SSQ insurance

Communities make us

Group insurance

Your Group Insurance Plan

FSSS (CSN)
RSGE
April 1st, 2022

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

FSSS CSN

Secteur des responsables de service de garde éducatif en milieu familial

FSSS CSN

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

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

Cette brochure est disponible en français.

PERSONAL INFORMATION PROTECTION

File and personal information

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

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

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

Legal agents and service providers

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

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

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

Available information on your group insurance plan

You are entitled to consult the policy at the policyholder's address and obtain a copy thereof.

Please note that even though this booklet is effective April 1, 2022, the definitions of "Total disability"and "Total disability period" in section 7.1 have been effective since July 1, 2021.

Table of Contents

SUMMARY OF BENEFITS

This table summarizes the modalities applicable to each benefit. For a more complete description of the applicable conditions, consult the other provisions of this booklet.

HEALTH PLAN
OVERVIEW This table presents the expenses that are eligible under each of the three Health Plans (Health 1, Health 2 and Health 3), provided the eligibility provisions for expenses described in Section **1** - "**Health Plan**" are respected, as are the coordination provisions and the exclusions, limitations and restrictions of the Health benefit.
When a maximum of eligible expenses is indicated, it must be multiplied by the percentage of reimbursement to determine the reimbursable amount. The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for expenses incurred during a single calendar year. The note **PCRP** (planned calculated reimbursement percentage) in the "COVERAGE" column indicates that the amount (ceiling) at which the reimbursement percentage indicated for prescription drugs is increased to 100% applies to all coverage marked PCRP.
When a medical prescription is required, the note **PR** appears in the "COVERAGE" column. In this case, the prescription must indicate the name of the medication or, in the case of other products or services, the diagnosis, medical reasons, indications for use justifying the prescription and the planned duration of use. **Unless specified otherwise:** • the maximums indicated in this table are maximums **per insured person per calendar year**; • any maximum indicated on a given line applies as a total for all of the items in the "COVERAGE" column of this line and not to each item separately; • in the case of expenses incurred for the services of health care professionals, eligible expenses are limited to a single treatment per day per health profession.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Prescription drugs			
Deductible per prescribed drug	$5	$5	$5
Percentage of reimbursement for all coverage with PCRP mention	65% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate	75% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate	80% of eligible expenses and 100% of out-of-pocket amount exceeding $950 for each certificate
Prescription drugs* PR and PCRP RAMQ List (Health 1) SSQ's Regular List (Health 2 and Health 3)	Drugs that appear on the list of drugs covered by the BPDIP[(1)] and meet the requirements	Drug that meets the following requirements: • It bears a valid DIN (Drug Identification Number) issued by the federal government. • It is available only on prescription from a health care professional legally authorized to prescribe it. • It is available exclusively in pharmacies and sold by a health care professional in accordance with the *Pharmacy Act*. • It is used in compliance with government-approved indications for use or, in the absence of such indications, the indications for use provided by the manufacturer.	
Exception drugs* PR and PCRP	Prescription drugs named "exception drugs" that are part of the list of drugs whose cost is covered under the BPDIP according to the conditions and instructions for use specified in the Regulation Respecting the Basic Prescription Drug Insurance Plan. These drugs require prior authorization from SSQ.		
Medication injected at a doctor's office* PR and PCRP	Only the cost of the injected substance is eligible; the expenses incurred for the medical procedure and the portion of the product that is not actually injected are not eligible.		
Smoking cessation products* PCRP	Those that are covered under the BPDIP.		

[(1)] BPDIP means Quebec Basic Prescription Drug Insurance Plan.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Eligible pharmaceutical services* PR and PCRP	Those that are covered under the BPDIP.		
Intrauterine devices* PR and PCRP	Those that bear a valid DIN, containing an active medicinal ingredient and that are covered under the BPDIP.		
Diabetic products PR and PCRP	Insulin, syringes, lancets, needles, test strips and glucose sensors, for the treatment of diabetes. For test strips and glucose sensors for intermittent blood glucose monitors to be considered eligible expenses, the following conditions must be met: • the number of test strips that can be reimbursed is limited to an annual maximum; this maximum may be increased based on the insured's medical condition, provided prior approval by SSQ is obtained; • the number of glucose sensors that can be reimbursed is limited to an annual maximum, and prior approval by SSQ is required.		

*** Reimbursement of brand name drugs**

If the insured chooses to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons, by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by SSQ.

Brand name drugs are those which are sold under the original maker's trademark and for which there is at least one generic equivalent on the market.

Direct payment of prescription drug expenses

The insured can use the electronic claims transmission service offered by SSQ. For instructions on how to use this service, please refer to section **8** "**How to submit claims**".

Certain provisions exist to limit the payment of monthly expenses by **high-cost prescription drug users** who meet the criteria established by SSQ. The insured may contact SSQ to learn more about these criteria.

Sclerosing injections PR and PCRP	For substances provided and administered by a physician for curative and non-aesthetic purposes. Medical procedure not covered.
Maximum	Reimbursement of $25 per day of treatment.

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Emergency Care			
Travel Insurance with Assistance	The Travel Insurance provisions can be found in a separate electronic format document entitled "Travel Insurance with Assistance and Trip Cancellation Insurance" on the secure site for insureds at ssq.ca.		
Percentage of reimbursement	100%	100%	100%
Maximum	Reimbursement of $5,000,000 for the duration of the trip.		
Trip Cancellation Insurance	The Travel Insurance provisions can be found in a separate electronic format document entitled "Travel Insurance with Assistance and Trip Cancellation Insurance" on the secure site for insureds at ssq.ca.		
Percentage of reimbursement	100%	100%	100%
Maximum	Reimbursement of $5,000 per trip.		
Transportation by an ambulance service PCRP	When the person's state of health requires it, ground transportation to or from the nearest hospital offering care, including oxygen therapy treatments received immediately prior to and during transport.Transportation by plane (or by helicopter in cases where it is not covered by a third party), by boat or by train is also covered when part or all of the journey requires the use of one of these means of transportation and the insured is bedridden and must occupy the equivalent of two seats. In this case, medical necessity must be demonstrated to the satisfaction of SSQ. In all cases, transportation must be provided by a licensed ambulance service.		
Percentage of reimbursement	65%	75%	80%
Maximum	Customary and reasonable expenses.		
Other medical expenses			
Insulin pump accessories PR	Not covered	Purchase of accessories used exclusively with an insulin pump.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Hearing aid	Not covered	Purchase, adjustment or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $480 per period of 48 months.	
Therapeutic devices and breathing assistance apparatus PR	Not covered	Rental. Upon prior agreement with SSQ, expenses for purchase can also be eligible, as well as expenses for replacement or repair. Breathing assistance apparatus: The items must be used to replace, compensate for or improve the functional respiratory capacities of the insured. Therapeutic devices: The items must be necessary for the healing or treatment of the insured.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $10,000.	
Orthopaedic devices PR and PCRP	Not covered	Purchase, adjustment, replacement, repair. To be covered as an orthopaedic device, the item must be used to support or maintain part of the insured's body to prevent and correct body deformities or to treat disorders of the bone structure, muscles or tendons. It must also be considered as such by SSQ. Foot orthoses must be provided by an officially licensed specialized laboratory.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Ostomy appliances PR and PCRP	Not covered	Purchase.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	

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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Support stockings
PR</td><td rowspan="3">Not covered</td><td colspan="2">Purchase of support stockings (20 mm Hg or above) for venous or lymphatic system deficiency, if obtained from a health-care establishment or a pharmacy.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">3 pairs.</td></tr>
<tr><td>Cannabis for medical purposes
PR</td><td colspan="3">The purchase of cannabis for medical purposes requires prior approval by SSQ and must meet the following conditions in order to be considered an eligible expense:

a. the cannabis for medical purposes must be prescribed by a physician or nurse practitioner according to their respective definitions provided in the federal regulations governing access to cannabis for medical purposes

b. the cannabis for medical purposes is only covered if its use is for conditions and therapeutic indications determined by SSQ

c. the insured must submit to SSQ for approval, at the time of the first claim and upon the renewal of the prescription afterwards:
• the Health Canada medical document authorizing the use of cannabis for medical purposes duly completed by a physician or authorized nurse practitioner
• the SSQ “Prior authorization request” form duly completed by the insured and that same physician or authorized nurse practitioner

d. the cannabis for medical purposes must be purchased only from a holder of a licence for sale duly authorized by Health Canada.</td></tr>
<tr><td>Percentage of reimbursement</td><td>65%</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="3">Reimbursement of $2,000.</td></tr>
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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Orthopaedic shoes
PR and PCRP</td><td rowspan="3">Not covered</td><td colspan="2">Purchase of shoes:
• designed and made to measure from a cast when such shoes are required to correct or compensate for a foot defect; or
• prefabricated open, flared or straight shoes; or
• shoes needed to support Denis Browne splints.
These shoes must have been obtained from an officially licensed specialized laboratory.
Cost of additions or alterations made to orthopaedic shoes.
For the purposes of this coverage, deep shoes and sandals are not considered to be orthopaedic shoes.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Customary and reasonable expenses.</td></tr>
<tr><td>Deep shoes
PR and PCRP</td><td rowspan="3">Not covered</td><td colspan="2">Purchase and replacement of prefabricated deep shoes, when these shoes are required to correct a foot defect and are obtained from an officially licensed specialized laboratory.
For the purposes of this coverage, sandals are not considered to be deep shoes.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Reimbursement of $150.</td></tr>
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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Gender affirmation surgery</td><td rowspan="3">Not covered</td><td colspan="2">Expenses incurred while undergoing gender-affirming surgery performed by a physician to modify the insured's sexual characteristics so that they correspond to those associated with their self-identified gender. Expenses incurred for hair removal through electrolysis or laser treatment are also eligible expenses.

The surgery or hair removal must meet the following conditions to be considered an eligible expense:

• the insured must have received a gender dysphoria diagnosis from a physician;

• the surgery or hair removal must be performed in Canada;

• the surgery or hair removal must not be covered under the health insurance plan of the insured's province of residence.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Reimbursement of $10,000 per calendar year.
Lifetime reimbursement of $30,000.</td></tr>
</table>

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Dental care required following an accident	Not covered	Fees of a dental surgeon, dental specialist or denturist, to repair accidental damage to sound natural teeth or to treat an accidentally fractured jaw. The accident must occur while the person is insured under Health 2 or Health 3. The treatments must begin within 12 months of the date of the accident and must end within 36 months of the date of the accident. Expenses related to implants and damage to teeth while eating are not covered. However, dentures attached to implants can be recognized as eligible, up to the cost and maximum applicable to a covered alternative treatment and payable only at the time of the final insertion of the dentures attached to the implant.	
Percentage of reimbursement		75%	80%
Maximum		Rates recommended by the ACDQ for the year the treatments are received.	

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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td>Detoxification
PR</td><td rowspan="3">Not covered</td><td colspan="2">Detoxification therapies provided by a clinic specialized in rehabilitation treatment for alcoholism or drug or gambling addiction, including all treatment-related expenses.

For expenses incurred for this type of treatment to be considered eligible, the following conditions must apply:
• the clinic must be recognized by SSQ;
• the insured must be receiving curative treatment;
• the clinic must be run by a licensed physician and be under the continuous supervision of a registered nurse.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td>Reimbursement of $50 per day.
Lifetime reimbursement of $3,000.</td><td>Reimbursement of $85 per day.
Lifetime reimbursement of $5,000.</td></tr>
<tr><td>Wheelchair and walker
PR</td><td rowspan="3">Not covered</td><td colspan="2">Rental for a temporary need.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">For a wheelchair: eligible expenses up to the cost of a non-motorized wheelchair of a type generally used in a hospital</td></tr>
<tr><td>Blood glucose monitor
PR</td><td rowspan="3">Not covered</td><td colspan="2">Purchase, adjustment, replacement or repair.</td></tr>
<tr><td>Percentage of reimbursement</td><td>75%</td><td>80%</td></tr>
<tr><td>Maximum</td><td colspan="2">Reimbursement of $240 per period of 36 consecutive months.</td></tr>
</table>

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Intraocular lens implants PR and PCRP	Not covered	Purchase, if required to correct the symptoms of an eye disease in cases where the use of contact lenses or eyeglasses is not sufficient to correct such symptoms.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Hospital bed PR	Not covered	Rental or purchase of a hospital bed, whichever is more economical. The hospital bed must be similar to the type normally used in a hospital.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
External prostheses and artificial limbs PR and PCRP	Not covered	The loss of a natural limb must occur while the person is insured under this benefit. Items already covered under another section of this table **are not covered as external prostheses or artificial limbs**.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Transcutaneous electrical nerve stimulator PR	Not covered	Purchase, rental, adjustment, replacement or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $560 per period of 60 consecutive months.	
Insulin pump PR	Not covered	Purchase, adjustment, replacement or repair.	
Percentage of reimbursement		75%	80%
Maximum		Reimbursement of $6,400 per period of 60 consecutive months.	

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Wig PR	Not covered	Purchase of an initial wig following: • chemotherapy; or • any form of alopecia, provided the wig is medically required.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $300.	
Breast prostheses PR and PCRP	Not covered	Purchase if required following a mastectomy.	
Percentage of reimbursement		75%	80%
Maximum		Customary and reasonable expenses.	
Surgical brassieres PR	Not covered	Purchase following a mastectomy or breast reduction.	
Percentage of reimbursement		75%	80%
Maximum		Lifetime reimbursement of $200.	
Intrauterine devices (IUDs) PR and PCRP	Purchase of IUDs not covered under the prescription drug insurance benefit of this plan.		
Percentage of reimbursement	65%	75%	80%
Maximum	Customary and reasonable expenses.		

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Transportation and accommodation in Quebec to consult a medical specialist or receive specialized treatment PR and PCRP	Transportation of at least 400 kilometres (round trip), from the insured's place of residence by the most direct route to the nearest establishment, and accommodation in a public establishment. Also, if the insured is under age 18, transportation of an accompanying parent. • Supporting documents for accommodation expenses must be attached to the claim. • In the case of use of a private vehicle, receipts for the purchase of gas are required. • A report signed by the attending physician demonstrating that specialized consultation or treatment is required and indicating where it will take place must be sent to SSQ. It must be demonstrated to the satisfaction of SSQ that the medical specialist and the specialized treatment are not available in the region, and that accommodation is necessary if accommodation expenses are claimed.		
Percentage of reimbursement	65%	75%	80%
Maximum	• Reimbursement of $48 per day. • Reimbursement of $1,000. Eligible transportation expenses limited to the average cost of the most economical means of transportation, regardless of whether the person uses a public or private means of transportation.		

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<tr><th>COVERAGE</th><th>HEALTH 1</th><th>HEALTH 2</th><th>HEALTH 3</th></tr>
<tr><td colspan="4">Health Care Professionals</td></tr>
<tr><td colspan="4">Expenses covered: Fees for services in a private clinic.</td></tr>
<tr><td>Dietitian</td><td rowspan="11">Not covered</td><td rowspan="4">Not covered</td><td rowspan="11">80%, combined maximum reimbursement of $750

Furthermore, for kinesitherapist, massage therapist and orthotherapist: reimbursement of $65 per treatment</td></tr>
<tr><td>Nutritionist</td></tr>
<tr><td>Kinesitherapist (including kinotherapist)</td></tr>
<tr><td>Massage therapist</td></tr>
<tr><td>Orthotherapist</td><td rowspan="7">75%, combined maximum reimbursement of $500</td></tr>
<tr><td>Acupuncturist</td></tr>
<tr><td>Chiropractor (including X-rays)</td></tr>
<tr><td>Osteopath</td></tr>
<tr><td>Physiotherapist</td></tr>
<tr><td>Physicial rehabilitation therapist</td></tr>
<tr><td>Podiatrist</td></tr>
<tr><td>Audiologist</td><td rowspan="11">Not covered</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Occupational therapist</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Speech language pathologist</td><td>75%, maximum of 20 visits</td><td>80%, maximum of 20 visits</td></tr>
<tr><td>Psychoanalyst</td><td rowspan="8">50%, maximum reimbursement of $1,000</td><td rowspan="8">50%, maximum reimbursement of $1,500</td></tr>
<tr><td>Psychiatrist</td></tr>
<tr><td>Psychoeducator</td></tr>
<tr><td>Psychologist</td></tr>
<tr><td>Psychotherapist</td></tr>
<tr><td>Career counsellor</td></tr>
<tr><td>Social worker</td></tr>
</table>

HEALTH PLAN (continued)			
The general information that complements the information below can be found at the top of this table.			
COVERAGE	**HEALTH 1**	**HEALTH 2**	**HEALTH 3**
Vision Care			
Eye exams	Not covered	Not covered	Eye examinations by an optometrist or ophthalmologist.
Percentage of reimbursement			80%
Maximum			**Adults and dependent children age 18 or over:** Reimbursement of $80 per period of 36 consecutive months
• **Laser eye surgery** • **Contact lenses** • **Eyeglasses** PR	Not covered	Not covered	A prescription from an ophthalmologist or optometrist is required. Laser surgery must be carried out to correct myopia, hypermetropia, astigmatism or presbyopia.
Percentage of reimbursement			80%
Maximum			**Adults and dependent children age 18 or over:** Reimbursement of $400 per period of 36 consecutive months

DENTAL CARE

OVERVIEW

This table presents the expenses eligible under the Dental Care Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.

The maximum reimbursement per calendar year is equal to the maximum SSQ must reimburse for the expenses incurred in a calendar year.

Unless specified otherwise:

- the maximums indicated in this table are **per insured per calendar year**;
- the maximum indicated on a line applies to all items in the "COVERAGE" colum of this line and not to each separate item.

COVERAGE	DESCRIPTION
Basic Dental Care	• Diagnosis • Prevention and space maintainers • Minor restorative services • Periodontics • Oral surgery • Local anesthesia See *Article* ***2.1*** "**Eligible expenses under the Dental Care Insurance**".
Percentage of reimbursement	80% Eligible laboratory expenses are limited to **50%** of the fees detailed in the fee guide for the orodental act in question.
Maximum	Fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.
Restorative Dental Care	• Major restorative services • Endodontics • Fixed prosthodontics • Removable prosthodontics See *Article* ***2.1*** "**Eligible expenses under the Dental Care Insurance**".
Percentage of reimbursement	60%
Maximum	Reimbursement of $1,000. Fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.

ASSISTANCE PROGRAM
OVERVIEW
This table presents the Assistance Program, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.
DESCRIPTION
The coverage of the Assistance Program is limited to 9 hours of services per calendar year per family unit.

SHORT TERM DISABILITY INSURANCE	
OVERVIEW	
This table presents the insurance coverage under the Short Term Disability Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.	
COVERAGE	**DESCRIPTION**
Option 1	
Benefit amount	$300 per week
Taxability	Non taxable
Maximum duration	Until the 52nd week of disability
Option 2	
Benefit amount	$400 per week
Taxability	Non taxable
Maximum duration	Until the 52nd week of disability
Option 3	
Benefit amount	$500 per week
Taxability	Non taxable
Maximum duration	Until the 52nd week of disability
Option 4	
Benefit amount	$600 per week
Taxability	Non taxable
Maximum duration	Until the 52nd week of disability

LONG TERM DISABILITY INSURANCE

OVERVIEW

This table presents the insurance coverage under the Long Term Disability Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.

The option chosen for the Short Term Disability Insurance benefit automatically applies to the Long Term Disability Insurance benefit, if the participant participates in this benefit.

COVERAGE	DESCRIPTION
Option 1	
Benefit amount	$1,300 per month
Taxability	Non taxable
Maximum duration	Until age 65
Option 2	
Benefit amount	$1,650 per month
Taxability	Non taxable
Maximum duration	Until age 65
Option 3	
Benefit amount	$2,000 per month
Taxability	Non taxable
Maximum duration	Until age 65
Option 4	
Benefit amount	$2,350 per month
Taxability	Non taxable
Maximum duration	Until age 65

LIFE INSURANCE	
OVERVIEW This table presents the insurance coverage under the Life Insurance, provided they are aligned with the provisions in this document, including applicable exclusions, limitations and restrictions.	
COVERAGE	**DESCRIPTION**
Participant's Basic Life Insurance	Amount of $25,000 or $50,000
AD&D (Accidental Death and Dismemberment)	Accidental death = Amount of $25,000 or $50,000 Accidental dismemberment = 10% to 100% of insurable annual salary, depending on the loss suffered
Participant's Optional Life Insurance	1 to 20 units of $10,000
Spouse's and Dependent Children's Life Insurance	$5,000/deceased person; if proof is provided that the participant has no spouse at the time of death: $10,000/deceased child
Spouse's Optional Life Insurance	1 to 10 units of $10,000

1 - HEALTH PLAN

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

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

Limitations – Health care professionals

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

1.1 Tax credits

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

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

1.2 Exclusions, limitations and restrictions

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

The Health Plan does not provide reimbursement for the following:

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

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

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

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

e. For expenses incurred for aesthetic purposes not explicitly covered under this benefit.

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

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

h. For services or products related to smoking cessation that are not explicitly covered under this benefit.

i. For preventive vaccines, care, services or products that are not explicitly covered under this benefit.

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

k. For expenses for purchasing non-oral contraceptives that are not explicitly covered under this benefit.

l. For surgically-implanted prostheses, except those covered under the "Gender affirmation surgery" benefit and intraocular lens implants.

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

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

1.2.2 Exclusions, limitations and restrictions specific to the "Prescription drug insurance" benefit

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

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

b. Drugs obtained through the federal Emergency Drug Release.

c. Homeopathic and natural products.

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

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

f. Sunscreens and tanning creams.

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

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

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

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

1.2.3 Exclusions, limitations and restrictions specific to the "Cannabis for medical purposes" benefit

In addition to the exclusions, limitations and restrictions that apply to all benefits of the Health Plan, the following apply:

The following are not considered eligible expenses:

a. The costs related to the production of cannabis for medical purposes (including, but not limited to, the cost of seeds and plants of cannabis for medical purposes).

b. The costs related to the administration of cannabis for medical purposes (including, but not limited to, the cost of vaporizers, water pipes and rolling paper).

c. The administrative costs related to the prescription of cannabis for medical purposes or to obtaining cannabis for medical purposes (including, but not limited to, file opening fees, postal fees, consultation fees and referral fees).

2 - DENTAL CARE

Expenses eligible under the Dental Care Insurance are those that are covered and provided by an accredited dentist or denturist.

Dental care eligible expenses cannot exceed the fees recommended in the Fee Guide and Description of Dental Treatment Services of the *Association des chirurgiens dentistes du Québec* for the year during which the treatments are received.

SSQ offers an electronic claims transmission service with direct payment for dental care. Information on how to use this system is provided in section **8 - "How to submit claims"**.

2.1 Eligible expenses for Dental Care

2.1.1 Basic dental care reimbursed at 80%

1) Diagnosis

   a) Clinical oral examination

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

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

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

      iv) emergency examination: 2 examinations per calendar year

      v) specific oral examination: 2 examinations per calendar year

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

   b) Dental X-rays

      i) Intraoral films

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

ii) Extraoral films

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

c) Lab examinations, tests and diagnostic casts

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

ii) Bacteriological test

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

iv) Cytological test

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

2) Prevention and space maintainers

a) Preventive services

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

ii) Scaling: once per period of 9 months

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

iv) Analysis of diet and recommendation: once per lifetime

v) Oral hygiene instructions: once per lifetime

vi) Oral hygiene re-instruction: once per lifetime

vii) Plaque control program: 5 times per lifetime

viii) Finishing restorations

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

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

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

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

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

i) Space maintainer

- one fixed or removable device per period of 24 months

ii) Control of oral habits

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

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

3) Minor restorative services*

a) Sedative filling

b) Recontouring and polishing of traumatized tooth

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

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

e) Amalgam or composite restorations

f) Retentive pins

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

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

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

4) Periodontics

a) Treatment of acute infection or inflammation

b) Desensitization

c) Periodontal surgery (except periodontal guided tissue regeneration)

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

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

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

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

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

i) Relining of appliance for bruxism

j) Periodontal irrigation

5) Oral surgery

a) Removal of erupted tooth, complex or uncomplicated

b) Supplement for suturing

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

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

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

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

g) Extension of mucous folds

h) Surgical incision and drainage

i) Frenectomy

j) Dislocation of mandible

k) Treatment of salivary glands

l) Sinus treatment or surgery

m) Hemorrhage control

n) Post-surgical treatment

6) General services

a) Palliative treatment of dental pain

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

c) Local anesthesia

2.1.2 Restorative dental care reimbursed at 60%

1) Major restorative services and fixed prosthodontics

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

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

c) Individual crown

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

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

f) Prefabricated post and cast metal post

g) Build-up for crown restoration

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

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

j) Removal of cemented post

k) Repair of crown/veneer

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

2) Endodontics

a) Endodontic emergency

i) Pulpotomy

ii) Pulpectomy

iii) Open and drain

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

c) Root canal therapy and periapical endodontic surgery

3) Removable prosthodontics

a) Complete dentures

b) Partial dentures

c) Denture adjustments

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

e) Structure additions to partial dentures

f) Palatal obturator: once per period of 48 months

g) Denture cleaning and polishing

h) Duplication of a denture

i) Rebasing and relining

j) Therapeutic tissue conditioning

k) Repairs with or without impression

l) Resetting of denture teeth

m) Remake of partial dentures

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

4) Bridges and fixed prosthodontics

   a) Pontics

   b) Abutment

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

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

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

   f) Telescoping crown unit

   g) Precision attachment

   h) Sectioning of an abutment or pontic

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

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

   k) Repair

5) Implant

   Dentures attached to implants may be eligible, up to the cost and maximum limitations applicable to an equivalent alternative treatment provided for under this benefit, and payable only at the time of the final insertion of the dentures attached to the implants.

2.2 Treatment plan

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

2.3 Tax credits

The portion of certain dental care expenses not reimbursable by the Dental Care Plan and insurance premiums for the Dental Care Plan may entitle participants to provincial and federal tax credits. For more information, refer to publication IN-130 on dental care expenses, found on the *Ministère du Revenu du Québec* website at **www.revenu.gouv.qc.ca** or consult the most recent income tax package found on the Canada Revenue Agency Web site at **www.cra-arc.gc.ca**.

2.4 Exclusions, limitations and restrictions

2.4.1 The following are excluded from Dental Care Insurance:

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

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

c. For expenses incurred for medical examinations further to a request by a third party (insurance, school, employment, etc.).

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

e. For expenses incurred for aesthetic purposes not explicitly covered under this benefit; transformation or extraction and replacement of sound teeth to modify their appearance is not covered under this benefit.

f. Supplementary procedures and treatments related to implants (surgery, grafts, etc.).

g. An intra-oral appliance or services related to the treatment of temporomandibular joint dysfunction or correction of vertical dimension. However, a portion of the expenses incurred for an intra-oral appliance is eligible, i.e. an amount equal to the amount specified in the fee guide of the dentist's professional association for bruxism appliances.

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

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

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

k. Transfer copings.

l. Transitional crowns, pontics or abutments.

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

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

o. Diagnostic photographs.

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

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

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

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

2.4.3 In the case of a cast metal post, crown, removable denture or fixed bridge being subject to benefits, no replacement treatment can count as an eligible expense if the insertion occurs within 48 months following the previous installation. However, a permanent removable prosthesis (partial or full), may be eligible for reimbursement if it replaces a transitional removable prosthesis (partial or full) and is installed within 6 months of the date the transitional prosthesis was installed.

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

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

3 - ASSISTANCE PROGRAM

This benefit is automatically included in the contract of all people responsible for a home childcare service.

Insured participants and their dependents who suffer from personal issues that may affect their normal functioning and their psychological state may be eligible for support, consultation, counselling and intervention services available through the Assistance Program.

3.1 Coverage details

The services covered under the Assistance Program are the following:

- Services for participants going through marital or family problems
- Services for participants going through work-related problems
- Services for participants going through personal issues such as loss of interest, fatigue, stress, anxiety, insomnia, communication problems
- Services for participants with drugs, alcohol or prescription drugs addictions
- Services for participants on legal or financial matters

The coverage of the Assistance Program is limited to 9 hours of services per insurance year per family unit. The services on legal or financial matters are each subject to a maximum of 2 30-minute phone meetings per year and the total number of hours used for these services is deducted from the annual maximum of 9 hours available for all assistance services.

3.2 Special provisions applicable upon the participant's death

In the event of the participant's death, the soupse and dependent children remain entitled to services under the Assistance Program for 3 months following the participant's death, subject to any maximum provided for in this program.

3.3 Special provisions applicable upon termination of this contract

Upon termination of this contract, the services under the Assistance Program will remain in force for 30 days following termination, subject to any maximum provided for in this program and a maximum of 2 hours of consultation time per insured.

Insured participants who wish to take advantage of this program can refer to Article 8.4 - How to submit claims - Assistance Program of this booklet.

4 - SHORT TERM DISABILITY INSURANCE PLAN

The participant must choose one of the four options available for their Short Term Disability Insurance benefit during the first 52 weeks of disability.

The option chosen for the Short Term Disability Insurance benefit automatically applies to the Long Term Disability Insurance benefit, if the participant participates in this benefit.

4.1 Amount of benefits

The participant must choose one of the following four options:

Option 1	Option 2	Option 3	Option 4
Benefits per week	Benefits per week	Benefits per week	Benefits per week
$300 (1)	$400 (1)	$500 (1)	$600 (1)

(1) Non taxable benefits

4.2 Elimination period

The elimination period lasts for 7 consecutive days of total disability. It starts the first day on which the participant would have returned to work if not totally disabled.

4.3 Payment of benefits

The first benefit payment is made one week following the end of the elimination period, and thereafter on a weekly basis, provided the total disability persists.

4.4 Duration of benefits

The Short Term Disability Insurance benefit payments period terminates no later than 52 weeks after the onset of total disability and no later than the date the participant reaches age 65.

4.5 Returning to work

Participant returns to work gradually to "own employment"

The participants gradual return to work to "own employment" may involve benefit payments under this Short Term Disability Insurance coverage only if:

- the total disability period preceding the gradual return to work lasted at least for 30 days, and
- an agreement is reached between the participant and SSQ prior to the start date of the gradual return to work, and
- the period of the gradual return to work is established by taking into account the nature of the illness or accident having caused the disability and does not exceed a maximum period of 3 months.

In such a case, the amount of benefits payable under this Short Term Disability Insurance is reduced by an amount equal to the percentage of the actual period of work in relation to the normal work period.

To prevent a reduction in benefits, both of the following conditions must be met to the satisfaction of SSQ:

- In spite of their gradual return to work, the participants' condition does not allow them to carry out certain important duties of their employment.
- They would not be able to return to active work without an additional person needing to be hired and paid to assist with childcare.

Participant returns to work to "any other employment"

When the participant takes part in a rehabilitation program approved by SSQ and designed to support a return to the labour market to an employment other than the one held by the participant at the onset of total disability, the total remuneration earned through such employment is considered income for the purposes of reduction of benefits. Therefore, total income plus benefits payable to the participant for any given week (including both benefits payable under this insurance benefit and remuneration from the rehabilitation program) cannot exceed 100% of the participant's gross benchmark salary. Benefits are therefore reduced by any excess amount. Such a program may not exceed a maximum period of 6 months.

4.6 Reduction

Benefits paid are reduced by the amount of disability benefits payable under the *Act respecting industrial accidents and occupational diseases*, the Quebec Pension Plan (QPP), the Canada Pension Plan (CPP) and Quebec's *Automobile Insurance Act* or any social legislation.

4.7 Exclusions

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

- disability periods during which the participant does not follow the recommendations of a physician, except if the participant's condition is declared stable by a physician to the satisfaction of SSQ;
- disability periods during which the participant holds a position or performs work that may provide a salary or any profit whatsoever;
- disability periods during which the participant fails to participate in a rehabilitation program recommended by SSQ;
- disability periods during which the participant fails to undergo, when requested to do so by SSQ, any examination with a health care professional or any treatment or program likely to favour recovery of their health;
- disability periods resulting from alcoholism or drug addiction, active participation in a riot or insurrection, criminal acts or active service in the armed forces.

However, disability periods resulting from alcoholism or drug addiction during which the participant receives treatments or continuous medical care for the purposes of rehabilitation is recognized as a total disability period.

This benefit does not cover:

a) Disabilities that are attributable to aesthetic or cosmetic treatments, unless these treatments are required due to an illness or injury;

b) Disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:

   i) A criminal act that the participant commits or attempts to commit;

   ii) Active participation in a riot or insurrection;

   iii)War, whether declared or undeclared;

iv) Active service in the armed forces;

v) Intentional self-inflicted injuries, regardless of the participant's state of mind.

4.8 Rehabilitation

In the event the participant becomes totally disabled, they must agree to participate in any rehabilitation program approved by SSQ and follow the program as prescribed. The benefits will be reduced by any remuneration they receive during the rehabilitation period that, when combined with other income from the sources specified under the reduction and coordination sections with regard to direct and indirect offsets, exceed 100% of your weekly net salary prior to the start of their total disability.

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

4.9 Proof and medical examinations

Claims and proof of total disability must be submitted to SSQ within 90 days following the end of the elimination period. Proof of recurring total disability and related claims must be submitted within 90 days following the date the total disability recurs. Any additional information required with regard to a disability must be provided within 90 days following SSQ's request. If the participant fails to meet these deadlines, they must prove that they were unable to submit their application and supporting documents earlier otherwise SSQ may decline their claim or interrupt payment of benefits.

From the time SSQ notifies the participant that their claim has been declined or payment of benefits is to be terminated, they have 90 days in which to provide additional proof justifying their continued entitlement to benefits or request that their file be reviewed.

If the participant fails to submit their claim, request for a review, or the required proof within the time specified under this insurance benefit, they will not be entitled to receive benefits for any period prior to the date SSQ receives the claim, request or proof.

For a claim or request to be approved, all required documents must in all cases be submitted to SSQ no later than 12 months following the end of the elimination period and no later than 12 months after termination of this insurance benefit. In addition, in the event that a claim is declined or payment of benefits is terminated, no new benefits may be paid with regard to your disability if all documents required are not submitted to SSQ at the latest 12 months after the date on which notice of refusal or termination is issued.

5 - LONG TERM DISABILITY INSURANCE

This optional benefit completes the Short Term Disability Insurance benefit and provides disabled participants with income until their 65th birthday, should a disability render them totally incapable of working for an extended period.

The option chosen for the Short Term Disability Insurance benefit automatically applies to the Long Term Disability Insurance benefit, if the participant participates in this benefit.

5.1 Amount of benefits

The participant must choose one of the following four options:

Option 1	Option 2	Option 3	Option 4
Benefits per month	Benefits per month	Benefits per month	Benefits per month
$1,300 (1)	$1,650 (1)	$2,000 (1)	$2,350 (1)

(1) Non taxable benefits

5.2 Elimination period

The elimination period lasts for 52 weeks. It starts the first day on which the participant would have returned to work if not totally disabled.

5.3 Duration of benefits

After the elimination period, benefits are paid monthly for as long as the total disability persists, until the last day of the month when the participant reaches age 65.

5.4 Rehabilitation employment

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

Benefits paid together with the income earned from such employment cannot exceed 100% of the gross monthly salary of the participant at the start of the total disability.

5.5 Reduction

Benefits paid are reduced by the amount of disability benefits payable under Quebec's *Automobile Insurance Act*, the *Act respecting industrial accidents and occupational diseases*, the Quebec Pension Plan (QPP), the Canada Pension Plan (CPP), or any social legislation other than benefits payable under the *Employment Insurance Act* and the *Act respecting parental insurance.*

Monthly benefits payable by SSQ are also reduced by 65% of the retirement pension that is received under a private pension plan.

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

5.6 Exclusions

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

- disability periods during which the participant does not follow the recommendations of a physician, except if the participant's condition is declared stable by a physician to the satisfaction of SSQ;
- disability periods during which the participant holds a position or performs work that may provide a salary or any profit whatsoever;
- disability periods during which the participant fails to participate in a rehabilitation program recommended by SSQ;
- disability periods during which the participant fails to undergo, when requested to do so by SSQ, any examination with a health care professional or any treatment or program likely to favour recovery of their health;
- disability periods resulting from alcoholism or drug addiction, active participation in a riot or insurrection, criminal acts or active service in the armed forces.

However, disability periods resulting from alcoholism or drug addiction during which the participant receives treatments or continuous medical care for the purposes of rehabilitation is recognized as a total disability period.

This benefit does not cover:

a) Disabilities that are attributable to aesthetic or cosmetic treatments, unless these treatments are required due to an illness or injury;

b) Disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:

   i) A criminal act that the participant commits or attempts to commit;

   ii) Active participation in a riot or insurrection;

   iii) War, whether declared or undeclared;

   iv) Active service in the armed forces;

   v) Intentional self-inflicted injuries, regardless of the participant's state of mind.

5.7 Proof and medical examinations

Claims and proof of total disability must be submitted to SSQ within 90 days following the end of the elimination period. Proof of recurring total disability and related claims must be submitted within 90 days following the date the total disability recurs. Any additional information required with regard to a disability must be provided within 90 days following SSQ's request. If the participant fails to meet these deadlines, they must prove that they were unable to submit their application and supporting documents earlier otherwise SSQ may decline their claim or interrupt payment of benefits.

From the time SSQ notifies the participant that their claim has been declined or payment of benefits is to be terminated, they have 90 days in which to provide additional proof justifying their continued entitlement to benefits or request that their file be reviewed.

If the participant fails to submit their claim, request for a review, or the required proof within the time specified under this insurance benefit, they will not be entitled to receive benefits for any period prior to the date SSQ receives the claim, request or proof.

For a claim or request to be approved, all required documents must in all cases be submitted to SSQ no later than 12 months following the end of the elimination period and no later than 12 months after termination of this insurance benefit. In addition, in the event that a claim is declined or payment of benefits is terminated, no new benefits may be paid with regard to your disability if all documents required are not submitted to SSQ at the latest 12 months after the date on which notice of refusal or termination is issued.

6 - LIFE INSURANCE

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

This coverage is offered to all eligible home childcare providers by automatic enrollment on the date of eligibility with the option to opt out.

6.1.1 Participant's Basic Life Insurance

In the event of the participant's death, the designated beneficiary (or, if no beneficiary has been designated, the estate of the participant) receives an amount of life insurance that corresponds to $25,000 or $50,000, depending on the amount held by the participant.

6.1.2 Limitation

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

6.1.3 Participant's AD&D

In case of accidental death or accidental loss of a limb, the designated beneficiary or the participant receives a certain percentage of the participant's amount of Basic Life Insurance chosen by the participant.

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

6.1.4 Exclusions for AD&D Insurance

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

a) Suicide, attempted suicide or intentional self-inflicted injuries, regardlessof the participant's state of mind.

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

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

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

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

f) Poisoning or intoxication.

6.2 Spouse's and Dependent Children's Life Insurance

This coverage is offered to all RSGEs' spouses and dependent children by automatic enrollment with the option for the home childcare provider to opt out.

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

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

6.3 Optional Life Insurance

6.3.1 Participant

In addition to the amount provided for the Participant's Basic Life Insurance, participants may opt for an amount of Optional Life Insurance in units of $10,000 up to $200,000. Evidence of insurability deemed satisfactory by SSQ is always required.

6.3.2 Spouse

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

6.3.3 Premium rates

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

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

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

6.3.4 Limitation

If the participant commits suicide within 12 months following the effective date of coverage amounts requested for Participant's Basic Life Insurance, Participant's Optional Life Insurance and Spouse's Optional Life Insurance, no benefits are payable for these coverage amounts. However, SSQ will reimburse the premiums paid for these amounts.

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

Life insurance amounts are offered upon the participant's retirement for participants aged 55 years old or over. For more information, the participant may refer to the Optional Group Life Insurance Plan for the Retiree and the Spouse of the Retiree pamphlet available on the secure site for insureds (refer to section 8 "How to submit claims" to learn more about this service).

7 - GENERAL INFORMATION

7.1 Definitions

"**Accident**": an unintentional, sudden, unforeseen and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injury.

"**Dependent**":

a) Spouse

Spouse means persons:

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

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

b) Dependent child

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

- be under age 18;
- be age 25 or under and be a duly registered full-time student in an accredited educational institution;
- regardless of the child's age, became totally disabled when he or she met one of the above conditions and has remained continuously disabled since that date;

- be a person of full legal age, without a spouse, suffering from a functional impairment defined in the *Regulation respecting the basic prescription drug insurance plan* of the RAMQ, impairment that occurred before the person reached 18 years of age, who does not receive any benefits under a last resort financial assistance program provided for in the *Act respecting income support, employment assistance and social solidarity*, who is residing with the participant and on whom the participant or the participant's spouse would exercise parental authority were the person a minor.

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

Furthermore, a dependent child on a sabbatical school leave maintains the dependent child status, provided that the participant meets the requirements under *section* **5.13 - Dependent child on sabbatical school leave**.

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

"**Elimination period":** period of total disability that must elapse before the participant is entitled to benefits under a disability insurance coverage.

"**Events":**

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

"**Hospital**": any establishment considered a hospital under the acts and regulations respecting health services and social services (R.S.Q., ch. S-4.2). A hospital centre is a facility or department whose mission is to provide diagnostic services, as well as general and specialized medical care, or physical or psychiatric rehabilitation services, excluding private clinics and nursing care centres where religious orders or teaching institutions accommodate their members or students, as well as the part of a hospital intended for long term care. Outside the province of Quebec, the term means any establishment meeting the same standards.

"Insured": the participant or the participant's dependents who are covered by this insurance.

"Participant" : any home childcare provider (RSGE) participating in this insurance plan, who is subject to a collective agreement provided for under this group insurance plan.

"Physician": an individual who is legally authorized to practise medicine where he or she practises.

"SSQ": SSQ, Life Insurance Company Inc.

"Subrogation": the substitution of one person or thing in the place of another with respect to a lawful claim. SSQ's right of subrogation is described later in this "General Provisions" section.

"Total disability" : during the first 24 months of the same disability period, a state of incapacity resulting from an accident or illness, complications of a pregnancy, tubal ligation, vasectomy, or similar cases related to family planning, or organ or bone marrow donation, provided this state of incapacity requires medical care and renders the participant totally incapable of carrying out the normal duties of his/her employment or any comparable employment with similar remuneration.

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

"Total disability period": any continuous total disability period or successive total disability periods separated by a period of active full-time work or availability for full-time work, unless the participant demonstrates, to the satisfaction of the employer or a representative thereof, that the subsequent period results from an illness or accident completely independent of the cause of the previous total disability.

This period of active full-time work or availability for full-time work must be:

- less than 30 days if the duration of the total disability is shorter than 6 months; and
- less than 180 days if the duration is 6 months or longer.

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

7.2 Eligibility to insurance

7.2.1 Eligibility of the RSGE

To become eligible for insurance, the home childcare provider must be recognized by *Ministère de la Famille* as responsible for providing home childcare to 3 or more children and the recognition must be permanent. The participant becomes eligible 3 months after the opening of the home childcare as long as they maintained responsability of an average of 3 children during those 3 months.

No evidence of insurability is required by SSQ, with the exception of the evidence required for a change in participation in Participant's Life Insurance following an opt out.

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

7.2.2 Termination of eligibility related to the number of children

Termination of insurance may be requested by someone who ceases being subsidized by the *Ministère de la Famille* as responsible for providing home childcare to 3 or more children during the course of the year. Insurance will be terminated on the date the provider is no longer so subsidized by the *Ministère*, provided that due proof is received by SSQ within 30 days after such date. Before terminating coverage, SSQ may require that the person provides evidence that he/she is no longer subsidized by the *Ministère de la Famille* as responsible for providing home childcare to 3 or more children.

Those who again become subsidized by the *Ministère* as responsible for providing home childcare to 3 or more children must give notice to SSQ and provide evidence of their eligibility. In such cases, eligibility is no longer subject to the 3-month waiting period. The following rules will apply, depending on the date they have become subsidized again for 3 or more children:

- If it occurs within 30 days following the termination date of insurance, all coverage held before termination will become effective again.
- If it occurs more than 30 days after the termination date of insurance, coverage must be chosen again as if it were a new enrolment. If the person was covered under the Participant's Basic Life Insurance and the Spouse's and Dependent Children's Life Insurance, he/she can enrol again in these benefits without having to provide evidence of insurability. However, those who opted out of these benefits will have to provide evidence of insurability.

Subject to the above, evidence of insurability will be required for participation in optional benefits, except if it is requested after a coverage interruption period whose whole duration is totally beyond this insured's control and results from the insured's interruption of eligibility.

7.3 Participation to insurance

7.3.1 Health Plan

Compulsory participation

Participation in this plan is **compulsory** for all eligible RSGE, subject to the exemption entitlement (section ***7.6* "Exemption entitlement to Health Plan"**) or a valid claim slip issued by the *Ministère de l'Emploi et de la Solidarité sociale*.

Coverage options and statuses

Participants must choose one of the available options (Health 1, Health 2 or Health 3) and a coverage status (individual, single-parent or family) for themselves as well as for dependents.

Participation in Health 2 and Health 3 is optional. However, participation in one of these plans must be maintained for at least 36 months before the insured can change to a lower option, except as provided under *section* ***7.10*** **"Changes to status and coverage options (Health Insurance and Dental Care)".**

Employees age 65 and over

Employees age 65 and over may choose to obtain coverage for themselves and their dependents under the RAMQ's Basic Prescription Drug Insurance Plan even if covered under Health 2 and Health 3 (with no minimum participation of 36 months requirement), or they may choose to continue coverage under their group insurance plan. Dependents under age 65 must be covered under the same plan as the participant.

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

However, if the spouse has access to a private plan that provides a protection equivalent to the RAMQ's Basic Prescription Drug Insurance Plan, they must be insured under that plan as well as their dependent children. The participant has the choice of participating in the BPDIP or in the private plan of their spouse.

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

7.3.2 Dental Care

Optional participation with automatic enrolment

Participation is **optional** for all RSGE and their dependents if the employee is covered under the Health Insurance plan or is exempted. Participation in the Dental Care benefit is automatically granted with an individual status.

The participant can opt out of this benefit (section ***7.7* "Opting Out of Dental Care Insurance"**).

Coverage status

Participants must choose a coverage status (individual, single-parent or family) (section ***7.5* "Coverage statuses and options"**).

Minimum period of participation of 36 months

Participants who have subscribed to the Dental Care Insurance must maintain their participation for at least **36 months** from the effective date of this benefit, even when an event stated in the contract occurs. However, the participant may change their coverage status (refer to section ***7.10* "Changes to status and coverage options (Health Insurance and Dental Care)"**).

Participants may terminate their participation to this benefit during the 36-month period if they provide satisfactory evidence to SSQ that they are newly covered under another group insurance plan with a Dental Care benefit.

Thereafter, if participants want the Dental Care Insurance benefit back, a new minimum period of participation of 36 months starts from the new effective date to this benefit.

7.3.3 Calculation of the minimum period of participation of 36 months - Health Insurance and Dental Care

The following periods are included in the calculation of the minimum period of participation of 36 months:

- a period of temporary interruption of work during which participation in Health 1 was maintained;
- a period during which premiums were waived as a result of total disability;
- a period during which time worked was reduced to 25% or less of full-time, and during which Health 1 only was maintained;
- for Health Insurance only: an exemption period.

7.3.2 Short Term Disability Insurance Plan

Participation in this plan is **compulsory** for all eligible RSGE.

The RSGE must choose one of the following gour options:

Option 1 : Weekly benefits of $300

Option 2 : Weekly benefits of $400

Option 3 : Weekly benefits of $500

Option 4 : Weekly benefits of $600

The option chosen for the Short Term Disability Insurance benefit automatically applies to the Long Term Disability Insurance benefit, if the participant participates in this benefit.

The participant can opt out of this benefit (section ***7.8*** **"Opting Out of Short Term Disability Insurance"**).

7.3.5 Long Term Disability Insurance

Participation in this benefit is **optional** for all eligible RSGE.

The option chosen for the Short Term Disability Insurance benefit automatically applies to the Long Term Disability Insurance benefit, if the participant participates in this benefit.

The Long Term Disability Insurance coverage is not available to participants or coverage terminates at age 64.

7.3.6 Life Insurance

Optional participation with automatic enrolment

Participation in this benefit is **optional** for all eligible RSGE and their dependents.

Participation in Option 1 ($25,000) of Participant's Basic Life Insurance, Participant's Accidental Death and Dismemberment Insurance and Spouse's and Dependent Children's Life Insurance is granted **automatically** to all home childcare providers.

Participants may opt out of the Life Insurance (refer to section ***7.9*** **"Opting Out of Life Insurance"**).

Participation in the Participant's Basic Life Insurance and Participant's Accidental Death and Dismemberment Insurance is indissociable.

Participation in the Participant's Optional Life Insurance is conditional to participation under Option 2 ($50,000) in the Participant's Basic Life Insurance. Participation in the Spouse's Optional Life Insurance is conditional to participation under Option 1 ($25,000) or Option 2 ($50,000) in the Participant's Basic Life Insurance.

7.4 Application for insurance and effective date of coverage

7.4.1 Application deadline

The RSGE must complete the form sent by SSQ. Once completed, this form must be returned to SSQ within 30 days of the date the form was sent.

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

7.4.2 Effective date of coverage for Health Insurance

The Health Insurance benefit comes into force on the RSGE's date of eligibility (refer to section ***7.2.1*** **"Eligibility of the RSGE").**

If the RSGE is disabled when their insurance comes into force, their coverage status under the Health Insurance comes into force on their date of eligibility if SSQ receives their coverage status choice prior to the start of the disability.

7.4.3 Effective date of coverage for Dental Care

The RSGE must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 30 or 180 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***7.1*** **"Definitions"**).

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

7.4.4 Effective date of coverage for Short Term Disability Insurance and Long Term Disability Insurance

The RSGE must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 30 or 180 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***7.1*** **"Definitions"**).

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

7.4.5 Effective date of coverage for Life Insurance

The RSGE must be able to work on the effective date specified below, otherwise the effective date is postponed until the date on which they come back to work for 30 or 180 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***7.1*** **"Definitions"**). The effective date for Spouse's and Dependent Children's Life Insurance is not subject to the RSGE's ability to work.

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

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

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

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

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

The insurance comes into force on the first day of the premium period that coincides with or follows the date SSQ approves the evidence of insurability.

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

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

When the request for change form is submitted within 30 days following the date of one of the events below, the insurance comes into force on the date of the event:

- marriage or civil union;
- cohabitation for a period of one year;
- birth or adoption of a first child;
- involuntary termination of the spouse's or dependent children's insurance.

Following an opting out of more than 30 days after the eligibility date or the date of the event above, evidence of insurability is required and the insurance comes into force on the first day of the premium period that coincides with or follows the date SSQ approuves the evidence of insurability.

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

7.5 Coverage status and option

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

Available coverage statuses are the following:

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

Participants can change their and their dependents' coverage status and option, according to the rules provided for in section ***7.10* "Changes to status and coverage options (Health Insurance and Dental Care)**".

7.6 Exemption entitlement to Health Insurance

7.6.1 Application for exemption

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

Note: Home childcare providers must provide SSQ with a copy of the insurance certificate or claim slip.

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

The exemption entitlement also allows participants to cease participation in Health 2 and Health 3, even if the minimum period of participation of 36 months has not yet been completed.

7.6.2 Start of exemption

a) The exemption of new eligible home childcare providers begins on **their date of eligibility** if, within 30 days after this date, SSQ receives a duly completed written request. Otherwise, it begins on the first day of the premium payment period that coincides with or follows the date SSQ receives the request.

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

7.6.3 End of exemption

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

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

a) **Provisions applying to requests received by SSQ within 30 days following the end of participation to the group insurance plan that allowed the exemption**

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

b) **Provisions applying to requests received by SSQ more than 30 days following the end of participation to the group insurance plan that allowed the exemption**

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

   Any participant who was participating in Health 2 or Health 3 before the beginning of the exemption cannot decrease their coverage or their dependents' coverage if the minimum period of participation of 36 months is not yet completed. The exemption period is considered to be part of the minimum 36-month period.

If the participant chooses to increase the Health Plan held before the exemption and they have been granted a waiver of premiums at the time they make their application, that increase becomes effective on the first day of the premium payment period that follows the date of return to active work for 31 or 180 days, according to the duration of the disability as stated in the total disability period definition (refer to section ***7.1*** **"Definitions"**).

7.7 Opting out of Dental Care Insurance

Eligible RSGE may opt out of the Dental Care Insurance.

To benefit from the opt out option, a written request must be received by SSQ within 30 days following the effective date of the Dental Care Insurance. The benefit terminates retroactively on the effective date of the benefit.

However, if the request is received more than 30 days following the effective date of the benefit, the opt out is not granted and the participant must participate in this benefit for the minimum period of participation of 36 months.

7.8 Opting out of Short Term Disability Insurance

An opt out option is available to participants when they reach the age of 64.

Participants must make requests for change using the "Right to opt out of compulsory Short Term Disability Insurance coverage" form and hand them to SSQ.

The opting out becomes effective on the first day of the premium period coinciding with or following the date SSQ receives the form.

Participants who opt out can no longer benefit from the Short Term Disability Insurance, with or without evidence of insurability.

7.9 Opting out of Life Insurance

Eligible RSGE may opt out of the Participant's Basic Life Insurance, Participant's Accidental Death and Dismemberment and Spouse's and Dependent's Basic Life Insurance.

To benefit from the opt out option, participants must submit a request to SSQ.

If the request is received by SSQ **within 30 days** following the effective date of these benefits, the benefit terminates retroactively to the effective date of these benefits.

However, if the request is received **more than 30 days** following the effective date of these benefits, the opting out becomes effective on the first day of the premium period coinciding with or following the date SSQ receives the request.

7.10 Changes to status and coverage options (Health Insurance and Dental Care)

<table>
<tr><th rowspan="2">Events</th><th colspan="2">Effective date of the change</th></tr>
<tr><th>If the request is received by SSQ <u>within 30 days following the event</u></th><th>If the request is received by SSQ <u>more than 30 days following the event</u></th></tr>
<tr><td colspan="3">Change of coverage status (individual, single-parent or family)[1]:
• Health Insurance
• Dental Care</td></tr>
<tr><td>Events identified in section 7.1 “Definitions”
The participant may choose a new coverage status among the statuses shown in section 7.5 “Coverage statuses and options”</td><td>On the date of the event</td><td>On the first day of the premium period that coincides with or follows the date SSQ receives the written request</td></tr>
<tr><td colspan="3">• Increase of coverage option (Health 2 or Health 3)[1] of the Health Insurance; or
• Addition of Dental Care</td></tr>
<tr><td rowspan="2">Events identified in section 7.1 “Definitions”</td><td>On the date of the event</td><td>On the first day of the premium period that coincides with or follows the date SSQ receives the written request</td></tr>
<tr><td colspan="2">The increase of coverage option for Health Insurance is possible even if the minimum period of participation of 36 months is not completed.
A new minimum period of participation of 36 months begins on the date the change is approved.</td></tr>
</table>

<table>
<tr><th rowspan="2">Events</th><th colspan="2">Effective date of the change</th></tr>
<tr><th>If the request is received by SSQ <u>within 30 days following the event</u></th><th>If the request is received by SSQ <u>more than 30 days following the event</u></th></tr>
<tr><td colspan="3">Decrease of coverage option (Health 1 or Health 2)[1]:
• Health Insurance</td></tr>
<tr><td rowspan="2">Events identified in section 7.1 “Definitions”</td><td rowspan="2">On the date of the event, regardless of the minimum period of participation of 36 months</td><td>Request is declined, unless the minimum period of participation of 36 months is completed
In this case, the request is approved on the first day of the premium period that coincides with or follows the date SSQ receives the written request</td></tr>
<tr><td colspan="2">A new minimum period of participation of 36 months begins on the date the change is approved, if the participant chooses Health 2.</td></tr>
</table>

[1] The participant must complete the “Request for Change” form and submit it to SSQ.

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

No premiums shall be payable by the participant as of the first day of the premium payment period that coincides with or follows the first 7 days of total disability.

Insurance is maintained in force for the duration of the same total disability period, until no later than any of the following dates:

Coverage	Waiver termination
Health Insurance	3 years after the onset of total disability, until no later that the date of the 71st birthday and the termination of the group insurance plan, provided the participant maintains their recognition
Dental Care	
AD&D Insurance	
Spouse’s and Dependent Children’s Life Insurance	

If any of the above-mentioned benefits is terminated for all the eligible employees, it is also terminated for the employees on disability.	
Short Term Disability Insurance	At age 65
Long Term Disability Insurance	At age 65
Participant's Basic Life Insurance	• At age 65, regardless if the group insurance plan terminates or not, if the participant becomes totally disabled before age 62; • 3 years after the onset of total disability, until no later that the date of the 71st birthday, if the participant becomes totally disabled at age 62 or over.
Participant's and Spouse's Optional Life Insurance	At age 65

These provisions regarding waiver of premiums do not apply to participants benefiting from a preventive leave related to pregnancy or breastfeeding and approved by the CNESST.

7.12 Temporary absences from work

7.12.1 Preventive leave and maternity leave

Participation in insurance is maintained and the amount of insurance and premium are determined according to the participant's situation prior to the start of the leave.

7.12.2 Unpaid leave and parental leave

The participant must inform SSQ as soon as possible.

Participation in the group insurance plan is suspended for the duration of the authorized leave, with the exception of Health 1. However, participation in all other plans (Health Insurance, Dental Care Insurance, according to the same coverage and status chosen, Short Term Disability, Long Term Disability and Life **indissociably**) can be maintained if the participant notifies SSQ in writing of their decision to maintain participation prior to the start of the unpaid leave.

If SSQ is informed prior to the start of the leave:

The participant may choose one of the following options:

- Participate in Health 1 only;
- Maintain participation in all benefits they held prior to the start of the unpaid leave.

If SSQ is informed after the start of the leave:

If the participant does not submit a written request to SSQ prior to the start of the leave, only the participation in Health 1 will be maintained.

The temporary absence from work is considered to have started on the first day of the premium period that coincides with or follows the date SSQ receives the request.

For participants who maintain participation in Health 1 only or Health 2 or Health 3 held prior to the start of the leave, the previous coverage and status are automatically reinstated when they actively return to work.

7.12.3 Permit suspension from the Director of Youth Protection (DYP)

When the participant is subject to a complaint from the DYP for a particular situation that occured in their daycare centre, they must close their centre and inform SSQ of the situation to maintain insurance according to the below:

During the first four (4) weeks of suspension:

Participation in insurance must be maintained because the participant still receives a subsidy during this period. The participant must submit to SSQ a copy of the permit suspension letter.

After four (4) weeks of suspension:

Until the DYP's final decision is revealed, the participant can only maintain participation in Health 1.

The decision is favourable to the home childcare provider:

The participant must inform SSQ of the reopening of the daycare centre All benefits held prior to the suspension are reinstated retroactively to the first day following the 4-week suspension period. Therefore, total disabilities that began during the 4-week suspension period can be considered as insured and the elimination period can be determined as from the onset of total disability. All required premiums for this plan are payable retroactive to the date premiums began to be waived, if applicable.

7.12.4 Contesting period following withdrawal of accreditation by the *Ministère de la Famille*

During a period when the person is contesting through formal appeal process a withdrawal of accreditation by the *Ministère de la Famille*, the person can choose from the following options:

- Participate in Health 1 only;
- Maintain participation in all benefits they held prior to the start of the contesting period.

If the decision is favourable to the home childcare provider, coverage will be reinstated retroactively to the date the accreditation was withdrawn.

If the decision is unfavourable to the home childcare provider, coverage will be terminated on the date of the decision.

7.12.5 Disability not recognized by SSQ

If the participant disputes the non-recognition of their disability, an interruption of work equivalent to an unpaid leave will be coded in their file.

If their disability is recognized, the interruption of work is cancelled and all benefits held before the dispute period are reinstated retroactively to the date the interruption of work began. Disability and waiver of premiums provisions are also applied retroactively.

If the non-recognition of their disability is maintained, the interruption of work terminates and all benefits held before the dispute priod are reinstated. In this case, premiums msut be paid retroactively without exceeding the date the waiver of premiums began.

7.12.6 Return to work following a disability with less than 3 registered children

At the time the participant returns to work following a disability, if there are less than 3 children registered in the daycare centre, the participant does not meet the eligibility criteria of this contract anymore.

The participant can maintain the insurance for a period of 90 days following the return to work.

The choices are the following:

- Maintain participation indissociably to all insurance benefits they held, including the coverage option;
- Decrease the coverage option to Health 1 and terminate participation in the other benefits.

The participant must inform SSQ if they have 3 registered children or more once again, otherwise their certificate will be terminated at the end of the 90-day period without notice.

7.13 Dependent child on sabbatical school leave

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

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

Each dependent child is only eligible for one sabbatical leave.

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

7.14 Termination of coverage

The participant is responsible of informing SSQ of their end of eligibility to the group insurance plan due to the closing of their daycare centre within 30 days following this event. The participant must submit to SSQ the permit revocation letter that was provided by their coordinating office.

A request received by SSQ past the 30-day deadline will result in the termination of the group insurance plan at the end of the premium period of the termination request. Therefore, the participant will not be eligible to retroactive reimbursement of their premiums.

7.14.1 Participants

a) <u>All insurance benefits</u>

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

- The date on which the contract ends.
- The date on which the participant ceases to meet the eligibility criteria.
- The due date of any unpaid premiums.
- The date the participant retires.

b) Health Plan

In addition to the dates specified in paragraph a) "All insurance benefits", insurance terminates on the earliest of the following dates:

- The the first day of the premium payment period that follows the acceptance of a request for exemption from the Health Plan.
- The date the waiver of premiums ends, unless the participant remains eligible for insurance and pays premiums.

c) Dental Care

In addition to the dates specified in paragraph a) "All insurance benefits", insurance terminates on the earliest of the following dates:

- The end date of the premium period during which a request is received by SSQ, indicating the participant's decision to terminate participation in the Dental Care benefit, as long as the minimum period of participation of 36 months is completed.
- The date SSQ receives a request indicating the participant's decision to terminate participation in the Dental Care benefit, if the participant provides satisfactory evidence that they are newly eligible to another group insurance plan with a Dental Care benefit, even if the minimum period of participation of 36 months is not completed.
- The date the waiver of premiums ends, unless the participant remains eligible to insurance and pays premiums.

d) Short Term Disability Insurance Plan

In addition to the dates specified in paragraph a) "All insurance benefits", insurance terminates on the earliest of the following dates:

- The date the participant reaches age 65.
- The date SSQ receives a written request and supporting documents attesting the participant's right to opt out (refer to section *7.8* "**Opting Out of Short Term Disability Insurance**" for the conditions related to the right to opt out).

e) Long Term Disability Insurance

In addition to the dates specified in paragraph a) "All insurance benefits", insurance terminates on the earliest of the following dates:

- The end date of the premium period during which a request is submitted to SSQ, indicating the participant's decision to terminate participation to the Long Term Disability Insurance;
- The date on which the participant reaches age 64.

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

f) Life Insurance

In addition to the dates specified in paragraph a) "All insurance benefits", insurance terminates on the earliest of the following dates:

- The end date of the premium period during which a request is submitted to SSQ, indicating the participant's decision to terminate participation in basic or optional life insurance.
- The end date of the premium period during which the participant opts out of the Participant's Basic Life Insurance.
- The date on which the participant reaches **age 65** for the Participant's Optional Life Insurance and Spouse's Optional Life Insurance.

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

7.14.2 Dependents

a) Health Plan and Dental Care

Insurance terminates on the earliest of the following dates:

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

b) Life Insurance

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

- The date the participant's insurance terminates.

- The end date of the premium period during which a request is received by SSQ, indicating the participant's decision to terminate participation in Spouse's and Dependent Children's Life Insurance or Spouse's Optional Life Insurance.
- The date the Participant's Basic Life Insurance terminates, for Spouse's Optional Life Insurance.
- The date the participant reaches age 65 for Spouse's Optional Life Insurance.

7.15 Life insurance conversion privilege

Those who cease to belong to the group of persons eligible under the group life insurance of the plan described in this document, e.g. in cases of termination of the insurance following resignation or the end of a waiver of premiums, may obtain a conversion of their group life insurance to an individual life insurance without having to prove their insurability, provided they submit a request in writing to SSQ within 31 days following the date they cease to be eligible for coverage under the group plan and provided they pay the entire first premium. It will then be possible to obtain a one-year term life insurance that can be converted into a whole or mixed life insurance policy normally offered by SSQ in accordance with applicable legislation.

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

- $400,000;
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (refer to section ***7.16***).

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

- $25,000;
- The difference between the group life insurance amount held immediately before the conversion and the amount that may be maintained in force under the life insurance plan for retirees (refer to section ***7.16***) , or under any other group insurance contract.

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

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

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

8 - HOW TO SUBMIT CLAIMS

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

8.1 Health Insurance

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

8.1.1 Prescription drug expenses

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

a) Eligible prescription drugs

Insureds must present their insurance card to the pharmacist when purchasing prescription drugs. If the drug is eligible for reimbursement, the insured only needs to pay the cost of the drug that is not reimbursed by their Health Plan and SSQ pays the insured portion directly to the pharmacist. The pharmacist must charge the usual and reasonable price, that is, the same price as charged to any other client.

b) Non-eligible prescription 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.

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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 SSQ.

c) First use

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

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

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

The school attendance statement can be submitted on the secure site for insureds, by calling SSQ Customer Service, or by writing to SSQ at the address specified in section *8.8* "**Contact SSQ**". SSQ reserves the right to request proof of school attendance.

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

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

Receipts from the pharmacy must mention the name of the insured, the number and date of the medical prescription, the name of the physician and the name and quantity of the drug. In addition, invoices must be duly paid.

Claims must be sent to SSQ at the address specified in section *8.8* "**Contact SSQ**".

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

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

8.1.3 Expenses covered under Health Insurance

Many claims can be submitted via the secure site for insureds. Participants can also use their smartphone and the free SSQ Mobile Services application.

Claim forms are also available on SSQ's website at **ssq.ca**, a customized version of which is also available on the secure site for insureds. These claim forms can be mailed to SSQ with the original receipts.

As SSQ does not return receipts, participants are advised to always keep copies for their records.

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

SSQ's address is specified in section *8.8* "**Contact SSQ**".

8.2 Travel Insurance and Assistance and Trip Cancellation Insurance

Information on how to submit claims for Travel Insurance and Assistance and Trip Cancellation Insurance is available in a separate electronic format document entitled "Travel Insurance and Assistance and Trip Cancellation Insurance", available online on the secure site for insureds at **ssq.ca**.

8.3 Dental Care Insurance

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

Insureds must present their insurance card to the dentist's office and pay the portion of expenses not covered by SSQ. If the dentist does not offer an electronic claims submission service, the insured must have them fill out and sign the "Dental Care Insurance Claim" form or the form provided by the dentist. These claims can be submitted on the secure site for insureds website or by writing to SSQ at the address specified in section *8.8* "**Contact SSQ**".

8.4 Assistance Program

Offered in partnership, the assistance program allows insureds to get in touch with qualified actors that can help them.

These actors are all members of a recognized professional order (nurses, ergonomists, psychotherapists, social workers, career counsellors, etc.), allowing insureds to obtain confidential and quality services.

Insureds can reach professionals of the assistance program by phone at the following number: 1-877-480-2240. They must have their contract number in hand.

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

A copy of the life insurance claim form may be obtained directly from SSQ. Claims and proof of death must be submitted to SSQ within 90 days following the date of death. For more information, insureds can consult section *8.8* "**Contact SSQ**".

8.6 Short Term Disability Insurance

Claims for Short Term Disability Insurance benefits must be submitted to SSQ within 90 days before the expected benefit start date.

To file such claims, the insured must complete the disability insurance claim form available from SSQ.

8.7 Long Term Disability Insurance

Claims for Long Term Disability Insurance benefits must be submitted to SSQ no later than 90 days before the expected start date of benefit payments.

To file such claims, the insured must complete the disability insurance claim form available from SSQ.

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

8.8 Third-party liability and subrogation

The participant must notify SSQ of any notice served to, or legal action taken against a third party or any judgment, claim or settlement related to an event which may result in entitlement to benefit under the insurance plan.

If the participant is entitled to receive financial compensation from a third party with respect to which benefits are payable under the contract, you will be required to reimburse SSQ the amount of any benefits overpaid.

SSQ is subrogated to all rights of the insured against a third party liable for damage that results in an entitlement to payment of benefits under the terms of the contract, up to the amounts paid by SSQ. Should SSQ decide to exercise its right of subrogation, the insured may be required to sign a letter of subrogation drafted by SSQ.

8.9 Contact SSQ

By mail

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

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

By phone

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

By fax

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

By email

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

Change of address

Do not forget to inform SSQ of any change of address. To do so, use the **secure site for insureds** or contact SSQ's Customer Service department.

9 - SSQ'S INTERNET SERVICES

9.1 Customer Centre

This handy online service gives insureds access to their insurance file at any time. Here are a few of the operations that can be carried out quickly, securely and confidentially:

- register for direct deposit of Health Insurance benefits;
- consult electronic claim statements online;
- print customized claim forms;
- print tax receipts for claims;
- print a temporary SSQ card;
- make a change of address;
- view the coverage included as part of their insurance file;
- submit a claim online and get reimbursed in 48 hours with direct deposit (for most types of claims);
- change beneficiairy designations online;
- view the expenses covered, including drugs;
- view the balance of their counter for the coverage involved;
- print a proof of coverage for Travel Insurance benefits.

To register and take advantage of SSQ's online services, insureds can simply visit the Customer Centre website at **customer-centre.ssq.ca**. Online instructions will explain how to register. Please note that documents are available in the file for a period of 12 months.

If they require assistance, insureds can contact SSQ Customer Service, Monday through Friday, from 8:00 a.m. to 8:00 p.m., at one of the numbers indicated on the back of this booklet.

9.2 SSQ's Mobile Services

Participants who have a mobile device* can download SSQ's free Mobile Services application at **www.ssq.ca/mobile**.

The application enables them to carry out the same operations as they would on the Customer Centre website.

* Currently available on Apple and Android platforms.

Use our online services and get reimbursed in 48 hours!

Take advantage of the online claim service via the **Customer Centre** at **customer-centre.ssq.ca**.

Head Office

2525 Laurier Boulevard
P.O. Box 10500, Stn Sainte-Foy
Quebec QC G1V 4H6
1-888-651-8181

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