Version finale

SSQ Financial Group

We thrive on mutual trust

Contract Y9999

Management Personnel of the Quebec Public
and Parapublic Sectors

January 2013

The Intersectorial parity committee on insurances (IPC), together with SSQ, Life Insurance Company Inc., is pleased to present this booklet describing the main features of the benefits available to you under the group insurance plan for management personnel of the Quebec public and parapublic sectors.

This booklet is divided into two sections. The first (grey pages) briefly describes the plans self-insured by the Quebec government that are part of your working conditions. The second describes the group insurance plans underwritten by SSQ[1] that round out the Quebec government's self-insured plans.

Please read this booklet carefully. It describes the benefits you are entitled to. If you have any questions concerning your insurance, contact the personnel department of the organization where you work.

This document has been prepared for information purposes only and has no contractual value. The insurance contracts alone can be used to settle legal questions.

In this document, the masculine form is used to designate both men and women.

COMPOSITION OF THE INTERSECTORIAL PARITY COMMITTEE (IPC):

GOVERNMENT REPRESENTATIVES	**MANAGEMENT ASSOCIATION REPRESENTATIVES**
Co-chairperson	Co-chairperson
Secretary of the committee	
Actuary	1 representative for retirees
PUBLIC SERVICE AND TREASURY BOARD	
1 representative	1 representative
HEALTH AND SOCIAL SERVICES	
2 representatives	3 representatives
EDUCATION	
3 representatives	2 representatives

TO CONTACT THE MEMBERS OF THE INTERSECTORIAL PARITY COMMITTEE
Secretariat of the Intersectorial Parity Committee
875 Grande Allée East, Suite 100
Quebec QC G1R 5R8

assurances.cadres@sct.gouv.qc.ca

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[1] Please note that in this booklet the name SSQ is used to designate SSQ, Life Insurance Company Inc.

Cette brochure est disponible en français.

Save on your medication costs by shopping around!

By shopping around for your medication, you'll spend less and have a positive impact on your group plan' s premium cost. It's a fact that the differences in cost from one phamacy to another can be significant. For this reason we recommend that you get cost estimates on your medication at more than one pharmacy. Then you'll be in a better position to choose the quality of service and price that's right for you.

A friendly tip from your committee

TABLE OF CONTENTS

Page

YOUR PLAN AT A GLANCE i

PLANS SELF-INSURED BY THE QUEBEC GOVERNMENT: 1
- I- Uniform life insurance plan 1
- II- Survivor's pension plan 1
- III- Short term disability insurance plan 3

PLANS INSURED BY SSQ 5

1- General information: insured plans 5
- 1.1 Eligibility 5
- 1.2 Participation in the Group Insurance Plan 5
- 1.3 Exemption and termination of the exemption entitlement 7
- 1.4 Participant 8
- 1.5 Insureds 8
- 1.6 Beneficiary 9
- 1.7 Individual, single-parent or family coverage status 10
- 1.8 Changes to coverage status 10
- 1.9 Smoker/non-smoker status 11
- 1.10 Earnings 11
- 1.11 Maintaining insurance without payment of premiums and waiver of premiums 12
- 1.12 Temporary absence from work 12
- 1.13 Sabbatical leave with deferred earnings 16
- 1.14 Measures for end of agreement, employment or contract, Reduction of surplus or leave of absence, early retirement (total or gradual) or progressive retirement 16
- 1.15 Termination of insurance 16
- 1.16 Extension and conversion privilege 17
- 1.17 Prepayment entitlement - Life Insurance Plans (Compulsory Basic and Optional) 19
- 1.18 Provisions in force during disability 19
- 1.19 Currency 19

2- Compulsory Basic Accident and Health Insurance Plan 20
- 2.1 Hospital expenses (reimbursed at 100%) 20

2.2 Prescription Drugs and Paramedical Expenses........................20
2.3 Exclusions........................29
2.4 Limitations........................30
2.5 Coordination........................30

3- Compulsory Basic Life Insurance Plan........................31
3.1 Participant’s Life Insurance........................31
3.2 Spouse’s and Dependent Children’s Life Insurance........................31
3.3 Participant's, Spouse's and Dependent Children's Accidental Dismemberment Insurance........................31
3.4 Exclusion in the event of accidental dismemberment........................31

4- Compulsory Basic Long Term Disability Insurance Plan........................32
4.1 Amount of pension........................32
4.2 Elimination period........................32
4.3 Duration of benefits........................32
4.4 Coordination of benefits........................32
4.5 Pension plan contribution........................32
4.6 Definition of total disability........................33
4.7 Period of total disability (after 104 weeks)........................33
4.8 Indexation........................33
4.9 Rehabilitation program........................33
4.10 Termination of benefits........................34
4.11 Right of Appeal........................34
4.12 Exclusions........................35

5- Compulsory Additional Long Term Disability Insurance Plan (CAP)........................36
5.1 Eligibility for benefits........................36
5.2 Benefits........................36
5.3 Payment of benefits........................37
5.4 Termination of benefits........................37
5.5 Pension Plan contribution........................38
5.6 Life insurance and survivor’s pension benefits........................38
5.7 Exclusion........................38

6- Optional Life Insurance Plan........................39
6.1 Participant's Optional Life Insurance........................39
6.2 Spouse’s Optional Life Insurance........................39
6.3 Exclusions........................39

7- Description of Travel Insurance and Trip Cancellation Insurance........................40
7.1 Travel Insurance........................40
7.2 Travel Assistance........................42

7.3 Trip Cancellation Insurance..43
7.4 Definitions applicable to Trip Cancellation Insurance 46
7.5 Exclusions, limitations and coordination 47

8- How to submit a claim 50
8.1 Hospital and medical expenses...50
8.2 Prescription drug expenses...50
8.3 Other accident and health insurance expenses.........................52
8.4 Hospital or medical expenses related to a workplace or automobile accident..52
8.5 Participant's, Spouse's and Dependent Children's Life and Accidental Dismemberment (AD) Insurance............................52
8.6 Long Term Disability Insurance...53
8.7 Travel Insurance and Trip Cancellation Insurance...................53
8.8 Personal information and insurance file....................................54

9- Insurance Plan for Retired Management Personnel 55
9.1 Eligibility 55
9.2 Application Period..55

10- SSQ's Online Services 57
10.1 ACCESS | Plan members 57
10.2 SSQ Mobiles Services..57

11- Good things to know 58

12- Rates 59

YOUR PLAN AT A GLANCE

Benefit	Reimbursement limitations	Prescription required	Percentage reimbursed
COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN			
Travel Insurance and Assistance	Maximum reimbursement of $5,000,000 / trip / insured	YES	100%
Trip Cancellation Insurance	Maximum reimbursement of $5,000 / trip / insured	Medical justification	
Hospital expenses in Quebec	Semi-private room, no limit on days	NO	
Medical expenses outside Quebec	Three (3) times the amount paid by the RAMQ	Prior authorization by the RAMQ	
Hospital expenses outside Quebec	One (1) time the amount paid by the RAMQ	Prior authorization by the RAMQ	
Transportation and accommodation fees outside Quebec	Maximum reimbursement of $5,000 / calendar year / insured	Prior authorization by the RAMQ	
Prescription drugs	Available by prescription only	YES	75% on the first $2,000, 100% of subsequent amounts
Home care:	Within 30 days of a hospitalization		
- Nursing care	Eligible expenses of $60 / day / insured	YES	
- Transportation expenses	Eligible expenses of $30 / trip / maximum of 3 trips / week	YES	
- Convalescent home	Eligible expenses of $125 / day / insured	YES	
- Home assistance services	Eligible expenses of $60 / day / insured	YES	
- Childcare expenses	Eligible excess expenses of $25 / day / child	YES	

Benefit	Reimbursement limitations	Prescription required	Percentage reimbursed
Wheelchair - hospital bed	Temporary use only	YES	75% on the first $2,000, 100% on subsequent amounts
Artificial limbs and external prostheses	In compliance with customary and reasonable standards of current practices	YES	
Trusses, corsets, crutches, splints, casts, foot orthoses (specialized laboratory) and other orthoses	In compliance with customary and reasonable standards of current practices For foot orthoses, refer to the price schedule of the *Association nationale des orthésistes du pied*	YES	
Blood glucose monitor	Eligible expenses of $300 / 36 months / insured	YES	
Therapeutic devices	In compliance with customary and reasonable standards of current practices	YES	
Insulin pump	Eligible expenses of $7,500 / 60 months / insured for the purchase of the pump Eligible expenses of $4,000 / calendar year / insured for maintenance expenses (tubes and catheters)	YES	
Percutaneous or transcutaneous electrical nerve stimulator (PENS/TENS)	Eligible expenses of $1,000 / 60 months	YES	
Wig required following chemotherapy	Maximum reimbursement of $500 / 48 months / insured	YES	
Orthopaedic shoes (specialized laboratory)	In compliance with customary and reasonable standards of current practices	YES	
Electrocardiograms, X-rays (including scanner), magnetic resonance, ultrasounds and lab tests	In compliance with customary and reasonable standards of current practices	YES	

Benefit	Reimbursement limitations	Prescription required	Percentage reimbursed
Respirators and oxygen	In compliance with customary and reasonable standards of current practices	YES	75 % on the first $2,000, 100% on subsequent amounts
Hearing aids	Eligible expenses of $1,000 / 48 months / insured	NO	
Nurse	In compliance with customary and reasonable standards of current practices	YES	
Plastic surgery	Following an accident	YES	
Support stockings	21 mm Hg or more, 3 pairs / calendar year / insured	YES	
Sclerosing injections (substance) Professional fees	Eligible expenses of $20 / treatment / day / insured Eligible expenses of $25 / treatment / day / insured	YES	
Dental surgery required following accident	Treatment received during the 12 months following the accident	NO	
Ambulance	In compliance with customary and reasonable standards of current practices	NO	
Vaccines	Eligible expenses of $200 / calendar year / insured	NO	
Transportation and accommodation in Quebec	Maximum reimbursement of $1,000 / calendar year / insured	YES	
Detoxification treatment	Eligible expenses of $50 / day, maximum of 30 days / calendar year / insured	YES and in a recognized establishment	
Optometrist or ophthalmologist	Maximum reimbursement of $50 / 24 months / insured	NO	

COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN - Professional fees			
Grouping	**Eligible expenses per treatment**	**Maximum reimbursement per insured, per calendar year and per grouping**	**Percentage reimbursed**
Dietitian	$30	$500	75% on the first $2,000, 100% on subsequent amounts
Naturopath Homeopath Phytotherapist	$30 $30 $30	$600	
Acupuncturist Osteopath Kinesitherapist Orthotherapist Massage therapist	$30 $30 $30 $30 $30	$600	
Chiropractor*	$30	$500	
Physiotherapist	$40	Unlimited	
Audiologist Hearing aid specialist	$60 $40	$500	
Occupational therapist	$40	$500	
Speech language pathologist	$60	$600	
Podiatrist	$40	$500	
Psychiatrist Psychoanalyst Psychologist Social worker Marital and family therapist Career counsellor	In compliance with customary and reasonable standards of current practices	$1,000	

No medical prescription is required for reimbursement of the professional fees indicated in the above table.

* Fees for X-rays taken in a chiropractor's office are limited to $50 / year, subject to a $500 maximum reimbursement per calendar year, per insured.

COMPULSORY BASIC LIFE INSURANCE PLAN	
- Participant's Basic Life Insurance:	50% of salary
- Spouse's Life Insurance:	$17,200
- Dependent Children's Life Insurance:	$5,000 / child
- Participant's, Spouse's and Dependent Children's Accidental Dismemberment Insurance	
COMPULSORY BASIC LONG TERM DISABILITY INSURANCE PLAN	
COMPULSORY ADDITIONAL LONG TERM DISABILITY INSURANCE PLAN (CAP)	
PARTICIPANT'S AND SPOUSE'S OPTIONAL LIFE INSURANCE PLAN	

Please refer to the text in the booklet for specific details concerning each benefit and applicable exclusions and limitations.

PLANS SELF-INSURED BY THE QUEBEC GOVERNMENT:

- UNIFORM LIFE INSURANCE PLAN
- SURVIVOR'S PENSION PLAN
- SHORT TERM DISABILITY INSURANCE PLAN

The Quebec government covers these plans for management personnel of the Quebec public and parapublic sectors. You pay no premiums under these plans.

Please note that this document has been prepared for information purposes only and has no legal value. Only the full texts approved by the appropriate authorities can be used to specifically determine the benefits of these plans and how they apply and, if required, settle any dispute concerning these plans.

Contact your employer for further information.

I- UNIFORM LIFE INSURANCE PLAN

A- Benefit

Management personnel benefit from life insurance coverage of $6,400, payable to the legatees designated in a will or, failing that, to the heirs as defined in the Civil Code. This amount is reduced to $3,200 for participants working part time.

B- Death benefit claim

To obtain payment of the amount of coverage provided by the Quebec government, the heirs must complete the *Application for a survivor's benefit* form available from their employer or from the CARRA. The form must be sent to:

Commission administrative des régimes
de retraite et d'assurances (CARRA)
475 rue Saint-Amable
Quebec, QC G1R 5X3
Telephone: 418-643-4881 for the Quebec City area
1-800-463-5533 for other areas (toll free)

II- SURVIVOR'S PENSION PLAN

Survivor's pensions are payable monthly, starting on the first day of the month during which a participant with a spouse or dependent children dies.

A- Spouse's pension

This pension is payable to the spouse, as defined in the *1-General Information* section, until his or her death.

- The survivor's pension will be paid to the spouse as named by the participant to the Insurer. Any change of spouse should be made using the *Declaration of spouse* form (FV3435), which can be obtained from your employer.

The initial amount of the pension is equal to 40% of the participant's monthly earnings and is reduced by the initial amount of the similar pension payable under the Quebec Pension Plan.

B- Dependent children's pension

This pension is payable to the dependent children, as defined in the *1-General Information* section, or to their guardian.

When a spouse's pension is payable, the initial amount of the dependent children's pension is equal to 15% of monthly earnings for all of the dependent children combined.

If there is no spouse or if the spouse who had been receiving a pension dies, the initial amount of the dependent children's pension is equal to 15% of monthly earnings for the first dependent child and to 10% of the same earnings for each additional dependent child.

However, the initial amount of the pensions payable to the spouse and dependent children can never exceed 55% of the participant's monthly earnings at the time of his death.

C- Earnings used to calculate the pension

These pensions are based on the participant's monthly earnings at the time of his death and, if applicable, on the Compulsory Additional Long Term Disability Insurance Plan (CAP).

If a participant is totally disabled at the time of his death, pensions are calculated in accordance with the earnings on which the short term disability benefit is based or, if the disability has lasted for more than 104 weeks, in accordance with the insurable earnings on which calculation of the Long Term Disability Benefit is based.

D- Survivor's pension claims

All requests for survivor's pension payments must be sent in writing to SSQ.

E- Exemption

A participant who does not have a spouse or dependent children and who provides evidence that no benefits will be payable under the survivor's pension plan may be exempted from participation in this plan during the following periods:

1- unpaid absence or leave for more than 30 days; or

2- period not worked at the time of an unpaid partial leave that is spread out over a period of more than 30 days; or

3- period not worked within the context of an agreement of reduced working time; or

4- non-rehiring, termination of employment or dismissal contested by appeal.

The participant must file his request for exemption with his employer under the circumstances described in items 1, 2 and 3 before the leave starts, or with SSQ under the circumstance described under item 4, at the time of submitting his request for maintaining the insured plans for the duration of this appeal.

Under the circumstances described above, the participant must use the form entitled *Request for exemption of participation in the survivor's pension plan* that can be obtained from his employer.

III- SHORT TERM DISABILITY INSURANCE PLAN

This plan covers the first 104 weeks of disability for management personnel. Your employer is responsible for paying the benefits under this plan.

A- Disability

Total disability is defined as a state of incapacity resulting from illness, accident or serious complications arising from pregnancy or from a surgical procedure directly related to family planning requiring medical care, and rendering the participant totally incapable of carrying out the usual duties of his employment or any other employment with similar remuneration offered to him by the employer.

No total disability period is recognized if resulting from self-inflicted injury or illness, alcoholism or drug addiction, active duty in the armed forces or active participation in a riot, insurrection, offences or criminal acts.

In the case of alcoholism or drug addiction, a total disability period is recognized if during such period, the participant receives treatment or medical care with a view to rehabilitation.

B- Benefits under the plan

First period

During the first week of total disability, the participant receives the earnings he would have been entitled to had he been at work.

Second period

From the second week of total disability to the 26th week from the onset of the disability, the disability insurance benefit is equal to 80% of the earnings the participant would have been entitled to had he been at work.

Third period

From the 27th week of total disability up to the 104th week from the onset of the disability, the disability insurance benefit is equal to 70% of the earnings the participant would have been entitled to had he been at work.

- For a participant whose rehabilitation started during the first 104 weeks of the disability, benefits are equal to 90% of the participant's earnings for the working period provided for in the rehabilitation plan.

C- Coordination of benefits

The amount of the benefits payable under the short term disability insurance plan is reduced by any disability benefits payable under the Quebec Automobile Insurance Act, the Quebec Pension Plan, the Act respecting industrial accidents and occupational diseases and any other pension plan to which the employer contributes.

PLANS INSURED BY SSQ

1- GENERAL INFORMATION: INSURED PLANS

1.1 ELIGIBILITY

The employer determines, based on sectoral working conditions policies, which management personnel are eligible for insurance.

Management personnel working less than 25% of full time and those who participate in the Retired Management Personnel of the Quebec Public and Parapublic Sectors or who receive a pension administered by CARRA (except for the Régime de retraite des élus municipaux (RREM), the Régime de retraite des maires et des conseillers des municipalités (RRMCM) and the Régime de retraite des membres de l'Assemblée nationale (RRMAN)) are not eligible for this group insurance plan.

Provided the manager is at work, participation in the plan begins:

- one (1) month after the date he began employment as a full-time manager;
- three (3) months after the date he began employment as a part-time manager.

The above-mentioned waiting periods do not apply to any individual who had been working for an employer in the Quebec public and parapublic sectors in the 30 days prior to his date of employment.

1.2 PARTICIPATION IN THE GROUP INSURANCE PLAN

All eligible management personnel must participate in the Compulsory Basic Accident and Health Insurance Plan, the Compulsory Basic Life Insurance Plan and the Compulsory Long Term Disability Insurance plans.

Under Quebec's Act respecting prescription drug insurance, the participant must cover his spouse, dependent children, and any persons suffering from a functional impairment, if applicable, for prescription drug coverage. As this coverage is part of the Compulsory Basic Accident and Health Insurance Plan, coverage under this plan should comply with statutory requirements governing this matter.

Participant aged 65 or over

All modifications to age-based premiums and coverage will take effect on January 1 following or coinciding with the participant's 65th birthday.

Between the participant's 65th birthday and the following December 31, the participant should opt out of the Régie de l'assurance maladie du Québec (RAMQ) plan for prescription drug coverage (otherwise he will be required to pay a premium to the RAMQ without being entitled to coverage). On January 1 of the following year, the participant can register with the RAMQ or remain with SSQ by paying the additional premium.

Management personnel aged 65 or over who register for coverage with the RAMQ must first file their prescription drug claims with the RAMQ to obtain a reimbursement. At that time, the portion paid by the insured is considered an eligible expense by the Insurer, in accordance with the "prescription drug" clause. **The decision to register with the RAMQ is irrevocable.**

Management personnel aged 65 or over who do not register with the RAMQ continue to file their prescription drug claims with SSQ. They must submit their claims to the Insurer in writing and pay the extra premium (every 14 days) indicated in the table of premiums shown at the end of this booklet.

Unless instructions to the contrary are received from the participant, SSQ prescription drug insurance ends on the first January following the participant's 65th birthday.

Spouse who reaches age 65 before the participant

If the spouse turns age 65 before the participant, the spouse has the choice of maintaining prescription drug insurance with SSQ or registering for the RAMQ public plan.

Unless instructions to the contrary are received, SSQ and the RAMQ will automatically assume that a spouse turning age 65 is registered for the RAMQ's public prescription drug insurance plan. The following table explains how to inform SSQ of the spouse's choice upon turning 65:

Spouse remains insured with SSQ for prescription drugs	Spouse is insured with RAMQ for prescription drugs
• Registration in RAMQ's public prescription drug insurance plan happens automatically upon reaching age 65. The RAMQ will therefore have to be informed that the spouse wishes to opt out of the public plan upon turning age 65.	• Registration in RAMQ's public prescription drug insurance plan happens automatically upon reaching age 65. No particular action needs to be taken in relation to the RAMQ.
• SSQ will have to be informed of the spouse's decision. SSQ will maintain the spouse's prescription drug coverage as well as other coverage held under the Basic Accident and Health Insurance Plan.	• No particular action needs to be taken in relation to SSQ. SSQ will maintain the spouse's other coverage under the Basic Accident and Health Insurance Plan, including prescription drugs not covered under the public plan that are eligible for reimbursement by SSQ. In addition, the required amount paid by the spouse (deductible and coinsurance) under the public plan is considered an eligible expense under SSQ's prescription drug provision.

Spouse remains insured with SSQ for prescription drugs	Spouse is insured with RAMQ for prescription drugs
• The participant pays the family premium for the Compulsory Basic Accident and Health Insurance Plan. • No additional premium will be applicable to SSQ coverage for a spouse aged 65 or over.	• The participant pays the family premium for the Compulsory Basic Accident and Health Insurance Plan. • The public plan premium must be paid the next time the spouse files an income tax report.
• This decision is revocable. The spouse may register for the public plan at any time.	• The decision to register for the public plan is **irrevocable**. The spouse will no longer be able to be insured by SSQ for prescription drugs covered under the RAMQ's public plan.

As the Compulsory Basic Accident and Health Insurance Plan does not charge an additional premium for spouses aged 65 or over, the best choice is for the spouse to maintain his prescription drug insurance coverage with SSQ.

1.3 EXEMPTION AND TERMINATION OF THE EXEMPTION ENTITLEMENT

Upon presentation of proof of coverage under a group insurance contract providing benefits similar to the compulsory basic accident and health insurance plan, a manager may be exempted from participation in this plan. However, he must participate in the other compulsory plans (Life and Disability), and may choose to participate in the Optional Life Insurance Plan.

Participants who wish to take advantage of this option must complete the *application or change* form (FV3435) available from the employer and send it to SSQ via the employer. The exemption becomes effective on the date the request is received by the employer and the premium is modified as of the first day of the pay period following or coinciding with this date.

An exempted manager may resume participation in the Compulsory Basic Accident and Health Insurance Plan (Individual, Single-Parent or Family coverage status) without evidence of insurability being required, provided the request is made to SSQ via the employer within **60 days** following termination of the insurance that allowed the manager to be exempted. The insurance then takes effect as of the date of termination of the exemption and the premium is payable as of the first day of the pay period following or coinciding with this date.

After this 60-day period, coverage takes effect on the first day of the pay period following or coinciding with the date on which the request is received by SSQ.

1.4 PARTICIPANT

An employee accepted for insurance and who pays the required premiums.

1.5 INSUREDS

The persons insured are the participant himself, his spouse, their dependent children and any persons suffering from a functional impairment, in accordance with Quebec's Act respecting prescription drug insurance.

1.5.1 Spouse

A spouse is a person who so became following a marriage or civil union contracted legally and recognized as valid by Quebec law or a person who so became by residing permanently for more than one (1) year, or immediately if a child is born of their union, with a person presented publicly as a spouse.

The dissolution of a marriage by divorce or the annulment of a marriage or civil union cancels the status of spouse, as does a de facto separation for more than three (3) months in the case of a union not contracted legally.

When the participant is legally united to another person through marriage or civil union, he may designate to the Insurer some other person as the spouse in lieu of the legal spouse, providing that the designated spouse is covered under the definition of a common-law spouse provided above. The designation of this person takes effect on the date the Insurer is notified.

1.5.2 Dependent children

A dependent child is a child of the participant, of the participant's spouse or of both, or a child of whom the participant has legal custody or had legal custody when the child became of age or that he had then de facto adopted, who is neither married nor civilly united and dependent on the participant for support and:

- under age 18; or
- under age 26, if a full-time student in an accredited educational institution.

  A declaration of school attendance must be provided to the Insurer via SSQ's ACCESS | Plan Members Web site, by telephone or in writing once every school year (September 1 to August 31) for prescription drug claims to be accepted directly at the pharmacy. SSQ reserves the right to require proof of school attendance; or
- regardless of age, if the child became fully disabled while meeting one of the previous criteria and remained continually disabled since that time.

Quebec's Act respecting prescription insurance **requires** parents who have access to a group insurance plan to cover their dependent children, independently of whether or not they have legal custody, in the case of divorce for example. If both parents are eligible for a group insurance plan, they must reach an agreement between themselves.

Leave from studies for dependent children

For the purposes of the Compulsory Basic Accident and Health Insurance and Compulsory Basic Life Insurance plans, a dependent child who takes an extended leave from studies may retain the status of a dependent so long as he satisfies the following conditions:

- prior to the leave, a written request must be submitted to and accepted by the Insurer before the leave begins;
- the request must indicate the date the leave is to begin along with its duration;
- for each dependent there is a single lifetime entitlement to such a leave;
- the leave may not exceed 12 months, subject to eligibility for the RAMQ, and must end at the beginning of a school year or term (September or January);
- the eligible expenses incurred during such leave may not exceed $1,000,000.

1.5.3 Persons suffering from a functional impairment

A person of age, with no spouse, suffering from a functional impairment as defined in the Regulation respecting the basic prescription drug insurance plan and which occurred while he met the definition of "dependent" under this contract, who is not receiving benefits under a last resort financial assistance program under the Act respecting income support, employment assistance and social solidarity, is living with the participant and over whom the participant or the participant's spouse would exercise parental control if he were a minor.

A person suffering from a functional impairment can only be covered under the Compulsory Basic Accident and Health Insurance Plan.

1.6 BENEFICIARY

A person designated by the participant to whom the amount insured will be paid upon the death of the participant. In the absence of a designated beneficiary, the insured sum is paid to the participant's estate.

Benefits payable on the death of the insured spouse or dependent child are always payable to the participant.

The participant may change beneficiary within the limits provided by law via SSQ's ACCESS | Plan members Web site or by notifying SSQ's Head Office in writing.

1.7 INDIVIDUAL, SINGLE-PARENT OR FAMILY COVERAGE STATUS

One of the following options must be selected for the Compulsory Basic Accident and Health Insurance Plan:

- **Individual** coverage status (covers the participant only);
- **Single-Parent** coverage status (covers the participant, his/her dependent children and person suffering from a functional impairment);
- **Family** coverage status (covers the participant, spouse, their dependent children and person suffering from a functional impairment).

This is an important choice, since the premium payable depends directly on the coverage status chosen. This choice does not affect the other available plans (such as the Spouse's and Dependent Children's Life Insurance Plan provided under the Compulsory Basic Life Insurance Plan described in *Section 3* and the survivor's pension described in *Section II*).

1.8 CHANGES TO COVERAGE STATUS

1.8.1 Increase in coverage status

Coverage status can be increased by changing from **Individual** coverage to **Single-Parent** or **Family** coverage, or by changing **Single-Parent** coverage to **Family** coverage.

Any increase in coverage status for the **Compulsory Basic Accident and Health Insurance Plan** is subject to the following conditions:

a) when a request for Single-Parent coverage status is submitted to the employer within 60 days following the birth or adoption of a child or within 60 days following termination of insurance for dependent children under another group insurance plan with similar coverage:
   - Single-Parent coverage status takes effect retroactive to the date of birth or adoption or termination of insurance.

b) when a request for Family coverage status is submitted to the employer within 60 days following the marriage, acknowledgment of a common-law spouse or termination of the spouse's insurance:
   - Family coverage status takes effect retroactive to the date of the event.

c) when the request for a Single-Parent or Family coverage status is submitted after the periods mentioned in paragraphs a) and b):
   - the requested coverage status takes effect on the date the request is received by SSQ and the premium is payable on the first day of the pay period that follows or that coincides with the date on which the request is received by SSQ.

Please note that upon the birth or adoption of a dependent child, such child is automatically insured if the participant already holds Single-Parent or Family coverage.

1.8.2 Reduction in coverage status

Coverage status can be reduced by changing **Family** coverage to **Single-Parent** or **Individual** coverage, or by changing **Single-Parent** coverage to **Individual** coverage.

However, under Quebec's Act respecting prescription drug insurance, the participant must cover his spouse, dependent children, and any persons suffering from a functional impairment, if applicable, for prescription drug coverage. As this coverage is part of the Compulsory Basic Accident and Health Insurance Plan, coverage under this plan should comply with statutory requirements governing this matter.

For any request to change coverage status, the participant must complete a new *Application and/or change* form, indicating the desired status change, and provide this to his employer.

- the coverage status requested becomes effective as of the date the form is received by the employer, and the premium is payable as of the first day of the pay period coinciding with or following this date.

1.9 SMOKER/NON-SMOKER STATUS

The premium rates for Optional Life Insurance provide for a premium reduction for a participant or spouse who is a non-smoker.

To benefit from this reduction, the participant must complete the *Application and/or change* form (FV3435) and sign the non-smoker declaration provided. This form may be obtained from the employer's human resources department. **Any false declaration may lead to cancellation of coverage.**

To be considered a non-smoker, the person must not have smoked any tobacco products such as cigarettes, cigars, cigarillos or pipes, nor any drugs, during the previous 12 months.

If the participant or his spouse ceases to meet the required conditions, SSQ must be notified in order to correct the case file and premium accordingly.

In each case, a new certificate is issued confirming the status of smoker or non-smoker.

1.10 EARNINGS

Earnings used for insurance purposes are determined in accordance with working conditions.

In the event of total disability, the annual earnings used for insurance purposes are those used for the calculation of benefit payments under the employer's short term disability insurance plan. If the disability lasts more than 104 weeks, the earnings used are the gross earnings at the end of the first 104 weeks of total disability, indexed in accordance with the rules defined in *Section 4.8* of this booklet.

1.11 MAINTAINING INSURANCE WITHOUT PAYMENT OF PREMIUMS AND WAIVER OF PREMIUMS

Any participant who becomes totally disabled remains covered under the compulsory and optional plans without payment of premiums as of the 2nd week of disability and for the duration of his disability.

However, any participant who is totally disabled who takes paid early retirement leave may not benefit from the waiver of premiums during this leave.

In addition, a participant may not benefit from a waiver of premiums during CSST-approved preventive maternity leave.

1.12 TEMPORARY ABSENCE FROM WORK

1.12.1 Leave without pay for 30 days or less - Reduction in work time of 30 days or less

All of the participant’s coverage is automatically maintained in force and the applicable premiums (employee and employer share) continue to be paid to the Insurer in the usual manner.

1.12.2 Temporary unpaid leave - Full-time leave without pay for more than 30 days

In the case of temporary unpaid leave (**including suspension**) or full-time leave without pay for more than 30 days, the participant must maintain his participation in the Compulsory Basic Accident and Health Plans and pay the entire premiums (employee and employer share). Participation in the other insurance plans is automatically suspended. However, if the participant wishes, he may maintain coverage under the other plans **by assuming full payment for all premiums (employee and employer share)** based on the earnings he was receiving immediately before the beginning of his absence.

For a participant who maintains coverage in force, and who then becomes disabled, the disability is considered to have started on the date of the end of the absence or leave.

1.12.3 Partial leave without pay for more than 30 days - Reduction in work time of more than 30 days

Participation in the Compulsory Basic Accident and Health Insurance Plan continues as if the manager were working full time. The participant and the employer assume their respective portions of the premiums for this plan.

Participation in Life Insurance (Compulsory Basic and Optional), Long Term Disability Insurance (Compulsory Basic and CAP), and survivor’s pensions, continues based on the time worked and according to the coverage held immediately before the leave or agreement.

The participant can maintain coverage under these plans based on the time normally worked prior to the beginning of the leave or agreement.

In such a case, he must assume full payment for all premiums (employee and employer share) for the portion of time not worked.

1.12.4 Maternity leave (paid)

All of the participant's coverage is maintained in force without payment of premiums by the participant during the period prescribed by the maternity leave described in the working conditions.

1.12.5 Leave for a birth or a paternity or adoption leave (paid)

All of the participant's coverage is automatically maintained in force and the applicable premiums (employee and employer share) continue to be paid to the Insurer.

Any disability that begins during the period of leave is deemed to have begun when the leave for a birth or the paternity or adoption leave ends.

1.12.6 Parental leave (unpaid)

During an unpaid parental leave, the employee's participation in the Compulsory Basic Accident and Health Insurance is maintained in force for the duration of the leave.

Coverage under the other insurance plans is as follows.

In the case of unpaid parental leave;

a) of a maximum of 2 years immediately following the maternity, paternity or adoption leave; or
b) no more than 52 continuous weeks that must end no later that 70 weeks after the birth or, in the case of an adoption, within 70 weeks after the child has been given over to the employee;

in the case of a full-time unpaid leave, the participant must choose one of the following options:

1. maintain participation in all plans. The premiums are based on the pay the employee would receive if he were working and all provisions apply. The choice to suspend or maintain participation in these plans must be indicated before the leave starts. The Insurer may refuse any request received more than 30 days after the beginning of this type of leave. The choice to suspend participation is irrevocable. The choice to maintain participation may be cancelled by the participant during the leave.

   In the case of any disability period beginning while the participant is insured during an unpaid parental leave, the waiting period for the Compulsory Basic Long Term Disability Insurance Plan and the Compulsory Additional Long Term Disability Insurance Plan is deemed to start on the date of the end of the employee's leave.

2. maintain his coverage under only the Compulsory Basic Accident and Health Insurance Plan for the duration of the leave.

During the first 52 weeks of the full-time unpaid parental leave, the employer and employee pay their respective premiums.

In the case in paragraph a), after the 52nd week, the employee pays both premiums (employee and employer share).

in the case of an unpaid partial leave, the participant must choose one of the following options:

1. maintain participation in all plans he is participating in before the beginning of the leave, based on the time normally worked before the leave. Premiums are based on the earnings the employee would receive if at work and all provisions of the plans apply.

   During the first 52 weeks of an unpaid partial leave, the employer and employee pay their respective premiums.

   After the 52nd week of the unpaid partial leave, the employer and employee pay their respective share of the premiums, for the days worked by the employee, and the employee pays both premiums (employee and employer share), for the unworked days;

2. maintain participation in all plans he is participating in before the beginning of the leave, based on the time worked during the unpaid partial leave. Premiums are based on the salary received during the unpaid partial leave. During the leave, the employer and employee pay their respective share of the latter premiums.

1.12.7 Certain unpaid leaves provided for under sections V.0.1 and V.1 of the Act Respecting Labour Standards

In the case of certain unpaid leaves provided for under sections V.0.1 and V.1 of the Act Respecting Labour Standards, the employee's participation in the Compulsory Basic Accident and Health Insurance Plan is maintained for the duration of the leave.

Coverage under the other insurance plans is as follows

In the case of an unpaid absence up to the maximum duration provided for under the Act Respecting Labour Standards the participant must choose one of the following options.

1. maintain participation in all plans. Choosing to suspend or maintain participation in these plans must be reported at the beginning of the leave. The Insurer may refuse any request it receives more than 30 days after the beginning of such a period of absence. The choice to suspend participation is irrevocable. The choice to maintain participation may be cancelled by the participant during the period of absence.

   In the case of any period of disability beginning while the participant is insured during an unpaid period of absence, the waiting period for the Compulsory Basic Long Term Disability Insurance Plan and the Compulsory Additional Long Term Disability Insurance Plan is deemed to start on the date of the end of the employee's absence.

2. maintain in force only his coverage under the Compulsory Basic Accident and Health Insurance for the duration of the absence. In such a case, the employee's other coverage resumes automatically when he returns to paid work. This provision applies automatically to any participant who has not asked to have his coverage maintained according to the terms described in the previous point subject to the exemption entitlement.

The employer and employee pay their respective premiums based on the pay the employee would receive if he were working and all provisions apply.

When the duration of the unpaid absence reaches the maximum provided for under the Act Respecting Labour Standards, the employee pays the two premiums (employee and employer share).

1.12.8 Non-rehiring, suspension and dismissal contested by appeal

The participant must maintain his participation under the Compulsory Basic Accident and Health Insurance Plan and pay all premiums (employee and employer share). He may, if he wishes, maintain his participation in the Compulsory Basic and Optional Life Insurance plans by assuming payment of the total premiums (employee and employer share). Participation in the Compulsory Long Term Disability Insurance plans (Basic and CAP) is suspended during the contestation.

Regarding the Compulsory Long Term Disability Insurance plans, if the appeal favours the employee and if he is actually reinstated, premiums for these plans are payable by the employer retroactive to the date of non-rehiring, suspension or dismissal contested by appeal, and any disability that began since this date is then recognized.

1.12.9 Request to maintain coverage

A participant who wishes to maintain coverage must submit a request to his employer **before the beginning of one of the above-mentioned absence**. In the case of *Section 1.12.8*, the request must be sent to **SSQ within 90 days** following the event.

When maintaining coverage, it is compulsory to participate in ALL the plans, including the survivor's pension. The participant must assume the cost of this plan, which was set for 2013 at 1.09% of earnings.

In the case of absences provided for in sections V.0.1 and V.1 of the Act Respecting Labour Standards, see clause 1.12.7.

However, a participant who does not have a spouse or dependent children and who provides evidence that no benefits will be payable under the survivor's pension may be exempted from participation in this plan during temporary absences from work as described in this section, according to the conditions determined in the working conditions.

Please note that should a participant **terminate** his participation, this decision is **irrevocable**.

1.13 SABBATICAL LEAVE WITH DEFERRED EARNINGS

Coverage and premiums for all the insurance plans in which the manager participates are maintained, both during the periods of accumulated leave and the period of leave itself, based on the earnings he would have had received had he not participated in the deferred income plan.

Any disability that begins during the period of leave is deemed to have begun on the planned date of return to work.

1.14 MEASURES FOR END OF AGREEMENT, EMPLOYMENT OR CONTRACT, REDUCTION OF SURPLUS OR LEAVE OF ABSENCE, EARLY RETIREMENT (TOTAL OR GRADUAL) OR PROGRESSIVE RETIREMENT

Specific rules for eligibility and participation in insurance plans are applicable at the time of the above-mentioned situations and terminate upon retirement or breach of employment relations.

The participant must contact his employer's personnel department for full details of such a situation.

The general rules for eligibility and participation in insurance plans during these events are described below.

Participation in the Compulsory Basic Accident and Health Insurance Plan is maintained. The participant is responsible for paying his portion of the premiums, and the employer continues to pay its portion. The participant also maintains participation in the Compulsory Basic and Optional Life Insurance plans, as well as in the survivor's pension and all related premiums (employee and employer share) continue to be paid based on the earnings received. In the case of early retirement, premiums and coverage are established based on the earnings received prior to the agreement.

Participation in the Compulsory Long Term Disability Insurance Plans (Basic and CAP) ceases on the start date of the event, except in the event of gradual early retirement or progressive retirement over more than 104 weeks. In these two situations, participation in the Compulsory Long Term Disability Insurance Plans (Basic and CAP) ceases at the 104th week preceding the definitive date of retirement. Premiums and coverage are established based on earnings received.

If the participant wishes to use the earnings received immediately before the event for calculation purposes, he can make a request as explained under *Section 1.12.9*. **He must then assume full payment of all premiums (employee and employer share) for the insured plans and for the survivor's pension. These premiums are established on the portion of earnings not received.**

1.15 TERMINATION OF INSURANCE

The insurance for any participant terminates on the first of the following dates:

- the date on which he ceases to be part of the management personnel of the Quebec public and parapublic sectors, except for an employee

maintaining participation in accordance with his working conditions; in this case, it is the date he loses his status as an employee;

- the date of retirement;
- the date on which the plan is cancelled.
- the date premium payments cease;
- at the end of the period of the employer's short-term disability benefit (104 weeks), if the participant becomes totally disabled after age 63;
- upon termination of Long Term Disability Insurance benefits, except if the termination is due to a total early retirement.

In addition to the preceding, premiums cease to be payable (and consequently coverage ceases) for the Compulsory Long Term Disability Insurance plans (Basic and Additional) at age 63.

Insurance for a spouse, dependent children or a person suffering from a functional impairment terminates on the first of the following dates:

- the date upon which the participant's insurance terminates;
- the date on which the insured ceases to be a spouse, dependent child or a person suffering from a functional impairment;
- the date upon which the participant's employer receives a request from the participant for Single-Parent or Individual coverage status, as the case may be;
- 6 months after the participant's death (*see Section 1.16.4 hereafter*).

1.16 EXTENSION AND CONVERSION PRIVILEGE

While the contract is in force, when a participant ceases to be eligible for insurance because he leaves his employment or retires, his Life Insurance coverage (Basic and Optional) is extended for a period of 31 days.

1.16.1 Participant's Compulsory Basic Life Insurance

During this 31-day period, the participant may apply to SSQ for an individual life insurance contract, without evidence of insurability being required, the amount of this insurance not exceeding one (1) time his annual earnings if he has no dependent children, or two (2) times his annual earnings if he has a spouse or dependent children. For participants eligible for the plan for retired management personnel or another group insurance plan, this amount is reduced by the maximum amount of life insurance available under that plan. Only the surplus may be converted up to a maximum of $500,000.

1.16.2 Participant's Optional Life Insurance

If the participant has Optional Life Insurance coverage, the amount of insurance may be converted into an individual life insurance contract for an amount of coverage equivalent to that in force before the termination of his insurance.

To do so, the participant must send a written request to SSQ within the 31-day extension period.

The following table shows the amounts that can be obtained in accordance with the conversion privilege:

Conversion privilege (in units of earnings)		
Amount of Life Insurance	**Converson Privilege [(1)]**	
	With no spouse or dependent children	**With spouse or dependent children**
Basic (½ time)	1 time	2 times
Basic + Opt. (1 time)	2 times	3 times
Basic + Opt. (2 times)	3 times	4 times
Basic + Opt. (3 times)	4 times	5 times
Basic + Opt. (4 times)	5 times	5 times
Basic + Opt. (5 times)	5 times	5 times

(1) This amount is reduced by the maximum amount of life insurance available under another group insurance plan (including the plan for retired management personnel for which the available amount is 1.5 times the earnings) for which the participant became eligible when he exercised his conversion privilege. Only the surplus can be converted up to a maximum amount of $500,000.

1.16.3 Spouse's and Dependent Children's Life Insurance

The amount of life insurance provided for the spouse and dependent children under the Compulsory Basic Life Insurance Plan and the amount of Spouse's Optional Life Insurance can be converted to individual life insurance without evidence of insurability being required in the event the participant ceases to be eligible for the plan.

However, the amount of life insurance that can be converted is reduced by the amount of life insurance available for these dependents under another group insurance plan to which the participant would have become eligible when the dependent involved exercised the conversion privilege.

This privilege preserves the insurability of the spouse and dependent children, provided the insured submits his request for conversion to SSQ within 31 days following termination of his participation.

1.16.4 Upon the death of a participant who held Family or Single-Parent coverage status

The participant's spouse, dependent children and persons suffering from a functional impairment **continue to be covered under the benefits provided** under the Compulsory Basic Accident and Health Insurance Plan and the Spouse's and Dependent Children's Life Insurance Plan without payment of premiums **for a maximum period of 6 months** beginning on the date of participant's death.

After this 6-month period, the spouse and dependent children may take advantage of the conversion privilege, provided in *Section 1.16.3* to obtain life insurance coverage.

The Basic Accident and Health Insurance Plan can be maintained, with the exception of prescription drugs, in a separate plan offered by SSQ without evidence of insurability and for which the premium is payable directly to SSQ in accordance with the conditions in force at the time of the request. This request for the accident and health insurance plan must be submitted to SSQ within 31 days following the termination of the 6-month period mentioned above. After this period, no coverage is available.

The conversion privilege for the Basic Accident and Health Insurance Plan is available only when the person is not eligible for coverage under another group insurance plan.

1.17 PREPAYMENT ENTITLEMENT - LIFE INSURANCE PLANS (COMPULSORY BASIC AND OPTIONAL)

When a participant's coverage is extended without payment of premiums in accordance with the provisions in the "Waiver of premiums" clause and his life expectancy is no more than 12 months, he is entitled, provided he submits a written request to SSQ, to receive a disability benefit equal to 25% of the amount of life insurance for which he is covered. The amount of life insurance is determined by immediately considering any reduction in coverage provided for in the contract that is due to occur during the 24-month period following the date of the participant's request.

The participant who wishes to exercise this privilege must provide the Insurer with evidence showing:

a) that his life expectancy is less than 12 months at the date of his request; and, if applicable,
b) the consent of his designated irrevocable or revocable beneficiary if the latter is other than "the participant's estate or assignees."

The insurance amount payable upon the death of the participant is reduced by the prepayment to which is added the interest based on the average rate of return of one-year treasury bills, plus 2%. Interest runs from the prepayment date until the final payment of the outstanding balance on the insurance amount payable upon the participant's death.

1.18 PROVISIONS IN FORCE DURING DISABILITY

Whenever a participant becomes disabled, the provisions applicable for the Compulsory Basic Life Insurance and Basic and Additional (CAP) Long Term Disability Insurance Plans are those of the contract in force on the date of onset of disability.

Any changes to these plans while the participant is disabled apply when the participant qualifies for a new period of disability under the short term disability plan offered by the employer.

Any changes to the Compulsory Basic Accident and Health Insurance Plan apply as of their effective date, whether or not the participant is disabled on this date.

1.19 CURRENCY

All amounts mentioned in this booklet are in Canadian currency.

2- COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN

2.1 HOSPITAL EXPENSES (reimbursed at 100%)

2.1.1 Hospital expenses in Quebec

Subject to Quebec's Hospital Insurance Act, when a participant incurs hospital expenses in Quebec for himself or one of his insured dependants as a result of accident, illness, pregnancy or serious complications arising from pregnancy, he is entitled to a reimbursement of such expenses up to **100% of the cost of a semi-private room.**

The patient contribution required for accomodation or long-term care by a health facility, and administrative fees required by the hospital are not covered by this clause.

2.1.2 Medical and hospital expenses outside Quebec

When medical and hospitalization expenses are incurred for treatment that cannot be provided in Quebec, expenses in excess of those paid by the Régie de l'assurance maladie du Québec (RAMQ) are eligible insofar as they have been pre-authorized by the RAMQ and are in compliance with Quebec's Hospital Insurance Act standards, subject to the following maximum amounts:

- medical expenses:
  three (3) times the amount paid for professional fees by the RAMQ;
- hospital expenses:
  one (1) time the amount paid for hospitalization expenses by the RAMQ.

2.1.3 Transportation and accommodation expenses for care not available in Quebec

Eligible expenses include the cost of any transportation and accommodation for care pre-authorized by the Régie de l'assurance maladie du Québec (RAMQ) but not available in Quebec. Such expenses are reimbursed to a maximum of $5,000 per insured, per calendar year.

This coverage complements coverage for medical and hospitalization expenses for care not available in Quebec.

2.2 PRESCRIPTION DRUGS AND PARAMEDICAL EXPENSES (reimbursed at 75% or 100%, as applicable)

Subject to Quebec's Health Insurance Act, when a participant incurs, either personally or for an insured dependent, expenses resulting from accident, illness, pregnancy or serious complications arising from pregnancy, expenses eligible under this section are reimbursed at 75% for the first $2,000 of eligible expenses and at 100% for any surplus, per certificate and per calendar year (excluding hospital expenses, travel insurance and trip cancellation insurance). The term 'certificate' refers to Individual, Single-Parent or Family coverage status.

These expenses are also eligible for non-emergency care outside Quebec. However, under such circumstances, these expenses are reimbursed up to what would have been reimbursed by the Insurer had they been incurred in Quebec.

<u>Definition of eligible expenses and reimbursement</u>

When the term "eligible expenses" is used in the description of a benefit, the amount of eligible expenses must be multiplied by the percentage of reimbursement to establish the maximum amount of reimbursement.

The maximum reimbursement per calendar year corresponds to the total of all reimbursements made by SSQ for expenses incurred between January 1 and December 31 of the same year.

E.g.: Physiotherapy treatment expenses

a) Example 1: Receipt submitted: $45

This amount is adjusted to the $40 maximum and reimbursed at 75%, namely $30.

b) Example 2: Receipt submitted: $25

This amount is reimbursed at 75 %, namely $18.75.

Eligible expenses detailed **in Sections 2.2.2 to 2.2.16 inclusive, 2.2.33 and 2.2.34** must be prescribed by a physician. Provided they are necessary for the medical treatment of the participant, the spouse, a dependent child or any persons suffering from a functional impairment, as defined in the Act respecting prescription drug insurance, eligible expenses include:

2.2.1 **Expenses for drugs that can only be obtained by prescription**, bearing a valid DIN (Drug Identification Number) issued by the Federal government, prescribed by a health professional authorized by law to do so, available only in pharmacies and sold by a pharmacist or a health professional in accordance with section 37 of the Pharmacy Act, upon submission of suitably itemized and duly paid receipts.

The drugs referred to in this clause are those listed in the records of the AQPP (Association québécoise des pharmaciens propriétaires), the use of which is in compliance with government-approved indications or, in the absence of such, indications provided by the manufacturer. However, some of these drugs, commonly called "RAMQ exception drugs", are covered only if they meet the conditions and therapeutic indications determined by the regulations applying to the Quebec basic prescription drug insurance plan.

Prior authorization for an exception drug must be received from the Insurer for the costs incurred by the insured to be covered.

In the case of medication injected by a health professional in a private practice, only the injected substance and not the medical procedure is covered, up to a maximum reimbursement of $20.

Smoking cessation products covered under the basic prescription drug insurance plan are also covered under this plan and subject to a maximum

reimbursement equal to the amount established and updated each year by the Régie de l'assurance maladie du Québec (RAMQ).

For insureds age 65 or over, this clause covers the patient contribution (deductible and coinsurance) required for an insured covered under the public prescription drug insurance plan administered by the RAMQ.

Intra-uterine devices (I.U.D.) prescribed by a physician are also covered under this benefit.

Transfer of all contributions spent on prescription drugs, combined

A participant who changes insurance plans during the course of the calendar year can obtain, for himself and his dependents, a year-to-date statement of contributions. This statement is issued by the Insurer or by the RAMQ, upon request by the participant or the employer, for each person affected by the change in insurance. In all cases, requests for statements must be made within six months of the termination of the insurance. This means that the participant is not forced to pay out-of-pocket for drugs under the new plan when the plan's annual limit is reached.

Note: If the participant remains with SSQ, the year-to-date contribution is automatically transferred.

Direct reimbursement service for prescription drug purchases

The plan includes the direct reimbursement service at the pharmacy for the purchase of medication. This way, the insured person only pays the part of the cost of the medication that is not reimbursed by the insurance plan since SSQ reimburses the insured portion directly to the pharmacist.

For example, for $40 in eligible medication costs, reimbursable at a rate of 75%, the person only pays $10 to the pharmacist.

To use this service, read the section *How to submit a claim (Section 8)*.

Exclusions to prescription drug coverage:

This clause does not cover the following products, whether or not they are considered drugs:

1. products used for aesthetic, cosmetic or personal hygiene purposes;
2. experimental drugs or those obtained under the federal Emergency Drug Release Program;
3. homeopathic or natural products;
4. smoking cessation products, except those specifically covered under the basic prescription drug insurance plan;
5. dietary supplements intended as a meal supplement or replacement;

   However, dietary supplements prescribed as treatment for a clearly diagnosed metabolic disease, in accordance with the conditions and directions for use determined by the regulations applicable to the basic prescription drug insurance plan, remain covered. The only acceptable evidence shall be a full medical report describing to the Insurer's satisfaction the conditions justifying the prescription of such products not otherwise covered.
6. sunscreens;

   However, sunscreens meeting the conditions provided under this clause that are necessary for individuals afflicted with an illness requiring treatment with such products may be covered upon presentation of a full medical report describing to the Insurer's satisfaction all conditions justifying the prescription of such products not otherwise covered.
7. drugs supplied during hospitalization, supplied by a hospital pharmacy or administered at a hospital;
8. medications used for the purpose of assisted procreation, artificial insemination or in vitro fertilization, except those covered under a provincial prescription drug insurance plan;
9. drugs used to treat erectile dysfunction.

2.2.2 Expenses incurred for home care. In this clause:

- "**basic daily activities**": means eating, dressing, moving around or satisfying basic hygienic requirements;
- "**home assistance service supplier**": means a person working for remuneration for an incorporated or registered agency or cooperative specializing in home care, as well as any self-employed worker contracted by such cooperative or agency, as well as any self-employed worker, only if there is no agency or cooperative in the region
- "**family member of the participant or spouse**": means spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, brother-in-law, sister-in-law, half-brother, half-sister, son-in-law, daughter-in-law, grandparent and grandchild.

Eligible expenses are those incurred by the insured during a period of convalescence rendered necessary following hospitalization or day surgery and during which he is unable to carry out his basic daily activities.

a) **nursing care**: fees of a registered nurse or nursing assistant for nursing care rendered at the insured's residence up to an eligible expense of $60 per day. The nurse must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family. The nursing care covered includes, among others:
   - re-education following surgery;
   - checking blood pressure and vital signs;
   - changing bandages and dressing wounds;
   - administering medications and monitoring solutions;
   - removal of sutures and staples;
   - taking samples (e.g. blood, etc.).

b) **transportation expenses**: expenses for transportation of the insured to receive medical care or medical check-ups following hospitalization or day surgery, up to a maximum of 3 round trips per week and a maximum of $30 per round trip.

c) **convalescent home**: expenses incurred for a stay at a convalescent home supervised by a physician or a registered nurse or nursing assistant, including the cost of accommodation and meals, as well as nursing care up to a maximum eligible expense of $125 per day.

d) **home assistance services**: fees of a home assistance service supplier to help the insured carry out his basic daily activities up to an eligible expense of $60 per day. These services must be rendered at the insured's home and the supplier of the home care services must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family. The services covered include, among others:
   - personal care (assistance with bathing, dressing/undressing, general hygiene, help or assistance with eating, help getting in and out of bed, etc);
   - household maintenance (regular maintenance, dish-washing, laundry);
   - general home maintenance (snow removal, lawn mowing, etc);
   - meal preparation;
   - accompaniment to medical appointments;

e) **childcare expenses**: the expenses for taking care of the participant's dependent children at his home or at a day care centre, up to an eligible maximum of $25 per day per child. The person providing these services must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family.

   Only expenses that exceed those normally incurred by the participant or his spouse prior to the period of convalescence are covered under this clause.

Limitations regarding home care

Only expenses incurred for care received **within 30 days** immediately following hospitalization or day surgery are covered under this clause. Hospitalization following childbirth is not covered unless complications require hospitalization for an extended period of four (4) days or more.

Recommendations

- Always check with your local CLSC to learn about the treatment available and provided for your health condition, as well as to ensure that your file is adequately monitored by the CLSC.
- Although you are not required to obtain prior authorization from the Insurer, you may wish to contact SSQ Customer Service to assess your file and avoid any unpleasant surprises in the event that the treatment required by your health condition is not covered under your insurance contract.

2.2.3 whichever is less expensive, for a temporary need only, the cost to purchase or rent a **non-motorized wheelchair** or a **hospital bed**;

2.2.4 the cost to purchase or replace an **artificial limb or prosthetic appliance** with the exception of eyeglasses, contact lens or dental protheses;

2.2.5 expenses for purchasing, renting or replacing **trusses, corsets, casts, splints, crutches and other orthoses**, it being understood that the expression "orthoses" describes certain parts assembled into a unit to support or maintain part of the body to prevent and correct physical deformities or to treat skeletal, muscular, or tendon disorders.

Purchase costs of **foot orthoses** are also eligible. These are limited to the amounts provided in the price schedule for the *Association nationale des orthésistes du pied*. The orthosis must be supplied by a specialized laboratory holding a permit issued by the Ministère de la Santé et des Services sociaux du Québec (MSSS) under the provisions of the Public Health Protection Act.

2.2.6 expenses for purchasing one (1) **device to measure blood glucose levels** (Blood glucose monitor), up to an eligible amount of $300 per period of 36 months;

2.2.7 expenses for the rental, adjustment, replacement or purchase, if the latter is more economical, of **therapeutic devices**.

Some examples of this category of device include:

- Aerosoltherapy appliances, namely devices required for treating, among others, acute emphysema, chronic bronchitis or chronic asthma (e.g.: vaporizer);
- non-union bone stimulators;
- respiratory monitors in case of respiratory arrhythmia (e.g.: apnea monitor);
- intermittent positive pressure respirators (e.g.: volume ventilator, CPAP);
- burn treatment garments (e.g.: Jobst);
- purchase of diapers for incontinence, probes, catheters and other similar sanitary articles required following a total and irrecoverable loss of bowel or bladder functions, the expression "loss" meaning loss of use.

Exclusions applying to therapeutic devices

This benefit does not cover monitoring equipment (such as stethoscopes or other similar devices) or home accessories.

"Home accessories": means toilet seats, support rails, humidifiers, air conditioners, "air filters", Doctor Gibaud articles (heating devices), heating pads, heated car seat cushions, sun lamps, thermometers, sitz baths, pressure devices, sphygmomanometers or similar devices, electric toothbrushes ("Waterpik"), hydrotherapy devices, sheepskin (for bedsores), alarms for children suffering enuresis (nighttime incontinence) and other accessories of this type;

2.2.8 costs covered for one (1) **insulin pump** are the purchase of the pump and its repair up to $7,500 per 60-month period per insured person and the purchase of items needed to operate the pump up to $4,000 per insured, per calendar year.

2.2.9 purchase, rental, adjustment, replacement or repair expenses for **percutaneous or transcutaneous electrical nerve stimulator** (PENS/TENS) up to an eligible expense of $1,000 per period of 60 months;

2.2.10 purchase cost of a **wig** required following chemotherapy. The maximum reimbursement per period of 48 full consecutive months is limited to a single wig per insured, and subject to a maximum of $500 per insured;

2.2.11 expenses incurred for the purchase of **orthopaedic shoes**, namely made-to-measure shoes designed for an insured from a cast, or prefabricated open, flared, straight shoes as well as those needed to support Dennis Browne splints when such shoes are required to correct or compensate for a foot defect and when they are obtained from a **specialized orthopaedic laboratory** holding a permit issued by the ministère de la Santé et des Services sociaux du Québec (MSSS) under the provisions of the Public Health Protection Act.

Also eligible are expenses incurred for corrections made by such a laboratory to prefabricated shoes. Deep shoes as well as all types of sandals are not eligible;

2.2.12 expenses incurred for **electrocardiograms, X-rays (including scanner), magnetic resonance, ultrasounds and lab tests**, performed outside of health institutions. Laboratory tests covered are the same as those available at a hospital and must be recognized by Health Canada;

2.2.13 expenses incurred for the rental or purchase, **if the latter is more economical, of a respirator and oxygen** and oxygen (e.g.: concentrator, oxylite);

The cost to purchase an oxygen filling station may be eligible for reimbursement if the participant can demonstrate that it is cheaper for the plan to purchase than to have the tank filled;

2.2.14 expenses incurred for **the professional services of a registered nurse** the professional services of a registered nurse or nursing assistant, provided such services are rendered outside a health institution or convalescent home. The person providing these services must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family;

2.2.15 expenses for **cosmetic surgery** necessary to repair a disfigurement due to an accident that occurred while the insurance was in force;

2.2.16 expenses for the purchase of **medium or full support stockings** (21 mm Hg or more), supplied and sold in a pharmacy or a medical establishment, in cases of venous or lymphatic system deficiency, subject to a maximum reimbursement of 3 pairs per insured per calendar year;

2.2.17 eligible expenses for the substance used in **sclerosing injections** are limited to a maximum of $20 per treatment (maximum one treatment per day) and also the professional fees related to the injections, up to an eligible expense of $25 per treatment (maximum one treatment per day);

2.2.18 expenses incurred to rent, purchase or repair a **hearing aid**, up to $1,000 per period of 48 full consecutive months per insured;

2.2.19 professional fees of a **dental surgeon for treatment of a fractured jaw or injury to natural teeth,** further to an accident while the insurance was in force, provided such treatment is rendered within 12 months following the date of the accident.

Eligible expenses are limited to the rates provided in the current edition of the Quebec Dental Surgeons Association's fee guide.

However, no benefits are payable for any act, treatment, or prosthesis of any nature related to a dental implant.

2.2.20 expenses for **round-trip transportation by ambulance,** including transportation by a regular scheduled airline (excluding air ambulance) in an emergency situation.

Medical necessity must be demonstrated when a claim for transportation by air is submitted to the Insurer.

2.2.21 expenses incurred for the substance used in **preventive or curative vaccines**, up to an eligible amount of $200 per insured per calendar year;

2.2.22 expenses for **eye examinations** by an ophthalmologist or an optometrist, subject to a maximum of $50 per insured per period of 24 full consecutive months;

2.2.23 expenses for **physiotherapy treatments** rendered in a private clinic by a physiotherapist or by a physical rehabilitation therapist working under the supervision of a physiotherapist or a physiatrist, subject to a maximum amount of $40 per treatment;

2.2.24 professional fees of a **speech-language pathologist,** up to $60 per consultation, subject to a maximum reimbursement of $600 per insured per calendar year;

2.2.25 professional fees of an occupational therapist, up to $40 per consultation, subject to a maximum reimbursement of $500 per insured per calendar year; **occupational therapist,** up to $40 per consultation, subject to a maximum reimbursement of $500 per insured per calendar year;

2.2.26 professional fees of an **audiologist** or **hearing aid specialist**, up to $60 per consultation for an **audiologist** and up to $40 per consultation for a **hearing aid specialist**, subject to a combined maximum reimbursement of $500 per insured per calendar year;

2.2.27 professional fees of a **chiropractor,** up to $30 per treatment* and $50 per calendar year for X-rays, and subject to a combined annual reimbursement of $500 per insured;

2.2.28 professional fees of a **dietitian**, up to $30 per consultation, subject to a maximum reimbursement of $500 per insured per calendar year;

2.2.29 professional fees of a **podiatrist**, up to $40 per consultation, subject to a maximum reimbursement of $500 per insured per calendar year;

2.2.30 professional fees of a **naturopath (**(or **naturotherapist**), **homeopath** or **phytotherapist,** up to $30 per treatment* or consultation, subject to a combined maximum reimbursement of $600 per insured per calendar year;

As regards the naturopath (or naturotherapist), eligible expenses are those related to a consultation in order to obtain dietary advice or for a check-up or to develop a diet based on natural products. Natural products, massages, baths, posturology, physical exercises or other consultations not recognized by the Insurer are not covered.

2.2.31 professional fees of an **acupuncturist**, **osteopath**, **kinesitherapist**, **orthotherapist** or **massage therapist**, up to $30 per treatment* or consultation, subject to a combined maximum reimbursement of $600 per insured per calendar year;

The notion of treatment does not refer to any remedies, products or other articles such professionals may provide.

2.2.32 professional fees of **a psychiatrist**, **psychoanalyst** , a **psychologist**, a **social worker, a marital and family therapist** or a **guidance counsellor**, subject to a combined maximum reimbursement of $1,000 per insured, per calendar year;

2.2.33 **transportation and accommodation expenses (including meals)** incurred in Quebec due to one of the following events:

- consultation **with a medical specialist for professional services not available** within a 200 km radius of the insured's place of residence;
- specialized **treatments provided by a physician and not available** within a 200 km radius of the insured's place of residence;
- hospitalization **for treatment not available** within a 200 km radius of the insured's place of residence;

Eligible expenses are:

- Expenses for **transportation** by automobile or with a public carrier by bus, train, boat or air, whichever is the most economical means, taking into account the health condition of the insured, including the cost of **meals**;
- Expenses **for accommodation** incurred for a stay in a commercial establishment, provided that the event requires an overnight stay.

The combined maximum reimbursement is $1,000 per insured per calendar year.

However, the following conditions apply to the eligible expenses indicated above:

- the event incurring these eligible expenses must be on a physician's orders;
- receipts or paid invoices are required for the reimbursement of eligible expenses;
- the event incurring these eligible expenses must require travel of at least 200 km one way by the most direct route, from the insured's place of residence to the place of the event. In addition, the event must take place at the closest possible site to the insured's place of residence;
- reimbursement of eligible expenses for accommodation and meals is subject to production of receipts or paid invoices and is limited to the amounts detailed in the Directive sur les frais remboursables lors d'un déplacement et autres frais inhérents, applicable to management personnel of the Quebec public and parapublic sectors;
- eligible expenses for trips by automobile are equal to those that would have been incurred had the trip been taken by bus;
- eligible expenses include expenses incurred by the insured as well as the person accompanying the insured.

COMMENT:

These expenses may be eligible for reimbursement under a program introduced by a number of regional health and social services centres. However, this program is administered by the establishment responsible for the insured's treatment. In order to verify whether such a program exists in his region of residence, the insured should contact his local hospital, CLSC or health and social services centre. These organizations are "first payers." Therefore, only expenses that are not reimbursed by these organizations and that are eligible under this contract will be reimbursed.

2.2.34 in the case of **detoxification treatment** are eligible the expenses incurred for room and board in a centre for alcoholism or drug or gambling addiction**, officially recognized** for such purposes, up to a maximum of $50 per day and 30 days per insured, per calendar year.

2.3 EXCLUSIONS

Under the prescription drug benefit, certain products are excluded from coverage. The participant is invited to read these exclusions carefully under *Section 2.2.1.*

Moreover, **no benefits are payable** for expenses incurred:

- as a result of an accident or illness for which the participant is entitled to compensation under the Act respecting industrial accidents and occupational diseases, the automobile insurance Act or any other similar legislation of another Canadian province or another country;
- for medical examinations for the purposes of a third party (insurance, school, employment, etc.) or for trips for health reasons, except those expressly provided for;

- for eyeglasses or contact lenses;
- as a result of self-inflicted injury, regardless of the mental state of the insured;
- for dental care or plastic surgery, except those expressly provided for;
- as a result of an accident suffered or illness contracted while the insured is on active duty in the armed forces;
- for care and services provided by a member of the participant's family;
- for medical services for which the insured is not required to pay, or for which he would not have been required to pay had he availed himself of any public plan for which he was eligible, or for which he would not have been required to pay in the absence of his group insurance plans, including expenses covered under a plan financed wholly or partly by taxes or under any government initiative and those which would have been covered had the provider of such services chosen to participate in such a plan;
- for all products, devices or services used or offered for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the appropriate government authorities or, in the absence of such, with the indications provided by the manufacturer;
- for all substances, care or procedures relating to infertility treatment or artificial insemination or in vitro fertilization, except those covered under a provincial prescription drug insurance plan;
- for services or supplies, examinations, care or expenses that do not comply with the customary and reasonable standards of current practices of the health professionals concerned.

2.4 LIMITATIONS

For each specialist eligible under this plan, reimbursement of eligible expenses is limited to **one treatment per day.**

2.5 COORDINATION

If the total amount of benefits payable under this plan, and those payable under the terms of any other group or individual insurance plan under which the participant is entitled to receive benefits, exceeds the expenses actually incurred for the supplies and services covered under this contract, the benefits payable under this plan are reduced so as to eliminate this surplus.

3- COMPULSORY BASIC LIFE INSURANCE PLAN

3.1 PARTICIPANT'S LIFE INSURANCE

The amount of coverage is equal to 50% of annual earnings.

3.2 SPOUSE'S AND DEPENDENT CHILDREN'S LIFE INSURANCE

- Spouse: $17,200
- Dependent children age 24 hours or over: $5,000 per child

Note: These amounts are reduced by half for participants working less than 70% of full time.

3.3 PARTICIPANT'S, SPOUSE'S AND DEPENDENT CHILDREN'S ACCIDENTAL DISMEMBERMENT INSURANCE

As described in the following table, this benefit provides a payment not exceeding 100% of the participant's annual earnings if the participant, his spouse or dependent children suffer any of the following losses as a result of an accident within 365 days of such accident while insurance is in force;

Loss	Amount
- both hands, both feet or complete loss of sight in both eyes	100% of annual earnings
- one hand and one foot	100% of annual earnings
- one hand and sight in one eye	100% of annual earnings
- one foot and sight in one eye	100% of annual earnings
- one hand	50% of annual earnings
- one foot	50% of annual earnings
- sight in one eye	50% of annual earnings

Note: "Loss" means total and irrecoverable loss of use of a limb as the result of an accident. Loss of sight means the total, definitive and irrecoverable loss of sight.

3.4 EXCLUSION IN THE EVENT OF ACCIDENTAL DISMEMBERMENT

Accidental Dismemberment Insurance is not payable if the loss is due to one of the following causes: self-inflicted injuries, suicide, war, riot, insurrection, active participation in a criminal act or attempted crime, active duty in the armed forces, carrying out any duties as an aircraft crew member (unless the participant is present as a crew member within the scope of his duties as a member of management personnel of the Quebec public and parapublic sectors).

4- COMPULSORY BASIC LONG TERM DISABILITY INSURANCE PLAN

The Compulsory Basic Long Term Disability Insurance Plan is designed to complement the employer's short term disability insurance plan when a participant becomes totally disabled.

A brief description of this plan and the main conditions pertaining to it are presented hereafter:

4.1 AMOUNT OF PENSION

The monthly pension is equal to 65% of the gross monthly earnings the participant would have been entitled to, had he or she been at work at the end of the 104th week of total disability.

4.2 ELIMINATION PERIOD

The elimination period is 104 weeks, corresponding to the duration of the employer's short term disability insurance plan.

4.3 DURATION OF BENEFITS

A disabled participant is entitled to receive the Long Term Disability pension starting at the end of the elimination period for as long as he remains totally disabled, though not beyond the first of the dates mentioned under *Section 4.10 - Termination of benefits* hereafter.

4.4 COORDINATION OF BENEFITS

Monthly benefits are reduced by the amount of any monthly disability pension **paid** under the Act respecting industrial accidents and occupational diseases, the Quebec Automobile Insurance Act, the Quebec Pension Plan (QPP), under any previous contract and any other social legislation. This reduction also takes into account any applicable retroactive amounts.

If the participant is not receiving payments from the aforementioned sources of income, it is his responsibility to provide evidence that he is not entitled to any amount from such sources.

Moreover, the monthly pension is reduced by any amount of disability or retirement pension the participant receives under the employer's pension plan and the QPP.

This reduction is determined on the basis of the pensions payable after the 104th week of total disability, regardless of any future cost-of-living adjustments.

4.5 PENSION PLAN CONTRIBUTION

In addition to the disability pension, starting on the 156th week of total disability, the Insurer pays the participant's contribution to the employer's pension plan if the participant was a contributor prior to his disability, for as long as the total disability persists, though not beyond the first of the dates mentioned under *Section 4.10 - Termination of benefits* hereafter.

In case of a terminal illness of an eligible participant in accordance with the provisions of the PPMP, RPSO, RREGOP or PPPOCS, if the participant requests reimbursement of his accumulated contributions with interest or the present value of his retirement pension, the Insurer ceases the payment of the participant's contribution to the PPMP, RPSO, RREGOP or PPPOCS upon the date the CARRA receives the request for reimbursement.

4.6 DEFINITION OF TOTAL DISABILITY

Total disability is a state of incapacity resulting either from illness, accident, serious complication of pregnancy or surgery directly related to family planning requiring medical care and making the participant totally unable to carry out any remunerative employment for which he is reasonably qualified because of his education, training and experience, regardless of the availability of such employment.

4.7 PERIOD OF TOTAL DISABILITY (after 104 weeks)

Any continuous period of total disability or series of successive periods of total disability resulting from the same illness or accident, separated by a period of less than 3 months of active full-time work or, if applicable, part-time work, in accordance with the participant's regular position.

If, for a period, the total disability results from an illness or accident completely independent from the illness or accident that caused the total disability during the preceding period, such period is considered a new period of total disability.

4.8 INDEXATION

The amount of the pension payable by the Insurer is indexed according to the lesser of the following percentages:

a) the increase in the pay scale of civil servant managers (class 4) applied during the preceding year;

b) 5%.

This indexation clause applies annually as of the January 1 that follows a period of at least six months of benefits.

4.9 REHABILITATION PROGRAM

The program is designed to foster the participant's reintegration into the workplace by providing the support necessary to both the participant and the employer. The main provisions of this program and working conditions conducive to its application are outlined in the Rehabilitation Program booklet. For further information, please contact your employer's personnel department.

4.10 TERMINATION OF BENEFITS

Disability benefits terminate on the first of the following dates:

a) the date on which the participant reaches age 65;

b) the first date on which the disabled participant becomes eligible for:

- a retirement pension without actuarial reduction calculated with 35 credited years of service for calculation purposes under the employer’s retirement pension plan (e.g.: PPMP, TPP, CSSP, RPSO) or 32 credited years of service (PPPOCS);

or

- a total benefit within the meaning of the PPCT corresponding to 70% of the average pensionable salary on the basis of which the pension under this plan is calculated;

or

- a retirement pension with actuarial reduction, the amount of which corresponds to a retirement pension without actuarial reduction, calculated with 35 credited years of service for calculation purposes under the employer’s retirement pension plan or 32 credited years of service (PPPOCS);

c) the date of full retirement or full early retirement;

d) the date on which total disability terminates.

Contributions to the employer’s pension plan, if applicable, terminate on the date stipulated above, but not later than the date on which the participant actually receives a disability or retirement pension under the employer’s pension plan.

4.11 RIGHT OF APPEAL

Two types of decisions can be contested:

- the Insurer's refusal to recognize a disability condition;
- the tasks established for the rehabilitation job.

4.11.1 Objection to the Insurer's refusal to recognize a disability condition

The manager or the employer, provided the manager agrees, may jointly or separately object to the Insurer's decision not to recognize, or to cease recognizing, as of the 105th week, the manager's disability condition.

To avoid a lengthy and costly procedure, the government, the manager associations and the Insurer have agreed to set up a medical arbitration tribunal to settle such disputes.

In consideration of the Insurer’s obligation to abide by the decision of the medical arbitration tribunal, the employee must apply to the medical arbitration tribunal in writing and as such refrain from any further legal recourse to the civil courts or any other tribunal.

To submit an argument to the medical arbitration tribunal, the manager or the employer must provide the Insurer with a notice in writing **within 90 days**:

- of the date the Insurer's decision comes into force, if the decision is made before the end of the first 104 weeks of disability;

or

- of the date of the Insurer's decision, if the decision is rendered after the first 104 weeks of disability.

The manager must send a copy of the contestation documents to the employer.

4.11.2 Objection to tasks established for the rehabilitation job

The sectoral committee is the first to intervene in this type of objection as well as in the case of temporary assignments (lasting for a maximum of one year).

If the manager does not obtain a satisfactory solution at this stage, the working conditions provide for a recourse mechanism whose decision for settling disputes is executory.

4.12 EXCLUSIONS

No benefits are payable for any period of disability resulting from self-inflicted illness or injuries, active participation in a riot, insurrection or criminal acts, or active duty in the armed forces or resulting directly or indirectly from a war or civil war, whether declared or not.

This plan does not cover any period of disability during which the participant is not receiving regular care from a physician, except in the case that the participant’s condition is deemed stable, and is attested to by a physician to the satisfaction of the Insurer.

5- COMPULSORY ADDITIONAL LONG TERM DISABILITY INSURANCE PLAN (CAP)

This benefit plan provides supplementary income that complements, in part, the income received from rehabilitation employment.

A brief description of this plan and the main conditions pertaining to it are presented below:

5.1 ELIGIBILITY FOR BENEFITS

The participant is entitled to CAP benefits:

- if he meets the definition of disability under the employer's short term disability insurance plan; or
- after the first 104 weeks of disability, if he does not qualify or no longer qualifies under the definition of total disability provided for under the compulsory basic long term disability insurance plan.

In addition, he must:

- have successfully completed a rehabilitation program; or
- be in the process of completing a rehabilitation program; or
- not require rehabilitation, according to the evaluation report of his rehabilitation needs;

and

- occupy the rehabilitation position offered by the employer and approved by the Insurer; or
- be temporarily assigned to a position for a period not greater than 12 months.

5.2 BENEFITS

The CAP benefits are equivalent to 95% of the participant's gross earnings on the first day of disability less the rehabilitation employment or temporary assignment earnings.

When the participant is employed on a gradual basis, the benefit amount is pro rated to the remunerated portion of the rehabilitation employment in contrast to full-time.

At no time may the CAP benefits exceed $30,000 per year.

Note : Earnings on the first day of disability and CAP benefits are not subject to the indexation clause indicated in *Section 4.8.*

The rehabilitation or temporary assignment earnings are defined as being the higher of:

i) an amount equal to the benefits that would be payable under the Compulsory Basic Long Term Disability Insurance Plan (annual maximum of $58,000);

ii) the rehabilitation employment or temporary assignment earnings on the basis of the normal work period at the beginning of the disability.

The benefits provided for under this plan may at no time however begin before a period of 104 weeks has elapsed since the beginning of the disability.

5.3 PAYMENT OF BENEFITS

When the participant qualifies for CAP benefits, they are paid during each of the following periods:

a) when the participant has completed his rehabilitation plan, the period during which he is permanently employed in the rehabilitation position offered by the employer and approved by the Insurer;

b) during the gradual return to work period provided for in the rehabilitation plan approved by the Insurer;

c) the period during which the participant is employed in a temporary assignment while awaiting a rehabilitation position for a period not exceeding 12 months.

5.4 TERMINATION OF BENEFITS

CAP benefits terminate on the first of the following dates:

a) the date on which the participant reaches age 65;

b) the first date on which the disabled participant becomes eligible for:

- a retirement pension without actuarial reduction calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan (e.g.: PPMP, TPP, CSSP, RPSO) or 32 credited years of service (PPPOCS);

or

- a total benefit within the meaning of the PPCT corresponding to 70% of the average pensionable salary on the basis of which the pension under this plan is calculated;

or

- a retirement pension with actuarial reduction, the amount of which corresponds to a retirement pension without actuarial reduction, calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan or 32 credited years of service (PPPOCS);

c) the retirement date;

d) date on which the participant completes a temporary assignment period of 12 months and still does not have a rehabilitation position approved by the Insurer on this date. In such a case, the Insurer informs the sectoral committee before ceasing payments;

e) date on which ceases the rehabilitation position approved by the Insurer or any subsequent rehabilitation position that follows with no period of interruption;

f) the date when payable CAP benefits are less than 5% of the participant's earnings at the beginning of his disability.

5.5 PENSION PLAN CONTRIBUTION

CAP benefits are considered eligible earnings under the pension plan. Thus, the participant’s contributions are deducted from the CAP benefits. The Insurer assumes the employer’s contributions, which are equal to those of the employee.

5.6 LIFE INSURANCE AND SURVIVOR’S PENSION BENEFITS

In the event of death, CAP benefits are included in the calculation of earnings used to establish the overall amount of life insurance and survivor’s pension benefits.

5.7 EXCLUSION

No benefits are payable for any period of disability resulting from self-inflicted illness or injuries, active participation in a riot, insurrection or criminal acts, or active duty in the armed forces or resulting directly or indirectly from a war or civil war, whether declared or not.

6- OPTIONAL LIFE INSURANCE PLAN

The Optional Life Insurance Plan complements the Insurer's Compulsory Basic Life Insurance Plan, the uniform life insurance plan and the survivor's pension plan.

6.1 PARTICIPANT'S OPTIONAL LIFE INSURANCE

The participant may apply for an additional amount of Life Insurance coverage equal to 1, 2, 3, 4 or 5 times his annual earnings.

The participant must hold Participant's Optional Life Insurance in order to apply for Spouse's Optional Life Insurance.

Evidence of insurability

a) Evidence of insurability is **always** required if the application for Optional Life Insurance is submitted **more than 60 days** after the eligibility date.

b) Evidence of insurability is **always** required for any application for Optional Life Insurance greater than 3 times the participant's annual earnings, even if the request is submitted within the first 60 days of his eligibility.

c) Evidence of insurability is also required for a new participant who submits his request within the first 60 days of his eligibility for an amount greater than $148,900*, if he is age 40 to 49, and for an amount greater than $62,000*, if he is age 50 or over.

   * These amounts are those in force for 2013. They are adjusted on January 1 of each year, according to the pension Index for the Quebec Pension Plan, subject to a maximum of 4%.

6.2 SPOUSE'S OPTIONAL LIFE INSURANCE

To apply for Spouse's Optional Life Insurance, the participant must have Participant's Optional Life Insurance. **Coverage is available in increments of $10,000, subject to a maximum of $100,000, evidence of insurability being required at all times.**

6.3 EXCLUSIONS

No benefits are payable for an insured (participant or spouse) in accordance with the present plan in case of suicide:

- if the amounts of coverage are requested more than 60 days after the eligibility date of the insured; and
- if the insured's death occurs within 12 months following the effective date of the additional amounts of coverage.

7- DESCRIPTION OF TRAVEL INSURANCE AND AND TRIP CANCELLATION INSURANCE

7.1 TRAVEL INSURANCE (reimbursed at 100%)

Depending on the coverage status held (Individual, Single-Parent or Family), Travel Insurance covers the participant and, if they are insured, the spouse, dependent children, and persons suffering a functional impairment.

Expenses are eligible insofar as they are incurred following a death, an accident or a **sudden and unexpected illness** occurring while the insured was temporarily outside his province of residence and requiring **emergency care**. The expenses must be incurred for supplies or services prescribed by a physician as necessary to treat an illness or injury.

If the insured already has a known disease or illness before a trip, he must ensure that his health condition is good and stable, that he can carry out usual daily activities and that he is experiencing no symptoms that may reasonably suggest that any complications may arise or that medical care may be required during the trip outside the province of residence. In other words, prior to departure, the known disease or illness must be under control and must not:

- have taken a turn for the worse;
- have relapsed or recurred;
- be unstable;
- be entering a terminal phase;
- be chronic and indicate a risk of deterioration or foreseeable complications during the trip.

If any of the aforementioned criteria is applicable to your current health condition, **you must contact** the travel assistance firm (CanAssistance) several weeks before your departure, to clarify whether your health condition meets the eligibility criteria for this coverage. CanAssistance's telephone numbers are printed on the back of the SSQ Card accompanying the certificate issued by SSQ.

Travel Insurance covers the insured provided that coverage is in force under the government health and hospitalization insurance plan of that person's province of residence (e.g.: the RAMQ).

7.1.1 Eligible expenses are as follows:

- the portion of **hospitalization** expenses in excess of the expenses covered under the provincial plan;
- the portion of professional fees of a **physician** in excess of expenses covered under the provincial plan;
- expenses for transportation by **ambulance** to the nearest hospital;
- expenses for **drugs** requiring a medical prescription;

- fees of a **private registered nurse** in hospital, when medically necessary and prescribed by the attending physician who is neither a relative nor a travelling companion of the insured. These expenses are limited to a maximum reimbursement of $5,000;
- expenses for treatment by a **chiropractor**, **podiatrist** or **physiotherapist**; rental expenses for a **wheelchair**, **hospital bed** or **respirator**;
- **lab tests** and **x-ray** expenses;
- purchase cost of **trusses, corsets, crutches, splints, casts and other orthoses**;
- fees of a **dental surgeon** for accidental injuries to natural teeth, subject to a maximum reimbursement of $1,000 per accident, for treatment provided within 12 months following such an accident;
- expenses to **return** the hospitalized insured to his province of residence, subject to prior authorization from the Insurer*;
- the cost of **economy class return air travel** for a **medical escort**, subject to prior authorization from the Insurer*;
- the cost of **returning** the insured's **vehicle**, whether rented or not, by means of a commercial agency. A medical certificate attesting to the incapacity of the insured is required. Maximum reimbursement: $1,000, subject to prior authorization from the Insurer*;
- in the event of the insured's death, the expenses for **preparing and returning the remains** (excluding the cost of the coffin or casket) are covered up to a maximum reimbursement of $5,000, subject to prior authorization from the Insurer*;
- the cost of **accommodation and meals** in a commercial establishment, for insureds, up to $200 per day and subject to a maximum of $1,600 per stay for all insureds if the return is postponed following a hospitalization lasting for 24 hours or more for one of the insureds, an immediate family member or travel companion;
- the cost of **accommodation and meals** in a commercial establishment, for only one close relative, as well as return, economy-class **transportation expenses** by the most direct route by plane, bus or train in order to visit the hospital where the insured is staying for at least seven (7) days, or to identify the body of the deceased insured before the remains are returned. Eligible expenses are limited to the following:
  - transportation: $2,500;
  - accommodation and meals: $200 per day, up to a maximum of $1,600 per trip for all covered parties combined.

  The notion of "close relative" may also include a friend in the event that the insured has no close relatives. Prior authorization from the Insurer* is required;
- travel assistance services as *described below.*

* The expression **"prior authorization from the Insurer"** used in this text means prior authorization from SSQ or the travel assistance service (CanAssistance), which is authorized to act on behalf of SSQ *(see Section 7.2 hereafter)*.

7.1.2 Reassignment outside of the province of residence

Hospital expenses and the professional fees of a physician in excess of those covered under the provincial plan, and which are not eligible as being due to non-urgent care or constituting fees related to a pregnancy, are covered under the present benefit when these fees are incurred while the participant is reassigned outside of his province of residence for work-related reasons for more than 30 consecutive days. To be eligible, these fees must be incurred in the area offering the care or services required that is closest to the place where the insured has been reassigned.

Note: Please refer to *Section 7.5* for limitations and exclusions to this coverage.

7.2 TRAVEL ASSISTANCE

The Travel Insurance benefit includes a special travel assistance component.

When needed, each insured has access to a travel assistance service when travelling outside of his province of residence. This service is offered by a specialized company (CanAssistance) under agreement with SSQ.

If emergency medical or hospital care or services provided under the Travel Insurance benefit become necessary, CanAssistance can not only advance the funds required, but also intervene to help arrange admission of the insured to hospital or arrange access to the various services provided under the insurance plan.

CanAssistance can act as the intermediary between SSQ and the insured when the latter must obtain "**prior authorization from the Insurer,**" as stipulated under this Travel Insurance benefit, in order to be entitled to the services covered.

The following is a detailed list of the services CanAssistance can provide following an accident or sudden and unexpected illness:

- refer the insured to an appropriate clinic or hospital;
- verify the insured's medical insurance coverage in order to prevent the insured from having to pay for services up front, where possible;
- ensure follow-up of the insured's medical file;
- coordinate the insured's return and transportation as soon as medically possible;
- provide emergency assistance and coordinate claims;
- if necessary, arrange for the transportation of a family member to the bedside of the insured or to identify the insured's body if deceased and coordinate the return of the deceased insured;
- if necessary, arrange for the return of dependents to their home (return expenses not included);
- if necessary, coordinate the return of the insured's personal vehicle if he is unable to do so because of illness, accident or death;
- if necessary, communicate with the insured's family or employer;
- act as an interpreter for emergency calls;

- recommend a lawyer in case of a serious accident (lawyer's fee not included).

Insureds travelling outside of the United States or Western Europe may wish to contact CanAssistance prior to departure for useful health care advice.

CanAssistance representatives can be reached at the following numbers.

A)	**CANADA - UNITED STATES**	1-800-465-2928
B)	**ELSEWHERE IN THE WORLD**	(collect call): 514-286-8412

The insured must provide the contract number specified on the participant's SSQ Card when calling.

The above telephone numbers are also printed on the back of the participant's SSQ Card. These numbers appear on the reverse side of the card.

Note: Please refer to *Section 7.5* for limitations to this coverage.

7.3 TRIP CANCELLATION INSURANCE (reimbursed at 100%)

Trip Cancellation Insurance covers the participant and, if they are insured, his spouse, dependent children or persons suffering from a functional impairment, depending on the coverage status held (Individual, Single-Parent or Family).

Eligible expenses are those incurred by the insured following cancellation or interruption of a trip, provided these expenses relate to travel expenses paid in advance by the insured and provided that, at the time the travel arrangements were finalized, he was unaware of any event that could have reasonably led to the cancellation or interruption of the planned trip.

7.3.1 A trip must be cancelled or interrupted for one of the following reasons:

a) an **illness** or **accident** suffered by the insured, his travel companion, a business associate or a member of his family (*see Section 7.4 hereafter*), that prevents the insured from performing his usual activities and which is serious enough to justify cancellation or interruption of the insured's trip;

b) the **death** of the participant, his spouse, a child of the participant or his spouse, a travel companion or a business associate;

c) the **death** of a member of the insured's family (other than the participant, the participant's spouse or a child of the participant or the participant's spouse) or of the insured's travel companion, provided the funeral takes place during the time of the planned trip or within 14 days prior to departure;

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

e) if the insured or his travel companion must **report for jury duty**, or receives a subpoena to appear as **a witness in a case** scheduled to be heard during the trip, but only if the person involved has taken all necessary measures to have the hearing postponed.

However, a subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or has been subpoenaed as part of his duties as a police officer;

f) **quarantine** of the insured, if such quarantine terminates seven (7) days or less before the scheduled date of departure, or occurs during the time of the trip;

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

h) **damage** rendering the principal residence of the insured or of the host at destination uninhabitable, provided the residence remains uninhabitable 7 days or less before the scheduled date of departure or the damage occurs during the trip;

i) **transfer** of the insured, for the same employer, to a location more than 100 kilometres from his current residence, if required within 30 days preceding departure;

j) **terrorism, war, whether declared or undeclared, or epidemic** in the country to which the insured is travelling, provided the Government of Canada issues a travel warning to that effect, after the arrangements relating to the trip have been finalized;

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

l) **weather conditions** such that:

   i) the departure of the public carrier, at the point of departure of the planned trip, is delayed for a period of at least 30% of the scheduled duration of the trip (minimum 48 hours); or

   ii) after departure, the insured is unable to make a scheduled connection with another carrier, provided the scheduled connection after departure is delayed for a period of at least 30% of the time scheduled for the trip (minimum 48 hours);

m) **damage** to the place of business or physical location where a commercial business activity is to be held, such damage making it impossible to hold

the planned activity, such that the official organization responsible for organizing the activity issues a written notice cancelling the activity;

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

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

p) the **death** of a person for whom the insured is the testamentary executor;

q) the **death** or **hospitalization** of the person with whom the arrangements for a business meeting or activities of a commercial nature had previously been made. **In such a case, the reimbursement is limited to transportation expenses and to a maximum of three (3) days of accommodation.**

7.3.2 Expenses covered under this benefit are payable at 100% up to a maximum of $5,000 per insured for the planned trip, namely:

a) <u>In case of cancellation prior to departure</u>
- the non-refundable portion of prepaid travel expenses;
- additional expenses incurred by the insured in the event that the person who was to accompany him and share the room or the apartment at destination must cancel for one of the reasons mentioned under *Section 7.3.1* and the insured decides to proceed with the trip as initially planned, up to the amount of the cancellation penalty (single occupancy) applicable at the time the travel companion has to cancel;
- the non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's departure is delayed due to weather conditions and he **decides not to proceed with the trip**.

b) <u>If a departure is missed (at the start or during the trip)</u>
- The additional cost required by the scheduled public carrier (airline, bus, train) in economy class by the most direct route to the planned destination.

c) <u>If the return is earlier or later than scheduled</u>
- the additional cost of a **one-way economy class ticket**, by the most direct route, for a return trip to the point of departure, **by the means of transportation initially planned**.

  If the means of transportation initially planned cannot be used, whether or not travel expenses have been prepaid, the expenses covered correspond to the expenses required by a scheduled carrier for an economy class ticket, by the most economical means, by the most direct route to return the insured to the point of departure. **These expenses require prior authorization from the Insurer (*see Section 7.2*);**

However, if the insured's return is delayed by more than seven (7) days as the result of an illness or accident suffered by the insured or his travel companion, the expenses incurred are covered provided the person in question is admitted to hospital as an inpatient for more than 48 hours within such seven (7)-day period.

If the travel expenses have not been prepaid, the expenses incurred by the insured are covered provided he was not aware, before the start date of the trip, of any event that could reasonably lead to the interruption of the planned trip;

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

d) Round-trip transportation

Trip Cancellation Insurance covers transportation expenses by the most economical means, after prior authorization from the Insurer (*see Section 7.2*) to return the insured to his province of residence and then to return to the place where he was travelling provided the reason is:

- the death or hospitalization of a family member of the insured, or a person for whom the insured is the legal guardian or testamentary executor;
- damage rendering the principal residence of the insured uninhabitable or causing major harm to his business establishment.

Note: Please refer to *section 7.5* for limitations and exclusions to this coverage.

7.4 DEFINITIONS APPLICABLE TO TRIP CANCELLATION INSURANCE

Under this benefit, the words and expressions below are defined as follows:

- Accident

  An unintentional, sudden, fortuitous and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injuries;

- Insured

  The participant, spouse, their dependent children or persons suffering from a functional impairment covered under this benefit;

- Travel companion

  The person with whom the insured shares the room or apartment at destination or whose travel expenses were paid along with those of the insured;

- Host at destination

  The person with whom the insured shares accommodation arranged in advance, provided the accommodation is at the principal residence of the host at destination;

- Family member

  Spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, grandparent, grandchild, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in law;
- Business partner

  A person with whom the insured is associated for business purposes in a company composed of four (4) co-shareholders or fewer, or a commercial company or association composed of four (4) partners or fewer;
- Prepaid travel expenses

  Amounts paid by the insured to purchase a package trip, a ticket from a public carrier or to rent a motor vehicle from an accredited commercial establishment. Also included are amounts paid by the insured concerning reservations for ground arrangements usually included in a package trip, whether the reservations are made by the insured or a travel agent, as well as amounts paid by the insured in relation to registration fees for a commercial activity;
- Commercial activity

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

  A trip, as a tourist or for pleasure, or for a commercial activity, which entails the absence of the insured from his place of residence for a period of at least two (2) consecutive nights and requiring a trip of at least 400 kilometres (round trip) from his place of residence; a cruise lasting at least two (2) consecutive nights, under the responsibility of an accredited firm, is also considered to be a trip.

7.5 EXCLUSIONS, LIMITATIONS AND COORDINATION

7.5.1 Exclusions applicable to Travel Insurance

This benefit does not cover:

- expenses incurred after the insured has returned to his province of residence;
- expenses payable under any social legislation;
- expenses related to elective and non-emergency treatment;
- hospital or medical expenses that are not insured in accordance with a provincial plan;
- expenses incurred abroad when such expenses could have been incurred in the province of residence of the insured without danger to his life or health, except for expenses required immediately following an emergency situation;

- hospital expenses in a facility treating chronic illnesses or expenses for similar services in a public hospital, and expenses incurred in an extended-care or thermal spa facility.

7.5.2 Exclusions applicable to Trip Cancellation Insurance

This benefit does not apply if the trip is taken for the purpose of visiting or being at the bedside of a person who is ill or has suffered an accident, and whose medical condition or subsequent death leads to cancellation, early return or late return.

7.5.3 Exclusions applicable to Travel Insurance and Trip Cancellation Insurance

These benefits do not cover losses caused by the following or to which the following causes have contributed:

- active participation by the insured in a riot or insurrection, a criminal act or attempted crime;
- service in the armed forces, a war or acts of war, whether declared or not, in Canada or in a foreign country, provided the government of Canada has issued a travel warning for the country in question;

  This exclusion does not apply to an insured already present in a foreign country at the time war or acts of war break out. However, if the Government of Canada then recommends leaving the country, the insured must, to remain covered, take the necessary measures to leave the country as soon as possible;
- intentional self-inflicted injury by the insured or his travel companion, suicide or attempted suicide, whether the person in question was sane or not. However, in the case of a death resulting from suicide, only the costs incurred to prepare and return the remains are covered under the provisions of this benefit;
- abusive consumption of medication, drugs or alcohol and the ensuing consequences;
- participation in extreme or combat sports, gliding, hang gliding, paragliding, bungee jumping, mountain climbing, parachuting or skydiving or any other similar activity, or participation in any motorized vehicle competition, or participation in any sporting activity involving remuneration;
- pregnancy, miscarriage, childbirth or related complications occurring within the two (2) months preceding the normal expected date of delivery;
- a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician.

7.5.4 Limitations to Travel Insurance

- In the event of a medical condition requiring extended medical services, treatment or surgery, if medical evidence indicates that after diagnosis or emergency treatment of this condition, the insured could have returned to his province of residence but chose to obtain services elsewhere, the Insurer will not assume the cost of services, treatments, surgeries and other expenses.
- The Insurer reserves the right to repatriate the insured to his province of residence when his medical condition permits. Any refusal to be repatriated discharges the Insurer from any liability for expenses subsequently incurred.
- Total benefits may not exceed $5,000,000 per insured, per trip abroad.

7.5.5 Limitations to Travel Assistance

- Neither the Insurer nor the company providing travel assistance is responsible for the availability or quality of the medical and hospital care administered, or for the possibility of obtaining such care.
- Some of the services described may not be available in certain countries.
- The services offered are subject to change by the Insurer without prior notice.

7.5.6 Limitations to Trip Cancellation Insurance

In the event of cancellation prior to departure, the trip must be cancelled through the travel agent or carrier within 48 hours of the event causing cancellation, or, if this 48-hour period ends on a statutory holiday, on the next working day. If the end of the period coincides with a statutory holiday, the notice must be sent on the 1st working day afterwards. The Insurer's liability is limited to the cancellation costs stipulated in the travel contract that are applicable at the time such notification should have been given.

However, this limitation will not apply if the insured and spouse provide proof deemed satisfactory by the Insurer that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so. The Insurer's liability is limited to the applicable cancellation expenses stipulated in the travel contract at the time of cancellation.

7.5.7 Coordination

Expenses eligible for reimbursement under this contract will be reduced by the amount of any corresponding benefits payable under another individual or group insurance contract. However, if the insured is entitled to similar benefits under other provisions of this contract, benefits will only be payable under the provisions of this benefit. This clause should not be interpreted as limiting the scope of other coverage under the accident and health insurance plan when benefits are not payable under Travel or Trip Cancellation Insurance.

8- HOW TO SUBMIT A CLAIM

8.1 HOSPITAL AND MEDICAL EXPENSES

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

8.2 PRESCRIPTION DRUG EXPENSES

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

8.2.1 The SSQ Card

Only prescription drug expenses can be forwarded to SSQ via the electronic claims transmission system.

Upon presentation of your SSQ Card, your pharmacist will immediately validate whether the drug is eligible for reimbursement.

a) Eligible drugs

You pay your pharmacist the portion of the cost that is not reimbursed by your plan. SSQ reimburses the insured portion directly to the pharmacist. You have nothing else to do. The pharmacist is required to charge you the standard price, namely the same price paid by all other customers.

b) Non-eligible drugs

If the drug purchased is not eligible for reimbursement, the pharmacist will also give you a receipt with different messages, for example:

Indication	Meaning
“Drug not covered"	Request for reimbursement refused, since the drug is not covered under the drug benefit.
"Maximum duration of treatment 90 days"	The quantity of drugs purchased cannot exceed a treatment period of 90 days. However, if for specific reasons your prescription exceeds a treatment period of 90 days, submit your claim, along with an explanatory note, directly to SSQ.

Indication	Meaning
“Submit to Insurer"	The drug cannot be processed by using the SSQ Card but could be eligible for reimbursement. Example: If the prescription must be prepared by the pharmacist (magistral prescription).
"Exception drugs"	Drugs for which prior authorization must be obtained from the Insurer (*see Section 2.2.1*).

c) First use

If you have Family or Single-Parent coverage status, when you first use your SSQ Card for a member of your family, the pharmacist must complete the file by entering the first name and date of birth of the insured. Please provide your pharmacist with this information, if it has not already been entered in the system. This information remains confidential. As proof of age may be required by the pharmacist, you may wish to present the insured’s RAMQ health insurance card.

d) Dependent children: full-time students aged 18 to 25, inclusive

Drug expenses for dependent children aged 18 to 25, inclusive, are covered upon presentation of a declaration of school attendance.

A declaration of school attendance must be provided to the Insurer via SSQ’s ACCESS | Plan Members Web site, by telephone or in writing once every school year (September 1 to August 31) for prescription drug claims to be considered directly at the pharmacy. SSQ reserves the right to require proof of school attendance.

8.2.2 By mail

If you are unable to use your SSQ Card (lost, non-participating pharmacist, etc.), submit your claim using the claim form.

You can also print a claim form from our ACCESS | Plan Members Web site. For more information about our online services, please refer to *section 10* of this booklet.

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

The pharmacist’s invoice must be duly paid and show the participant’s name, the patient’s name, the number and date of the medical prescription, the physician’s name, the drug name and quantity.

Where permitted by law, drugs supplied by a physician are also eligible for reimbursement upon submission of receipts indicating the drug name and quantity.

8.3 OTHER ACCIDENT AND HEALTH INSURANCE EXPENSES

The insured must file claims for all other eligible expenses directly with SSQ.

The originals of receipts and paid invoices should be submitted on a regular basis, **once every three** (3) months. As receipts and invoices will not be returned, you may wish to keep copies. **To be eligible for reimbursement, all receipts and invoices, including prescription drug expenses, must be presented within 12 months of the dates they were incurred.** Please note that the use of the SSQ Card for drug purchases ensures that receipts and invoices are submitted on time.

Claims should be submitted to SSQ at the address below using the claim form. This personalized claim form is attached to your last benefit payment. You can also print out a personalized claim form on the ACCESS | Plan Members Web site. For more information about our online services, please refer to *section 10* of this booklet. Please indicate your contract number on all claims or any other correspondence sent to SSQ.

SSQ, 2525 Laurier Blvd. 10500, Stn. Ste-Foy, Quebec QC G1V 4H6

Direct Deposit of Accident and Health Insurance Benefits

Direct Deposit enables you to obtain reimbursement of your claims more quickly and eliminates any risk of loss or theft of your benefit cheques.

You can opt for Direct Deposit when registering to use our secure transactional site ACCESS | Plan Members. When registering, be sure to have your SSQ Card to hand, as well as a personal cheque showing your bank account number. To find out how to register and for more details on our online services, go to *Section 10*.

If you would like to register for Direct Deposit but do not have access to the Internet, or if you require assistance in any way, contact SSQ Customer Service at one of the numbers provided on the back of this booklet.

8.4 HOSPITAL OR MEDICAL EXPENSES RELATED TO A WORKPLACE OR AUTOMOBILE ACCIDENT

In the event of a workplace or automobile accident, all ensuing medical or hospital expenses are payable by the CSST or the SAAQ. Receipts and invoices should therefore be submitted to the CSST or the SAAQ and not to SSQ.

8.5 PARTICIPANT'S, SPOUSE'S AND DEPENDENT CHILDREN'S LIFE AND ACCIDENTAL DISMEMBERMENT (AD) INSURANCE

Claim forms for Life and Accidental Dismemberment Insurance are available directly from SSQ. These claims must be submitted within 90 days following the event.

8.6 LONG TERM DISABILITY INSURANCE

In all cases, claims for Long Term Disability Insurance benefits must be submitted to SSQ no later than 90 days following the date on which Long Term Disability Insurance benefits become payable. The employer is responsible for sending the declaration of disability to SSQ **at the beginning of the seventh month** after the employee's disability start date.

8.7 TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE

8.7.1 Travel Insurance

Hospital and medical expenses payable under the Travel Insurance benefit are reimbursed only after assessment by government agencies (the RAMQ, the SAAQ, etc.), if applicable.

All expenses covered under this benefit may be claimed directly from CanAssistance upon presentation of supporting documents deemed satisfactory by the Insurer (invoices, receipts, prescriptions, etc.).

8.7.2 Trip Cancellation Insurance

When submitting a claim, the insured must include the following supporting documents:

a) unused travel tickets;

b) official receipts for additional transportation expenses;

c) receipts for ground travel and other expenses. Receipts must include contracts officially issued by a travel agent or accredited firm indicating the non-refundable amounts in case of cancellation. Written proof that the insured has submitted a request for reimbursement of travel expenses from the travel agent or accredited firm must be forwarded to the Insurer, along with the reply received from the agent or firm;

d) an official document certifying the reason for cancellation. If cancellation is due to medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising in the locality where the illness or accident occurred; the medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip;

e) a police report (in the event of delay due to a traffic accident or emergency road closure);

f) an official weather report issued by the appropriate authorities;

g) written proof issued by the official organizer of a commercial activity to the effect that an event is cancelled and indicating the specific reasons why;

h) any other report required by the Insurer in support of the insured's claim.

8.8 PERSONAL INFORMATION AND INSURANCE FILE

To maintain the confidentiality of personal information, SSQ will create an insurance and annuity file to hold information about your application for insurance or an annuity, along with information about any insurance claims you make.

Access to this file will be restricted to employees or agents who are responsible for underwriting, investigations and claims, and any other person you may authorize. Your file will be kept in SSQ's offices in Quebec.

You have the right to consult the personal information held in your file and, if necessary, have this information rectified by submitting a request in writing to the address specified in *Section 8.3.*

9- INSURANCE PLAN FOR RETIRED MANAGEMENT PERSONNEL

9.1 ELIGIBILITY

Any member of the management personnel of the Quebec public and parapublic sectors who, at the time his duties cease, is eligible for an immediate retirement pension, with or without actuarial reduction, in accordance with the retirement plan to which his employer contributes, and who participates in the group insurance plan for management personnel.

> **Note: Principals and vice-principals who were members of the Association québécoise des directeurs et directrices d'établissement d'enseignement (FQDE) at the time of their retirement are not eligible for these plans since they are covered under their own plan.**

9.2 APPLICATION PERIOD

Insurance for eligible individuals who submit their applications within the timeframe described below becomes effective on the date upon which they become eligible.

9.2.1 Accident and health insurance plan for retired management personnel under age 65

Individuals have **90 days** following the date they become eligible for the accident and health insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

If the Insurer receives the form after this period, participation in the expanded plan is no longer possible. Coverage under the Compulsory Basic Accident and Health Insurance Plan is accessible at all times and premium payment is retroactive to the eligibility date without exceeding 12 months, for individual, single parent and family. Benefits for this period are also retroactively reimbursed, up to a maximum of 12 months.

Moreover, individuals must pay RAMQ premiums for the period that is not covered by SSQ without, however, being entitled to reimbursement for prescription drug purchases during this period. Participation in the retirees' accident and health insurance plan is compulsory under Quebec's Act respecting prescription drug insurance.

9.2.2 Accident and health insurance plan for retired management personnel aged 65 or over

From age 65, participants may choose to maintain prescription drug insurance coverage with SSQ, or opt for coverage with the RAMQ. Individuals have **90 days** following the date they become eligible for the

accident and health insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

A retiree, aged 65 or over, who does not file an application with the Insurer for coverage under the accident and health insurance plan within 90 days following the date of eligibility forfeits any right to participate in the plan thereafter.

9.2.3 Life insurance plan

Individuals have **90 days** following the date they become eligible for the life insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

A retiree who fails to file an application for the retired management personnel life insurance plan with the Insurer within 90 days following the date of eligibility forfeits any right to participate in the plan thereafter.

Once you **change from the employee group insurance plan to the retiree group insurance plan**, all the information in your file at the time will be transferred to your new file under the retiree group insurance plan. Documents already provided to SSQ, such as the declaration of school attendance for your dependent children or the form for exception drugs, if applicable, will not need to be submitted again. SSQ keeps track of the reimbursement in health insurance expenses, which means that the amounts you have incurred since January 1 will be included under your new plan. During this transfer of information, the amount of claims paid by SSQ for each type of treatment is also compiled and included under your new plan. However, for any given type of treatment, it is possible to ask that SSQ reset your counter to zero. As such, you will be entitled to the maximum reimbursement stipulated under the retiree group insurance plan.

For a complete description of the plans available for retired management personnel, please consult the booklet entitled: **Group Insurance Plans offered to Retired Management Personnel of the Quebec Public and Parapublic Sectors,** which you may obtain by contacting SSQ's Customer Service.

10- SSQ'S ONLINE SERVICES

10.1 ACCESS | Plan members

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

- Register for Direct Deposit of your Accident and Health Insurance benefits;
- View your electronic claim statements;
- Print personalized claim forms;
- Order tax receipts for incurred medical expenses;
- Print a temporary SSQ Card if you lose or misplace your existing card;
- Change your address;
- View the coverage included as part of your contract.

To register for Access and take advantage of our handy online services, visit our Web site at www.ssq.ca. Click on the **ACCESS |** Plan Members link in the group insurance area of the site. Then, just follow a few simple online instructions designed to guide you through the registration process.

If you require assistance, contact SSQ Customer Service, Monday to Friday from 8:30 a.m. to 4:30 p.m. at one of the numbers on the back of the booklet.

10.2 SSQ MOBILE SERVICES

If you have a smart phone* you can download the SSQ Mobile Services application at www.ssq.ca/mobile.

The application enables you to:

- submit your claims;
- view your previous payments;
- have an electronic version of your SSQ Card at hand;
- reach our Customer Service with just one click.

* Now available on Apple and Android platforms.

11- GOOD THINGS TO KNOW

- If the health care professional who is treating you recommends a particular treatment and you're not sure whether this treatment is covered, call SSQ.
- If the cost of proposed treatment or products is over $200 and you're not sure whether you're covered, call SSQ.
- For income tax purposes, keep the claim summary that is attached to your reimbursement cheque. When you prepare your income tax return, add up all of your claim summaries to determine the total amount of medical expenses that could increase your tax credits. If you are registered to use SSQ's ACCESS | Plan Members Web site, you can submit a request on line for a tax receipt that includes the amounts of claims made and the amounts reimbursed under your contract. You can include the receipt with your income tax return.
- For income tax purposes, only your employer can provide you with details of the total premiums you paid for your group insurance coverage. Contact your group plan administrator for more information.
- Did you know that if you are covered under two group insurance plans, you may be able to obtain full reimbursement of your expenses if they are eligible under both plans? You should first submit your claim to the insurer who covers your plan with your main employer. When you receive your claim summary, you can send a copy of it, along with copies of your receipts and paid invoices, to submit a claim for the difference to your other insurer.
- Misplaced your claim form? Simply write your name and Insurance Certificate number on a separate sheet of paper and attach it to your claim. Your claim will be processed in the usual manner. You can also print a personalized claim form from SSQ's ACCESS | Plan Members Web site.
- Always use your SSQ Card and you will immediately know whether your prescription drugs are eligible for reimbursement.
- If you experience health problems while travelling, don't hesitate to contact CanAssistance at one of the numbers on the back of your SSQ Card.
- We wish to remind you that generic drugs are less costly than brand-name drugs and their therapeutic benefits are generally identical. This means that each dollar that is saved by you is also saved by the entire group. We therefore suggest you discuss the possibility of using generic drugs with your attending physician and pharmacist.

12- RATES

BI-WEEKLY RATES FROM JANUARY 1 TO DECEMBER 31, 2013

Plan	Employer	Premium holiday (employee)	Employee	Total	Additional premium for participants age 65 or over[1]
Compulsory Basic Accident and Health Insurance Plan					
Individual coverage	$22.23	$3.89	$31.10	$57.22	$78.94
Single-Parent coverage	$23.44	$4.09	$32.79	$60.32	$91.16
Family coverage	$44.93	$7.85	$62.87	$115.65	$169.81
Compulsory Basic Life Insurance Plan (as % of salary)					
- Participant's	–	0.059%	0.006%	0.065%	
- Spouse's and Dependent Children's	–	0.021%	0.002%	0.023%	
- Accidental Dismemberment	–	0.005%	0.001%	0.006%	
TOTAL	–	**0.085%**	**0.009%**	**0.094%**	
Compulsory Basic Long Term Disability Insurance Plan (as % of salary)	0.530%	–	–	0.530%	
Compulsory Additional Long Term Disability Insurance Plan (as % of salary)	0.015%	–	–	0.015%	

Premiums do not include the 9% provincial sales tax.

[1] Additional premiums paid by participants age 65 or over, starting the January 1 following their 65th birthday if opting for prescription drug coverage under the group insurance plan, rather than under the RAMQ plan.

Plan	Male [2]							
	Smoker				Non-smoker			
	Premium holiday	Employee	Total in $	Employee as % of salary	Premium holiday	Employee	Total in $	Employee as % of salary
Participant's Optional Life Insurance Plan (Rates per $1,000 of coverage and as % of salary)								
Age 34 and under	$0.014	$0.001	$0.015	0.003%	$0.007	$0.001	$0.008	0.003%
Age 35 to 39	$0.021	$0.002	$0.023	0.005%	$0.009	$0.001	$0.010	0.003%
Age 40 to 44	$0.032	$0.003	$0.035	0.008%	$0.015	$0.002	$0.017	0.005%
Age 45 to 49	$0.053	$0.006	$0.059	0.016%	$0.028	$0.003	$0.031	0.008%
Age 50 to 54	$0.089	$0.010	$0.099	0.026%	$0.052	$0.006	$0.058	0.016%
Age 55 or over	$0.140	$0.015	$0.155	0.039%	$0.095	$0.011	$0.106	0.029%
	Female [2]							
Age 34 and under	$0.009	$0.001	$0.010	0.003%	$0.004	$0.000	$0.004	0.000%
Age 35 to 39	$0.015	$0.002	$0.017	0.005%	$0.008	$0.001	$0.009	0.003%
Age 40 to 44	$0.029	$0.003	$0.032	0.008%	$0.014	$0.001	$0.015	0.003%
Age 45 to 49	$0.041	$0.005	$0.046	0.013%	$0.022	$0.002	$0.024	0.005%
Age 50 to 54	$0.068	$0.007	$0.075	0.018%	$0.038	$0.004	$0.042	0.010%
Age 55 or over	$0.097	$0.011	$0.108	0.029%	$0.069	$0.008	$0.077	0.021%

Premiums do not include the 9% provincial sales tax.

[2] All premium rate changes applicable subsequent to an age change are effective as of January 1 coinciding with or following the age change.

Plan	Male [3]					
	Smoker			Non-smoker		
	Premium holiday	Employee	Total	Premium holiday	Employee	Total
Spouse's Optional Life Insurance Plan (Rates per $10,000 of coverage according to participant's age)						
Age 34 and under	$0.14	$0.01	$0.15	$0.07	$0.01	$0.08
Age 35 to 39	$0.21	$0.02	$0.23	$0.09	$0.01	$0.10
Age 40 to 44	$0.32	$0.03	$0.35	$0.15	$0.02	$0.17
Age 45 to 49	$0.53	$0.06	$0.59	$0.28	$0.03	$0.31
Age 50 to 54	$0.89	$0.10	$0.99	$0.52	$0.06	$0.58
Age 55 or over	$1.40	$0.15	$1.55	$0.95	$0.11	$1.06
	Female [3]					
Age 34 and under	$0.09	$0.01	$0.10	$0.04	$0.00	$0.04
Age 35 to 39	$0.15	$0.02	$0.17	$0.08	$0.01	$0.09
Age 40 to 44	$0.29	$0.03	$0.32	$0.14	$0.01	$0.15
Age 45 to 49	$0.41	$0.05	$0.46	$0.22	$0.02	$0.24
Age 50 to 54	$0.68	$0.07	$0.75	$0.38	$0.04	$0.42
Age 55 or over	$0.97	$0.11	$1.08	$0.69	$0.08	$0.77

Premiums do not include the 9% provincial sales tax.

[3] Rates for Spouse's Optional Life Insurance are determined based on the spouse's gender or smoking habits (smoker or non-smoker) and on the participant's age. All premium rate changes applicable subsequent to an age change are effective as of January 1 coinciding with or following the age change.

NOTES

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Please keep this booklet for future reference.

SSQ Financial Group

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