SSQ Financial Group

Values in the right place

YOUR GROUP ***INSURANCE PLAN***

FSSS - FP (CSN) – PUBLIC SECTOR

April 1, 2016

The Inukshuk is an Inuit figure
that symbolizes the importance of human
relationships and of mutual aid and solidarity.

FSSS CSN

FÉDÉRATION DES PROFESSIONNÈLES

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

The present document is provided for information purposes only and in no way affects the terms, conditions and provisions of the group insurance contract.

Cette brochure est disponible en français.

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1 - HEALTH PLAN

The expenses covered under the Health Plan are those that apply to supplies, care or services necessary for the treatment of the insured person following an illness, an accident, a pregnancy, complications arising from a pregnancy, a surgical intervention related to family planning or organ or bone marrow donation, or to dental care that is explicitly covered, and when specified, have been prescribed by a physician.

The expenses must not exceed usual and reasonable expenses normally paid for these services in the region they are given in. They must apply to care commonly provided for a similar condition.

Limitations – Health care professionals

To be eligible, expenses related to care and treatments by health care professionals must be incurred for fees payable to a person who is a member in good standing of the professional order relevant to the care or treatments that were rendered (in the case of dental care, by a legally recognized dental surgeon or denturist) or, if no such order exists, a relevant professional association recognized by SSQ. Eligible expenses only cover one treatment per day per health profession per insured. The health professional and the insured cannot ordinarily reside in the same home or be closely related.

1.1 Table of maximum reimbursements or eligible expenses

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN		
HEALTH I	**HEALTH II**	**HEALTH III**
GENERAL This table describes the expenses that are eligible under each of the three Health Plans, provided the above-mentioned eligibility provisions for expenses are respected, as are the coordination provisions and the exclusions, limitations and restrictions of the Health Plan.		
When a maximum of eligible expenses is indicated, it must be multiplied by the percentage of reimbursement to determine the reimbursable amount. The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for expenses incurred during a single calendar year. The note PCRP (planned calculated reimbursement percentage) in the "SUBJECT" column indicates that the amount (ceiling) at which the reimbursement percentage indicated for prescription drugs is increased to 100% applies to all coverage marked PCRP.		

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)		
HEALTH I	**HEALTH II**	**HEALTH III**
When a medical prescription is required, the note PR appears in the "SUBJECT" column. In this case, the prescription must indicate the name of the medication or, in the case of other products or services, the diagnosis, medical reasons, indications for use justifying the prescription and the planned duration of use. Unless specified otherwise: • the maximums indicated in this table are maximums per insured person per calendar year; • any maximum indicated on a given line applies as a total for all of the items in the "SUBJECT" column of this line and not to each item separately; • in the case of expenses incurred for the services of health care professionals, eligible expenses are limited to a single treatment per day per health profession.		

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)				
The general information that complements the information below can be found at the top of this table.				
SUBJECT		**HEALTH I**	**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 100%				
1	Travel Insurance **PR in some cases**	The Travel Insurance provisions can be found in a separate electronic format document on the **ACCESS | Plan members** Web site at **ssq.ca**. (Refer to section 5 to learn more about this service.)		
	Maximums	Reimbursement of $5,000,000 for the duration of the trip		
2	Trip Cancellation Insurance	The Trip Cancellation Insurance provisions can be found in a separate electronic format document on the **ACCESS | Plan members** Web site at **ssq.ca**. (Refer to section 5 to learn more about this service.)		
	Maximums	Reimbursement of $5,000 per trip		
Percentage of reimbursement: 80%				
3	Transportation by an ambulance service **(PCRP)**	When the person's state of health requires it, ground transportation to or from the nearest hospital offering care, including oxygen therapy treatments received immediately prior to and during transport. Transportation by plane (or by helicopter in cases where it is not covered by a third party), by boat or by train is also covered when part or all of the journey requires the use of one of these means of transportation and the insured is bedridden and must occupy the equivalent of two seats. In this case, medical necessity must be demonstrated to the satisfaction of SSQ. In all cases, transportation must be provided by a licensed ambulance service.		
	Maximums	Not applicable		

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)				
The general information that complements the information below can be found at the top of this table.				
SUBJECT		**HEALTH I**	**HEALTH II**	**HEALTH III**
4	Prescription drugs **(PR and PCRP)**	**Percentage of reimbursement:** 80% of eligible expenses (68% for brand-name drugs*) and 100% of out-of-pocket amount exceeding $950 for each certificate. A percentage of reimbursement of 80% also applies to brand-name drugs that cannot be replaced with a generic equivalent for medical reasons, provided that an appropriate form duly completed by the attending physician has been received by SSQ. However, approval by SSQ is always required. * Brand-name drugs are those which are sold under the original maker's trademark and for which there is at least one generic equivalent on the market.		
		Eligible prescription drugs: Drugs that appear on the list of drugs covered by the Quebec Basic Prescription Drug Insurance Plan (BPDIP), or any other drug that meets the following requirements: • It bears a valid DIN (Drug Identification Number) issued by the federal government. • It is available only on prescription from a health care professional legally authorized to prescribe it or it can be sold only under the control of a pharmacist. • It is prescribed by a health care professional legally authorized to prescribe it, even if this is one that can be sold only under the control of a pharmacist. • It is available exclusively in pharmacies and sold by a health care professional in accordance with the *Pharmacy Act*. • It is used in compliance with government-approved indications for use or, in the absence of such indications, the indications for use provided by the manufacturer.		

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)				
The general information that complements the information below can be found at the top of this table.				
SUBJECT		**HEALTH I**	**HEALTH II**	**HEALTH III**
	Exception drugs **(PR and PCRP)**	Prescription drugs named "exception drugs" that are part of the list of drugs whose cost is covered under the BPDIP according to the conditions and instructions for use specified in the Regulation Respecting the Basic Prescription Drug Insurance Plan. **These drugs require prior authorization from SSQ.**		
	Medication injected at a doctor's office **(PR and PCRP)**	**Only the cost of the injected substance is eligible**; the expenses incurred for the medical procedure and the portion of the product that is not actually injected are not eligible.		
	Smoking cessation products **(PCRP)**	Those that are covered under the BPDIP **The maximum amount of eligible expenses is updated on an annual basis by the RAMQ.**		
	Intrauterine devices **(PR and PCRP)**	With no additional specific conditions		
	Eligible pharmaceutical services **(PR and PCRP)**	Those that are covered under the BPDIP		
	<u>Direct payment of prescription drug expenses</u> The insured can use the electronic claims transmission service offered by SSQ. For instructions on how to use this service, please refer to section 5 - How to submit claims. Certain provisions exist to limit the payment of monthly expenses by high-cost prescription drug users who meet the criteria established by SSQ. The insured may contact SSQ to learn more about these criteria.			

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
5	Sclerosing injections **(PR and PCRP)**	For substances provided and administered by a physician for curative and non-aesthetic purposes Medical procedure not covered	
	Maximums	Reimbursement of $25 per day of treatment	
6	External prostheses and Artificial limbs **(PCRP)**	The loss of a natural limb must occur while the person is insured under this benefit. Items already covered under another section of this table **are not covered as external prostheses or artificial limbs**	
	Maximums	Not applicable	
7	Orthopaedic devices **(PR and PCRP)**	Purchase, adjustment, replacement, repair. To be covered as an orthopaedic device, the item must be used to support or maintain part of the insured's body to prevent and correct body deformities or to treat disorders of the bone structure, muscles or tendons. It must also be considered as such by SSQ. Foot orthoses must be provided by an officially licensed specialized laboratory. SSQ Customer Service, whose telephone number is provided on the back of this booklet, can confirm whether or not an orthopaedic device is covered under the Health Plan.	
	Maximums	For foot orthoses: amounts specified on the price list of the *Association des orthésistes et des prothésistes du Québec.*	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
8	Transportation and accommodation in Quebec to consult a medical specialist or receive specialized treatment **(PR and PCRP)**	Transportation of at least 400 kilometres (round trip), from the insured's place of residence by the most direct route to the nearest establishment, and accommodation in a public establishment. Also, if the insured is under age 18, transportation of an accompanying parent. • Supporting documents for accommodation expenses must be attached to the claim. • In the case of use of a private vehicle, receipts for the purchase of gas are required. • A report signed by the attending physician demonstrating that specialized consultation or treatment is required and indicating where it will take place must be sent to SSQ. • It must be demonstrated to the satisfaction of SSQ that the medical specialist and the specialized treatment are not available in the region, and that accommodation is necessary if accommodation expenses are claimed.	
	Maximums	• Eligible transportation expenses limited to the average cost of the most economical means of transportation, regardless of whether the person uses a public or private means of transportation. • Eligible expenses for accommodation are limited to $60 per day. • Reimbursement of $1,000 per calendar year.	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
9	Orthopaedic shoes **(PR and PCRP)**	Purchase of shoes • designed and made to measure from a cast when such shoes are required to correct or compensate for a foot defect; or • prefabricated open, flared or straight shoes; or • shoes needed to support Denis Browne splints. These shoes must have been obtained from an officially licensed specialized laboratory. Cost of additions or alterations made to orthopaedic shoes. For the purposes of this coverage, sandals are not considered to be orthopaedic shoes.	
	Maximums	Not applicable	
10	Deep shoes **(PR and PCRP)**	Purchase and replacement of prefabricated deep shoes, when these shoes are required to correct a foot defect and are obtained from an officially licensed specialized laboratory.	
	Maximums	Reimbursement of $150	
11	Audiologist Occupational therapist Speech language pathologist	Fees for services	
	Maximums	Not applicable	
12	Chiropractor Osteopath	Fees for services	
	Maximums	• Maximum reimbursement of $30 per treatment • Maximum reimbursement of $32 for X-rays by a chiropractor • Maximum reimbursement of $400	
13	Physiotherapist Physical rehabilitation therapist	Fees for services	
	Maximums	Reimbursement of $30 per treatment	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
14	Dental care required following an accident	Fees of a dental surgeon, dental specialist or denturist, to repair accidental damage to sound natural teeth or to treat an accidentally fractured jaw. The accident must occur while the person is insured under Health Plan II or Health Plan III. The treatments must begin within 12 months of the date of the accident and must end within 36 months of the date of the accident. Expenses related to implants and damage to teeth while eating are not covered. However, dentures attached to implants can be recognized as eligible, up to the cost and maximum applicable to a covered alternative treatment and payable only at the time of the final insertion of the dentures attached to the implant.	
	Maximums	Rates recommended by the ACDQ for the year the treatments are received	
15	Wheelchair Walker **(PR)**	Rental for a temporary need	
	Maximums	For a wheelchair: eligible expenses up to the cost of a non-motorized wheelchair of a type generally used in a hospital	
16	Blood glucose monitor **(PR)**	Purchase, adjustment, replacement or repair	
	Maximums	Reimbursement of $240 per period of 36 months	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
17	Therapeutic devices and breathing assistance apparatus **(PR)**	Rental. Upon prior agreement with SSQ, expenses for purchase can also be eligible, as well as expenses for replacement or repair. To be covered as therapeutic devices, the items must be necessary for the healing or treatment of the insured. They must also be considered as such by SSQ. To be covered as a breathing assistance apparatus, the item must be used to replace, compensate for or improve the functional respiratory capacities of the insured. It must also be considered as such by SSQ. SSQ Customer Service, whose telephone number appears on the back of this booklet, can confirm whether a therapeutic device or breathing assistance apparatus is covered under the Health Plan.	
	Maximums	Lifetime reimbursement of $10,000	
18	Insulin pump **(PR)**	Purchase, adjustment, replacement or repair	
	Maximums	Maximum reimbursement of $6,400 per period of 60 months	
19	Insulin pump accessories **(PR)**	Purchase of accessories used exclusively with an insulin pump	
	Maximums	Not applicable	
20	Hearing aid	Purchase, adjustment or repair	
	Maximums	Reimbursement of $480 per period of 48 months	
21	Support stockings **(PR)**	Purchase of support stockings (20 mm Hg or above) for venous or lymphatic system deficiency, if obtained from a health-care establishment or a pharmacy	
	Maximums	3 pairs	
22	Transcutaneous electrical nerve stimulator **(PR)**	Purchase, rental, adjustment, replacement or repair	
	Maximums	Maximum reimbursement of $560 per period of 60 months	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)			
The general information that complements the information below can be found at the top of this table.			
SUBJECT		**HEALTH II**	**HEALTH III**
Percentage of reimbursement: 80%			
23	Wig **(PR)**	Purchase of an initial wig following chemotherapy	
	Maximums	Lifetime reimbursement of $300	
24	Intraocular lens implants **(PR and PCRP)**	Purchase, if required to correct the symptoms of an eye disease in cases where the use of contact lenses or eyeglasses is not sufficient to correct such symptoms.	
	Maximums	Not applicable	
25	Surgical brassieres **(PR)**	Purchase following a mastectomy or breast reduction	
	Maximums	Lifetime reimbursement of $200	
26	Breast prostheses **(PR and PCRP)**	Purchase if required following a mastectomy	
	Maximums	Not applicable	
27	Ostomy appliances **(PR and PCRP)**	Purchase	
	Maximums	Not applicable	
28	Basic dental care	Diagnostic services, prevention, space maintainers, minor restoration, periodontics, oral surgery, anesthesia Refer to section 1.2 "Dental Care Insurance"	
	Maximums	Rates recommended by the ACDQ for the year the treatments are received	
SUBJECT		**HEALTH III**	
Percentage of reimbursement: 80%			
29	Kinesitherapist Orthotherapist Massage therapist	Fees for services	
	Maximums	• Reimbursement of $25 per treatment • Reimbursement of $200	
30	Acupuncturist	Fees for services	
	Maximums	Reimbursement of $30 per treatment	

MAXIMUM REIMBURSEMENTS OR ELIGIBLE EXPENSES UNDER THE HEALTH PLAN (cont'd)		
The general information that complements the information below can be found at the top of this table.		
SUBJECT		**HEALTH PLAN III**
		Percentage of reimbursement: 80%
31	Podiatrist	Fees for services
	Maximums	Reimbursement of $30 per treatment
32	Eye examination Eyeglasses Contact lenses Laser eye surgery	With the exception of eye examinations, a prescription from an ophthalmologist or optometrist is required. Laser surgery must be carried out to correct myopia, hypermetropia, astigmatism or presbyopia.
	Maximums	Adult or child 13 years of age or older: Reimbursement of $320 per period of 36 months, including a maximum reimbursement of $40 per period of 36 months for eye examinations. Child under 13 years of age: Reimbursement of $160 per period of 12 months, including a maximum reimbursement of $40 per period of 12 months for eye examinations.
		Percentage of reimbursement: 60%
33	Restorative dental care	Major restoration, endodontics, fixed prosthodontics or removable prosthodontics Refer to section 1.2 "Dental Care Insurance"
	Maximums	Rates recommended by the ACDQ for the year the treatments are received Reimbursement per calendar year, starting on the date the employee is enrolled: • $500 on the first year • $750 on the second year • $1,000 afterwards
		Percentage of reimbursement: 50%
34	Psychology Social worker	Fees for the services of a psychiatrist, psychoanalyst, psychologist, psychotherapist, psychoeducator, social worker or guidance counsellor. For insureds who reside in remote areas, expenses for telephone consultation for psychological help.
	Maximums	Reimbursement of $1,000

1.2 Dental Care Insurance

Dental care eligible expenses cannot exceed the fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received. However, eligible laboratory expenses are limited to 50% of the fees detailed in the fee guide for the orodental act in question.

SSQ offers an electronic claims transmission service with direct payment for dental care. Information on how to use this system is provided in section 5 - How to submit claims.

a) Eligible expenses for dental care

i) Basic dental care - Percentage of reimbursement: 80% (applies to Health Plan II and Health Plan III only)

1) Diagnosis

a) Clinical oral examination

i) recall or periodic oral examination: one examination per period of 9 months

ii) complete oral examination: one examination per period of 36 months

iii) complete periodontal examination: one examination per period of 36 months

iv) emergency examination: 2 examinations per calendar year

v) specific oral examination: 2 examinations per calendar year

(Only one recall, preventive or complete examination per period of 9 months)

b) Dental X-rays

i) Intraoral films

- Periapical film
- Occlusal film
- Bitewing film
- Soft-tissue film

ii) Extraoral films

- Extraoral film
- Panoramic film: one film per period of 36 months
- Cephalometric film
- Sinus examination
- Sialography
- Use of radiopaque dyes to show lesions
- Temporomandibular joint
- Duplicate radiograph or file: 2 times per calendar year

c) Lab examinations, tests and diagnostic casts

i) Pulpal test: 3 times per period of 12 months

ii) Bacteriological test

iii) Histological tests: Biopsy of soft tissue, biopsy of hard tissue

iv) Cytological test

v) Diagnostic casts (excluded if related to a restorative treatment, prostheses or other service)

2) Prevention and space maintainers

a) Preventive services

i) Polishing of coronal portion of teeth: once per period of 9 months

ii) Scaling: once per period of 9 months

iii) Topical application of fluoride: once per period of 9 months (only children under age 14 are eligible for this procedure)

iv) Analysis of diet and recommendation: once per lifetime

v) Oral hygiene instructions: once per lifetime

vi) Oral hygiene re-instruction: once per lifetime

vii) Plaque control program: 5 times per lifetime

viii) Finishing restorations

ix) Pit and fissure sealants, only on the occlusal surfaces of permanent premolar and molar teeth of children under age 14: once per period of 36 months for a same tooth

x) Removal of surplus subgingival filling material when local anesthesia is needed

xi) Interproximal discing: 2 times per calendar year (only children under age 14 are eligible for this procedure)

xii) Ameloplasty for non-aesthetic purposes (only children under age 14 are eligible for this procedure)

b) Space maintainers and appliances for the control of oral habits*

i) Space maintainer

- one fixed or removable device per period of 24 months

ii) Control of oral habits

- one fixed or removable device per period of 24 months
- one myofunctional evaluation per period of 24 months
- motivation of patient: once per lifetime
- myofunctional therapy: 5 times per lifetime

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

3) Minor restorative services*

a) Sedative filling

b) Recontouring and polishing of traumatized tooth

c) Bonding/cementation of broken tooth chip: 2 times per calendar year, per tooth

d) Preventive resin restoration: once per period of 12 months for a same tooth

e) Amalgam or composite restorations (the equivalent of the bonded amalgam restoration is covered by the insurance plan when a claim involving composite restoration on molars is submitted)

f) Retentive pins

g) Laboratory processed veneer: once per period of 48 months, for a same tooth

h) Amalgam/composite restoration made to an existing denture clasp or rest

* Treatment for the same surface or class of the same tooth is covered under the insurance plan once per period of 12 months, regardless of the material used and the treating dentist.

4) Periodontics

a) Treatment of acute infection or inflammation

b) Desensitization

c) Periodontal surgery (except periodontal guided tissue regeneration)

d) Gingival curettage and root planing: one treatment per calendar year, per tooth

e) Splint (for cast metal splint, refer to restorative dental care reimbursed at 60%, paragraph 1) h) of section ii)

f) Occlusal equilibration: one major and 3 minor treatments per calendar year

g) Periodontal appliance for bruxism: once per period of 48 months

h) Repair of appliance for bruxism: once per calendar year

i) Relining of appliance for bruxism

j) Periodontal irrigation

5) Oral surgery

a) Removal of erupted tooth, complex or uncomplicated

b) Supplement for suturing

c) Removal of impacted tooth, residual roots or tooth fragments

d) Surgical exposure of tooth, surgical movement of tooth, enucleation

e) Alveolectomy, alveoloplasty, osteoplasty, tuberoplasty, stomatoplasty, gingivoplasty

f) Removal of hyperplasic tissue, excess mucosa, surgical excision of cyst or tumour

g) Extension of mucous folds

h) Surgical incision and drainage

i) Frenectomy

j) Dislocation of mandible

k) Treatment of salivary glands

l) Sinus treatment or surgery

m) Hemorrhage control

n) Post-surgical treatment

6) General services

a) Palliative treatment of dental pain

b) Time and responsibility requirement, in addition to usual procedure

c) Local anesthesia

ii) Restorative dental care - Percentage of reimbursement: 60% (applies to Health Plan III only)

1) Major restorative services and fixed prosthodontics

a) Gold foil: once per period of 48 months for a same tooth

b) Inlays and onlays with retentive pins: once per period of 48 months for a same tooth

c) Individual crown

d) Preformed crowns made of stainless steel, plastic or other similar material: once per period of 12 months for a same tooth

e) Coping, precious metal or not: once per period of 48 months for a same tooth

f) Prefabricated post and cast metal post

g) Build-up for crown restoration

h) Cast metal splint: once per period of 48 months for a same tooth

i) Supplement for preparation of crown under existing partial denture structure

j) Removal of cemented post

k) Repair of crown/veneer

l) Recementation of inlay, onlay, crown or veneer: 2 times per calendar year for a same tooth

2) Endodontics

a) Endodontic emergency

i) Pulpotomy

ii) Pulpectomy

iii) Open and drain

b) Endodontic traumatism, reimplantation/repositioning, preparation of tooth for treatment

c) Root canal therapy and periapical endodontic surgery

3) Removable prosthodontics

a) Complete dentures

b) Partial dentures

c) Denture adjustments

d) Remount and equilibration: once per period of 48 months per maxillary

e) Structure additions to partial dentures

f) Palatal obturator: once per period of 48 months

g) Denture cleaning and polishing

h) Duplication of a denture

i) Rebasing and relining

j) Therapeutic tissue conditioning

k) Repairs with or without impression

l) Resetting of denture teeth

m) Remake of partial dentures

n) Analysis for fabrication of a partial denture: once per period of 48 months

4) Bridges and fixed prosthodontics

a) Pontics

b) Abutment

c) Metal cast retainer for butterfly bridge (Maryland, Rochette or Monarch)

d) Abutment, inlay or onlay: metal, porcelain, ceramic or resin

e) Retentive bar to be fixed to copings: once per period of 48 months

f) Telescoping crown unit

g) Precision attachment

h) Sectioning of an abutment or pontic

i) Removal of a fixed bridge to be recemented, solder indexing

j) Recementation: 2 times per calendar year, per tooth

k) Repair

5) Implants

Dentures attached to implants may be eligible, up to the cost and maximum 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: Supplementary procedures and treatments related to implants (surgery, grafts, etc.) do not qualify as eligible expenses under the contract.

b) Treatment plan

When the cost of a treatment is expected to exceed $800 or when the services planned are major restoration services, a treatment plan and X-rays may be submitted to SSQ before the beginning of the treatments. This allows SSQ to establish if the planned treatments are eligible and the amount of benefits the insured may be entitled to.

1.3 Tax credits

The portion of medical and dental expenses not reimbursable by the Health Plan, insurance premiums for the Health Plan and certain other medical expenses may entitle participants to provincial and federal tax credits.

For more information, refer to publication IN-130 on medical expenses, found on the *Ministère du Revenu du Québec* Web site at **www.revenu.gouv.qc.ca** or consult the most recent income tax package found on the Canada Revenue Agency Web site at **www.cra-arc.gc.ca**.

1.4 Exclusions, limitations and restrictions

a) Exclusions, limitations and restrictions applicable to all benefits of the Health Plan

The Health Plan does not provide reimbursement for the following:

i) For services or items that do not comply with the customary and reasonable standards of current practices of the health professions concerned.

ii) For expenses incurred for care, services or items for which the insured would not be required to pay in the absence of this plan.

iii) For expenses incurred for medical examinations further to a request by a third party (insurance, school, employment, etc.) or for trips for health reasons.

iv) For products or services used for experimental purposes or in the medical research stage, or whose use does not comply with the indications for use approved by the appropriate government authorities or, in the absence of such indications, with those provided by the manufacturer.

v) For expenses incurred for aesthetic purposes not explicitly covered under this plan.

vi) For the patient's contribution required for an insured who is eligible for free prescription drugs under a government insurance plan.

vii) For expenses incurred for services, products, examinations or care received collectively.

viii) For services or products related to smoking cessation that are not explicitly covered under this plan.

ix) For preventive vaccines, care, services or products that are not explicitly covered under this plan.

x) For expenses related to artificial insemination, infertility treatment or in vitro fertilization that are not explicitly covered under this plan.

xi) For expenses for purchasing non-oral contraceptives that are not explicitly covered under this plan.

xii) For expenses resulting from active participation in a riot, insurrection, criminal act or from service in the armed forces, or resulting directly or indirectly from a war or civil war in Canada, whether declared or not;

xiii) For expenses resulting directly or indirectly from a war or civil war in a foreign country where the insured is travelling, and the Government of Canada has issued an advisory not to travel to the said country. This exclusion does not apply to an insured already present in a foreign country at the time war or civil war breaks out, provided that, should the government of Canada then recommend leaving the country, the insured then takes the necessary measures to leave the country as soon as possible.

Benefits payable under any public or private plan, individual or group, or under any government initiative, including expenses guaranteed by a plan financed entirely or partly by taxes and expenses that would have been incurred had the provider of these services been chosen to participate in such plans, are reduced from any payable benefits under the Health Plan.

b) Exclusions, limitations and restrictions specific to Prescription drug insurance

In addition to the exclusions, limitations and restrictions that apply to all benefits of the Health Plan, the following products are excluded from prescription drug insurance, regardless of whether or not the products are considered as medical drugs:

i) Products used for cosmetic purposes or for personal hygiene, including products used to compensate for hair loss.

ii) Drugs obtained through the federal Emergency Drug Release.

iii) Homeopathic and natural products.

iv) Smoking cessation products, except for those specifically covered under Quebec's Basic Prescription Drug Insurance Plan (BPDIP).

v) Dietary supplements serving as meal supplements or replacements. However, dietary supplements prescribed for the treatment of a clearly diagnosed metabolic disease, in accordance with the conditions and indications for use determined by Quebec's Regulation respecting the BPDIP remain covered; the only acceptable evidence shall be a full medical report describing, to the satisfaction of SSQ, all the conditions justifying the prescription of such products not otherwise covered.

vi) Sunscreens and tanning creams.

vii) Growth hormones whose diagnostic characteristics do not permit them to be included under the BPDIP on the basis of predetermined inclusion criteria.

viii) Drugs provided during hospitalization, or by a hospital's pharmacy department or administered in a hospital.

ix) Drugs used to treat erectile dysfunction and that are administered orally only.

Under no circumstances may the exclusions, limitations and restrictions of this plan render the plan less generous than the BPDIP.

c) Exclusions, limitations and restrictions specific to Dental Care Insurance

i) In addition to the exclusions, limitations and restrictions that apply to all benefits of the Health Plan, the following are excluded from Dental Care Insurance, unless the applicable Health Plan explicitly states that the expenses are eligible.

ii) No benefit payments are made under the Dental Care Insurance for the following:

1) Transformation or extraction and replacement of sound teeth to modify their appearance.

2) An intra-oral appliance or services related to the treatment of temporomandibular joint dysfunction or correction of vertical dimension. However, a portion of the expenses incurred for an intra-oral appliance is eligible, i.e. an amount equal to the

amount specified in the fee guide of the dentist's professional association for bruxism appliances.

3) Missed appointments, claims filed, treatment plans, written reports, travelling expenses, legal identification fees, court appearances as an expert witness or telephone consultations.

4) An appliance designed for protection when playing sports (mouth guards).

5) A dental appliance for the treatment of snoring or sleep apnea.

6) Transfer copings.

7) Transitional crowns, pontics or abutments.

8) Removal of crowns and bridges that did not need to be recemented.

9) Dental caries susceptibility tests or sampling and microscope viewing of bacterial plaque.

10) Diagnostic photographs.

11) Services or products that are charged by a third party or are received collectively.

12) Expenses paid under a public insurance or social security plan, or a government program, or under a law or regulation or decree adopted with regard to these laws, plans or programs.

iii) If an insured person changes dentists or denturists during a treatment, or if they must be transferred to another dentist or denturist, or if more than one dentist or denturist is participating in the same treatment, the amount of benefits payable by SSQ for this treatment is limited to the amount that would have been payable had services been provided by a single dentist or denturist.

iv) In the case of a cast metal post, crown, removable denture or fixed bridge being subject to benefits, no replacement treatment can count as an eligible expense if the insertion occurs within 48 months following the previous installation. However, a permanent removable prosthesis (partial or full), may be eligible for reimbursement if it replaces a transitional removable prosthesis

(partial or full) and is installed within 6 months of the date the transitional prosthesis was installed.

v) When the word "sextant" or "quadrant" is used in the description of a treatment that is covered by the insurance, the insured services corresponding to this treatment are limited to 6 different sextants per calendar year per insured and 4 different quadrants per calendar year per insured.

vi) 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.

2 - OPTIONAL PLAN I – LIFE INSURANCE

2.1 Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

This coverage is offered to all eligible employees by automatic enrolment at hiring with the option to opt out.

2.1.1 Participant's Basic Life Insurance

In the event of the participant's death, the designated beneficiary (or, if no beneficiary has been designated, the estate of the participant) receives an amount of life insurance that corresponds to one time the annual insurable salary of the participant.

Limitation – If the participant commits suicide within 12 months following the effective date of coverage amounts requested more than 30 days after the date of eligibility, no benefits are payable for these coverage amounts. However, SSQ will reimburse the premiums paid for these amounts.

2.1.2 Participant's AD&D Insurance

In case of accidental death or accidental loss of a limb, the designated beneficiary or the participant receives a certain percentage of the participant's annual insurable salary, not exceeding 100%, for the losses described in the following table.

Accidental loss	Percentage of insurable salary
Accidental death	100%
Loss (including loss of use):	
• of both hands, both feet or sight in both eyes	100%
• of one hand and one foot	100%
• of one hand or one foot, and sight in one eye	100%
• of one hand or one foot	50%
• of sight in one eye	50%
• of one finger or one toe	10%

2.1.3 Exclusions for AD&D Insurance

No insurance amount is payable under this benefit if the loss is attributable, directly or indirectly, in whole or in part, to one of the following causes:

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

b) Active participation in a riot, insurrection or criminal acts, or a war or civil war, whether declared or not.

c) Trip or flight in any kind of aircraft when the participant is a crew member or carries out any duties related to such flight.

d) Active service in the armed forces of any country.

e) Injuries exhibiting no visible external wound or contusion on the body (except in the case of drowning or internal injuries revealed by surgery or autopsy).

f) Poisoning or intoxication.

2.2 Spouse's and Dependent Children's Life Insurance

This coverage is offered to all eligible employees by automatic enrolment upon hiring with the option to opt out.

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

In the event of the death of a dependent child, if the participant does not have a spouse at the time the event occurs, upon approval of supporting documents by SSQ, the amount to be paid is increased to $10,000.

2.3 Optional Life Insurance

2.3.1 Participant

Participants with Basic Life Insurance may opt for an additional amount of Optional Life Insurance up to 5 times their annual insurable salary. Evidence of insurability deemed satisfactory by SSQ is always required.

2.3.2 Spouse

Participants with Basic Life Insurance can obtain units of $10,000 of Optional Life Insurance for their spouse up to $100,000. Evidence of insurability deemed satisfactory by SSQ is always required.

2.3.3 Limitation

If the participant or the participant's spouse commits suicide within 12 months following the effective date of coverage amounts requested more than 30 days after the date of eligibility, no benefits are payable for these coverage amounts. However, SSQ will reimburse the premiums paid for these amounts.

2.3.4 Premium rates

The premium rates for Participant's Optional Life Insurance are based on the participant's age, gender and smoking habits.

The premium rates for Spouse's Optional Life Insurance are based on the age of the participant, but on the gender and smoking habits of the spouse.

To take advantage of the reduced rates offered to non-smokers, the declaration of non-smoker status on the Application/Request for Change form or on the Declaration of Non-Smoker Status form must be signed by the appropriate individual. These forms are available from the employer. If such declaration is not received, the premium rates for a smoker apply.

2.4 Life Insurance for the Retiree and the Spouse of the Retiree

Life insurance amounts are offered upon the participant's retirement. For more information, the participant may refer to the Optional Group Life Insurance Plan for the Retiree and the Spouse of the Retiree pamphlet available on the ACCESS | Plan members Web site (Refer to section 5 to learn more about this service).

3 - OPTIONAL PLAN II – LONG TERM DISABILITY INSURANCE

This plan completes the disability insurance plan provided for in the collective agreement and provides disabled participants with income until their 60th birthday under optional coverage of option II F or compulsory coverage of option II O, and until their 65th birthday under compulsory coverage of option II O+, should a disability render them totally incapable of working for an extended period. However, in certain cases with options II F and II O, an additional benefit may be paid between ages 60 and 65.

3.1 Amount of benefits

The initial amount of monthly benefits is calculated based on the net benefit that is payable or would be payable by the employer at the 105th week of disability, in accordance with the disability insurance plan provided for in the collective agreement.

3.1.1 For options II F and II O

The percentage used to establish the payable benefit is 80%.

3.1.2 For option II O+

The percentage used to establish the payable benefit is 100%.

For all options, Long Term Disability Insurance benefits are non-taxable.

For part-time employees earning less than $10,000 per year, the minimum income used to calculate the amount of the benefit is $10,000, provided the average salary is higher than $0 for the last 12 weeks preceding the start of the total disability.

3.2 Elimination period

The elimination period is 105 weeks.

3.3 Duration of benefits

At the end of the elimination period, benefits are paid monthly for as long as the total disability persists, until:

3.3.1 Options II F and II O

the last day of the month when the participant reaches age 60.

Thereafter, if the income from all sources that a disabled participant receives or could receive on request is less than 35% of the Maximum Pensionable Earnings (MPE) under the Quebec Pension Plan, benefits enabling the participant's income to reach 35% of the MPE are payable up to the disabled participant's 65th birthday, without exceeding the benefit paid before the participant's 60th birthday.

3.3.2 Options II O+

the last day of the month when the participant reaches age 65.

3.4 Rehabilitation employment

Totally disabled participants may perform rehabilitation work with the agreement of SSQ. Benefits payable are reduced by 50% of the gross income earned by the disabled participant for such work.

Benefits paid together with the income earned from such employment cannot exceed 100% of the net monthly salary of the participant at the time payment of the Disability Insurance benefits began.

3.5 Cost-of-living adjustment

When Long Term Disability Insurance benefits have been paid by SSQ for 12 full months, consecutive or not, for the same total disability period, the amount of the monthly benefit being paid is indexed on January 1 of each subsequent year according to the same terms as the Quebec Pension Plan, up to a maximum annual adjustment of 3%.

3.6 Reduction

3.6.1 For options II F, II O and II O+

Benefits paid are reduced by the amount of disability benefits payable under Quebec's *Automobile Insurance Act*, the *Act respecting industrial accidents and occupational diseases*, the Quebec Pension Plan (QPP), the Canada Pension Plan (CPP), an employer's pension plan, or any social legislation and by any remuneration received from the employer, with the exception of the following sources of income:

- Benefits payable under the *Employment Insurance Act* and the *Act respecting parental insurance.*

- Paid vacation days.
- Any amount of money from the participant's sick leave bank used for the specific purpose of buying back past service from a pension plan, as long as the pension plan concerned so allows.

3.6.2 For option II O+

For a participant insured under option II O+, monthly benefits payable by SSQ are also reduced by 65% of the retirement pension that is received under the employer's retirement plan or, if the participant does not receive such a pension, the pension the participant could receive without actuarial reduction if he or she ceased to benefit from the waiver of contributions in the case of disability stipulated under the employer's retirement plan.

However, when a totally disabled employee who is not retired ceases to participate in the private pension plan while being entitled only to a deferred pension, and decides to transfer the current value of this pension to a Locked-in retirement account (LIRA), SSQ will reduce the monthly pension payable under this plan by any amount received from a Life Income Fund (LIF) or an income fund obtained through the conversion of amounts accumulated in the LIRA. The amounts considered for the LIRA are only those transferred from the private retirement plan in force at the start of the disability.

3.7 Exclusions

The Long Term Disability Insurance benefit does not provide coverage for:

- disability periods during which the participant does not follow the recommendations of a physician, except if the participant's condition is declared stable by a physician to the satisfaction of SSQ;
- disability periods during which the participant holds a position or performs work that may provide a salary or any profit whatsoever, subject to the provisions of the following box;

> The participant may be entitled to benefit payments when participating in a rehabilitation program as provided in section 3.4 or when carrying out duties or performing work that provides an income lower than 10% of the effective Maximum Pensionable Earnings (MPE) stipulated under the Quebec Pension Plan. In the latter case, if the participant's condition meets the definition of "total disability", the Long Term Disability Insurance benefits are not reduced by the participant's income.

- disability periods resulting from alcoholism or drug addiction, from active participation in a riot, insurrection or criminal acts, or from service in the armed forces. However, a disability period resulting from alcoholism or drug addiction during which the participant is receiving continuous treatment or medical care for rehabilitation is recognized as a total disability period.

Moreover, a CNESST-approved preventive leave related to pregnancy or breast-feeding is not recognized as a total disability period for the purposes of this plan.

3.8 Proof and medical examinations

SSQ may require the participant to provide additional information about the disability or to undergo a medical examination, the date of which is determined by SSQ.

For the period beginning 31 days after the date of the request, until the date SSQ actually receives the additional information requested, no benefits will be payable to the participant who has not submitted the information requested or undergone the required medical examination.

If SSQ's request remains unsatisfied for a period of 6 months, the participant forfeits the right to claim disability benefits for the total disability period retroactively to the date of the initial request made by SSQ.

4 - GENERAL INFORMATION

4.1 Definitions

4.1.1 Dependent

a) Spouse

Spouse means persons:

- who are married or civilly united and living together;
- who are living as if they were married and are the father and mother of a same child;
- of the same or opposite sex who have been living as if they were married for at least one year.

However, dissolution of the marriage by divorce or annulment or annulment of the civil union causes the status of spouse to be forfeited, as does de facto separation for more than three months in the case of a common-law spouse. The employee who is not living with the spouse can designate another person to replace the legal spouse if this person meets the other provisions of this definition.

b) Dependent child

A child of the participant, of the spouse or of both, who is unmarried and not in a civil union, who is residing or domiciled in Canada, who is dependent on the participant for support and who meets one of the following conditions:

- be under age 18;
- be age 25 or under and be a duly registered full-time student in an accredited educational institution;
- regardless of the child's age, became totally disabled when he or she met one of the above conditions and has remained continuously disabled since that date;
- be a person of full legal age, without a spouse, suffering from a functional impairment defined in the *Regulation respecting the basic prescription drug insurance plan* of the RAMQ, impairment that occurred before the person reached 18 years of age, who does not receive any benefits under a last resort financial assistance program provided for in the *Act respecting income support, employment assistance and social solidarity*, who is residing with the participant

and on whom the participant or the participant's spouse would exercise parental authority were the person a minor.

An unmarried child over whom the participant or spouse exercises parental authority or would have exercised such authority had the child been a minor is also considered a dependent child.

Furthermore, a dependent child on a sabbatical school leave maintains the dependent child status, provided that the participant meets the requirements under section 4.10.5 - Dependent child on sabbatical school leave.

A dependent child can also be any legally adopted child or any child for whom a legal adoption process is undertaken or an order of placement granted in compliance with the conditions for adoption.

4.1.2 Events

- Involuntary termination of the health insurance enabling the exemption
- Marriage, civil union or cohabitation for a period of one year
- Birth or adoption of a first child
- Involuntary termination of the spouse's or dependent children's insurance
- Separation
- Divorce
- Death of the spouse or death of a child

4.1.3 Insured

The participant or the participant's dependents who are covered by this insurance.

4.1.4 Participant

Any employee participating in the insurance plan.

4.1.5 Salary (also called insurable salary)

Salary following the rates of the scale applicable to the participant according to the collective agreement, including any regional disparity premiums and additional remuneration provided for in the collective agreement and used for the calculation of disability insurance benefits.

4.1.6 Self-insured plans under the collective agreement

The life insurance and short term disability insurance plans included in the collective agreement.

4.1.7 Total disability

From the 205th week of a total disability period until the 208th week thereof, 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 organ or bone marrow donation, provided this state of incapacity requires medical care and renders the participant totally incapable of carrying out the normal duties of his/her employment or any comparable employment with similar remuneration offered to the individual by the employer.

After this period, "total disability" is defined as a state of incapacity resulting from an accident or illness, or complications from a pregnancy or organ or bone marrow donation, provided this state renders the participant totally unable to carry out any remunerative employment for which the individual is reasonably qualified because of education, training and experience, regardless of the availability of such employment.

4.1.8 Total disability period

During the first 5 days of absence due to total disability and the immediately following 156 weeks of total disability, any continuous total disability period or successive total disability periods separated by a period of active full-time work or availability for full-time work, unless the participant demonstrates, to the satisfaction of the employer or a representative thereof, that the subsequent period results from an illness or accident completely independent of the cause of the previous total disability. This period of active full-time work or availability for full-time work must be less than 15 days if the duration of the total disability is shorter than 78 weeks, and less than 45 days if the duration is 78 weeks or longer.

For part-time employees the above-mentioned period of "5 days of absence" is replaced with a period of "7 calendar days starting on the first day the employee is required to go to work".

Afterwards, any continued total disability period or successive total disability periods separated by less than 6 months of active full-time work or availability for full-time work, unless it was established that a subsequent period was due to an illness or accident completely unrelated to the cause of the previous total disability.

Any period of rehabilitation during the elimination period applying to the Long Term Disability Insurance will not interrupt the total disability period.

4.2 Eligibility

Employees become eligible for coverage under the group insurance plans insured by SSQ when they become eligible for the self-insured plans provided for under their collective agreement.

Despite the preceding, the employee becomes eligible for coverage under Health Plan I after one month of continuous service.

However, 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 no later than 30 calendar days following their departure.

In the above-mentioned cases, no evidence of insurability is required by SSQ, with the exception of the evidence required for a change in participation in Optional Plan I – Participant's Life Insurance or Optional Plan II – Long Term Disability Insurance.

Dependents become eligible on the date of the employee's eligibility or on the date they become a dependent, if later.

4.3 Participation

Specific provisions applicable to employees working 25% or less of the full time work schedule are provided under Appendix 1.

4.3.1 Basic Health Insurance Plan

Participation in this plan is compulsory for all eligible employees and their dependents, subject to the exemption entitlement (section 4.6) or a valid claim slip issued by the *Ministère de l'Emploi et de la Solidarité sociale*.

Participants must choose one of the available options, Health Plan I, Health Plan II or Health Plan III for themselves as well as for dependents. The options available for dependents are those that provide the same or a lower coverage than the one chosen for the participant (Refer to section 4.5).

Participation in Health Plan II and Health Plan III is optional. However, participation in one of these plans must be maintained for at least 36 months before the insured can change to a lower option, except as provided under section 4.7.

In addition, **employees age 65 and over** may choose to obtain coverage for themselves and their dependents under the **RAMQ's Basic Prescription Drug Insurance Plan** even if covered under Health Plan II and Health Plan III (with no minimum participation of 36 months requirement), or they may choose to continue coverage under their group insurance plan. Dependents under age 65 must be covered under the same plan as the participant.

When employees aged 65 and over elect to become insured under the RAMQ's Basic Prescription Drug Insurance Plan, they can take advantage of the exemption entitlement of their group plan. In such a case, SSQ must be notified of the decision. A participant's or spouse's decision to obtain coverage under the RAMQ's BPDIP is irrevocable.

NOTICE
Under Quebec's *Act respecting prescription drug insurance*, all individuals eligible for coverage under a group insurance plan must participate in that plan and, depending on their situation, **pay the applicable premiums** for individual, single-parent or family coverage status. In the event of termination of the group insurance due to non-payment of premiums, individuals cannot register for coverage under the RAMQ's BPDIP but must pay the annual premium for such coverage to the RAMQ when filing their income tax return. Furthermore, neither SSQ nor the RAMQ will reimburse any prescription drug claims for expenses incurred during the period for which the premiums were not paid.

4.3.2 Optional Plan I - Life Insurance

Participation in this plan is **optional** for all eligible employees. However, participation in Participant's Basic Life Insurance and Spouse's and Dependent Children's Life Insurance is granted automatically to all employees when they are hired or when they become eligible for the first time and they have not given notice in writing that they wish to opt out.

4.3.3 Optional Plan II - Long Term Disability Insurance

Participation in this plan is **optional** for all eligible employees. However, **the members of a certification unit can decide to make participation compulsory. In that case, they must choose between option II O and option II O+.** Participation becomes compulsory for all eligible employees

of this unit, except for those who have already opted out of option II O or option II O+ in accordance with the opting out rules described below.

Opting out of options II O and II O+

Participants may opt out, provided they:

- Are age 53 or over, or
- Present evidence to SSQ that they participate in a retirement plan with at least 33 years of service or more for purposes of eligibility for the RREGOP, or
- Are already covered under a disability insurance plan for members of a professional order, provided such plan provides equivalent coverage.

The opting out becomes effective on the date SSQ accepts the request to do so.

Participants who opt out can later return to the Long Term Disability Insurance Optional Plan II if they provide evidence of insurability deemed satisfactory by SSQ.

4.4 Application for insurance

The eligible employees must complete the "Application/Request for Change" form available from their employer's human resources department. Once completed, this form is returned to the employer's group insurance plan administrator, who in turn submits it to SSQ.

Note: The *Act respecting prescription drug insurance* requires employees to insure their spouse, and dependent children if any, unless they are covered under another group insurance plan.

4.4.1 Automatic enrolment rule

Eligible employees **who fail or refuse to complete an application for insurance are automatically insured** under Health Plan I with an individual coverage status, under the Participant's Basic Life Insurance and Spouse's and Dependent Children's Basic Life Insurance of Optional Plan I, and under the Long Term Disability Insurance of Optional Plan II, if participation in this plan is compulsory.

4.5 Coverage status and option

For the Health Plan, the participant must choose a coverage status and a coverage option.

Available coverage statuses are the following:

Coverage status	Individuals covered
Individual	Participant
Single-parent	Participant and dependent children
Family	Participant, spouse, and dependent children, if any.

The chosen coverage status applies to all health and dental care insurance coverage under the Health Plan.

Participants must choose one of the available options, Health Plan I, Health Plan II or Health Plan III for themselves as well as for dependents. The options available for dependents are those that provide the same or a lower coverage than the one chosen for the participant. The available packages depend on the chosen status. They are as follows:

Individual coverage status			
Coverage package	**A**	**B**	**C**
Participant	Health I	Health II	Health III
Dependent children	--	--	--
Spouse and dependent children	--	--	--

Single-parent coverage status						
Coverage package	D	E	F	G	H	I
Participant	Health I	Health II	Health II	Health III	Health III	Health III
Dependent children	Health I	Health I	Health II	Health I	Health II	Health III
Spouse and dependent children	--	--	--	--	--	--

Family coverage status						
Coverage package	J	K	L	M	N	O
Participant	Health I	Health II	Health II	Health III	Health III	Health III
Dependent children	--	--	--	--	--	--
Spouse and dependent children	Health I	Health I	Health II	Health I	Health II	Health III

Participants can change their and their dependents' coverage status and option, according to the rules provided for in section 4.7.

4.6 Exemption

4.6.1 Application for exemption

Employees may be exempted from the Health Plan upon presentation of proof of coverage under a group insurance plan with prescription drug insurance coverage or a valid claim slip issued by the *Ministère de l'Emploi et de la Solidarité sociale*.

Note: Employees must provide their employer with a copy of the insurance certificate or claim slip.

Any person age 65 and over who is insured under the BPDIP of the RAMQ can also be exempted from participating in the Health Plan.

The exemption entitlement also allows participants to cease participation in Health Plan II and Health Plan III, even if the minimum period of participation of 36 months has not yet been completed.

4.6.2 Start of exemption

a) The exemption of a new employee begins on the employee's date of eligibility if, within 30 days after this date, the employer receives a duly completed written request. Otherwise, it begins on the first day of the pay period that coincides with or follows the date the employer receives the request.

b) The exemption of a participant begins on the date of the event entitling the employee to an exemption if, within 30 days after this date, the employer receives the duly completed written request. Otherwise, it begins on the first day of the pay period that coincides with or follows the date the employer receives the request.

4.6.3 End of exemption

Participants who wish to terminate their exemption must establish, to the satisfaction of SSQ and the employer, that they were previously insured under the Health Plan or another prescription drug insurance plan and that they and their dependents, if any, are no longer covered by the plan that allowed the exemption.

Applications to terminate an exemption must be accompanied by supporting documents.

a) Provisions applying to requests received by the employer within 30 days following the end of the exemption

   The insurance comes into force on the date the insurance allowing the exemption ended. The participant can take advantage of this opportunity to choose a new coverage package, without regard for the minimum period of participation of 36 months.

b) Provisions applying to requests received by the employer more than 30 days after the end of the exemption

   The insurance comes into force on the first day of the pay period that coincides with or follows the date the employer receives the request.

   Any participant who was participating in Health Plan II or Health Plan III before the beginning of the exemption cannot decrease their coverage or their dependents' coverage if the minimum period of participation of 36 months is not yet completed. The exemption period is considered to be part of the minimum 36-month period.

   If the participant chooses to increase the Health Plan held before the exemption and they have been granted a waiver of premiums at the time they make their application, that increase becomes effective on the first day of the pay period that follows the date they actively return to work.

4.7 Effective date of coverage

4.7.1 Health Plan

The insurance comes into force on the person's date of eligibility.

Following one of the **events identified in section 4.1.2**, the participant's and dependents' status and option may be increased or decreased. The participant may choose among the different coverage packages shown in section 4.5.

In the absence of the above mentioned events, the participant's and dependents' options **may be increased**. However, they **may not be decreased** before completion of **at least 36 months** of coverage under the same package.

For participants already covered under the Health Plan as of April 1, 2016, and for **one time only**, it will be possible to choose a lower option for themselves or their dependents without having to prove that an event occurred.

Participants must make requests for change using the "Application/ Request for change" form and hand them in, duly completed, to their plan administrator. Changes become effective on the earlier of the following:

a) If the request is received by the employer within 30 days following the event, on the date of the event.

b) If the request is received by the employer more than 30 days following the event, or in absence of such an event, on the first day of the pay period that coincides with or follows the date the employer receives the written request.

Notwithstanding any other provision, disabled employees cannot change their coverage package before the date they return to active work and are eligible for a new total disability period in accordance with the collective agreement.

Refer to section 4.6.3 for information on the rules applying at the end of exemption.

The following periods are included in the calculation of the minimum period of participation of 36 months provided above: an exemption period; a period of temporary interruption of work during which participation in Health Plan I was maintained; a period during which premiums were waived as a result of total disability; a period during which time worked was reduced to 25% or less of full-time, regardless of the option maintained.

Participants can decrease their own and their dependents' option under the Health Plan when their percentage of time worked is reduced to 25% or less of full time, regardless of the minimum participation period of 36 months.

4.7.2 Optional Plan I – Life Insurance

Employees must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they actively return to work. However, the effective date for Spouse's and Dependent Children's Life Insurance is not subject to the employee's ability to work.

a) Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

The insurance comes into force on the date of eligibility, unless the insured opts out.

Following an opting out, evidence of insurability is required and the insurance comes into force on the first day of the pay period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

b) Participant's and Spouse's Optional Life Insurance

Evidence of insurability is required for all applications for participation in the Optional Life Insurance Plan.

The insurance comes into force on the first day of the pay period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

c) Spouse's and Dependent Children's Life Insurance

The insurance comes into force on the date of eligibility, unless the insured opts out.

When the "Application/Request for Change" form is submitted within 30 days following the date of one of the events below, the insurance comes into force on the date of the event:

- marriage or civil union;
- cohabitation for a period of one year;
- birth or adoption of a first child.

Following an opting out or more than 30 days after the event, evidence of insurability is required and the insurance comes into force on the first day of the pay period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

Any employees who were previously covered under any benefits of this plan and who have since ceased to participate in these benefits must submit evidence of insurability and be accepted by SSQ to obtain coverage once again.

4.7.3 Optional Plan II – Long Term Disability Insurance

Employees must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they actively return to work.

a) Optional participation (option II F)

When the "Application/Request for Change" form is submitted to the employer:

i) ***within 30 days following the date of eligibility:*** Optional Plan II coverage comes into force on the participant's date of eligibility;

ii) ***more than 30 days following the date of eligibility:*** Optional Plan II coverage comes into force on the first day of the pay period that coincides with or follows the date the employer receives notice of SSQ's approval of the evidence of insurability.

Any employees who were previously covered under any benefits of this plan and who have since ceased to participate in these benefits must submit evidence of insurability and be accepted by SSQ to obtain coverage once again.

b) Compulsory participation
(if voted for by the certification unit) (options II O or II O+)

The insurance for new employees comes into force on the date they become eligible.

When the certification unit submits written notice to SSQ that the majority of its members have voted in favour of compulsory participation, insurance for employees not already participating in Optional Plan II – Long Term Disability Insurance comes into force on the first day of the pay period following the date the vote is held, with the option chosen (options II O or II O+).

Coverage under Optional Plan II - Long Term Disability Insurance is not available to participants age 58 and over. Any coverage in force terminates at age 58 for options II F and II O and at age 63 for option II O+.

4.8 Continuation of coverage and waiver of premiums during a total disability period

No premiums shall be payable by the participant as of the first day of the pay period that coincides with or follows the 6th day of absence from work following the onset of total disability.

Insurance is maintained in force (without the payment of premiums) for the duration of the same total disability period, until no later than any of the following dates:

Plan or coverage	Waiver termination
• Health Plan • AD&D benefit of Optional Plan I – Life Insurance • Spouse's and Dependent Children's Life Insurance of Optional Plan I – Life Insurance	3 years after the onset of total disability until no later than the date of the 71st birthday
Notwithstanding the above-mentioned period of 3 years, the maximum duration of waiver of premiums for participants who become totally disabled on or after January 1, 2015, may be extended to 4 years if these participants still have their employee status with the same employer. If any of the above-mentioned benefits is terminated for all the eligible employees, it is also terminated for the employees on disability.	
• Participant's Life Insurance of Optional Plan I – Life Insurance	• At age 65, if the participant becomes totally disabled before age 62 • 3 years after the onset of total disability, until no later than age 71, if the participant becomes totally disabled at age 62 or over
• Optional Plan I (participant's and spouse's optional life insurance)	• At age 65
• Optional Plan II - Long Term Disability Insurance	At the age the participant's coverage under this benefit would have terminated, if it were not for total disability
For participants who became totally disabled before January 1, 2015, the above-mentioned limit of 3 years does not apply to periods during which they are receiving a full income replacement indemnity under the Quebec *Act respecting industrial accidents and occupational diseases*. For participants who become totally disabled on or after January 1, 2015, the maximum duration of the waiver of premiums is equal to 4 years.	

In the event that the same total disability period persists for more than 2 years, the totally disabled participant must submit an application for a waiver of premiums to SSQ in order to continue to benefit from the waiver and insurance coverage.

These provisions regarding waiver of premiums do not apply to employees benefiting from a preventive leave related to pregnancy or breastfeeding and approved by the CNESST. In addition, they do not apply to disabled employees on a temporary work assignment who are receiving the equivalent of 100% of their salary prior to the onset of disability.

4.9 Temporary absences from work

4.9.1 Partial unpaid leave

Participation in the group insurance plan is maintained. Employers and participants pay their respective premiums, based on the salary employees would have received if not benefiting from the partial unpaid leave. The amounts of insurance in force are also maintained on the basis of this salary.

4.9.2 Authorized paid leave and authorized unpaid leave not exceeding 28 days (including suspension)

Participation in the group insurance plan is maintained. Employers and participants pay their respective premiums. The total premium is paid to SSQ through the employer.

4.9.3 Authorized unpaid leave over 28 days (including suspension)

Participation in the group insurance plan is suspended for the duration of the authorized leave, with the exception of Health Plan I. However, participation in all other plans (Health coverage package already in force, Life and Disability **indissociably**) can be maintained upon the participant's request. Participants must pay the entire premium (both employee and employer contributions). **However**, the Quebec *Act respecting labour standards* requires employers to continue to pay their contribution in the case of a leave for family or parental reasons.

Participants must notify their employer in writing of their decision to maintain participation prior to the start of their unpaid leave. **Arrangements for the payment of premiums must be made with the employer to ensure that coverage is not interrupted due to non-payment of premiums.**

For participants who maintain participation in Health Plan I only, the previous coverage package is automatically reinstated when they actively return to work.

4.10 Other types of absences

4.10.1 Deferred salary leave plan:

a) During the leave contribution period

Participation is maintained.

For Optional Plan I – Life Insurance and Optional Plan II – Long Term Disability Insurance, the insurable salary is that agreed upon between the participant and the employer in the deferred salary leave plan agreement.

SSQ must be notified of the insurable salary agreed upon before the start of the deferred salary leave, i.e., before the start of the contribution period and not the period of leave itself. Premiums and benefits are therefore based on the insurable salary agreed upon.

b) During the period of the leave

Participation is suspended for the duration of the authorized leave, with the exception of Health Plan I. However, participation in all other plans (Health coverage package already in force, Life and Disability **indissociably**) can be maintained upon the participant's request. Participants must pay the entire premium (both employee and employer contributions).

Arrangements for the payment of premiums must be made with the employer before the start of the leave so as to ensure that coverage under Health Plan I or all plans is not interrupted. The insurable salary is as defined in paragraph a) above.

4.10.2 Phased retirement program

Participation in Health Plan I must be maintained.

If employees maintain participation in all plans (Health coverage package already in force, Life and Disability **indissociably**), the insurable salary for the purposes of Optional Plan II is the salary actually received during the phased retirement program. For Optional Plan I - Life Insurance, the insurable salary is the salary that employees would have received had they not been participating in the phased retirement program.

The premiums for these plans are established based on the salary actually received.

- If the duration of the program is 24 months or less, participation in the Long Term Disability Insurance Plan ceases when the program begins.

- If the duration of the program is over 24 months, participation in the Long Term Disability Insurance Plan ceases no later than 24 months prior to the end of the program initially planned.

4.10.3 Dismissal grievance

In such a situation, participants MUST maintain participation in Health Plan I and, if applicable, MAY maintain participation under the Health coverage package already in force and Life **plans indissociably** by paying the total premium provided for in the contract (both employee and employer contributions) until the final decision is made.

Participation in Optional Plan II – Long Term Disability Insurance is suspended until the decision is made in arbitration. If the decision is favourable to the employee, premiums for this plan are payable retroactive to the date of the dismissal and any disability that began during the period in question is recognized by SSQ.

4.10.4 Procedure during settlement of litigation regarding a disability not recognized by the employer

Insurance plans are maintained in force without payment of premiums until the earliest of the following:

- the date the insured actively returns to work;
- the date the employee withdraws the grievance;
- the date arbitration is made or an employer/union decision is made;
- the date the waiver of premiums would have terminated if total disability had been fully recognized by the employer.

4.10.5 Dependent child on sabbatical school leave

Dependent children between 18 and 25 years old who are on a sabbatical school leave can maintain their insurance coverage provided:

- a written request is submitted to SSQ before the beginning of the leave;
- the request specifies the start date of the sabbatical leave and its duration.

Each dependent child is only eligible for one sabbatical leave.

The leave may not exceed 12 months, subject to eligibility for RAMQ, and must end at the beginning of a school year or term (September or January).

4.10.6 Preventive leave and maternity leave (21 weeks)

Participation in insurance is maintained as though participants were at work.

4.11 Termination of insurance

4.11.1 Participants

a) All plans

Insurance terminates, subject to provisions regarding the waiver of premiums, on the earliest of the following dates:

- The date on which the contract ends.
- The date on which the participant ceases to be eligible for the Health Plan (termination of insurance certificate).
- The due date of any unpaid premiums.
- The date the participant retires.

b) Health Plan

Insurance terminates on the first day of the pay period that follows the acceptance of a request for exemption from the Health Plan.

c) Optional Plan I – Life Insurance

Insurance terminates on the earliest of the following dates:

- The end date of the premium period during which an "Application/ Request for Change" form is submitted to the employer, indicating the participant's decision to terminate participation in basic or optional life insurance.
- **For Optional Life Insurance**, the date on which the participant **reaches age 65**.

Termination of the Participant's Basic Life Insurance brings about termination of the Participant's and Spouse's Optional Life Insurance.

d) Optional Plan II – Long Term Disability Insurance

When participation is optional (option II F), insurance terminates on the earliest of the following dates:

- The end date of the premium period during which an "Application/ Request for Change" form is submitted to the employer, indicating the participant's decision to terminate participation.
- The date on which the participant reaches age 58.

When participation is compulsory, insurance terminates on the earliest of the following dates:

Option II O

The date on which the participant reaches age 58.

Option II O+

The date on which the participant reaches age 63.

The date the employer receives a written request and supporting documents attesting the employee's right to opt out (refer to 4.3.3 for the conditions related to the right to opt out).

However, when the plan has been in force for a minimum period of 36 months and the members of a certification unit vote in favour of terminating compulsory participation, the plan ceases to be compulsory on the first day of the pay period that follows the date of the vote.

All employee members of the certification unit remain insured and may terminate their insurance on an individual basis in accordance with the provisions of option II F.

However, it is possible to cease participation in option II O before the end of the minimum period of 36 months if the certification unit votes in favour of option II O+. At that time, the minimum period of participation begins again for option II O+. If the certification unit votes in favour of changing from option II O+ to option II O, the minimum period of participation of 36 months must be completed. Any change comes into force on the first day of the pay period following the date the vote is held.

4.11.2 Dependents

a) Health Plan

Insurance terminates on the earliest of the following dates:

- The date the participant's insurance terminates.
- The date the dependents cease to be eligible.
- The date the participant opts for an individual or single-parent coverage status.

b) Optional Plan I – Life Insurance

Subject to the waiver of premium provisions, insurance terminates on the earliest of the following dates:

- The date the participant's insurance terminates.
- The end date of the premium period during which an "Application/Request for Change" form is sent to the employer, indicating the participant's decision to terminate participation in Spouse's and Dependent Children's Life Insurance or Spouse's Optional Life Insurance.
- The date the Participant's Basic Life Insurance terminates, for Spouse's Optional Life Insurance.
- The date the participant reaches age 65 for Spouse's Optional Life Insurance.

4.12 Life insurance conversion privilege

The group life insurance of someone who ceases to belong to the group of persons eligible under the life insurance described in this document, e.g. in cases of resignation or termination of the insurance following the end of a waiver of premiums, may be converted into an individual life insurance without evidence of insurability, provided the written request is submitted to SSQ within 31 days following the date the person ceases to be eligible for coverage under the group plan and provided the entire first premium has been paid. It is possible to obtain a one-year term life insurance that can be converted into a whole or mixed life insurance policy normally offered by SSQ or in accordance with applicable legislation.

For an insured **under age 65**, the maximum amount of individual life insurance that can be converted cannot be higher than the lesser of the following amounts:

- $400,000
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (Refer to section 4.13).

For an insured **age 65 or over**, the maximum amount of individual life insurance that can be converted cannot be higher than the lesser of the following amounts:

- $25,000
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (Refer to section 4.13), or under any other group insurance contract.

Individual life insurance policies issued after having exercised this conversion privilege do not provide for accidental death and dismemberment insurance nor for waiver of premiums.

4.13 Retiree – Life Insurance for the Retiree and the Spouse of the Retiree

In order to obtain life insurance for themselves and their spouse, participants who retire and those whose life insurance terminates as a result of retirement after having been maintained during their total disability must notify SSQ of their intention by submitting the life insurance application form provided in the retirees' life insurance booklet. This booklet is available from your employer or SSQ or on the ACCESS | Plan members Web site at **ssq.ca**. This form must be submitted to SSQ **within 60 days** following the date of retirement or following the termination of life insurance for disabled participants. Participants are encouraged to obtain a copy of the booklet well in advance to ensure that this deadline is respected.

This benefit is also available to employees not disabled at the time of retirement and who were not participating in SSQ's Optional Plan I but who were participating in the self-insured plans under the collective agreement, provided their application is submitted within the above-mentioned deadline of 60 days.

4.14 Rehired retiree

Retirees who are rehired can maintain the life insurance coverage they hold under the retiree's Optional Life Insurance plan for themselves and their spouse, as the case may be. However, they do not become eligible for the other coverage of the group insurance contract.

5 - HOW TO SUBMIT CLAIMS

The procedure and deadlines for submitting claims are described in this section. 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 **ACCESS | Plan members** at **ssq.ca/access**.

2 When registering on **ACCESS | Plan members**, 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 **ACCESS | Plan members** web site, 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 ACCESS | Plan members web site.

- 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
- Find information on Travel Insurance and Trip Cancellation Insurance and on Life Insurance for retirees and their spouses.

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.

5.1 Health Insurance

All health insurance claims must be received by SSQ no later than 12 months after the date the eligible expenses are incurred. Claims not received on time will all be declined by SSQ.

5.1.1 Prescription drug expenses

Insureds must present their insurance card to the pharmacist. The pharmacist will immediately validate whether the drug expenses are eligible for reimbursement.

a) Eligible prescription drugs

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.

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.

b) First use

When the insurance card is used for an insured member of the participant's family for the first time, the pharmacist must register the first name and date of birth of this insured person. Proof of age may be required by the pharmacist.

c) Dependent children ages 18 to 25, inclusive, studying full-time

For dependent children ages 18 to 25, inclusive, a school attendance statement must be presented to SSQ once every school year (September 1 to August 31) for the insured's claim to be processed directly at the pharmacy.

The school attendance statement can be submitted on the ACCESS | Plan members Web site, by calling SSQ Customer Service, or by writing to SSQ at the address specified in section 5.5. SSQ reserves the right to request proof of school attendance.

If SSQ does not receive this statement before September 30, the child will not be considered as insured until it is received. An explanatory message will appear on the receipt issued by the pharmacist when the drugs are purchased.

Insureds who cannot use their insurance card (e.g.: forgotten, lost, pharmacist does not participate in the electronic claims submission service) can use the claim form available on SSQ's Web site at **ssq.ca** and on the **ACCESS | Plan members** Web site and submit it to SSQ with the original receipts. As SSQ does not return receipts, participants are advised to always keep copies for their records.

Receipts from the pharmacy must mention 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. In addition, invoices must be duly paid.

Claims must be sent to SSQ at the address specified in section 5.5.

5.1.2 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 au 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.

5.1.3 Expenses covered under 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 or the form provided by the dentist. These claims can be submitted on the **ACCESS | Plan members** Web site or by writing to SSQ at the address specified in section 5.5.

5.1.4 Other expenses covered under Health insurance

Many claims can be submitted via the **ACCESS | Plan members** Web site. Participants can also use their smartphone and the free **SSQ Mobile Services** application.

Claim forms are also available on SSQ's Web site at **ssq.ca**, a customized version of which is also available on the **ACCESS | Plan members** Web site. These claim forms can be mailed to SSQ with the original receipts. As SSQ does not return receipts, participants are advised to always keep copies for their records.

All claims must include the certificate number. Also, the patient's name and the dates of the visits or treatments received must be clearly indicated on the receipts and, when applicable, the name, address and professional association membership number of the practitioner consulted.

SSQ's address is specified in section 5.5.

5.2 Travel Insurance and Assistance and Trip Cancellation Insurance

Information on how to submit claims for Travel Insurance and Assistance and Trip Cancellation Insurance is available in a separate electronic format document on the **ACCESS | Plan members** Web site.

5.3 Participant's, Spouse's and Dependent Children's Life Insurance

A copy of the life insurance claim form may be obtained directly from SSQ. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. For more information, insureds can consult section 5.5.

5.4 Long Term Disability Insurance

Claims for Long Term Disability Insurance benefits must be submitted to SSQ no later than 90 days before the expected start date of benefit payments. To file such claims, the insured must complete the disability insurance claim form available from the employer or from SSQ.

Claims must be submitted even for insureds who receive disability benefits from other plans (e.g. CNESST, Retraite Québec).

5.5 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, Life Insurance Company Inc.
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 8:30 a.m. to 4:30 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

Change of address

Do not forget to inform SSQ of any change of address. To do so, use the **ACCESS | Plan members** Web site or contact SSQ's Customer Service department.

6 - PERSONAL INFORMATION PROTECTION

6.1 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, Life Insurance Company Inc., 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.

6.2 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 coverage and the quality of the services SSQ can offer.

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

Appendix 1 – Special provisions for employees working 25% or less of full time

Appendix 1 outlines specific provisions that apply only to employees working 25% or less of full time. Otherwise, the general provisions of the insurance booklet shall apply.

The self-insured plans under the collective agreement are the standard life insurance and short term disability insurance plans which employees working 25% or less of full time may choose to participate in or not.

General rule

Employees who choose not to participate in the self-insured plans under the collective agreement cannot participate in Health Plan II or Health Plan III or in the other life insurance and disability insurance plans offered by SSQ.

However, the provisions described in this booklet apply to participation in Health Plan I.

For employees who have chosen to participate in the self-insured plans under the collective agreement, the provisions described in the booklet apply for as long as they are working 25% or less of full time.

Health Plan

Employees working more than 25% of full time may decide to opt out of Health Plan II or Health Plan III if notified by their employer that their working hours for the reference period have been reduced to 25% or less of full time. This decision takes effect the following January 1. Employees must notify their employer of their decision within 10 days following receipt of notice from the employer specifying the time worked during the reference period. If they do not inform the employer of this choice, their participation in Health Plan II or Health Plan III will be maintained and the provisions described in the booklet will apply.

Optional Plan I – Life insurance

The participant's life insurance coverage and spouse's and dependent children's life insurance coverage under Optional Plan I are automatically granted to all employees whose percentage of time worked is increased to more than 25% of full time (this coverage becomes effective on the following January 1, unless the participants indicate in writing that they wish to opt out).

Optional Plan II – Long term disability insurance

The evidence of insurability normally required for option II F when making an application or request for change is not required **when the application is submitted no later than December 1 (to become effective the following January 1), in the case of initial participation in the self-insured plans under the collective agreement, or a return to participation in these plans if the participant has never been enrolled in the long term disability insurance plan or when the percentage of time worked is increased to more than 25% of full time.**

The plans in question become effective if the employee is at work or able to work on January 1, otherwise the effective date is delayed until the employee actively returns to work. This delay does not apply to Optional Plan I – Spouse's and dependent children's life insurance.

CONTACT US

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SSQ Head Office

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

Toll free: 1-888-651-8181

Please keep this insurance booklet for future reference.

SSQ Financial Group

Values in the right place

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