstances	If the request is received	
		Within 30 days after the event	**More than 30 days after the event**
DENTAL CARE PLAN (optional) **Minimal participation of 48 months**	**Application for insurance when becoming eligible and after exemption**	**When becoming eligible**: The chosen plan and coverage status [1] become effective on the latest of the following dates: • the eligibility date; • the eligibility date of a new spouse or dependent child. Participants must be actively at work or able to be actively at work. If not, coverage will become effective on the date they return to active work. For participants who were covered ny another similar Dental care plan, the chosen plan and coverage status become effective on the date the participant is no longer eligible to this other plan. **Termination of exemption**: The chosen plan and coverage status [1] become effective on the termination date of the coverage that allowed the exemption, regardless if the participant is actively at work or able to be actively at work. Dental care described at **3.3 3)** and **3.3 4)** are subject to the maximums specified at 3.4 Dependents are not eligible for coverage until employees are insured. Otherwise, their coverage is subject to the same rules.	The chosen plan and coverage status become effective on the January 1 which coincides with or follows the date SSQ receives the request. Dental care described at **3.3 3)** and **3.3 4)** is subject to the following maximum reimbursements: • $600 per insured for expenses incurred during the first calendar year of the participant's dental care coverage; • $800 per insured for expenses incurred during the second calendar year of the participant's dental care coverage; • $1,000 per insured per calendar year for expenses incurred during the subsequent years. Participants must be actively at work or able to be actively at work. If not, coverage will become effective on the January 1 which coincides with or follows the date they return to active work.

[1] The coverage status the participant may choose for the Dental Care Insurance Plan depends on the coverage status in force under the Health Insurance Plan. Refer to 1.3 3) for possible combinations.

Plan	Circumstances	If the request is received	
		Within 30 days after the event	**More than 30 days after the event**
DENTAL CARE PLAN (optional)	**Changing coverage status (Individual, Couple, Single-parent, Family)**		
	a) Increasing number of insureds	Changing coverage status in order to cover more individuals becomes possible as soon as the participant has a new spouse or new dependent children or as soon as the spouse's or dependent children's coverage terminates under another dental care group insurance plan. The new coverage status becomes effective on the date they become eligible or on the date their coverage terminates under the other group plan.	The new coverage status becomes effective on the first day of the pay period which coincides with or follows the date SSQ receives the request. Participants must be actively at work or able to be actively at work. If not, coverage will become effective on the January 1 which follows the date they return to active work. Maximum reimbursements applicable to dependents are the same as those applicable to participants.
	b) Decreasing number of insureds	Participants with Couple, Single-parent or Family status cannot change their status unless there is a change in the eligibility of their spouse or dependent children. The new coverage status becomes effective on the first day of the pay period which coincides with or follows the date the employer receives the request.	
	Termination of coverage	Coverage under this plan terminates on the first day of the pay period which coincides with or follows the date the participant terminates coverage in the plan, **provided the participant's coverage under this plan has been in force for at least 48 months on that date**.	

Plan	Circumstances	If the request is received	
		Within 30 days after the event	More than 30 days after the event
DENTAL CARE PLAN (optional)	**Starting exemption**	Exemption begins on the date of eligibility or the date of the event that allows the exemption.	Exemption begins on the first day of the pay period which coincides with or follows the date SSQ receives the request.
		Notice – To be exempted from participation in the Dental Care Insurance Plan, eligible employees must make a request to SSQ and establish that themselves and their dependents, if any, **are covered by a compulsory public sector Dental Care Insurance Plan which does not allow exemptions** from coverage.	
COMPLE-MENTARY PLAN I (Compulsory or optional benefits)	**1. PARTICIPANT'S BASIC LIFE INSURANCE (compulsory with possible opting out)** [2]		
	Participation	Coverage becomes effective on the date of eligibility. However, participants must be actively at work or able to be actively at work on that date. If not, coverage becomes effective on the date they return to active work.	
	Opting out (refer to 1.6)	Coverage terminates on the first day of the pay period which coincides with or follows the date SSQ receives the request.	
	2. PARTICIPANT'S OPTIONAL LIFE INSURANCE [3]		
	Participation	Coverage becomes effective on the first day of the pay period which coincides with or follows the date the employer receives SSQ's approval of the required evidence of insurability. The Participant's Basic Life Insurance must be in force and the participant must be actively at work or able to be actively at work on that date. If not, coverage will become effective on the date the participant returns to active work.	
	Termination of coverage	Coverage terminates on the first day of the pay period which coincides with or follows the date the employer receives the participant's request to terminate the Participant's Optional Life Insurance.	

Plan	Circumstances	If the request is received	
		Within 30 days after the event	More than 30 days after the event
COMPLE-MENTARY PLAN I (Compulsory or optional benefits)	**3. SPOUSE AND DEPENDENT CHILDREN LIFE INSURANCE (may be compulsory, depending on the coverage status under the Health Insurance Plan)**		
	Participation	Coverage becomes effective on the effective date of Couple, Single-parent or Family coverage status under the Health Insurance Plan.	
	Termination of coverage	Coverage terminates on the effective date of Individual coverage status or exemption under the Health Insurance Plan.	
	4. SPOUSE OPTIONAL LIFE INSURANCE [3]		
	Participation	Coverage becomes effective on the first day of the pay period which coincides with or follows the date SSQ approves the required evidence of insurability. However, participants must be actively at work or able to be actively at work on that date. If not, coverage becomes effective on the date they return to active work.	
	Termination of coverage	Coverage terminates on the first day of the pay period which coincides with or follows the date the employer receives the participant's request to terminate the Spouse's Optional Life Insurance.	
	5. PARTICIPANT'S ACCIDENTAL DISMEMBERMENT INSURANCE (compulsory)		
	Participation	Coverage becomes effective on the date of eligibility. However, participants must be actively at work or able to be actively at work on that date. If not, coverage becomes effective on the date they return to active work.	
	6. LONG TERM DISABILITY INSURANCE (compulsory with possible opting out)		
	Participation	Coverage becomes effective on the date of eligibility. However, participants must be actively at work or able to be actively at work on that date. If not, coverage becomes effective on the date they return to active work.	
	Opting out (refer to 1.3 1) c))	Coverage terminates on the first day of the pay period which coincides with or follows the date SSQ receives the request.	

[2] For participants who want to enrol in the Participant's Basic Life Insurance after having first opted out of this benefit, a written application must be sent to SSQ and evidence of insurability to the satisfaction of SSQ will also be required.

[3] When applying for coverage or increased coverage under the Participant's Optional Life Insurance and the Participant's Spouse Optional Life Insurance, evidence of insurability to the satisfaction of SSQ is always required.

3. TEMPORARY INTERRUPTIONS OF WORK

This section describes the provisions regarding different types of temporary interruptions of work.

Type of absence	Maintaining participation in insurance during a leave of absence
Unpaid leave (28 days or shorter) Unpaid partial leave Paid leave Suspension (28 days or less)	Participation in all plans must be maintained. Both the participant and the employer must maintain payment of their respective portion of the premium. In the case of unpaid partial leaves, premiums are based on the salary the participant would have received had it not been for an unpaid partial leave. Coverage amounts are also maintained based on this salary.
Unpaid leave (more than 28 days) Suspension (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. 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. Participants must personally pay the total premiums to their employer. 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. The same rules apply during an unpaid leave for service in the Canadian Armed Forces. However, the amounts payable under the present plan are reduced by the amounts paid under a marginal benefits plan of the Armed Forces.

Type of absence	Maintaining participation in insurance during a leave of absence
Deferred treatment leave	During the contribution period of the leave, participants must maintain participation in all plans held before the start of the leave period. 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 deferred treatment leave, in which case SSQ must be informed by the participant before the beginning of the period of contribution. During the actual period of leave, participants must 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. Participants must personally pay the total premiums to their employer. If participation in the participant's life insurance and long term disability insurance is maintained under Complementary Plan I, premiums and benefits are based on the same salary as during the contribution period.
Dismissal grievance	During the period of the participant's dismissal grievance or arbitration within the meaning of the Labour Code, the participant must choose one of the following two options: • maintain participation in all coverage held before the dismissal, except for the Long Term Disability Insurance of Complementary Plan I; or • participate in the Basic Health Insurance Plan only. Regardless of the chosen option, the participant must pay the entire premium until a final decision is rendered. The participant cannot be covered under the Long Term Disability Insurance before the final decision is known.

Type of absence	Maintaining participation in insurance during a leave of absence
Dismissal grievance (contd')	If the decision is favourable to a participant who returns to work, all coverage held before the dismissal becomes effective again as of the date of the decision. A participant who chose to maintain participation in all coverage held before the date of dismissal must pay all Long Term Disability Insurance premiums retroactively to the date of dismissal. As a result of the favourable decision, coverage is not considered as having been interrupted. Therefore, if a total disability occurred during the grievance period, the elimination period starts on the date of the disability period. Eligibility for coverage under the group plan terminates on the date of a final decision which is not favourable to the participant.
Strike, lock-out or concerted work stoppage	Participation is maintained in the Health Insurance Plan held before the leave, and for a maximum duration of 30 days. Both the participant and the employer must maintain payment of their respective portion of the premium. Thereafter, the insurance can be maintained during the strike, lock-out or concerted work stoppage if there is an agreement between the policyholder and SSQ.
Phased retirement program	Participation must be maintained under all plans. Both the participant and the employer must maintain payment of their respective portion of the premium. Premiums and benefits under Complementary Plan I for Participant's Life Insurance and Long Term Disability Insurance are based on the salary paid by the employer for the time the participant is actually at work. This must be confirmed in advance to SSQ. A participant who wants to cease participation in the Long Term Disability Insurance must send a request to SSQ before the start of the phased retirement program. The following provisions will be applicable: • if the agreement on the phased retirement program is for a duration of 24 months or less, participation in the Long Term Disability Insurance ceases on the effective date of the agreement; • if the agreement on the phased retirement program is for a duration of more than 24 months, participation in the Long Term Disability Insurance will cease no later than 24 months before the initially planned termination date of the agreement. If the participant became totally disabled while the Long Term Disability Insurance was in force, disability benefits may be payable up to age 65 (age 60 if the total disability period began before 2016).

4. SPECIFIC PROVISIONS FOR EMPLOYEES WORKING 25% OF FULL-TIME OR LESS

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 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.

The following pages outlines the rules applying at the time of application for insurance and when the percentage of time worked changes during coverage.

Circumstances		If the request is received	
		Within 10 days after the employer's notice	**More than 10 days after the employer's notice**
NEW ELIGIBLE EMPLOYEES	A) Employees who **do not participate** in the benefits provided for under their collective agreement (Life Insurance and Short Term Disability Insurance)	Coverage under the chosen Health Insurance Plan and coverage status becomes effective on the date of eligibility.	Coverage under the Basic Health Insurance Plan with an Individual coverage status becomes effective on the date of eligibility.
	B) Employees who **participate** in the benefits provided for under their collective agreement (Life Insurance and Short Term Disability Insurance)	The participant must choose one of the two following options: • participate in a Health Insurance Plan only and choose an appropriate coverage status; • participate in all plans. Coverage becomes effective on the date of eligibility. For benefits other than the Health Insurance Plan, the participant must be actively at work or able to be actively at work on that date. Otherwise, coverage becomes effective on the the participant returns actively at work. Those who participate in the Health Insurance Plan only or who are exempted from it may choose to participate in the other benefits provided for under the group plan as of January 1 of each year by making a written request to their employer before November 30 of the preceding year. The other benefits become effective on January 1 if the participant is actively at work or able to be actively at work on that date. Otherwise, coverage becomes effective on the the participant returns actively at work.	Coverage under the Basic Health Insurance Plan with an Individual coverage status becomes effective on the date of eligibility.

Circumstances		If the request is received	
		Within 10 days after the employer's notice	**More than 10 days after the employer's notice**
CHANGE OF PERCENTAGE OF TIME WORKED	A) If the percentage of time worked decreases 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 choose one of the three following options, subject to any provisions related to exemption: • participate in the Basic Health Insurance Plan only; • maintain participation only in the Health Insurance Plan held before the change in percentage of time worked; • maintain participation in all plans held before the change in percentage of time worked, if coverage provided for under the collective agreement is also maintained (Life Insurance and Short Term Disability Insurance). Coverage for the Basic Health Insurance Plan becomes effective as of January 1 following the date the application for coverage is received by the employer. Participation in the other benefits terminates on December 31 if only the Health Insurance is maintained. Those who participate in the Health Insurance Plan only or who are exempted from it may choose to participate in the other benefits provided for under the group plan as of January 1 of each year by making a written request to their employer before November 30 of the preceding year. The other benefits become effective on January 1 if the participant is actively at work or able to be actively at work on that date. Otherwise, coverage becomes effective on the the participant returns actively at work.	As of January 1 following the date the employer's notice is received, participation is maintained only under the health plan held before the change in the percentage of time worked. Participation in other benefits terminates on December 31.

Circumstances		If the request is received	
		Within 10 days after the employer's notice	**More than 10 days after the employer's notice**
CHANGE OF PERCENTAGE OF TIME WORKED (contd')	B) If the percentage of time worked increases to more than 25% of full-time	Participants whose percentage of time worked increased to more than 25% of full-time work during the reference period (12 complete months ending on October 31 of the preceding year) must participate in all plans as of the following January 1, subject to all of the rules of participation applicable to the other employees working more than 25% of full-time.	As of January 1 following the year of an increase of percentage of time worked to more than 25% of full-time, the applicable participation provisions are the same as those applying to full-time employees, provided that the participant is actively at work or able to be actively at work on that date. Otherwise, coverage becomes effective on the date the participant actively returns at work
	Notice: 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 time worked, must continue participation in these plans **until the minimum duration of 24 months for the Health Insurance Plan or 48 months for the Dental Care Insurance Plan has elapsed**. The duration of participation in the Basic Health Insurance Plan is included in this 24-month period for the Health Insurance Plan or 48-month period for the Dental Care Insurance Plan. In addition, eligible employees whose percentage of time worked is 25% of full-time or less and who do not already participate in the group plan must enrol in the Complementary Plan 1 and in one of the health plans when they obtain a position with a percentage of more than 25% of full-time work. The **gradual reimbursement limitations of $600, $800 and $1,000** indicated in part 2 of the present section apply to employees working 25% of full-time or less and who begin participation in the Dental Care Insurance Plan on January 1 of a given year.		

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: a 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 professional or 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:

   - 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 the APTS.

Employer: any establishment governed by the collective agreement, or any employer or category of employer accepted by the APTS**.**

Family member: a person whose relationship to another is one of the following: 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, grandchild, uncle, aunt, newphew or niece.

Healthy tooth: a 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: a 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 under this plan, either as a participant or as a dependent.

Net salary: the salary after deduction of federal and provincial taxes and contributions to the following: the Employment Insurance (EI), the Quebec

Parental Insurance Plan (QPIP), the Quebec Pension Plan (QPP), and the Canada Pension Plan (CPP).

Participant: any employee insured under this plan.

Salary: the basic salary the participant would receive if actively at work. Evening, night, weekend and shift premiums are excluded.

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 active 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 active 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 active 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 of 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, regardless of the state of mind of the participant 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 CNESST.

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

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 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 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) For employees who are moved to another job position under the employment security plan of their collective agreement, the duration of their employment with their previous employer is taken into account

in the calculation of the waiting period. Employees are eligible for coverage immediately if, after having permanently left an employer, they return to work for the same employer or start work for a new employer within the Health and social services sector within 30 days, 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 later of the following dates:

a) the employee's date of eligibility;

b) the date this 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 exemption entitlement described in section 1.3.4). However, eligible employees must choose to participate in one of the following three plans:

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

Participation in the Intermediate or Superior Plan must be maintained for at least 48 months before the employee can change 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 choose to be obtain coverage under the Public Prescription Drug Insurance Plan administered by the *Régie de l'assurance maladie du Québec* (with no minimum participation of 24 months requirement). Employees who choose to be covered under the BPDIP plan of the RAMQ can take advantage of the exemption entitlement, 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 opt out of the Participant's Basic Life Insurance coverage (see section 1.6); however, those who do so are not entitled to the Participant's Optional Life Insurance;

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

iii) employees may opt out of the Long Term Disability Insurance coverage if they meet one of the following conditions:

- they participate in the Government and Public Employees Retirement Plan (RREGOP) and have accumulated at least 33 years of service;
- they signed a retirement agreement (with no possibility of return) and 2 years or less remain between the date of withdrawal from the Long Term Disability Insurance coverage and the date of retirement;
- they are aged 59 or over;
- they are aged 58 or over, participate in the Government and Public Employees Retirement Plan (RREGOP) and have accumulated at least 28 years of service.

The choice to opt out of Long Term Disability Insurance coverage is irrevocable.

For specific provisions concerning employees working 25% of full-time or less, refer to section 4 of "Employees' Group Insurance Plan at a Glance", at the beginning of this booklet.

2) Dependents

a) Health Insurance Plan

All participants must insure their dependents under the Health Insurance Plan, subject to the exemption entitlement 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 and subject to the provisions of 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. However, participants who are exempted from coverage under the Health Insurance Plan and those who choose the individual coverage status cannot participate in the Spouse's and 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, no matter what coverage status they have.

Participation in the Spouse's Optional Life Insurance is not compulsory but is conditionnal to participation in Spouse's and Dependent Children's Basic Life Insurance. However, the employee must be at work or able to be at work at the time of application for this coverage.

3) Coverage status

Participants must select a coverage status for the Health Insurance Plan and for the Dental Care Insurance Plan. Available coverage statuses are the following:

Coverage status	Individuals covered
Individual – I	Participant
Single-Parent – S-P	Participant and dependent children
Couple – C	Participant and spouse
Family – F	Participant, spouse, dependent children if any

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

Plan	Packages								
	1	2	3	4	5	6	7	8	9
Health Insurance	I	S-P	S-P	C	C	F	F	F	F
Dental Care Insurance	I	S-P	I	C	I	F	C	S-P	I

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

4) 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 the Health Insurance Plan. The exemption entitlement also allows participants to cease participation in the Intermediate Health Insurance Plan or Superior Health Insurance Plan even if the minimum period of participation of 24 months has not yet been completed.

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 similar compulsory Dental Care Insurance Plan which does not allow exemptions from coverage. The exemption entitlement also allows participants to cease participation in the Dental Care Insurance Plan even if the minimum period of participation of 48 months has not yet been completed.

a) Start of exemption

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 coincides with or 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 coincides with or 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 covered under the insurance plan in question 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 covered under the plan that allowed the exemption.

If the request to terminate exemption is received by SSQ within 30 days following the termination date of coverage under the plan that allowed the exemption:

Coverage becomes effective on the date of termination of coverage under 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 period of participation of 24 months for the Health Insurance Plan or 48 months for the Dental Care Insurance Plan has not yet been completed. The exemption period is included as part of this minimum period of participation.

For participants whose Health Insurance Plan premiums are waived at the time they apply for coverage following termination of exemption, the Health Insurance coverage held before the exemption cannot be increased. 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.

If the request to terminate exemption is received by SSQ more than 30 days after the termination date of coverage under the plan that allowed the exemption:

- *Health Insurance Plan*

The **Basic Health Insurance Plan** is granted with 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 or July 1 following the date SSQ receives the end of exemption request, unless they are disabled on this planned effective date, in which case it will come into force on January 1 or July 1 following the date of their return to active 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 period of participation of 24 months has not yet been completed. The plan in question will come into force on January 1 or July 1 following the date SSQ receives the

end of exemption request, unless they are disabled on this planned effective date, in which case it will come into force on January 1 or July 1 following the date of their return to active work. Any minimum period of participation already underway will begin again as of the effective date. The exemption period that terminates at the end of the insurance having allowed the exemption is part of the minimum period of participation of 24 months.

- *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 planned effective date, in which case it will come into force on January 1 following the date of the person's return to active work. Refer to section 2 of "Employees' Group Insurance Plan at a Glance" for applicable gradual reimbursement maximums. Any minimum period of participation already underway will begin again as of the effective date. The exemption period that terminates at the end of the insurance having allowed the exemption is part of the minimum period of participation of 48 months.

1.4 ENROLMENT

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

2) All applications for coverage must indicate the employee's choice of one of the Health Insurance Plans and the requested coverage status. It must also indicate the employee's choice regarding participation in the Dental Care Insurance Plan. Subject to the participation rules concerning available packages, Couple coverage status includes coverage for the spouse, Single-Parent coverage status includes coverage for dependent children, and Family coverage status includes coverage for the spouse and dependent children.

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

1.5 EFFECTIVE DATE OF COVERAGE

For provisions concerning the effective date of coverage, refer to section 2 of "Employees' Group Insurance Plan at a Glance", at the beginning of this booklet.

1.6 OPTING OUT OF PARTICIPANT'S BASIC LIFE INSURANCE

All eligible employees and participants may opt out of the Participant's Basic Life Insurance under the Complementary Plan I, provided they are already insured for at least $25,000 under an individual life insurance policy. To do so, they must complete the required form available from their employer's Human Resources

department and provide proof of their individual insurance coverage. A decision to opt out will be applicable as of the first day of the pay period coinciding with or following SSQ's acceptance of the request. From that date onwards, these employees and participants may no longer participate in the Participant's Optional Life Insurance.

1.7 CHANGING COVERAGE STATUS

For provisions concerning the changes in coverage status, refer to section 2 of "Employees' Group Insurance Plan at a Glance", at the beginning of this booklet.

1.8 CHANGING HEALTH INSURANCE PLAN

For provisions concerning the changes in Health Insurance Plan, refer to section 2 of "Employees' Group Insurance Plan at a Glance", at the beginning of this booklet.

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 from the 6th working day following the beginning of total disability for employees working full-time or 70% of full-time or more (for all other employees, participation is maintained from the 8th day of total disability calculated from the first day where the person would have reported to work, had it not been for his/her total disability). This waiver of premiums cannot exceed 3 years. However, it can be extended to 4 years for totally disabled participants who still have their employee status with the same employer. 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 and whose disability entitling them to such compensation occurred on or 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 from the 6th working day following the beginning of total disability for employees working full-time or 70% of full-time or more (for all other employees, participation is maintained from the 8th day of total disability calculated from the first day where the person would

have reported to work, had it not been for his/her total disability). This waiver of premiums ends when the participant reaches age 65. However, when the disability began between July 1, 2001 and December 31, 2015, the waiver of premiums under the Long Term Disability Insurance ends when the participant reaches age 60.

However, for participants who become totally disabled on or after their 62nd birthday participation in the following coverage is maintained without payment of premiums for a maximum period of 3 years or until reaching age 71: Participant's Basic Life Insurance, Participant's Optional Life Insurance, Accidental Dismemberment Insurance, Spouse's and Dependent Children's Basic Life Insurance and Spouse's Optional Life Insurance.

These provisions apply to the period when the participant remains totally disabled, as long as the contract remains in force with respect to the Accidental Dismemberment Insurance, and whether or not it remains in force with respect to the other benefits of the Complementary Plan I.

2) **Employer's contribution**

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 leave related to pregnancy or breastfeeding and approved by the CNESST. In addition, it does not apply to participants on a temporary work assignment who are receiving the salary they received before their total disability began. For employees who are not working full-time, the salary that is taken into consideration is the one that is used for determining the total disability insurance benefits.

1.10 TEMPORARY ABSENCES FROM WORK

For provisions concerning temporary absences from work, refer to section 3 of "Employees' Group Insurance Plan at a Glance", at the beginning of this booklet.

1.11 TERMINATION OF INSURANCE

1) **Participant**

a) **Health Insurance Plan**

Health insurance coverage ends for any participant at 23:59:59, 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 date of the event enabling the exemption if the request for exemption is submitted within 30 days after this date, or, if the request is not submitted on time, 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, subject to the waiver of premiums provisions.

b) **Dental Care Insurance Plan**

Dental care insurance coverage ends for any participant at 23:59:59, 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, subject to the waiver of premiums provisions;

viii) December 31 following the reference period during which the percentage of time worked decreased to 25% of full-time or less, if the participant did not maintain participation in this plan.

c) **Complementary Plan I**

Coverage under the Complementary Plan I ends for any participant at 23:59:59, on the earliest of the following dates:

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

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 65 in the case of Long Term Disability Insurance, subject to the waiver of premiums provisions. However, the participant no longer pays the premium when he or she reaches age 63;

iv) the date the participant reaches age 65 in the case of Accidental Dismemberment Insurance, subject to the waiver of premiums provisions;

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 participant's opting out of the Participant's Basic Life Insurance. Participant's Optional Life Insurance ends no later than this date;

vii) the first day of the pay period following SSQ's acceptance of the withdrawal from the Long Term Disability Insurance coverage;

viii) the termination date of participation in the Long Term Disability

Insurance coverage, as provided under the phased retirement program;

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

x) the date of retirement, subject to the waiver of premiums provisions;

xi) December 31 following the reference period during which the percentage of time worked decreased to 25% of full-time or less, if the participant did not maintain participation in this plan.

2) **Dependents**

Coverage for any dependent ends at 23:59:59, on the earliest of the following dates:

a) the date the participant's insurance ends;

b) the date the person no longer meets the definition of dependent;

c) for the Health Insurance Plan, the date of the event enabling the exemption if the request for exemption is submitted within 30 days after this date, or, if the request is not submitted on time, the end of the pay period during which the participant obtains an exemption from participation for the dependent;

d) for the Dental Care Insurance Plan, the end of the pay period during which the participant obtains an exemption from participation for the dependent;

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

f) the due date of any premiums that have not been paid for the dependent;

g) 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;

h) for Spouse's and Dependent Children's Life Insurance, the first day of the pay period during which participants who are temporarily absent from work maintain participation in the Health Insurance Plan only.;

i) for Spouse's and Dependent Children's Life Insurance, December 31 following the reference period during which the percentage of time worked decreased to 25% of full-time or less, if the participant maintained participation in the Health Insurance Plan only.

1.12 CONVERSION PRIVILEGE

1) Life Insurance

Participants who cease to be eligible for group life insurance while the insurance contract is still in force are entitled to convert their group insurance into an individual life insurance without having to provide

evidence of insurability if they send a written request to SSQ within 31 days of the end of their eligibility to group insurance. In addition, participants whose amount of insurance is reduced on the date they retire are entitled to convert the amount by which their group insurance has been reduced into an individual life insurance. Rates and conditions in effect at SSQ will be applied to the conversion privilege.

If the participant dies within the 31-day period in which the conversion privilege could have been exercised, SSQ will pay to the beneficiary the group life insurance amount that was in force immediately before the participant ceased to be eligible, subject to the applicable provisions.

Dependents are entitled to convert the amount of their insurance at the same time and with the same conditions that apply to the participant, if their life insurance has ended or been reduced due to one of the following events:

a) they cease to meet the definition of dependent;

b) the participant's retirement;

c) the participant's death.

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 insurance with comparable coverage, but without prescription drug coverage, for themselves, and their dependents if applicable, at the rates and conditions in effect at SSQ and without having to provide evidence of insurability, if they send a written request to SSQ within 31 days of the end of their eligibility.

Spouses and dependent children are entitled to convert their insurance at the same time and with the same 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 participant's death.

1.13 CLAIMS

All claims and supporting documents must be submitted to SSQ by the participants, at their expense and to the satisfaction of SSQ, within the required deadlines.

Participants must provide the necessary evidence establishing their entitlement to benefits and the amount of such benefits, or have someone else provide them. When a claim for benefits or waiver of premiums is submitted as a result of an accident or illness, SSQ may require at any reasonable time that the person who had the accident or illness be examined by a physician chosen and hired by SSQ.

For more information on claims, refer to section **6 CLAIMS** of this booklet.

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 received when the insurance that was in force provided for their 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 similar 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. The health professional and the insured cannot be living in the same home or be closely related.

   The number of treatments covered for any insured person is limited as follows:

   a) maximum of one treatment per day per professional or specialist, regardless of the number of specialties practiced by the professional or specialist;

   b) maximum of one treatment per day per profession or specialty.

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 "Employees' Group Insurance Plan at a Glance" table.

PRESCRIPTION DRUGS

1) Prescription Drugs

Covered prescription drugs are those appearing on one or the other of the lists stated hereafter, depending on which Health Insurance Plan coverage is applicable. However, all of the following conditions must be met for prescription drugs expenses to be eligible:

- They must be incurred for prescription drugs bearing a valid DIN (Drug Identification Number) issued by the federal government.
- They must be available only on prescription by a health professional legally authorized to do so.
- They must be available only in pharmacy and sold by a pharmacist, except that in remote areas where there is no pharmacy or pharmacist, they may be dispensed by someone who is legally authorized to do so.

Eligible pharmaceutical services are also covered under the Health Insurance Plan.

RAMQ list (Basic Health Insurance Plan)

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

Standard list (Intermediate and Superior Health Insurance Plan)

Prescription drugs appearing on this list are not only those appearing on the RAMQ list, but also those that meet all of the above mentioned conditions even if not appearing on the RAMQ list.

Some prescription drugs, commonly called "**exception drugs**" in the RAMQ list, are only covered in cases determined by the regulation applicable to the Public PPDIP, 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 under the 3 plans, unless otherwise indicated:

- Syringes, needles, lancets, test strips and glucose sensors 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 (Intermediate and Superior Health Insurance);
- Drugs used for treating **infertility.** The maximum reimbursement for this type of medication is $1,500 per calendar year, per insured.

Reimbursement of brand-name drugs:

If the insured chooses to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However,

it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons, by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by SSQ.

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 all benefits of 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 products and natural products;

v) smoking cessation products, except those covered under the PPDIP;

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 PPDIP; 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;

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

ix) growth hormones that cannot be included in the PPDIP because of their diagnostic characteristics, according to the predetermined inclusion criteria;

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 PPDIP are not excluded.

The contribution required of a patient towards payment of the cost of prescribed drugs for an insured who is covered under the PPDIP is not covered under the present group insurance plan.

b) Direct payment

Insureds can use the electronic claim transmission service so that the pharmacist obtains payment directly from SSQ for the portion of expenses payable under the contract. Refer to section 6.1.2 a) for instructions on the claim transmission service.

2) Sclerosing injections

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

HOSPITALIZATION AND TRANSPORTATION

3) Hospitalization in Canada

The difference between the cost of hospital ward accommodation and the cost of accommodation in a semi-private room, during a period of short-term care provided in Canada, with no limitation as to the number of days. Administrative fees and incidental fees charged to the patient are not eligible for reimbursement. Expenses related to financial contribution for lodging (long-term care) and administrative expenses charged by the hospital are not covered.

4) Transportation by ambulance

When justified by the insured person's state of health, expenses for ground 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. In addition, the transportation services must be performed by a licensed ambulance service.

5) 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 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 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.

HEALTH CARE PROFESSIONALS

6) Audiologist, occupational therapist or speech therapist

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

7) 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.

8) Dietitian

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

9) Nurse or nursing assistant

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

10) Massage therapist, kinesitherapist or orthotherapist

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

11) Osteopath

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

12) Physiotherapist or physical rehabilitation therapist

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

13) Psychiatrist, psychoanalyst, career counsellor, psychotherapist or nurse specialized in psychoeducation

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

14) Psychologist or social worker

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

Expenses related to neuropsychological assessment are eligible up to a maximum of 3 hours of assessment.

VISION CARE

15) Eye examination

Expenses for eye examination by an ophthalmologist or optometrist.

16) Eye care

Expenses for 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.

OTHER MEDICAL EXPENSES

17) Hearing aid

Expenses for purchasing, adjusting or repairing a hearing aid.

18) Orthopaedic devices

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

19) Therapeutic devices or breathing assistance device

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);
- 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.

For the purposes of the group plan, the following devices are not considered as therapeutic devices or breathing assistance devices: transcutaneous electrical nerve stimulators, insulin pumps and their accessories, monitoring devices (such as a stethoscope or sphygmomanometer or other similar devices), domestic devices (such as a whirlpool bath, air purifier, humidifier, air conditioner or other devices of similar nature).

20) Ostomy appliances

Expenses for purchasing ostomy appliances (for the portion exceeding the amount reimbursed by the government).

21) 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.

22) 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 custom-made from a cast. Expenses incurred for prefabricated open, flared, straight last shoes and those required for use with 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.

23) 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.

24) Non-motorized wheelchair and hospital bed

Expenses for renting a non-motorized wheelchair or hospital bed (electrical or not) of the type generally used in hospital, for temporary use only.

25) Blood glucose monitor

Purchase of a monitor equipped with a lancing device and used to measure blood glucose levels. Purchase of an intermittent blood glucose monitor requiring glucose sensors may also be eligible, provided prior approval by SSQ is obtained.

26) 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 (fees for teeth broken while eating are not covered). Services must begin within 12 months following the date of the accident and be obtained within 36 months following the date of the accident.

Expenses are eligible up to the amounts specified in the fee guide of the Association des chirurgiens dentistes du Québec (ACDQ) for the year the services were obtained.

Expenses for dentures attached to implants may be considered eligible up to a maximum of the cost and limitations applicable to an equivalent alternative treatment provided for in the contract, and payable only at the time of the final insertion of the dentures attached to the implants. Expenses incurred for additional procedures or treatments related to implants (surgery, graft, etc.) are not eligible.

27) Intraocular lens implants

Expenses for purchasing intraocular lens implants required to correct the symptoms of an eye disease in cases where contact lenses or eyeglasses cannot be used to correct such symptoms.

28) Transcutaneous electrical nerve stimulator (TENS)

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

29) 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 des orthésistes et des prothésistes du Québec.*

30) Insulin pump and insulin pump accessories

Expenses for purchasing and servicing an insulin pump and insulin pump accessories.

31) Wig

Expenses for purchasing wigs following chemotherapy or radiotherapy.

32) External prostheses or artificial limbs

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

33) Breast prostheses

Expenses for purchasing breast prostheses required following a mastectomy.

34) Surgical brassieres

Expenses for purchasing surgical brassieres following a mastectomy or breast reduction, provided they are purchased from an adaptive clothing provider.

TRAVEL

35) Travel Insurance with Assistance

See section 2.5.

36) Trip Cancellation Insurance

See section 2.6.

2.4 GENERAL EXCLUSIONS, LIMITATIONS AND RESTRICTIONS APPLICABLE TO ALL COVERAGE UNDER THE HEALTH INSURANCE PLAN

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 or civil 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 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 WITH ASSISTANCE

1) Subject to the provisions of this travel insurance and to any limitations indicated in the "Employees' Group Insurance Plan at a Glance" table, 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 contact 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; reimbursement by SSQ is possible only if the government health insurance plan provides for benefits and SSQ's reimbursement is only applicable to the amount of expenses that exceeds the amount of benefits payable under the government health insurance plan.

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 $2,000. 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 $10,000. 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 $300 per day and of $2,400 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 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 abroad cannot exceed the following amounts:

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

   ii) Accommodation and meals: $300 per day for all insured family members, up to a maximum of $2,400 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 all coverage under 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 is 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

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

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

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

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

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

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

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 of one of the following individuals: the insured, the insured's spouse, a child of the insured, the insured's travel companion. The funeral must be scheduled to take place during the period extending from 31 days before and 31 days after the planned trip.

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

e) Regardless of any other provision of the 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 hospitalization 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 the 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 recommendation 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 the time of 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 cancelled or 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 cancelled or 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 trip cancellation insurance and to any limitations indicated in the "Employees' Group Insurance 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, flight cancellation 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 cancelled flight or 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.

<u>Restriction</u>

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 7-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 to the province of residence 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.

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

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

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

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

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

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

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

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

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

However, this exclusion does not apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If notice of cancellation of a trip prior to departure is not provided within the time specified herein, 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 or group contract purchased from an insurer, the benefits payable under this coverage are reduced by the benefits payable under any other contract. However, if the insured is entitled to similar benefits under other provisions of the 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 2021 fee guide of the Association des chirurgiens dentistes du Québec (ACDQ). SSQ manages this benefit by taking into account the ongoing changes in dental techniques and the updated service descriptions of the ACDQ fee guides.

1) PREVENTIVE DENTAL CARE REIMBURSABLE AT 80%

a) **Diagnostic**

i) **Clinical oral examination**

- complete oral examination, stomatognatic or prosthodontic: one examination per period of 36 months
- Preventive oral examination (recall or periodic): one examination per period of 9 months
- dental examination for children under age 10, if not covered under the RAMQ plan: one examination per period of 12 months
- emergency examination: 2 examinations per calendar year
- specific oral examination: 2 examinations per calendar year
- complete stomatognatic or prosthodontic 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
- X-ray, temporomandibular joint
- panoramic film: one film per period of 36 months
- cephalometric film
- duplicate radiograph: 2 times per calendar year

Note: X-rays (except panoramic films) are included with recall and complete examinations)

iii) **Tests and laboratory analyses**

- pulpal tests: 3 times per period of 12 months
- salivary tests: 3 times per period of 12 months
- bacteriologic test
- histological test
- cytological test
- local anesthesia
- diagnostic casts

b) **Preventive services**

i) **Preventive and other services**

- polishing of coronal portion of teeth: one visit per period of 9 months
- topical application of fluoride: once per period of 9 months (only children under age 14 are covered for this service)
- nutritional counselling: once per lifetime
- hygiene instructions and oral hygiene reinstruction: 2 times 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 tooth per calendar year (only children under age 14 are covered for this service)
- ameloplasty
- scaling: once per period of 9 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 ***

* **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) **Operative dentistry**

- sedative filling
- grinding and polishing of a traumatized tooth
- bonding/cementation of broken tooth chip: 2 times per calendar year
- resin restoration, glued amalgam restoration, composite restoration*
- laboratory processed veneer: 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
- Supplement for restoration of a tooth or inlays or onlays under an appliance or supporting an existing removable partial denture
- 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) **Periodontics**

- treatment of acute infection or inflammation
- desensitization
- occlusal equilibration: 3 times per calendar year
- surgical periodontal services (except periodontal surgery following the guided method)
- root planing under local anesthesia: one treatment per calendar year per tooth
- splint or ligation, except splint with metallic support
- removal or recementation of splint
- periodontal appliances: once per period of 48 months
- repair, maintenance or adjustments of periodontal appliances: once per period of 48 months
- relining of periodontal appliances

- subgingival periodontal irrigation

c) **Oral surgery**

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

3) ENDODONTICS REIMBURSABLE AT 80% AND MAJOR RESTORATIVE AND PROSTHETIC SERVICES REIMBURSABLE AT 50%

a) **Endodontics**

- endodontic emergency
- general endodontic treatment
- root canal therapy
- endodontic surgery
- other endodontic services

4) MAJOR RESTORATIVE AND PROSTHETIC SERVICES REIMBURSABLE AT 50%

a) **Fixed prostheses**

- prefabricated complete denture: once per period of 12 months
- individual crown
- transitional crown
- supplement for the fabrication of a crown or abutment under an appliance or an existing removable partial denture: once per period of 48 months
- coping, precious metal or not: once per period of 48 months
- reconstruction of tooth in preparation for crown

- post
- repair of crown or veneer
- recementation and/or removal: 2 times per calendar year

b) **Removable dentures**

- complete denture
- partial denture
- supplement for restoration done under the clasp of an existing denture

c) **Prostheses, complementary services**

- adjustments
- remount and equilibration (complete or partial dentures): once per period of 48 months
- repairs with or without impression
- structure additions to partial denture
- cleaning
- relining, rebasing
- remaking of a partial denture: once per period of 48 months
- resetting of teeth
- palatal obturator
- vertical dimension recuperation by addition of acrylic to existing prosthesis
- analysis in preparation for fabrication of a denture: once per period of 48 months

d) **Fixed Bridges**

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

e) **Implant**

Expenses for dentures attached to implants may be considered eligible up to a maximum of the cost and limitations applicable to an equivalent alternative treatment provided for in the contract, and payable only at the time of the final insertion of the dentures attached to the implants.

Exclusion:

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

3.4 MAXIMUM REIMBURSEMENT

Dental care provided for endodontics under 3.3.3) and major restorative and prosthetic services under 3.3.4) are subject to a maximum reimbursement of $1,000 per insured per calendar year for all these services. However, for the year during which the eligible employee or the participant applies for insurance, the maximum reimbursement applicable between the date of enrolment and December 31 is determined as follows, depending on the month of enrolment:

- 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 the Employees' Group Insurance Plan at a Glance section.

3.5 MINIMUM DURATION OF PARTICIPATION

Employees or participants who enrol in 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 for which this individual could have been eligible;
   c) expenses paid under a public insurance or social security plan, social or 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 plans or programs;
   d) expenses incurred for esthetic purposes. X-rays may be required to confirm the non-esthetic nature of the treatments;
   e) expenses related to the treatment of an illness or injury that was intentionally self-inflicted by the insured or resulting from the insured's 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 claim forms, 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 only one 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.

6) Benefits payable under the present dental care insurance are reduced by any expenses covered under any public or private individual or group plan, or under any government program, including coverage from plans that are financed in whole or in part with taxes, as well as those that would have been covered if the service provider had participated in such plans or programs.

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 could 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

During any period where the participant is totally disabled, amounts of insurance cannot be changed and the provisions used top establish these amounts cannot be modified.

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 actually 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 statement 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:

i) SSQ only reimburses the premiums paid for these amounts;

ii) any amount of life insurance that became effective more than 12 months before the suicide are payable by SSQ.

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

Totally disabled participants whose Basic or Optional Life Insurance is maintained without payment of premiums and who 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 or 50% of the Basic or Optional Life Insurance amount for which they would have been covered 24 months after the date the anticipated benefit payment request is received, taking into account 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 beneficiaries named for the Basic or Optional Life Insurance have accepted that this accelerated benefit payment be made.

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

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, on the Customer Centre website or by communicating with SSQ's head office.

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 the spouse and dependent children aged 24 hours and over, provided they 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 coverage status under the Health Insurance Plan, an amount of $5,000 is payable by SSQ upon the death of each insured dependent child aged 24 hours or more.

If the participant has a Couple coverage status under the Health Insurance Plan, an amount of $5,000 is payable by SSQ upon the death of the insured spouse.

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 $5,000 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 statement is received, the premium rates for a smoker apply.

Limitations in case of suicide – Spouses who commit suicide within 12 months following the coming into force of the Spouse's Optional Life Insurance they requested more than 30 days following their date of eligibility, no insurance amount is payable. In this case:

i) SSQ only reimburses the premiums paid for these amounts;

ii) any amount of life insurance that became effective more than 12 months before the suicide are payable by SSQ.

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 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, a hand, a foot, 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 intentionally self-inflicted injuries, regardless of the state of mind of the participant;

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 of the Long Term Disability Insurance benefit 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 been at work if they had not been totally disabled.

3) Amount of benefits

The initial amount of monthly benefits is equal 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 purposes 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 during the 52 weeks preceding the beginning of the total disability compared with the full-time work schedule. 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 actually 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 65 (age 60 for total disabilities that began between July 1, 2001 and December 31, 2015).

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' marginal benefits 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 sources of disability income in this paragraph.

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 all sources 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 coverage, or because the loss would not have been incurred in the absence of the group insurance contract;

d) any income from fringe benefits under any other legislation.

For the purposes of coordinating benefits, the cost-of-living adjustment of the above-mentioned sources of income is not taken into account.

7) Cost-of-living adjustment

When SSQ has paid Long Term Disability Insurance benefits for 12 full months, whether consecutive or not, for a same total 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 when the participant's condition is deemed stable as attested by a physician to the satisfaction of SSQ;

ii) periods during which the participant holds a position or does work that could provide a salary or any profit of 10% or more of the maximum pensionable earnings determined by Régime des rentes du Québec for the current year, except the case mentionned in paragraph **8) Rehabilitation employment**. In this case, if the participant does not meet the total disability definition, earnings do not reduce the Long Term Disability Insurance benefits;

iii) periods of disability resulting from esthetic treatments;

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

b) Unless they can prove that it was impossible to provide additional evidence required by SSQ, participants who fail to provide such evidence or who refuse to submit to a medical examination requested by SSQ within 90 days following the request may lose their entitlement to total disability benefits until SSQ receives the required documents.

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. RETIREES LIFE INSURANCE PLAN

5.1 AT RETIREMENT

New retirees have the opportunity to maintain life insurance via the group life insurance plan for retirees. Three benefits are available:

- Retired Participant Life Insurance;
- Retired Participant's Spouse and Dependent Children Life Insurance;
- Retired Participant's Spouse Additional Life Insurance.

Provisions of the GENERAL INFORMATION section apply to this plan wherever the context allows.

5.2 DEFINITION

The following definition applies specifically to this plan.

Retiree: Any person considered as an employee under the group insurance plan of the APTS and who is recognized as a retiree under the retirement plan of the employer.

5.3 COVERAGE

5.3.1 Retired Participant Life Insurance

a) Payment of insurance amount

In accordance with the provisions of the contract, SSQ shall pay the amount of insurance of the Retired Participant Life Insurance if the retiree dies while being insured under this benefit. This amount will be paid to the persons designated as beneficiaries in the most recent valid beneficiary designation SSQ received from the retiree.

b) Amount of insurance

The retired participant can choose an amount of insurance between $5,000 and $100,000 and this amount must be a multiple of $5,000.

However, the amount of life insurance for retirees cannot exceed the total amount held under the Participant's Basic Life Insurance and the Participant's Optional Life Insurance of Complementary Plan I on the date of retirement (or at the beginning of phased retirement if the participant provides SSQ with their phased retirement plan). If not already a multiple of $5,000, the result will be rounded to the higher multiple thereof.

After their effective date of coverage, retirees can obtain that their amount of insurance be decreased, but not increased.

c) Beneficiary

At any time, in compliance with applicable legislation, retired 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 retired participant, benefits are payable to the executors or administrators of the retired 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.

d) Accelerated benefit payment

Retired participants who 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 or 50% of the life insurance amount.

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

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

ii) that beneficiaries named for the Basic Life Insurance have accepted that this accelerated benefit payment be made.

Upon the death of the participant, the remaining amount of the Retired Participant Life Insurance coverage is payable by SSQ. This remaining amount is calculated by subtracting the amount of the accelerated benefit payment with accrued interest from the amount of insurance that would have been payable if the accelerated benefit had not been paid. The amount payable upon death will be reduced by the amount of the accelerated benefit payment plus interest calculated at the average return rate of a one year Treasury Bill plus 2%.

5.3.2 Retired Participant's Spouse and Dependent Children Life Insurance

a) Payment of insurance amount

In accordance with the provisions of the contract, SSQ shall pay the amount of insurance of the Retired Participant's Spouse and Dependent Children Life Insurance if one of them dies while being insured under this benefit. This amount will be paid to the retired participant.

b) Amount of insurance

The amount of insurance is determined as follows:

i) $5,000 upon the death of the insured spouse;

ii) $2,000 upon the death of each insured dependent child aged 24 hours or more.

5.3.3 Retired Participant's Spouse Optional Life Insurance

a) Payment of insurance amount

In accordance with the provisions of the contract, SSQ shall pay the amount of insurance of the Retired Participant's Spouse Optional Life Insurance if the spouse dies while being insured under this benefit. This amount will be paid to the retired participant.

b) Amount of insurance

The retired participant can choose an amount of insurance for the spouse between $5,000 and $100,000 and this amount must be a multiple of $5,000. However, the amount of life insurance for retirees cannot exceed the amount held under the Participant's Spouse Optional Life Insurance of Complementary Plan I on the date of retirement.

The retired participant can decrease the amount of insurance of this benefit while the benefit is in force, but cannot decrease this amount.

5.4 ELIGIBILITY

5.4.1 Retired participant

To be eligible for coverage, retirees must have become retired and they must have been participating in the Participant's Basic Life Insurance immediately before their retirement date.

Individuals become eligible for retiree coverage on their retirement date. However, those who are totally disabled on that date will become eligible on the date of termination of their waiver of premiums period under the Participant's Basic Life Insurance of the Complementary Plan I.

5.4.2 Dependents

Any person who is a dependent of the retiree is eligible for coverage on the date the retiree becomes eligible if the person is already insured as a spouse or dependent child immediately before the participant's date of retirement. If not, this person becomes eligible when becoming the retiree's spouse or dependent child.

5.5 PARTICIPATION

Participation in this plan is optional.

To enrol in this plan, retirees must submit the appropriate form to SSQ within 31 days after their retirement date, as provided at 5.6. After that period, retirees can no longer enrol in the plan.

5.5.1 Retired Participant Life Insurance

Retirees can participate in the Retired Participant Life Insurance if they were participating in the Participant's Basic Life Insurance of Complementary Plan I immediately before their retirement date.

5.5.2 Retired Participant's Spouse and Dependent Children Life Insurance

Retirees can participate in the Retired Participant's Spouse and Dependent Children Life Insurance if:

a) they are participating in the Retired Participant Life Insurance; and

b) they were participating in the Participant's Spouse Optional Life Insurance of Complementary Plan I immediately before their retirement date.

5.5.3 Retired Participant's Spouse Optional Life Insurance

Retirees can participate in the Retired Participant's Spouse Optional Life Insurance if:

a) they are participating in the Retired Participant's Spouse and Dependent Children Life Insurance; and

b) they were participating in the Participant's Spouse Optional Life Insurance of Complementary Plan I immediately before their retirement date.

Retirees can choose to terminate one or another coverage of this plan, subject to

the above rules. However, they cannot enrol again, except as provided under 5.9.

5.6 ENROLMENT

To enrol in this plan, retirees must submit the appropriate form to SSQ within 31 days after their retirement date and specify the amounts and coverage benefits they apply for.

5.7 EFFECTIVE DATE OF COVERAGE

5.7.1 Enrolment at time of retirement

For retirees who enrol within 31 days of their retirement date, the effective date of the benefits applied for becomes effective on the retirement date.

5.7.2 Enrolment after time of retirement

a) Retired Participant's Spouse and Dependent Children Life Insurance

For retirees who enrol in this benefit as provided under 5.9.1, coverage becomes effective on the eligibility date of the new dependent.

b) Retired Participant's Spouse Optional Life Insurance

For retirees who enrol in this benefit as provided under 5.9.2, coverage becomes effective on the first day of the month coinciding with or following the date the required evidence of insurability is approved by SSQ.

Insurance for any individual who is eligible as a spouse or dependent child cannot become effective before the participant's own insurance.

5.8 EVIDENCE OF INSURABILITY

For retirees who enrol in the Retired Participant's Spouse Optional Life Insurance after time of retirement because they have a new spouse, evidence of insurability satisfactory to SSQ must be provided for this new spouse.

5.9 CHANGES AFTER TIME OF RETIREMENT

5.9.1 Retired Participant's Spouse and Dependent Children Life Insurance

Retired participants who enrolled in Retired Participant Life Insurance only may apply for coverage under the Retired Participant's Spouse and Dependent Children Life Insurance when they have new dependents, provided their written application forwarded to SSQ within 31 days after the eligibility date of their new dependents.

5.9.2 Retired Participant's Spouse Optional Life Insurance

Retired participants who enrolled in Retired Participant Life Insurance may apply for coverage under the Retired Participant's Spouse Optional Life Insurance when they have a new spouse, provided they already participate or also apply for participation in the Retired Participant's Spouse and

Dependent Children Life Insurance in accordance with the provisions of 5.9.1. They must also:

a) forward a written application to SSQ within 31 days after the eligibility date of their new spouse;

b) provide SSQ with satisfactory evidence of insurability for the new spouse.

5.10 TERMINATION OF INSURANCE

5.10.1 Retiree

The Retired Participant Life Insurance terminates at 23:59:59, on the first of the following dates:

a) the termination date of the Retirees Life Insurance Plan;

b) the first day of the month coinciding with or following the date the retiree's written request to terminate coverage is received by SSQ;

c) the termination date of the last premium period for which the appropriate premium is paid;

d) the termination date of the insurance contract.

5.10.2 Dependents

a) Retired Participant's Spouse and Dependent Children Life Insurance

The Retired Participant's Spouse and Dependent Children Life Insurance terminates at 23:59:59, on the first of the following dates:

i) the termination date of the Retired Participant Life Insurance;

ii) the first day of the month coinciding with or following the date the retiree's written request to terminate coverage is received by SSQ;

iii) the termination date of the last premium period for which the appropriate premium is paid;

iv) the date the retired participant dies;

v) the date the person ceases to be a dependent as defined in the group insurance contract.

b) Retired Participant's Spouse Optional Life Insurance

The Retired Participant's Spouse Optional Life Insurance terminates at 23:59:59, on the first of the following dates:

i) the termination date of the Retired Participant Life Insurance;

ii) the termination date of the Retired Participant's Spouse and Dependent Children Life Insurance;

iii) the first day of the month coinciding with or following the date the retiree's written request to terminate coverage is received by SSQ;

iv) the termination date of the last premium period for which the appropriate premium is paid;

v) the date the person ceases to be a dependent as defined in the group insurance contract.

5.11 Conversion privilege

During the 31-day period following termination of this plan, if it is not replaced or if it is replaced by a plan offering lower amounts of insurance, retirees who have been covered for at least 5 years under the contract, whether as employees or retirees, and whose coverage terminates because of the termination of the plan, are entitled to convert their group insurance into a whole life or term to age 65 individual life insurance offered by SSQ, without having to provide evidence of insurability. The converted amount will not exceed the higher of the following:

a) $10,000;

b) 25% of the retired participant life insurance amount under this plan.

Within 31 days after the end of their coverage under this plan, dependents who have been covered for at least 5 years under the contract are entitled to convert their group insurance into a whole life or term to age 65 individual life insurance offered by SSQ, without having to provide evidence of insurability. The converted amount will not exceed $5,000.

5.12 CLAIMS

Claims and proof of death must be submitted to SSQ no later than 3 years after death, at the claimant's expense and to the satisfaction of SSQ.

Individuals filing claims must provide at their own expense or have them provided at their own expense, and to the satisfaction of SSQ, all other documents to prove that they are entitled to make their claims and that they did it on time.

6. CLAIMS

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

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

It is easy:

1 Complete your registration on the **Customer Centre** at **customer-centre.ssq ca**.

2 When registering on the **Customer Centre**, have your insurance card on hand, as well as a personal cheque showing your bank account number, in order to register for direct deposit.

3 Submit your claims on line, using the **Customer Centre**, or downloading the free SSQ Mobile Services (ssq.ca/mobile) application on your smartphone.

4 Receive your reimbursement within 48 hours*.

In addition, take advantage of many other features available on the Customer Centre.

- Simulate claims to ascertain the eligibility of expenses
- Consult benefit statements
- Order statements for tax return purposes
- Print additional SSQ insurance cards
- Make a change of address
- Confirm that a dependent child is still eligible
- Change beneficiary designations

And more!

* To be reimbursed within 48 hours, you must have registered for direct deposit. Then, most of the time, covered expenses will be reimbursed within 48 hours.

6.1 HEALTH INSURANCE

For all eligible expenses provided for under the Health Insurance Plan, claims must be submitted to SSQ no later than 12 months after the date the expenses are incurred. SSQ will decline all other claims.

6.1.1 Hospital expenses

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

6.1.2 Prescription drug expenses

a) Filing a claim using the direct payment card

The electronic transmission service allows prescription drug claims to be sent directly from the pharmacy to SSQ. Insureds must present their insurance card to the pharmacist when purchasing prescription drugs. If the drug is eligible for reimbursement, the insured only needs to pay the cost of the drug that is not reimbursed by the health plan and SSQ pays the insured portion directly to the pharmacist. The pharmacist must charge the usual and reasonable price, that is, the same price as charged to any other client.

In a pharmacy where the insureds have already used their insurance card, there is no need to present it again for subsequent purchases. When using it in another pharmacy, it will be necessary to present it again

Coordination of benefits at the pharmacy

Insureds who are covered under two group insurance plans that both include prescription drug coverage (double insurance) with a direct payment method can present their two cards to the pharmacist so that benefits can be coordinated at the time of purchase.

First use

For participants who have Couple, 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 statement can be done in writing or verbally.

Participants can also persent this statement via the Customer Centre and receive a receipt notice before the school year begins.

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, claims can be sent by mail, using the Health Insurance claim form available on the Customer Centre at ssq.ca. Benefits will be payable upon presentation of suitably itemized receipts to SSQ. The receipts must be sent to the address indicated in section 6.6**.** In such a case, the pharmacy receipts must indicate the name of the insured,

the number and date of the medical prescription, the name of the physician and the name and quantity of the drug.

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

Original receipts should be submitted to SSQ no later than 3 months after the purchase. **For expenses to be eligible for reimbursement, all receipts, including those for prescription drugs, must be submitted within the 12-month period following the date the expenses were incurred.**

6.1.3 Hospital or medical expenses resulting from a work or traffic accident

All medical or hospitalization expenses resulting from a work or traffic accident are reimbursable by the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) or the Société de l'assurance automobile du Québec (SAAQ). Claims for these expenses must be submitted to the CNESST or the SAAQ and not to SSQ.

6.1.4 Other expenses

Some claims can also be submitted via the Customer Centre or via the participant's smartphone and the free SSQ Mobile Services application. In both cases, the participant must keep the original receipts for at least 12 months after the date the expenses were incurred.

All other health insurance claims must be submitted directly to SSQ, together with the supporting documents (invoices, receipts, etc.) original receipts. A health insurance claim form is available on SSQ's Web site at ssq.ca, a customized version of which is also available on the Custome Centre . Participants can also use their smartphone and the free SSQ Mobile Services application to submit certain claims. As SSQ does not return receipts, participants are advised to always keep copies during at least 12 months for their records.

SSQ's address is specified at 6.6, "Contact SSQ".

Original receipts should always be sent within 3 months of the date the expenses were incurred. No reimbursement will be made for invoices submitted later than 12 months after the date the expenses were incurred.

6.2 TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE

6.2.1 Travel Insurance

In the event of an emergency that occurs during an insured's stay outside the province of residence, all travel assistance services, and reimbursement for most expenses eligible under Travel Insurance, will be coordinated by SSQ's travel assistance service, provided the insured contacts one of its representatives.

When the insured returns home, SSQ's travel assistance service will send this insured:

a) The documents needed to file claims. Originals of all receipts and paid invoices for eligible expenses paid should be enclosed with the claim.

b) A form for the insured to sign, authorizing SSQ's travel assistance service to obtain reimbursement on the insured's behalf for expenses eligible under the provincial health and hospitalization plan.

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.

Claims for all other expenses eligible for reimbursement under this coverage may be submitted directly to SSQ, with supporting documents deemed satisfactory by SSQ (e.g., invoices, receipts, prescriptions).

6.2.2 Trip Cancellation Insurance

When filing claims under the Trip Cancellation Insurance, insureds must include the following supporting documents with their claim:

a) Unused travel tickets.

b) Official receipts for additional transportation expenses.

c) Receipts for travel arrangements. 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 the insured has requested a reimbursement of travel expenses 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. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising 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) An official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure.

g) An official report pertaining to weather conditions.

h) Written proof issued by the official organizer of a commercial activity to the effect that an event is cancelled and the specific reasons why.

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

All invoices must be submitted to SSQ no later than 12 months after the date the expenses were incurred. If not submitted on time, expenses will not be eligible for reimbursement

6.3 DENTAL CARE INSURANCE

Insureds must present their insurance card to the dentist's office and pay the portion of expenses not covered by SSQ. If the dentist does not offer an electronic claims submission service, the insured must have them fill out and sign the "Dental Care Insurance Claim" form to SSQ and forward it at the address specified in section 6.6. This form is available SSQ's Web site at ssq.ca, a customized version of which is also available on the Customer Centre.

All invoices must be submitted to SSQ no later than 12 months after the date the expenses were incurred. If not submitted on time, expenses will not be eligible for reimbursement.

6.4 LIFE INSURANCE

Life Insurance claim forms are available directly from SSQ. Claims and proof of death must be submitted to SSQ no later than 3 years after death, at the claimant's expense and to the satisfaction of SSQ.

6.5 LONG TERM DISABILITY INSURANCE

Long Term Disability Insurance claims must be submitted no later than 3 months before the expected start date of SSQ benefit payments.

6.6 CONTACT SSQ

By mail

Insureds must indicate their certificate number on their claims or any other correspondence sent to SSQ at the following address:

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

By phone

Insureds can contact SSQ's Customer Service department, from 8:00 a.m. to 8:00 p.m., Monday to Friday, at the following number: **1-888-651-8181**.

By fax

Insureds who prefer to contact SSQ by fax can dial 418 652-2739.

By email

Insureds who prefer to contact SSQ by email can use the following address: **clientele@ssq.ca**.

7. PERSONAL INFORMATION PROTECTION

7.1 FILE AND PERSONAL INFORMATION

In order to maintain the confidentiality of information concerning the persons it insures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to reinsurers and any other person the participant may authorize. SSQ keeps its insurance files in its offices.

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

7.2 LEGAL AGENTS AND SERVICE PROVIDERS

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

When enrolling in a group insurance plan and also when making a claim (e.g. using the prescription drug insurance card), the participant consents that the insurer and its legal agents and service providers may use their personal information for the purposes mentioned above. It is understood that not giving this consent compromises the management of the insurance.

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