SSQ insurance

communities make us

Group insurance

Your plan



Policy 88H00

FÉDÉRATION DES MÉDECINS SPÉCIALISTES DU QUÉBEC

January 1, 2025

This document contains important information. Please keep it for future reference.

SSQ, LIFE INSURANCE COMPANY INC.

YOUR GROUP INSURANCE PLAN

FÉDÉRATION DES MÉDECINS SPÉCIALISTES DU QUÉBEC

This document shows the contractual provisions in force on January 1, 2025

Policy No.: 88H00

In this document, "SSQ Insurance (or SSQ)" refers to SSQ, Life Insurance Company Inc.

NOTICE REGARDING THE PROTECTION OF YOUR PERSONAL INFORMATION

Protecting your personal information is a priority for SSQ Insurance. For this reason, we want to inform you that we collect, use and disclose your personal information only with your consent, unless otherwise permitted by law, and only for the time necessary to:

- identify you
- establish and update your profile, needs and objectives
- evaluate your applications and eligibility for our products and services
- provide you with advice related to your situation
- administer your contracts as well as your products or services (e.g.: pricing, underwriting, enrolment, claims processing, etc.)
- comply with legal and regulatory requirements (e.g.: preventing, detecting or deterring violations, cyber threats, fraud, etc.)
- obtain your feedback on our products and services
- provide you with personalized offers and advice about our products and services (refer to your right to withdraw consent) based on your preferences and in compliance with the rules governing electronic and telephone communications
- conduct studies and research, including the design and application of statistical models, some of which may allow for creating or inferring new information about you

How does SSQ Insurance collect your personal information?

We may collect your personal information over the telephone, in person, and through the use of our forms and our digital platforms.

Who does SSQ Insurance share your personal information with?

For the purposes described above, and only in connection with your products and services, we share your personal information with our affiliates and distribution networks and with third parties, some of which may be located outside of Quebec and Canada.

These third parties may include:

- other financial institutions, such as insurers and reinsurers
- other organizations or entities that have information about you, including insurance, fraud or claims information
- intermediaries
- credit assessment agencies
- government departments, agencies or regulatory authorities
- employers

- claims-related service providers, such as healthcare professionals and auto repair shops
- other agents and service providers (technology services, printing and mailing services, etc.)

Please note that in all cases, we ensure that they respect the protection of your personal information.

What are your rights regarding access and rectification?

You may access your personal information or request the correction of incomplete or inaccurate information. Send us a request to the following address:

Chief Privacy Officer

625 rue Jacques-Parizeau

Quebec QC G1R 2G5

cpo@beneva.ca

For more information about our personal information protection practices, please refer to the complete version of our Personal Information Protection Statement at:

https://www.beneva.ca/en/legal-notes-confidentiality/personal-information-protection

Your consent for the collection, use and disclosure of your personal information is necessary in order to provide the product or service requested or offered. You have the right to withdraw your consent, but SSQ Insurance will not be able to continue providing you with its products or services.

AVAILABLE INFORMATION ON YOUR GROUP INSURANCE PLAN

If your contract has been modified since the production date of this booklet, there may be wording differences between the booklet and the policy. If so, the policy wording will prevail; hence, you are entitled to consult the policy at the policyholder's address and obtain a copy thereof.

The masculine gender is used throughout this document solely for readability purposes and applies to both men and women.

TABLE OF CONTENTS

SCHEDULE OF INSURANCE

General Provisions

This document shows the contractual provisions in force on January 1, 2025.

Category of individuals eligible as participants	All members of the FMSQ or MÉDECINS FRANCOPHONES DU CANADA, and all executives of the FMSQ or one of its subsidiaries.
Eligibility date	The date a physician becomes a member in good standing of the FMSQ or MÉDECINS FRANCOPHONES DU CANADA, provided they are under age 65. The date an executive of the FMSQ or one of its subsidiaries retires.

SCHEDULE OF INSURANCE

Health Care Insurance Plan

Health Insurance - Members under age 65

Unless specifed otherwise, the maximums indicated below are per insured person per calendar year

Coverage	Option 1	Option 2	Option 3
Prescription Drugs [1]	w		
Deductible per calendar year			
Individual and single-parent:	$200	$200	$150
Couple and family:	$400	$400	$300
Deductible carry over: Eligible expenses incurred during the last 3 months of a calendar year and which have been used to satisfy the deductible of this benefit for that year can be used to satisfy the deductible of this benefit for the following calendar year, if applicable.			
Percentage of reimbursement	**75%** [2]	**80%** [2]	**PBDIP percentage** [3]
Drugs with SSQ card – Direct *	Medications obtainable only with a medical prescription√		Products on the RAMQ list
Prescription drugs – Erectile dysfunction *	√		Not covered
Smoking cessation product *	According to the BPDIP		
Sclerosing injections *	$20 eligible per day		Not covered
Preventive vaccines (immunizing products) *	√		
Anti-obesity drugs	√		

[1] Options 1, 2 and 3: If you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons, by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by SSQ.

Options 1 and 2 only: If you choose to purchase a biologic drug instead of any existing biosimilar equivalent, the amount of reimbursement will be determined in accordance with its lowest cost biosimilar equivalent. However, it is possible to obtain a reimbursement based on the cost of the biologic 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.

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3

(2) Once the annual out-of-pocket maximum provided under the BPDIP is reached, expenses incurred subsequently during the same calendar year for drugs, whether or not covered by the RAMQ, are reimbursed at 100%. The annual out-of-pocket maximum includes expenses incurred for drugs, whether or not covered by the RAMQ, except biologic drugs for which the non-substitution was not approved by SSQ. For these drugs, the difference between the cost of the biologic and the biosimilar drugs is excluded from the annual out-of-pocket maximum, but the deductible and coinsurance applied to the biosimilar drug are included. This annual out-of-pocket maximum applies to each insured person and only your own out-of-pocket amount includes drug expenses for your dependent children.

(3) Once the annual out-of-pocket maximum provided under the BPDIP is reached, expenses incurred subsequently during the same calendar year for drugs, whether or not covered by the RAMQ, are reimbursed at 100%. The annual out-of-pocket maximum only includes expenses incurred for drugs, whether or not covered by the RAMQ. This annual out-of-pocket maximum applies to each insured person and only your own out-of-pocket amount includes drug expenses for your dependent children.

Hospitalization			
Percentage of reimbursement	**n/a**	**100%**	**n/a**
Hospital room	Not covered	Private room	Not covered
Specialized Health Care Establishments			
Percentage of reimbursement	**n/a**	**80%**	**n/a**
Convalescent home *	Not covered	Private room	Not covered
Rehabilitation centre *		Private room	

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3
Health Care Professionals			
Deductible per calendar year	n/a	Combined with drug deductible	n/a
Percentage of reimbursement	**n/a**	**80%**	**n/a**
Acupuncturist	Not covered	$30 eligible per treatment 20 treatments	Not covered
Audiologist *		√	
Chiropractor		$30 eligible per treatment 20 treatments	
Chiropractor – X-rays		√	
Dietitian		$25 eligible per treatment 20 treatments	
Occupational therapist *		√	
Osteopath		$65 eligible per treatment	
Physiotherapist, physical rehabilitation therapist and certified athletic therapist		Combined maximum of $1,000 reimbursement	
Podiatrist		$35 eligible per treatment	
Chiropodist		Combined maximum of $500 reimbursement	

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3
Psychoanalyst	Not covered	$95 eligible per treatment	Not covered
Psychologist			
Psychotherapist		Combined maximum of $1,000 reimbursement	
Social worker			
Speech therapist *		√	
Other Medical Expenses			
Deductible per calendar year	Combined with drug deductible	Combined with drug deductible	n/a
Percentage of reimbursement	**75 %**	**80%**	**n/a**
Ambulance	Not covered	√	Not covered
Apnea monitor *		√	
Blood glucose monitor *		$300 eligible per 60 consecutive months	
CAT scans *		√	
Cosmetic surgery following an accident *		$10,000 reimbursement per accident, within 12 months following the accident	
Deep shoes *		√	
Dental treatment required following accidental damage to natural teeth		Within 12 months following the accident	
Detoxification *		$80 eligible per day $2,500 reimbursement for the duration of the contract	

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3
Electrocardiograms (ECG) *	Not covered	√	Not covered
Foot orthoses *		$380 eligible	
Hearing aid		$800 eligible per 48 consecutive months, excluding batteries	
Hospital bed *		√	
Hygiene articles, catheters, diapers and feeding pump accessories *		√	
Insulin pump accessories *		√	
Intraocular lens implants *		Combined maximum of $5,000 reimbursement per limb or prosthesis	
External prosthesis and artificial limb *			
Breast prostheses *			
Surgical brassieres *			
Intrauterine device (IUDs)	√	√	
Laboratory analyses *	Not covered	√	
Magnetic resonance imaging *		√	
Nurse *		$300 eligible per day $10,000 reimbursement	
Orthopaedic devices *		√	

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3
Orthopaedic shoes *	Not covered	√	Not covered
Ostomy appliances *		√	
Oxygen and equipment for its administration *		√	
Pharmacogenetic tests *		Percentage of reimbursement: 100%	
Radiotherapy *		√	
Respirator (breathing apparatus) *		$10,000 reimbursement for the duration of the contract	
Support stockings *		3 pairs (20 mm HG or over)	
Therapeutic devices *		Combined maximum of $10,000 reimbursement for the duration of the contract	
Insulin pump *			
Transcutaneous electrical nerve stimulator *		$1,000 eligible per 60 consecutive months	
Ultrasound examinations *		√	
Wheelchair and walker *		√	
Wig *		$300 reimbursement for the duration of the contract	
X-rays *		√	

Health Care Insurance Plan

Health Insurance - Members under age 65 (continued)

Coverage	Option 1	Option 2	Option 3
Home Care and Assistance			
Deductible per calendar year	n/a	Combined with drug deductible	n/a
Percentage of reimbursement	**n/a**	**80%**	**n/a**
Childcare expenses *	Not covered	$25 eligible per day	Not covered
Transportation expenses *		$30 eligible per day	
Home assistance services *		$60 eligible per day	
Travel			
Percentage of reimbursement	**100%**	**100%**	**n/a**
Travel insurance and assistance	$5,000,000 reimbursement per trip per insured		Not covered
Travel cancellation insurance	$10,000 reimbursement per trip per insured		
Termination of insurance	January 1 coincident with or following your 65th birthday		

*** Medical prescription required**

√ Customary and reasonable expenses

SCHEDULE OF INSURANCE

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only)

Unless specifed otherwise, the maximums indicated below are per insured person per calendar year

Coverage	Option A	Option B
Prescription Drugs [1]		
Deductible per calendar year	Individual: $100 Family: $100 Single-parent: $100 Couple: $100	n/a
Deductible carry over: Eligible expenses incurred during the last 3 months of a calendar year and which have been used to satisfy the deductible of this benefit for that year can be used to satisfy the deductible of this benefit for the following calendar year, if applicable.		
Percentage of reimbursement	**75%** [2]	**n/a**
Drugs with SSQ card – Direct *	Medications obtainable only with a medical prescription√	Not covered
Prescription drugs – Erectile dysfunction *	√	
Smoking cessation product *	According to the BPDIP	
Sclerosing injections *	$20 eligible per day	
Preventive vaccines (immunizing products) *	√	
Anti-obesity drugs	√	

[1] If you choose to purchase a brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. If you choose to purchase a biologic drug instead of any existing biosimilar equivalent, the amount of reimbursement will be determined in accordance with its lowest cost biosimilar equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name or biologic 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.

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B

(2) Once the annual out-of-pocket maximum provided under the BPDIP is reached, expenses incurred subsequently during the same calendar year for drugs, whether or not covered by the RAMQ, are reimbursed at 100%. The annual out-of-pocket maximum includes expenses incurred for drugs, whether or not covered by the RAMQ, except biologic drugs for which the non-substitution was not approved by SSQ. For these drugs, the difference between the cost of the biologic and the biosimilar drugs is excluded from the annual out-of-pocket maximum, but the deductible and coinsurance applied to the biosimilar drug are included. This annual out-of-pocket maximum applies to each insured person and only your own out-of-pocket amount includes drug expenses for your dependent children.

Hospitalization		
Percentage of reimbursement	**n/a**	**100%**
Hospital room	Not covered	Private room
Specialized Health Care Establishments		
Percentage of reimbursement	**n/a**	**80%**
Convalescent home *	Not covered	Private room
Rehabilitation centre *		Private room
Health Care Professionals		
Deductible per calendar year	n/a	Individual: $50 Family: $50 Single-parent: $50 Couple: $50
Percentage of reimbursement	**n/a**	**80%**
Acupuncturist	Not covered	$30 eligible per treatment 20 treatments
Audiologist *		√

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B
Chiropractor	Not covered	$30 eligible per treatment 20 treatments
Chiropractor – X-rays		√
Dietitian		$25 eligible per treatment 20 treatments
Occupational therapist *		√
Osteopath		$65 eligible per treatment Combined maximum of $1,000 reimbursement
Physiotherapist, physical rehabilitation therapist and certified athletic therapist		
Podiatrist		$35 eligible per treatment Combined maximum of $500 reimbursement
Chiropodist		
Psychoanalyst		$95 eligible per treatment Combined maximum of $1,000 reimbursement
Psychologist		
Psychotherapist		
Social worker		
Speech therapist *		√

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B
Other Medical Expenses		
Deductible per calendar year	Combined with drug deductible	Combined with health care professionals deductible
Percentage of reimbursement	**75%**	**80%**
Ambulance	Not covered	√
Apnea monitor *		√
Blood glucose monitor *		$300 eligible per 60 consecutive months
CAT scans *		√
Cosmetic surgery following an accident *		$10,000 reimbursement per accident, within 12 months following the accident
Deep shoes *		√
Dental treatment required following accidental damage to natural teeth		Within 12 months following the accident
Detoxification *		$80 eligible per day $2,500 reimbursement for the duration of the contract
Electrocardiograms (ECG) *		√
Foot orthoses *		$380 eligible
Hearing aid		$800 eligible per 48 consecutive months, excluding batteries
Hospital bed *		√

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B
Hygiene articles, catheters, diapers and feeding pump accessories *	Not covered	√
Insulin pump accessories *		√
Intraocular lens implants *		Combined maximum of $5,000 reimbursement per limb or prosthesis
External prosthesis and artificial limb *		
Breast prostheses *		
Surgical brassieres *		
Intrauterine device (IUDs)	√	Not covered
Laboratory analyses *	Not covered	√
Magnetic resonance imaging *		√
Nurse *		$300 eligible per day $10,000 reimbursement
Orthopaedic devices *		√
Orthopaedic shoes *		√
Ostomy appliances *		√
Oxygen and equipment for its administration *		√
Pharmacogenetic tests *		Percentage of reimbursement: 100%

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B
Radiotherapy *	Not covered	√
Respirator (breathing apparatus) *		$10,000 reimbursement for the duration of the contract
Support stockings *		3 pairs (20 mm HG or over)
Therapeutic devices *		Combined maximum of $10,000 reimbursement for the duration of the contract
Insulin pump *		
Transcutaneous electrical nerve stimulator *		$1,000 eligible per 60 consecutive months
Ultrasound examinations *		√
Wheelchair and walker *		√
Wig *		$300 reimbursement for the duration of the contract
X-rays *		√
Home Care and Assistance		
Deductible per calendar year	n/a	Combined with health care professionals deductible
Percentage of reimbursement	**n/a**	**80%**

Health Care Insurance Plan

Health Insurance - Members age 65 or more and executives (option B only) (continued)

Coverage	Option A	Option B
Childcare expenses *	Not covered	$25 eligible per day
Transportation expenses *		$30 eligible per day
Home assistance services *		$60 eligible per day
Travel		
Percentage of reimbursement	**n/a**	**100%**
Travel insurance and assistance	Not covered	$5,000,000 reimbursement per trip per insured
Travel cancellation insurance		$10,000 reimbursement per trip per insured
Termination of insurance	Upon your death	

*** Medical prescription required**

√ Customary and reasonable expenses

SCHEDULE OF INSURANCE

Health Care Insurance Plan

Dental Care Insurance - Options 2 and B only

Deductible per calendar year:

Individual: $100 Family: $100 Single-parent: $100 Couple: $100

Reference year for maximum recommended fees: the year during which services are provided

Claims Submission Method: Electronic

Coverage	Maximum Reimbursement Amount	Deductible	Percentage of reimbursement
Diagnostic and Preventive Services			
Diagnostic Services Preventive Dental Care	Maximum combined with Basic Dental Care	√	100%
Basic Dental Care			
Minor Restorative Services Endodontics Periodontics Rebase, Reline, Adjustment and Repair of Removable Dentures Repair of Fixed Bridges and Crowns Oral Surgery General Additional Services	Combined maximum of $1,500 per calendar year per insured	√	80%
Major Restorative Services			
Major Restorative Services and Fixed Prosthodontics Removable Dentures Fixed Bridges	Maximum combined with Basic Dental Care	√	50%
Orthodontic Services			
Orthodontics	$1,500 for the duration of the contract per insured	√	50%
Frequency of recall examinations	6 months		
Termination of insurance	Upon your death		

GENERAL PROVISIONS

Definitions and Interpretation

Some of the terms used to describe your plan are defined below. These terms should be interpreted as defined wherever the context allows. These definitions apply to terms that are used in more than one part of the text. Where required, other terms are defined in the description of the benefit in which they are used.

In order to provide for the special features of your group coverage, *notes* may be included in the "Schedule of Insurance". If there are any discrepancies between the *notes* and the other terms and conditions of your group insurance plan, the notes will always take precedence.

Accident

Any event due to sudden and unforeseeable external causes that inflicts bodily injuries, certified by a physician other than the participant themselves, directly and independently of any other cause.

Administrator

Any corporation designated by the policyholder of this contract. (For the purposes of this contract, the policyholder designated SOGEMEC ASSURANCES INC. as the administrator.)

Contract

Agreement between SSQ and the Policyholder regarding the policy which number identifies the present document.

Dependent child

An eligible single person who:

1) is under 21 years of age and over whom the participant or the participant's spouse exercises parental authority or exercised parental authority until they reached the age of majority;

2) is 25 years old or under and is a full-time student at an accredited educational institution and over whom the participant or the participant's spouse would exercise parental authority if they were a minor;

3) has reached the age of majority and is suffering from a "functional impairment" referred to in the regulation pertaining to the Drug Insurance Act adopted by the Quebec government. This impairment must have existed when the person's status fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the participant or the participant's spouse who would exercise parental authority over them were they a minor.

   It is understood that the functional impairment will be defined as referred to in any provincial regulation, where applicable.

FMSQ

Fédération des médecins spécialistes du Québec.

Hospitalization

Admission to hospital for a minimum duration of 24 hours, or for day surgery.

Illness

A disease, deterioration of health or bodily disorder, as diagnosed by a physician other than the participant themselves. For the purposes of the contract, this term is also used to refer to organ donations and any related complications.

Insured

An individual covered under the benefit referred to in the context in which the term is used.

Member

Any member in good standing of the FMSQ or MÉDECINS FRANCOPHONES DU CANADA.

Participant

An individual enrolled in the insurance plan as a member or executive. The individual must also be covered under the public health and hospitalization insurance plan of a Canadian province. In addition, members will not be considered as participants unless they reside in Canada and their usual place of work is located in Canada, unless the parties expressly agree otherwise.

Period of total disability

Any continuous period of total disability or successive periods of total disability resulting from the same illness or accident.

Successive periods of total disability resulting from the same illness or accident must be separated by less than:

1) 31 consecutive days of full-time active work during the first 6 months of disability; and

2) 180 consecutive days of full-time active work thereafter;

to be considered the same period of total disability. In such a case, the minimum period of total disability of six consecutive months does not have to be satisfied again.

If a total disability results from an illness or accident entirely unrelated to the illness or accident that caused the total disability of the previous period of disability and the successive periods of total disability are separated by at least one day of full-time active work, the periods of total disability are considered distinct from each other. In such a case, the minimum period of total disability of six consecutive months must be satisfied again.

Physician

An individual who is legally authorized to practise medicine where he or she practises.

Spouse

Eligible person who, at the time giving rise to benefits:

1) is legally married to or lives in a civil union with the participant;

2) has been living in a conjugal relationship with the participant for at least 12 months, including any period of separation (due to a breakdown in the relationship) of less than 90 days;

3) is living in a conjugal relationship with the participant who is the natural parent of the spouse's child and has not been separated from the participant for 90 days or more as a result of a breakdown in the relationship.

However, if two persons fit the definition of "spouse," the insurer will recognize only one spouse for all coverages under the same plan in the following order:

1) the eligible spouse whom the participant last designated as such in writing to the insurer, subject to approval of any evidence of insurability required under this policy;

2) the spouse to whom the participant is legally married or with whom the participant lives in a civil union.

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

The definition chosen by the participant under the Loss of Income Insurance (Coverage C) of contract 88G00, or the definition provided for under the Long Term Disability Benefit of contract 88J00.

You

Personal pronoun used to refer to the participant. "You", "your" and "yours" refer to the participant directly.

Participation Requirements

1. Participation compulsory

Participation in the Health Insurance is compulsory. However, you may be entitled to an exemption from coverage under this benefit.

Participation in the Dental Care Insurance is optional. Application to this benefit is conditional to the participation to one of the following options under the Health Insurance benefit:

- Option 2; or
- Option B.

However, a minimum of 25 participants is required for this benefit to remain in force.

2. Eligibility conditions

Any individual residing in Canada, who meets the eligibility conditions specified in the "Schedule of Insurance", is eligible for insurance as a participant, unless specified otherwise.

Spouses and dependent children of individuals insured as participants are themselves eligible for insurance as spouses and dependent children.

Despite what precedes, any individual insured under the previous contract may not be excluded from the new contract or be denied benefits solely because of a pre-existing condition that was no longer applicable or that was not provided for in the previous contract, or because the individual is not at work on the effective date of the new contract.

All individuals insured under the previous contract are covered with full rights under the new contract upon termination of the previous contract if the termination of their insurance is exclusively attributable to the termination of the contract and if they belong to a class of participants covered by the new contract.

3. Applications for insurance

An application for insurance must be submitted to the administrator or SSQ for insurance to become effective, even in cases where participation in insurance is compulsory. If an application for insurance is not submitted within the time provided for under this plan, SSQ may require evidence of insurability and decline the application.

When you become eligible for insurance as a participant, you must choose the status of protection (individual, single-parent, couple or family) that will apply to the Health Insurance benefit and the Dental Care Insurance benefit, if applicable. The same status of protection will apply to both benefits. As a member, you must also choose the option (1, 2 or 3) that will apply to the Health Insurance benefit and decide if you want to be insured under the Dental Care Insurance benefit. These choices must be made within 180 days following your eligibility.

Certain events may enable you to make changes to the status of protection and option that became effective at the time of enrollment. Please refer to the provisions regarding periods of insurance for more information about making such changes.

The group administrator must notify SSQ in writing of any new person to be covered as a spouse or dependent child as well as anyone whose coverage as a spouse or dependent child must be terminated.

4. Insured persons age 65 or over residents of Quebec

Insured persons who are residents of Quebec when they reach age 65 become automatically covered under the Quebec public drug insurance plan. Individuals who would like to continue their coverage for drugs under their group insurance plan after they turn 65 must cancel their coverage under the public plan in order not to pay the premium for such coverage. They must also notify the administrator or SSQ accordingly and in advance and pay the premium applicable to individuals age 65 or over who are not covered under the public plan. However, dependents cannot continue their coverage if the participant does not remain insured. Individuals who elect to become insured under the public drug insurance plan cannot become insured again under the group health insurance coverage.

When you reach age 65, you must, as a member, choose the option (A or B) that will apply to the Health Care Insurance Plan. This choice is based on the option (1, 2 or 3) under which you were insured prior to age 65, in accordance with the following:

Option prior to age 65	Available options at age 65
Option 1 ou 2 *	Option B + remain covered under the Quebec public drug insurance plan
	Option A only
	Option A + option B
Option 3	Option A
	Remain covered under the Quebec public drug insurance plan and cease coverage under this policy

* A member who does not choose option B can no longer become insured under this option.

When you reach age 65, you become, as an executive, insured under option B and you must decide if you want to be insured under the Dental Care Insurance benefit. You must also enrol to the Quebec public drug insurance plan if not already done.

5. Evidence of insurability

You must provide evidence of insurability deemed satisfactory by SSQ to be entitled to options 1 and 2 of the Health Insurance benefit if you are in the following situations:

a) you are no longer eligible or have cancelled your participation in the insured of another group association;

b) you have not enrolled when you became eligible under this plan. Evidence of insurability is not required if you did not enrol because you were insured under the group insurance contract of your spouse or employer.

The insurance obtained as a result of the submission of evidence of insurability for your spouse or dependent children is only in force for the person for whom such evidence has been approved.

6. Exemption

If you are covered under an equivalent benefit of another group insurance contract, you may be entitled to an exemption from coverage under the Health Insurance benefit by contacting the administrator. You must notify the administrator in writing as soon as you cease to be insured under the coverage that exempted you from coverage under this plan. Coverage will be granted retroactive to the date your coverage under the other contract ceases, subject to payment of all premiums payable since that date. If you do not notify the administrator in writing within 31 days after the termination date of your coverage under the other contract, coverage under this benefit will become effective on the date the administrator or the insurer receives your written notice.

In addition, you will have to prove that you were insured under a group insurance plan similar to the one you request under this plan to enroll to options 2 or B.

Until all premiums are paid to SSQ, no benefits shall be payable for expenses incurred before your insurance under this plan becomes effective.

In the event that premiums are not paid retroactively, the only date on which coverage under a Health Insurance benefit of this plan may become effective is the date on which the administrator or SSQ receives the notice mentioned above.

Applicable Insurance Periods

1. Time insurance becomes effective

Any date on which insurance becomes effective begins at 12:01 a.m. in the insured's place of residence.

2. Effective date of insurance

Your insurance

If SSQ receives your application for insurance no later than 180 days following the date you become eligible, your insurance becomes effective on the latest of the following dates:

- The date you become eligible for insurance
- The date the administrator or SSQ receives your application
- If you are required to provide evidence of insurability, the date SSQ approves such evidence
- The date the administrator or SSQ receives your modification of option request, provided the applicable conditions under this policy are met

Insurance for your spouse or dependent children

Insurance for your spouse or dependent children becomes effective on the latest of the following dates, provided they are not hospitalized:

- The date your insurance becomes effective, if you applied for dependent coverage at the same time you did for yourself
- The date the administrator or SSQ receives the application
- The date a dependent becomes eligible, if the administrator or SSQ receives such dependent's application within 31 days following the date they become eligible

If a dependent is hospitalized on the day the insurance would normally become effective, insurance will begin 24 hours after returning to your home. However, the newborn child of a participant whose dependents are already insured is covered from birth.

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

3. Effective date of modifications to insurance

3.1 Modification of the option selected during re-enrollment periods

For members

It is possible to select a new option but only after a minimum period of 2 years of participation in the same option have elapsed. Exemption periods and periods of total disability will be considered as part of the required minimum period of participation in the same option.

During a minimum period of participation, it is possible to select a new option only after one of the following events occurs, provided your request is made in the 31 days following that event:

- a first dependent becomes eligible;
- legal separation or divorce.

In no time may totally disabled members change from one option to another. However, they can do so on the date they actively return to work by submitting their request to the administrator no later than 31 days after that date and provided the required minimum period of participation has elapsed.

If you are exempt from the Health Insurance benefit, you will be able to make a choice when you cease to be exempt.

For all participants

The minimum period of participation to the Dental Care Insurance benefit is 3 years. A participant who chooses to terminate his coverage under this benefit can no longer apply to it thereafter.

3.2 Increase in insurance coverage following a change in employment or family status

Any increase in your insurance coverage following a change in employment or family status becomes effective on the date of the change, provided the administrator or SSQ receives a written application to such effect within 31 days following the change and subject to the provisions on total disability. Otherwise, the change in coverage will become effective on the date you actively return to work, subject to any other eligibility provisions in force.

If the administrator or SSQ receives the application more than 31 days after the date of the event justifying an increase in insurance, it will become effective on the date the administrator or SSQ receives the application.

Notwithstanding any other provisions to the contrary, an increase in the type of coverage held under the Health Insurance Benefit will become effective on the date the administrator or SSQ receives the request for change.

3.3 Insurance that cannot be modified

No waiver of premiums shall apply to the premiums payable for individuals who were not already insured prior to a change in coverage status if such change must occur after the date of retirement or the start of a period of total disability.

3.4 Reduction in insurance coverage following a change in employment or family status

Any decrease in insurance coverage following a change in employment or family status becomes effective on the date of the change, provided the administrator or SSQ receives a written application to such effect within 31 days following the change. If the administrator or SSQ receives the application more than 31 days after the date of the event justifying a decrease in insurance, the decrease becomes effective on the date the administrator or SSQ receives the application.

4. Maintaining participation for the spouse and dependent children of a deceased participant

In the event of your death while insured under options 2 or B, your insured spouse and dependent children may maintain participation in insurance under option B, upon request and subject to premium payment and the following conditions:

- the request for maintaining participation in insurance must be submitted to the administrator or SSQ within 60 days following your death;
- regardless of their age, your spouse and your dependent children, if any, must apply to the Quebec Basic Prescription Drug Insurance Plan;
- no new spouse may become insured later on;
- the decision not to maintain participation in insurance is irrevocable.

Insurance for your spouse and dependent children, if any, is maintained until the latest of the following dates:

- The date of death of your spouse;
- The date your dependent children's participation in insurance would have ended, if your death had not occurred.

If participation in insurance is not maintained, Travel Insurance continues to apply for any one of your insured dependent travelling outside their province of residence at the time of your death, until the earliest of:

- the 31st day following your death;
- the date the trip ends.

For any benefit that provides for a conversion privilege, this entitlement applies to the end of the extended coverage, in accordance with applicable conditions.

5. Termination of insurance

Your insurance

Your insurance terminates no later than 12:01 a.m. on the earliest of the following dates:

a) On the date you no longer qualify as an individual eligible as a participant, as specified in the "Schedule of Insurance"

b) For each benefit, at the time specified for termination of insurance in the "Schedule of Insurance", if any

c) On the date when premiums are due, if such premiums are not paid to SSQ before the end of the grace period

d) the termination date requested in writing by the participant, provided the administrator or SSQ receives the request prior to that date. Otherwise, insurance will terminate on the date the administrator or SSQ receives the written request

e) On the date your waiver of premiums terminates because of the age you have reached, except when this termination would be legally forbidden

f) On the day following the termination date of the contract; if a benefit is being terminated without termination of the contract, this benefit terminates no later than the day following such termination

g) On the date you submit any claim or collect any benefits founded on misrepresentations, irrespective of the compulsory nature of any coverage or any other action SSQ may take

Insurance for your spouse and dependent children

Insurance for your spouse and dependent children terminates no later than 12:01 a.m. on the earliest of the following dates:

a) The date your insurance terminates, subject to the provisions of the section entitled "Maintaining participation for the spouse and dependent children of a deceased participant" section of these GENERAL PROVISIONS

b) On the date when premiums for their insurance are due, if such premiums are not paid to SSQ before the end of the grace period

c) The date the spouse or one of your dependent children is no longer eligible for insurance

Payment of Benefits

1. Amounts of coverage

In no case may you benefit from an amount of coverage greater than that for which SSQ has received the required premiums.

2. Deadlines for filing claims

Deadlines for filing claims vary from one benefit to another, and are specified in the description of each benefit.

3 Limitation of actions

Every action or proceeding against an insurer for the recovery of insurance money payable under a contract is absolutely barred, unless commenced within the time set out to this end, if any, in the applicable provincial Insurance Act or, in Quebec, set out under the Civil Code of Quebec.

4. Evidence that SSQ may require

You must provide SSQ with any information and supporting documents deemed necessary by SSQ to establish your eligibility for benefits and any amount payable, at your own expense. In the event that benefits may be payable, SSQ may require the insured to undergo examination, at any time, by one or more health care professionals selected and compensated by SSQ. If the insured fails to undergo an examination required by SSQ within 30 days of SSQ's request, SSQ may decline the claim or suspend or terminate benefits.

5. Currency

All amounts referred to in the contract are in the legal tender of Canada. For foreign currency expenses related to Travel Insurance, SSQ uses the exchange rate of the last day of the month during which expenses were incurred. However, if expenses are incurred and subsequently reimbursed within the same month, the exchange rate from the end of the previous month is used.

6. Third-party liability and subrogation

You 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 you are 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.

Limitation of Contractual Liability

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in employee working conditions or to an employer retirement plan has the effect of increasing liability under the contract, then the provisions of this contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to SSQ by the Policyholder. This additional premium shall be equal to the value of the increase in contractual liability.

Changes of Insurer

The expiry or cancellation of a group life insurance benefit may not be set up against a claim based on an insured event, including a death that results from a total disability, if this insured event occurred while the benefit was in force.

The expiry or cancellation of a group sickness or accident insurance that is not part of the Health Care Insurance Plan may not be set up against a claim based on death or insured mutilation resulting from an accident that occurred while the benefit was in force. It may neither be set up against a claim based on a total disability that arose or a sickness that was contracted while the benefit was in force.

The insurer of a group disability insurance benefit that expires is bound to compensate the participant for salary loss if the participant is still totally disabled after the benefit expires.

In the event of a change in insurer, be it at the beginning or end of the contract, SSQ's responsibilities are limited to what the law and standards that govern the industry of insurance of persons impose in order to protect the rights of insured individuals. As a result, SSQ is not responsible in the event of recurrence of the disabling affliction after the expiry of the period that has been determined in this regard by the law or standards of the industry and the provisions of the former and subsequent contracts are not binding on SSQ.

Waiver of Premiums in the Event of Total Disability

1. Entitlement to waiver of premiums

If you become totally disabled while your insurance is in force under the contract, your participation in insurance will be maintained for the following benefits, without payment of premiums, effective as of the waiver of premiums start date provided for under this plan:

- Health Insurance
- Dental Care Insurance

To qualify for the waiver of premiums privilege, you must meet the following conditions:

a) You must be covered under the Loss of Income Insurance (Coverage C) under contract 88G00 or the Long Term Disability Insurance under contract 88J00

b) Your disability must begin while you are covered under the contract and prior to age 60

c) You must be under the continuous care of a physician, except if your total disability is declared stable by your attending physician, to the satisfaction of SSQ

d) Your condition must meet the definition of a total disability that was in force at the time you became totally disabled

2. Start and end of waiver of premiums

The start and end dates for the waiver of premiums applicable to each benefit are specified below.

2.1 Health Insurance

Start date:

- The first day of the month following the first 6 months of a same period of total disability

End date (the earliest of the following):

- The date you reach age 65
- The date this benefit terminates
- The date specified in the "End of waiver of premiums for all benefits" section of these GENERAL PROVISIONS

2.2 Dental Care Insurance

Start date:

- The first day of the month following the first 6 months of a same period of total disability

End date (the earliest of the following):

- The date you reach age 65
- The date this benefit terminates
- The date specified in the "End of waiver of premiums for all benefits" section of these GENERAL PROVISIONS

3. End of waiver of premiums for all benefits

Your premium waiver automatically ends upon the earliest of the dates stated above and also upon the earliest of the following dates:

a) The date your condition no longer meets the definition of total disability;

b) The date you are no longer under the continuous care of a physician, except if your total disability, as defined in the contract, is a condition that is declared stable by a physician, to the satisfaction of SSQ;

c) The date SSQ requests proof of your total disability, if you are unable to submit or fail to submit such proof within 90 days of SSQ's request;

d) The date you refuse to participate in a rehabilitation program recommended by SSQ;

e) The date SSQ requests that you undergo an examination by a health care professional or a treatment likely to be beneficial to your recovery, if you fail to do so within 90 days of SSQ's request.

4. Application for waiver of premiums

The Loss of Income Insurance or Long Term Disability Insurance claim form is used to apply for a waiver of premiums. SSQ may require additional proof and supporting documents. Your application for a waiver of premiums and supporting documents must be submitted to SSQ within 90 days of the date you became eligible for the waiver. If you fail to meet this deadline, you must prove that you were unable to submit your application and supporting documents earlier, otherwise SSQ may decline your application or interrupt the waiver period.

From the time SSQ notifies you that your application has been declined or your waiver of premiums has been interrupted, you have 90 days in which to provide additional proof justifying your continued entitlement to a waiver or request that your file be reviewed.

Unless you submit your application for waiver or request for review within the time specified, your right to waiver will not apply to any period prior to the date SSQ receives your application or request.

For an application for waiver of premiums to be approved, all required documents must be submitted to SSQ no later than 12 months following the start date of your total disability. In addition, in the event that an application for waiver is declined or a waiver of premiums is interrupted, no waiver period will apply to your disability if all of the required documents are not submitted to SSQ at the latest 12 months after the date on which notice of refusal or interruption is issued.

HEALTH CARE INSURANCE PLAN

Health Insurance

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Basic activities of daily living

Refers to each and every one of the following activities: feeding oneself, dressing oneself, moving around and providing for one's own basic hygiene needs.

Business partner

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

Close relative

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Commercial activity

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

Deductible

The amount of eligible health care expenses that you must pay before being entitled to any reimbursement. The deductible is usually payable each year, but it may also become payable at other intervals, or at the time of each claim as is sometimes the case for prescription drugs.

Eligible expenses

For Health Insurance, health care expenses eligible for inclusion in the calculation of reimbursements, taking into account any deductible, percentage of reimbursement and other maximum provided for under the contract.

Family member

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, grandchild, uncle, aunt, nephew or niece.

Home assistance service supplier

Refers to a person working for remuneration for a company specialized in home care, be it a co-op or incorporated or registered agency. Also refers to a self-employed person providing home care services when contracted by such a company. Also refers to a self-employed person specialized in home care services, when services are provided in an area where no such company exists.

Hospital

Any establishment considered a hospital under applicable federal or provincial laws.

Host at destination

An individual at whose principal residence the insured is planning to stay for at least part of the trip.

Prepaid travel expenses

Refers to the following:

- Expenses incurred by the insured to purchase a trip, including tickets from a public carrier, rental of motor vehicles or accommodation from a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services.
- Amounts paid by the insured for travel arrangements usually included in a package trip.
- Amounts paid by the insured in relation to registration fees for a commercial activity.

Province

Used to refer to the provinces of Canada, as well as the Yukon, Northwest Territories and Nunavut.

Public carrier

Refers to any carrier approved by the appropriate authorities and operating with a transport licence for the transportation (air, sea, land) of passengers for remuneration.

Travel companion

Refers to the person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the insured.

Trip

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

For Travel Cancellation Insurance purposes: An occasional trip made by an insured from the usual place of residence to temporarily visit a place at least 200 kilometres away. To be recognized as a trip under Travel Cancellation Insurance, the trip must also require a period of absence of at least 2 consecutive nights and must be for tourism, pleasure or attendance at a commercial activity. In addition, in the case of a cruise, it must be operated under the responsibility of a business which is accredited or authorized by the appropriate authorities to operate such a business or provide such services.

2. Coverage

If an insured incurs expenses that are eligible under this benefit, SSQ agrees to reimburse such expenses as indicated in the "Schedule of Insurance", subject to the provisions of the contract.

Eligible expenses for Health Insurance are grouped together by type of service as follows:

- Prescription Drugs
- Hospitalization
- Specialized Health Care Establishments
- Health Care Professionals
- Other Medical Expenses
- Home Care and Assistance
- Travel Assistance Insurance
- Travel Cancellation Insurance

3. General conditions for eligibility of expenses

In all cases, to be considered eligible, expenses must meet the following conditions:

- Be incurred for an individual who is insured under this benefit
- Comply with the necessary, customary and reasonable standards of practice generally accepted in the health care sector with regard to the medical condition of the insured and to their cost
- Be used in compliance with the manufacturer's instructions, or, where no such instructions exist, in accordance with government-approved directives
- Be necessary for the medical treatment of the insured and, unless specified otherwise, not be administered for preventive purposes
- Services must be provided by an individual who is not the insured, who does not reside with the insured and who is not a close relative of the insured

For items, care or services obtained from health care professionals, the following conditions must also be met for the expenses to be considered eligible:

- the health care professional must be a member of a professional order governing the practice of the professional's activities or the use of the professional's title
- in the absence of a relevant professional order, the health care professional must be a member of a professional association recognized by SSQ
- the services must be within the professional's area of expertise and comply with all standards of right conduct provided by the professional's association code of ethics or other documents.

4. General exclusions, limitations and restrictions

All insureds are presumed to be covered under the public health and hospitalization plans of their province of residence; in the event that an insured is not covered, any amounts paid by SSQ are limited to the amounts that would have been payable had the insured been covered under the relevant plan.

Health Insurance provides for no reimbursement in the following cases:

a) Expenses incurred due to:
   - a criminal act the insured commits or attempts to commit
   - the insured's active participation in a riot or insurrection
   - war, whether declared or undeclared
   - the insured's active service in the armed forces
   - attempted suicide or self-inflicted injuries, regardless of the state of mind of the insured

b) Expenses payable by another insurer and expenses covered under any public plan or government program or that would have been covered had the service provider opted to participate in such plan or program

c) Expenses for which a third party is liable, except in the case of subrogation

d) Expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract

e) Expenses for products or services related to the treatment of cellulite and, for options 1, 2, 3 and A, that are not covered under the government prescription drug insurance plan

f) For options 3 and A, expenses for products related to the treatment of obesity that are not covered under the government prescription drug insurance plan

g) For option B, expenses for products related to the treatment of obesity;

h) Expenses for services related to the treatment of obesity and, for options 1, 2, 3 and A, that are not covered under the government prescription drug insurance plan

i) Expenses for dietary supplements or infant formula and, for options 1, 2, 3 and A, that are not covered under the government prescription drug insurance plan

j) Expenses for products or services designed as smoking cessation products and, for options 1, 2, 3 and A, that are not covered under the Prescription drugs benefit of this plan

k) Expenses for products or services designed to treat sexual dysfunction and, for options 1, 2, 3 and A, that are not covered under the Prescription drugs benefit of this plan

l) Expenses for products or services designed to stimulate hair growth or prevent hair loss and, for options 1, 2, 3 and A, that are not covered under the government prescription drug insurance plan

m) Expenses for products or services designed for the treatment of infertility and, for options 1, 2, 3 and A, that are not covered under the government prescription drug insurance plan

n) Expenses for which you are unable to prove that they were incurred by the insured and that they have been paid

o) Expenses incurred for items, care or services obtained from health care professionals whom SSQ can prove that they behave fraudulently or break the law as a result of issuing documents, bills, statements or evidence that contain false information or that do not exactly represent the obtained items, care or services

p) Expenses incurred for products or treatments of an experimental nature or obtained under a federal program providing special access to health products

q) Expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes or incurred further to a request by a third party

r) Expenses incurred in relation to eye tests or eye refraction examinations, or for the purchase of eyeglasses or contact lenses not explicitly insured under the contract

s) Expenses incurred in relation to services that are not provided while the individual is insured

t) Expenses incurred for service contracts or maintenance fees

u) Expenses for surgically-implanted prostheses

v) Expenses for delivery or mailing costs

Some other exclusions apply specifically to certain benefits provided under Health Insurance. These exclusions are shown following the description of expenses covered under the benefits in question.

5. Multiple coverage and coordination of benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not you have submitted a claim for such benefits.

If you are entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained. If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

If you and your spouse each have group health insurance coverage, each of you should first submit your own claims to your own group insurance plan.

If you and your spouse each have family coverage status for your group health insurance, claims for your dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If you are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If you share joint custody, claims for children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

Expenses eligible for reimbursement under the Travel Assistance Insurance or Travel Cancellation Insurance benefits will be reduced by the amount of any corresponding benefits payable under another insurance contract. If you are entitled to receive benefits under Travel Assistance Insurance or Travel Cancellation Insurance as well as under another benefit of this plan, benefits shall only be payable under Travel Assistance Insurance or Travel Cancellation Insurance.

6. Conversion privilege

Individuals whose insurance ends because they are no longer eligible may obtain individual health insurance coverage from SSQ without having to provide evidence of insurability, provided they apply to SSQ in writing within 31 days following the termination of their group insurance coverage. In other cases, individual health insurance coverage may only be obtained on presentation of evidence of insurability deemed satisfactory by SSQ.

7. Claims

Except when the SSQ card is used, all claims must be submitted:

a) on line on SSQ's **Customer Centre** web site at **customer-centre.ssq.ca**;

b) using the SSQ Mobile Services free application that can be downloaded at **www.ssq.ca/mobile**; or

c) using the claim form available on SSQ's **Customer Centre** web site or from SSQ's Customer Service. You must complete the form and send it to SSQ along with the originals of all receipts or paid invoices. As SSQ does not return receipts, always keep copies for your records.

Upon request, reimbursements may be issued by direct deposit.

Prescription drug expenses

Present your direct payment card to your pharmacist, who will obtain payment directly from SSQ for the portion of prescription drug expenses payable under the contract. You are then responsible for paying the portion of expenses that is not covered by SSQ.

Expenses for care provided in hospital

Present your SSQ Card at the hospital and the hospital will submit a claim for the expenses incurred directly to SSQ

Expenses incurred for prescription drugs where no SSQ card is used, expenses incurred in specialized health care establishments, expenses for consultations with health care professionals, other medical expenses and expenses for home care and assistance.

In cases where a medical prescription is required, you must attach the prescription to your claim.

Receipts and paid invoices submitted with claims must clearly show the following information:

a) The name of the individual who provided the services, the individual's association or professional order and the individual's membership number, or the name and address of the supplier or establishment from which services were obtained;

b) The dates when services were provided;

c) The cost of services provided;

d) The name of the insured for whom services were provided.

As home care and assistance services are subject to prior medical approval, receipts and invoices for these services must be accompanied by a "Convalescent Care" form duly completed and signed by the insured's attending physician.

Expenses covered under Travel Assistance Insurance

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

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

- The documents you need to file your claim. Originals of all receipts and paid invoices for eligible expenses paid should be enclosed with your claim
- A form for you to sign, authorizing SSQ's travel assistance service to obtain reimbursement on your behalf for expenses eligible under your provincial health and hospitalization plan

For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, contact SSQ's travel assistance service at one of the numbers below:

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

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

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

Travel Cancellation Insurance

To file a claim, contact SSQ's travel assistance service at one of the numbers below:

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

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

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

Insureds must include the following supporting documents with their claim:

a) Unused travel tickets

b) Official receipts for additional transportation expenses

c) Receipts for travel arrangements. Receipts must include the contracts officially issued by a travel agency or a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services, specifying the non-refundable amounts in the event of cancellation

d) Written proof that you have requested a reimbursement of travel expenses along with the reply you receive from the travel agency, public carrier or business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services

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

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

g) An official report pertaining to weather conditions

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

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

8. Deadlines for filing claims

Claims should be submitted to SSQ no later than 3 months following the date expenses are incurred.

SSQ declines all claims submitted more than 12 months after the date expenses are incurred and all claims submitted more than 12 months after termination of coverage under the benefit in question.

Prescription Drugs (Health Insurance)

1. Expenses covered

To be eligible, expenses for prescription drugs must be incurred for the purchase of the products described below for an individual who is insured at the time of purchase. The coverage maximums applicable to these expenses are specified in the "Schedule of Insurance", along with information about applicable deductibles and reimbursement percentages. However, the out-of-pocket maximum provided for under the Quebec Basic Prescription Drug Insurance Plan (BPDIP) applies to expenses incurred by any member, either for themselves or their insured dependents, following application of the deductible and percentage of reimbursement provided for under this coverage. The percentage of reimbursement applicable thereafter to eligible expenses incurred during the same calendar year is 100%.

Medications obtainable only with a medical prescription

Drugs that meet all of the following conditions:

a) Bearing a valid DIN (Drug Identification Number) issued by the federal government

b) Available only on prescription from a health care professional legally authorized to prescribe them

d) Available exclusively in pharmacies and dispensed by a pharmacist except that in remote areas where there is no pharmacy or pharmacist, they may be dispensed by someone who is legally authorized to do so

Products on the RAMQ list

Your insurance covers the same drugs as those covered under the Basic Prescription Drug Insurance Plan of the "Régie de l'assurance maladie du Québec" (RAMQ), subject to the same conditions as those applicable under the RAMQ plan.

Diabetic products

Insulin, syringes, lancets, needles, test strips and glucose sensors for intermittent blood glucose monitors, for the treatment of diabetes. Expenses incurred for the purchase of glucose sensors are limited to an annual maximum, and prior approval by SSQ is required.

Exception / prior approval drugs

Prior approval by SSQ is required for some prescription drugs commonly referred to as "exception" or "prior approval" drugs. For these drugs to be covered, their use must meet all of the following conditions:

- Comply with the specific clinical criteria and directions for use determined by the government authorities
- Comply with the usage criteria suggested by the recognized appropriate medical and governmental authorities of the medical sector
- Comply with the necessary, customary and reasonable standards of practice generally accepted in the health care sector, including the ratio between their cost and their effectiveness

Sclerosing injections

Only expenses for sclerosing injections that are not eligible under other provisions of the contract and that are provided and administered by a physician for curative and not aesthetic purposes. For the purposes of this insurance contract, the professional fees charged by the physician are not considered to be expenses for sclerosing injections.

Magistral Preparations

Expenses incurred for the purchase of a magistral preparation are eligible provided that such preparation is eligible under SSQ's policy concerning extemporaneous compounding products.

Smoking cessation products

Smoking cessation products.

Drugs used to treat sexual dysfunction

Drugs used to treat sexual dysfunction, provided they are not administered orally.

Preventive vaccines (immunizing products)

Only expenses for vaccines that are not eligible under other provisions of the contract. The medical procedure related to the injection of a vaccine is covered only if performed by a nurse.

Anti-obesity drugs

Expenses incurred for the purchase of anti-obesity drugs obtainable only on prescription from a health care professional legally authorized to prescribe such drugs. These drugs require prior approval from SSQ and are covered only if they meet the criteria determined by SSQ.

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to the Prescription Drugs benefit.

Expenses incurred for the following are not eligible under this benefit, regardless of whether or not they are considered prescription drug expenses:

a) Products used for aesthetic, cosmetic or personal hygiene purposes

b) Substances or drugs used or administered for preventive purposes, except in cases where eligible expenses are explicitly provided for such substances or drugs

c) Experimental drugs or products or those obtained under a federal program providing special access to health products

d) Homeopathic or natural products

e) Dietary supplements intended as a meal supplement or replacement. However, dietary supplements prescribed as treatment for a clearly diagnosed metabolic disease are covered, provided they are used in compliance with official conditions and directions for use. A complete medical report detailing all conditions justifying the prescription of such products must be presented to SSQ

f) Sunscreens

g) Drugs used for artificial insemination or in vitro fertilization

h) Growth hormones. However, growth hormones can be eligible, upon submission of a detailed medical report to SSQ, if they are prescribed in compliance with the conditions and directions for use determined by the provincial prescription drug insurance programs

i) The cost of services payable by an insured as a contribution to a public prescription drug insurance plan, which may consist of a premium, a deductible amount or a coinsurance payment

j) Drugs supplied during hospitalization, supplied by a hospital pharmacy, or administered at a hospital

k) The medical procedure related to drugs injected by a health care professional in a private clinic, except in cases where eligible expenses are explicitly provided for such services

Under no circumstances may the exclusions, limitations and restrictions that apply to the prescription drug coverage of this plan render the plan less generous than the Basic Prescription Drug Insurance Plan of the Régie de l'assurance maladie du Québec (RAMQ).

Hospitalization (Health Insurance)

1. Expenses covered

To be eligible, expenses for hospital care must be incurred for the services described below, and insureds must be covered at the time such services are obtained. Any coverage maximums applicable to these expenses are specified in the Schedule of Insurance, along with information about applicable deductibles and reimbursement percentages.

Hospital room

The difference between the cost of hospital ward accommodation and the cost of accommodation in the type of room specified in the "Schedule of Insurance" during a period of short-term care provided in Canada in an establishment that meets the definition of a hospital specified for this group insurance plan. Care provided for chronic illness or loss of independence, including that provided in residential long-term care facilities, is not considered to be hospital care for the purposes of this contract.

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to expenses for hospital care.

Administrative or incidental fees (TV, telephone, etc.) charged to the patient by the hospital are not eligible for reimbursement under this insurance contract.

Specialized Health Care Establishments (Health Insurance)

1. Expenses covered

To be eligible, expenses in specialized health care establishments must be incurred for the services described below, and insureds must be covered at the time such services are obtained. The coverage maximums applicable to these expenses are specified in the "Schedule of Insurance", along with information about applicable deductibles and reimbursement percentages.

Convalescent home

The difference between the cost of hospital ward accommodation and and the cost of accommodation in the type of room specified in the "Schedule of Insurance", during a necessary period of convalescence in an appropriate establishment located in Canada. For the purposes of this contract, an establishment is deemed appropriate to provide convalescent care if it offers on-site care by a registered nurse, nursing assistant or physician 24 hours a day and is recognized by SSQ or the ministry responsible for health in the province in which it is located. To be eligible, convalescent care must begin within the first few days following hospitalization. As medical evaluation is required in order to determine the necessity of the period of care, a "Convalescent Care" form must be completed by the attending physician and submitted to SSQ. A copy of this form may be obtained from your plan administrator or from SSQ Customer Service.

Rehabilitation centre

Accommodation expenses incurred for rehabilitative care, during a period of care required in an appropriate establishment located in Canada. For the purposes of this contract, an establishment is deemed appropriate if it specializes in providing rehabilitative care to an extent deemed adequate by the relevant health care professionals. The required period of care and the recommended duration of such period must both be confirmed by the attending physician.

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusion applies to expenses incurred in specialized health care establishments.

Administrative or incidental fees (TV, telephone, etc.) charged to the patient by the establishment are not eligible for reimbursement under this insurance contract.

Health Care Professionals (Health Insurance)

1. Expenses covered

To be eligible, expenses must be incurred for services provided by the health care professionals described below, for an individual who is insured at the time the services are obtained. The coverage maximums applicable to these expenses are specified in the "Schedule of Insurance", along with information about applicable deductibles and reimbursement percentages and the cases in which a prescription is required.

Only one treatment by the same professional or specialist is covered per day, per insured, or one treatment per day per profession or specialty, regardless of the number of fields of specialization the professional or specialist is licensed to practise in.

Acupuncturist

Cost of treatment.

Audiologist

Professional fees.

Chiropodist

Cost of consultation and treatment.

Chiropractor

Cost of treatment.

Chiropractor – X-rays

Cost of X-rays taken by a chiropractor.

Dietician

Cost of consultation.

Occupational therapist

Cost of treatment.

Osteopath

Cost of treatment.

Physiotherapist, physical rehabilitation therapist and certified athletic therapist

Professional fees or cost of treatment.

Podiatrist

Professional fees.

Psychoanalyst

Professional fees.

Psychologist

Professional fees.

Psychotherapist

Cost of consultation.

Social worker

Cost of consultation.

Speech therapist

Professional fees.

2. Exclusions, limitations and restrictions

The general exclusions, limitations and restrictions applicable to the Health Insurance plan apply.

Other Medical Expenses (Health Insurance)

1. Expenses covered

To be considered eligible, expenses must be incurred for the services or articles described below, for an individual who is insured at the time such services or articles are obtained. The coverage maximums applicable to these expenses are specified in the "Schedule of Insurance", along with information about applicable deductibles and reimbursement percentages.

Ambulance and ambulance transport by airplane or train

Ground transportation to or from a hospital by a licensed ambulance service. Oxygen treatments during or immediately prior to transportation are covered.

Return transportation by airplane or train of a bedridden patient occupying the equivalent of 2 single seats, when part of the journey requires the use of one of these means of transportation.

Apnea monitor

Rental or purchase of an apnea monitor, whichever is more economical.

Blood glucose monitor

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

Breast prostheses

Purchase of breast prostheses following a mastectomy.

CAT scans

CAT scans.

Cosmetic surgery following an accident

Cosmetic surgery required following an accident. For expenses incurred for this type of treatment to be considered eligible, the following conditions apply:

- The accident must occur while the individual is insured
- Treatment must begin within 12 months following the date of the accident

and

- Treatment must end within 36 months following the date of the accident and while the individual is still insured under this benefit

Deep shoes

Ready-made deep shoes. Shoes must be needed in order to use an orthosis designed to correct or compensate for a foot defect. Shoes must be obtained from a fully licensed specialized orthopaedic laboratory.

For the purposes of this insurance contract, sandals are not considered deep shoes.

Dental treatment required following accidental injury to natural teeth

Professional fees of a dentist to repair accidental damage to healthy, natural teeth.

For the purposes of this insurance contract, a "natural" tooth is one that has not been replaced. A tooth is considered "healthy" when it has not been affected by any pathology, either in the substance itself or in the adjacent structures. A treated or repaired natural tooth that has returned to its normal functioning and has not been affected by any pathology is also considered healthy. However, damage to teeth occurring while eating is not covered under the "Dental treatment required following accidental damage to natural teeth" provision.

For expenses to be considered eligible expenses for dental treatment following accidental damage to natural teeth, the following conditions must be met:

- The accident must occur while the individual is insured under this benefit
- Treatment must be administered by an accredited dentist or denturist
- Treatment must be provided within 12 months following the accident and while the individual is insured under this benefit

The expenses eligible for dental treatment following accidental injury to natural teeth are limited to the amounts specified in the fee guide for general dental practitioners of the dentist's province of practice for the year during which expenses are incurred.

Expenses related to new or existing dental implants or implant-related prostheses are not covered under the "Dental treatment required following accidental damage to natural teeth" provision.

Detoxification

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

Electrocardiograms

Electrocardiograms.

External prosthesis and artificial limb

External prostheses and artificial limbs required due to the loss of a natural limb occurring while the insured is covered under this benefit.

For the purposes of this insurance contract, the following articles are not considered to be external prostheses or artificial limbs: dentures, breast prostheses, wigs, hearing aids, eyeglasses, contact lenses and intraocular lens implants.

Foot orthoses

Foot orthoses obtained from an officially licensed laboratory or centre specialized in foot orthotics recognized by SSQ.

Hearing aid

Purchase and repair of hearing aids.

Hospital bed

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.

Hygiene articles, catheters, diapers and feeding pump accessories

Purchase of hygiene articles, catheters, diapers and feeding pump accessories, when prescribed by a physician.

Insulin pump

Purchase and repair of an insulin pump prescribed by a physician.

Insulin pump accessories

Purchase of accessories used exclusively with an insulin pump, when prescribed by a physician.

Intraocular lens implants

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

Intrauterine devices (IYDs)

Purchase of IUDs not covered under the prescription drug insurance benefit of this plan.

Laboratory analyses

Analyses of tissue or body fluids (blood, urine, etc.), if carried out in a private laboratory for preventive or diagnostic purposes and of the same type as those carried out in a hospital.

Magnetic resonance imaging

Magnetic resonance imaging (MRIs).

Non-emergency health services outside Canada (optional coverage)

Members and their dependents, if any, who must reside outside Canada for professional reasons are covered for the following expenses at 100% and with no deductible, subject to the payment of an additional premium:

- hospitalization in a hospital where the patient receives curative treatment;
- professional fees charged by physicians for medical and surgical treatment or anesthesia, excluding expenses for dental care;
- charges by a registered nurse for private nursing services provided exclusively in the hospital, when they are medically necessary and are prescribed by the attending physician, up to $5,000 per insured.

Only persons covered under Options 1 or 2 are eligible and they must be covered by the government health insurance plan and hospital insurance of their province of residence for the duration of their stay outside of their province of residence.

The eligible expenses are those exceeding the benefits payable under these provincial insurance plans.

Nurse

Treatment provided to the insured at home by a registered nurse or nursing assistant. To be eligible, expenses must be incurred for continuous care given for a minimum of 8 hours per day that requires the specific skills of one of the aforementioned nurses.

Orthopaedic devices

Corsets, splints, crutches, casts and items for severe burn victims.

For all orthopaedic devices, expenses may be considered eligible up to an amount deemed reasonable by SSQ for the device necessary for the insured to carry out basic activities of daily living. For the purposes of this insurance contract, orthopaedic shoes and foot orthoses are not considered to be orthopaedic devices.

Orthopaedic shoes

Purchase or repair of orthopaedic shoes, also known as “orthotic shoes”. The “Schedule of Insurance” specifies any differences between coverage for adults and coverage for dependent children.

The term “orthopaedic shoes“ is used to mean shoes that are designed for the insured and custom-made from a mould. Open, flared or straight last shoes, or those required for use with Denis Browne splints are also eligible. However, to be covered, shoes must be required to correct or compensate for a foot defect. Shoes must be obtained from a fully licensed specialized orthopaedic laboratory. Also eligible are expenses incurred for corrections made by such a laboratory to prefabricated shoes.

For the purposes of this insurance policy, deep shoes and sandals are not considered orthopaedic shoes.

Ostomy appliances

Purchase of ostomy appliances prescribed by a physician, in excess of the amount reimbursed by the government.

Oxygen and equipment required for its administration

Purchase of oxygen and equipment required for tis administration.

Pharmacogenetic tests

Tests used to identify genetic factors that influence the response to certain pharmacological treatments of a diagnosed illness, if prescribed by a health care professional legally authorized to prescribe them and analysed by a private laboratory duly licensed in Canada.

For the purposes of this insurance, expenses incurred for preventive pharmacogenetic tests or any other genetic tests that do not meet the criteria stated above are not considered eligible expenses.

Radiotherapy

Expenses for radiation treatments.

Respirator (breathing apparatus)

Rental or purchase of breathing assistance apparatus, whichever is more economical.

Support stockings

Graduated compression stockings of 20 mm HG or over. Stockings must be obtained from a pharmacy or medical establishment, for cases of venous or lymphatic system deficiency.

Surgical brassieres

Purchase of surgical brassieres following a mastectomy or breast reduction.

Therapeutic devices

Rental or purchase of therapeutic devices, whichever is more economical, and repair of such devices.

For the purposes of this insurance contract, the following articles are not considered to be therapeutic devices: insulin pumps, monitoring devices such as blood glucose monitors, dextrometers, stethoscopes, sphygmomanometers or other similar devices, home accessories such as whirlpool baths, air purifiers, humidifiers, air conditioning units, or other devices of a similar nature.

Transcutaneous electrical nerve stimulator

One transcutaneous electrical nerve stimulator.

Ultrasound examinations

Ultrasound examinations.

Wheelchair and walker

Rental or purchase, whichever is most economical, of a non-motorized wheelchair or walker. In the case of purchase, expenses incurred for the repair of a wheelchair or walker are also considered eligible. The wheelchair or walker must be similar to the type normally used in a hospital. A motorized wheelchair is only covered if the insured's health condition requires its use.

Wig

Purchase of an initial wig (capillary prosthesis) following chemotherapy.

X-rays

X-rays other than those covered under other provisions of the contract.

For the purposes of this insurance contract, MRI and CAT scans are not considered X-rays.

2. Exclusions, limitations and restrictions

The general exclusions, limitations and restrictions applicable to the Health Insurance plan apply.

Home Care and Assistance (Health Insurance)

1. Expenses covered

To be eligible, expenses must be incurred for the care or services described below deemed necessary during a period of convalescence following hospitalization or day surgery, for an individual who is insured at the time the care or services are obtained. The coverage maximums applicable to these expenses are specified in the "Schedule of Insurance", along with information about applicable deductibles and reimbursement percentages.

In addition for expenses to be considered eligible, home care must meet the following conditions:

- Be prescribed by the attending physician
- Obtain the prior approval of SSQ
- Be provided during a period of convalescence, within 30 days immediately following hospitalization or day surgery
- The insured must be unable to carry out basic activities of daily living during the period of convalescence
- Incur expenses that exceed those normally incurred by the insured prior to the period of convalescence
- The inability to carry out basic activities of daily living must be solely due to a deterioration in the insured's health and not due to a change in the tasks the insured must carry out, e.g. upon returning home following childbirth without complications

Nursing care

The professional fees of a registered nurse or nursing assistant for nursing care provided in the insured's home.

Home assistance services

Fees of a home assistance service supplier to help the insured carry out the following activities at home:

- Basic activities of daily living
- Household maintenance
- General home maintenance (snow removal, lawn mowing, etc.)
- Meal preparation
- Accompanying the insured to medical appointments

Transportation expenses

Transportation expenses incurred by the insured to obtain medical treatment or follow-up.

Childcare expenses

Expenses incurred for childcare services provided in the insured's home or in a daycare centre.

2. Exclusions, limitations and restrictions

The general exclusions, limitations and restrictions applicable to the Health Insurance plan apply.

Travel Assistance Insurance (Health Insurance)

For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, you must contact SSQ's travel assistance service at one of the numbers below:

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

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

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

1. Expenses covered

The percentage of reimbursement applicable to the following eligible expenses is specified in the "Schedule of Insurance".

Coverage under this benefit is limited to the period while individuals are outside their province of residence and are also covered under their public health and hospitalization plans. For any trip scheduled for a period of time exceeding the period covered by these public plans, all excess days are not covered by this coverage. Furthermore, coverage under this benefit only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the insured's province of residence.

In the event that the insured dies during the coverage period, or suffers accidental injury or a sudden and unexpected illness during such period, emergency expenses incurred by or for the insured as described below are eligible, up to the maximum reimbursement specified in the "Schedule of Insurance".

In the following cases, approval must be requested as soon as possible from SSQ's travel assistance service, either by the insured or by any other adult able to do so: hospitalization, medical care, transportation by ambulance.

In the following cases, insureds must obtain prior approval from SSQ's travel assistance service: treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist; repatriation; medical escort; living expenses and transportation of a close relative of the insured; transportation of the insured's body if deceased; return of a vehicle; expenses described under the "Services, products and articles" section.

For the expenses described below to be considered eligible, insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, services must be obtained from an individual who does not reside with the insured and is neither a close relative nor a travel companion of the insured.

Insureds who already have a known disease or illness before the trip must ensure before departure that:

- their health condition does not require any change in the treatment or any increase in prescribed or recommended medication; or
- they experience no symptoms that would prompt any reasonably cautious person to consult a physician.

SSQ's travel assistance service can confirm whether coverage may be limited in any way by the insured's condition.

Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

Physician fees

Professional fees of a physician for medical, surgical or anaesthetic care, other than fees for dental care.

Nursing fees

When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $5,000 per insured per trip.

Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees

Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $1,000 per insured per trip.

Prescription drugs

Expenses for the purchase of drugs available only on prescription from a health care professional legally authorized to do so.

Transportation by ambulance

The cost of transportation by ambulance to the nearest hospital by a licensed ambulance service.

Repatriation of the insured

The cost of returning the insured to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the insured's health condition into account.

Transportation by plane of a medical escort

The cost of economy class round-trip transportation by air for a medical escort who is neither a member of the insured's family nor a travel companion, when required by the air carrier or the attending physician of the insured.

Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class round-trip transportation for one close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days or, in case of death, between the place of residence and the place where the deceased insured's body must be identified. Eligible expenses are subject to the following limits:

- Transportation: $2,500 per trip for all insured family members
- Accommodation and meals: $300 per day for all insured family members, up to a maximum of $2,400 for the whole duration of the stay

Eligible transportation expenses are limited to the cost of making the trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

In case of death of the insured, preparation and transportation of the body or burial or cremation on the spot

The expenses of preparing and returning the remains of the insured by the most direct route home, or burial or cremation on the spot, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of $10,000 for preparation of the body and transportation.

Return of vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per trip.

The vehicle must be returned by a recognized commercial agency. The insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the insured's travel companions, if applicable, must also be unable to return the vehicle.

Services, products and articles

Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator
- X-rays and laboratory analyses
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices

Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to modify the planned trip due to an illness or injury of the insured, a close family member or a travel companion. The illness or injury must be certified by a physician other than the participant themselves.

Eligible expenses are subject to a maximum of $200 per day per participant, during a maximum of 10 days.

Travel assistance services

Your insurance provides access to certain travel assistance services when you need them. These services may not be available in all countries and are subject to change by SSQ without notice.

The following services are available:

a) Directing the insured to an appropriate clinic or hospital

b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front

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

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

e) Providing emergency support and coordinating settlement applications

f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured

g) Arranging for the return of insured persons to their home (return expenses not included)

h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident

i) Communicating with the insured's family or employer

j) Acting as an interpreter for emergency calls

k) Recommending a lawyer in the event of legal difficulties

2. Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel Assistance Insurance.

The following expenses are not eligible for reimbursement under the Travel Assistance Insurance benefit of this plan:

a) Expenses incurred as a result of the insured's refusal to be repatriated to the province of residence, upon SSQ's request

b) Expenses incurred by the insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the insured's life or health

c) Expenses incurred in a location for which the Government of Canada issued an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the insured is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline

d) Expenses payable under any public plan

e) Expenses related to elective or non-emergency surgery or treatment

f) In the case of a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the trip is taken, whether or not the trip is taken upon the recommendation of a physician

g) Expenses for chronic care incurred in a facility treating chronic illnesses

h) Expenses incurred for insureds in thermal spa facilities or extended care homes

i) Expenses incurred due to injury or death as a result of practising any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to.

j) Expenses related to an event occurring during the trip, or shortly thereafter, that insureds may reasonably have predicted due to their state of health at the start of the trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter

k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the public health or hospitalization plan of the insured's province of residence

Travel Cancellation Insurance (Health Insurance)

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

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

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

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

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

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

1. Reasons for cancellation

For cancellation expenses to be considered eligible, the trip must be cancelled, extended or interrupted due to one of the following causes:

a) An illness or accident suffered by the insured, a travel companion or a business partner of the insured, or suffered by a member of the insured's family or travel companion's family. The illness or accident must prevent the individual from performing his or her usual activities and must be sufficiently serious to justify or force the cancellation or interruption of the insured's trip

b) Death of: the insured; the insured's spouse; the insured's or spouse's child; the insured's travel companion; or the insured's business partner

c) Death of a family member of any of the following individuals: the insured; the insured's spouse; the insured's child; the insured's travel companion. The funeral must be scheduled to take place during the period extending from 31 days before and 31 days after the planned trip

d) Death, illness or accident suffered by a person for whom the insured is the legal guardian

e) Notwithstanding any other provision of the contract, suicide or attempted suicide of the insured's travel companion or a member of the insured's family

f) Death of a person for whom the insured is the testamentary executor

g) Death or emergency hospitalization of the host at destination

h) The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or is a police officer and has been subpoenaed as part of his or her regular duties

i) Quarantine of the insured, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the trip

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

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

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

m) **For trip cancellation**

The issuance by the Government of Canada of an advisory:

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

The advisory must be issued after the insured has made the travel arrangements. The advisory must be in force 14 days before the scheduled date of departure.

For trip interruption

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured is on a trip; or
- to avoid all cruise ship travel when the insured is already on a cruise ship.

The advisory must be in force during the trip. The insured must comply with the advisory within 14 days following its issuance.

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

o) Weather conditions such that:

- the departure of the public carrier used by the insured, at the point of departure of the planned trip, is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the trip;

  or

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

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

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

2. Expenses covered

To be eligible, expenses must be incurred by the insured following the cancellation, extension or interruption of a trip, provided such expenses are related to amounts paid in advance by the insured and that, at the time travel arrangements were made, the insured was not aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation.

Eligible expenses are described hereafter and are reimbursed according to the indications in the "Schedule of Insurance":

In the event of cancellation prior to departure

a) The non-refundable, unusable, non-transferrable and irrecoverable portion of prepaid travel expenses. Any form of credit, compensation or indemnification (with or without restriction on use) offered by a travel provider, a travel agency, a public carrier, an accommodation facility or an agency is considered as a reimbursement of prepaid travel expenses

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

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

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

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

If the return is earlier or later than planned

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

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

Restriction

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

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

Round-trip transportation

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

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

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

3. Exclusions, limitations and restrictions

In addition to the exclusions, restrictions and limitations applicable to all benefits of the Health Insurance plan, the following exclusions apply to Travel Cancellation Insurance.

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

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

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

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

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

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

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

g) A cause which, beyond any possible doubt, does not prevent the insured from proceeding with the trip

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

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

However, this exclusion does not apply:

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

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

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

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

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

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

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

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

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

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

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

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

If notice of cancellation of a trip prior to departure is not provided within the time specified herein, SSQ's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and any adult accompanying the insured on the planned trip provide proof deemed satisfactory by SSQ that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and SSQ's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

Dental Care Insurance

1. Definitions

Some of the terms used to describe your group insurance plan are defined in the GENERAL PROVISIONS section. Whenever the context allows, the following definitions shall apply specifically to the interpretation of this benefit.

Close relative

An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Deductible

The amount of eligible dental care expenses that you must pay before being entitled to any reimbursement. The deductible is usually payable each year, but it may also become payable at other intervals, or at the time of each claim.

Eligible expenses

Dental care expenses eligible for inclusion in the calculation of reimbursements, taking into account any deductible, percentage of reimbursement and other maximum provided for under the contract.

2. Coverage

If an insured incurs expenses that are eligible under this benefit, SSQ agrees to reimburse such expenses as indicated in the "Schedule of Insurance", subject to the provisions of the contract.

Eligible expenses for Dental Care Insurance are grouped together by type of service as follows:

- Diagnostic and Preventive Services
- Basic Dental Care
- Major Restorative Services (Prosthodontics)
- Orthodontics Services

The description of dental care expenses covered is established based on the dental fee guide that SSQ uses as of the most recent update of its contractual documents. SSQ manages the benefit by taking into account the ongoing changes in dental techniques and the updated service descriptions of the fee guide of the concerned dental association. Although there may be differences in the description of dental care expenses between SSQ's contractual documents and the dental fee guide, the equivalent of the description continues to apply.

3. General conditions for eligibility of expenses

In all cases, to be considered eligible, expenses and services must meet the following conditions:

- Services must be obtained while the individual is insured under this benefit
- Treatment must be provided by an accredited dentist, denturist or dental hygienist working under supervision of a dentist
- Treatment must be administered in compliance with current dental practice standards
- Services must be provided by an individual who is not the insured, who does not reside with the insured and who is not a close relative of the insured

Treatment plan

In order to determine the eligibility of certain treatments, appropriate X-rays may be required and should be provided to SSQ through the submission of a detailed treatment plan. If expenses incurred are expected to be significant, SSQ recommends that a treatment plan and appropriate X-rays be submitted before the start of treatment. This will allow insureds to be informed in advance of the eligibility of the treatment and of the portion of the expenses covered under this benefit.

4. General exclusions, limitations and restrictions

For insureds who are not covered under the public health insurance plan of their province of residence, any amounts paid by SSQ are limited to the amounts that would have been payable had the insured been covered under the relevant plan.

If an insured enrols in Dental Care Insurance more than 180 days following the date they became eligible, no reimbursement is made for dental care expenses during the first 6 months of insurance.

Expenses are eligible up to the amount of the fees recommended in the following professional association's fee guide for the year specified in the Schedule of Insurance: For services of a general dental practitioner or dental specialist, the fee guide for general dental practitioners of the dentist's province of practice; For services of a denturist, the fee guide for denturists of the denturist's province of practice. In the absence of fees recommended by an appropriate professional association, eligible expenses are limited to reasonable amounts that uninsured individuals would normally have to pay for the services in question, taking into account standards that SSQ deems applicable to the dentist's or denturist's province of practice. With respect to eligible laboratory expenses, they are limited to 50% of the fees detailed in the fee guide for the orodental act in question.

In the event that a less expensive treatment than that received by the insured would have given the appropriate results, eligible expenses are calculated based on the fee provided for the less expensive treatment, taking into account, however, the applicable fees provided for above.

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

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.

Installation of gold foil, inlays or replacement prostheses (individual crowns, veneers, cast posts, prefabricated posts, removable dentures, fixed bridges) is not considered a service covered under this benefit if installed within 60 months of the previous one. However, expenses for replacing partial or complete permanent removable dentures may be eligible for reimbursement when such replacement is carried out within 12 months of the date the transitional dentures were installed (only when waiting for completion of the healing process).

Dental Care Insurance provides for no reimbursement in the following cases:

a) Expenses incurred due to self-inflicted injuries, regardless of the state of mind of the insured

b) Expenses payable by the government or by another insurer

c) Expenses for which a third party is liable, except in the case of subrogation

d) Expenses incurred for treatment provided for aesthetic purposes not explicitly covered under the contract; for example, transformation, extraction or replacement of healthy teeth to modify their appearance are considered treatment for aesthetic purposes

e) Expenses for which you are unable to prove that they were incurred by the insured and that they have been paid

f) Expenses incurred for treatments or services of an experimental nature or at the medical research stage

g) Expenses incurred to undergo medical examinations for insurance, monitoring or verification purposes

h) Expenses incurred in relation to services that are not provided while the individual is insured

i) Expenses regarding implants and any implant-related treatment or prosthesis

j) Expenses regarding an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction or vertical dimension correction; 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 for the dentist's professional association for bruxism appliances

k) Expenses regarding the replacement of appliances or dentures that are lost or stolen

l) Expenses in relation to appointments not kept, filing claims, treatment plans, written reports, travelling expenses, correspondence expenses, legal identification, and appearance in court as an expert witness or telephone consultations

m) Expenses for mouth guards

n) Expenses that the insured would not have had to pay if uninsured

o) Expenses regarding a dental appliance for treatment of snoring or sleep apnea

p) Expenses regarding transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort

q) Expenses regarding transitional pontics or abutments

r) Expenses related to microbiological tests or analyses

s) Expenses regarding diagnostic photographs

5. Multiple coverage and coordination of benefits

Expenses eligible for reimbursement under the contract will be reduced by the amount of any benefits payable under a government plan, regardless of whether or not you have submitted a claim for such benefits.

If you are entitled to benefits payable under this coverage and similar coverage under another group insurance contract, benefits from all contracts will be coordinated so that the amounts paid do not exceed the actual expenses paid for the services obtained, nor the eligible expenses, based on the fee guide of the attending professional's association for the reference year indicated in the "Schedule of Insurance". If the other insurance plan does not provide for coordination of benefits, expenses incurred are primarily the responsibility of the other plan. Otherwise, the following provisions apply.

If you and your spouse each have group health insurance coverage, each of you should first submit your own claims to your own group insurance plan.

If you and your spouse each have family coverage status for your group dental care insurance, claims for your dependent children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year. If you are separated or divorced, claims for dependent children should first be submitted to the plan of the parent with custody. If you share joint custody, claims for children should first be submitted to the plan of the parent whose birthday occurs earliest in the calendar year.

6. Claims

If the dentist uses electronic claim submission

When the insured incurs dental expenses, he or she must present the dental claim card to the dentist and pay only the portion of the expenses not covered by the insurance. SSQ will reimburse the insured portion of the expenses directly to the dentist.

If the dentist does not use electronic claim submission

You may file your claim by completing and returning to SSQ the dental claim form provided by the dentist.

Claims should be submitted to SSQ no later than 3 months following the date expenses are incurred. SSQ declines all claims submitted more than 12 months after the date expenses are incurred and all claims submitted more than 12 months after termination of coverage under the benefit in question.

Diagnostic and Preventive Services (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "Schedule of Insurance".

Eligible expenses are provided under this contract for the following diagnostic and preventive services:

a) Diagnostic services

1) Clinical oral examination
   - For Quebec residents: Dental examination for children under age 10, if not covered under public plan: one examination per period of 12 months
   - Recall or periodic oral examination: one examination per period of 6 months
   - Complete oral examination or prosthodontic examination: one examination per period of 36 months
   - Examination of stomatognatic system dysfunctions: one examination per period of 36 months
   - Complete periodontal examination: one examination per period of 36 months
   - Emergency examination: 2 examinations per calendar year
   - Specific oral examination: 2 examinations per calendar year

2) X-rays
   a) Intra-oral X-rays
      - Periapical film
      - Occlusal film
      - Bitewing film
      - Soft-tissue film
   b) Extra-oral X-rays
      - Extraoral film
      - Sinus examination
      - Sialography
      - Use of radiopaque dyes to demonstrate lesions
      - Temporomandibular joint
      - Panoramic film: one film per period of 36 months
      - Cephalometric film
   c) Other
      - Duplicate radiograph: 2 times per calendar year

3) Laboratory tests and examinations
   - Pulpal tests: 3 times per period of 12 months
   - Bacteriologic tests
   - Histological tests: Biopsy of soft tissue, biopsy of hard tissue
   - Cytological tests
   - Diagnostic casts (excluded if associated to restorative treatment)
   - Case presentation / treatment plan
   - Consultation with patient

b) Preventive services

1) Preventive services
   - Polishing of coronal portion of teeth: one visit per period of 6 months
   - Scaling: 6 units of time per calendar year
   - Topical application of fluoride*: once per period of 6 months
   - Diet assessment: one visit per lifetime
   - Oral hygiene instruction: once per lifetime
   - Plaque control program: 5 times per calendar year
   - Finishing restorations
   - Pit and fissure sealants, including prophylactic odontotomy and acid etch preparation* (only on occlusal surfaces of premolar and permanent molar teeth): once per period of 36 months per tooth
   - Removal of subgingival filling material requiring anesthesia, without flap
   - Interproximal discing*
   - Enameloplasty (recontouring of natural tooth for non-aesthetic reasons)

2) Space maintainers*

3) Control of oral habits*
   - Fixed or removable appliance
   - Myofunctional evaluation: one visit per period of 24 months
   - Motivation of patient: one visit per lifetime
   - Myofunctional therapy: 5 visits per lifetime

4) Intraoral appliance for bruxism
   - One appliance per period of 60 months
   - Repair: one visit per calendar year
   - Adjustment: one visit per calendar year

5) Occlusal equilibration
   - 8 units of time per calendar year or 3 times per calendar year

* Expenses for these services may only be considered eligible when provided for children under age 16.

Basic Dental Care (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "Schedule of Insurance".

Eligible expenses are provided under this contract for the following basic dental care:

a) Minor restorative services
- Sedative filling
- Smoothing of traumatized tooth
- Recementation of a broken tooth fragment
- Resin, amalgam or composite restorations*
- Retentive pins

* Restoration treatment for the same surface or class of the same tooth may be considered eligible for reimbursement only once per period of 12 months, regardless of the material used and the treating dentist.

b) Endodontics
- Supplement for endodontic treatment through a crown
- Endodontic emergency: pulpotomy, pulpectomy, open and drain
- Endodontic trauma, treatment and surgery
- Apexification

c) Periodontics
- Non-surgical treatment
- Periodontal surgery
- Root planing (maximum 6 units of time per calendar year or maximum one visit per tooth per period of 24 months)
- Splinting (excluding Maryland type)
- Periodontal irrigation

d) Rebase (jump), reline, adjustment and repair of removable dentures
- Rebase, reline: one visit per period of 36 months
- Repairs with or without impression
- Palatal lift: one per period of 60 months
- Remount and equilibration of complete or partial dentures: one visit per period of 60 months

e) Repair of fixed bridges and crowns

- Repair of fixed bridges
- Repair of crowns
- Recementation / rebonding of bridges, inlays, onlays, crowns, posts or veneers: 2 visits per calendar year for the same tooth or abutment
- Supplement for acid-etch restoration: 2 times per calendar year
- Immobilization, sectioning
- Removal of cemented post or cast metal post

f) Oral surgery

- Removal of erupted teeth, complex or uncomplicated
- Removal of impacted teeth, roots and tooth fragments
- Supplement for suturing per visit
- Surgical exposure of tooth, including orthodontic attachment: Once per lifetime per tooth
- Transplantation of tooth: Once per lifetime per tooth
- Surgical repositioning of tooth: Once per lifetime per tooth
- Enucleation of an unerupted tooth and follicle: Once per lifetime per tooth
- Alveolectomy, alveoloplasty, osteoplasty, tuberoplasty, stomatoplasty, gingivoplasty
- Removal of hyperplasic tissue or excess mucosa, surgical excision of cysts or tumors
- Extension of mucosal folds
- Surgical incision and drainage
- Reduction of fracture
- Frenectomy
- Treatment of salivary glands
- Sinus treatment or surgery
- Hemorrhage control
- Post-surgical treatment
- Repair of soft tissue or through and through laceration

g) General additional services

- Local anesthesia
- Conscious sedation
- Home, hospital or dental office visit outside normal office hours

Major Restorative Services - Prosthodontics (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "Schedule of Insurance".

Eligible expenses are provided under this contract for the following prosthodontic services:

a) Major restorative services and fixed prostheses

- Gold foil
- Inlays and retentive pins
- Metal cast retainer, Maryland type: once per period of 60 months for any one tooth
- Preformed crowns - stainless steel, plastic or other similar material; also transitional crowns: once per period of 12 months for any one tooth
- Individual crown
- Coping crown (cap), precious metal or not
- Cast metal posts
- Laboratory processed veneer for anteriors and premolars
- Prefabricated post
- Tooth reconstruction (core build up) in preparation for crown
- Supplement for restoration

b) Removable dentures

- Complete dentures*
- Partial dentures*
- Analysis in preparation for fabrication of partial denture: Once per period of 60 months
- Supplement for restoration in preparation for removable prosthodontics

* Expenses for equilibrated dentures are reimbursed based on the cost of the equivalent standard dentures.

c) Fixed bridges

- Pontics
- Metal cast retainer (inlay) for Maryland, Rochette or Monarch bridge
- Abutment
- Retention bar for attachment to coping crowns
- Abutments, inlays or onlays: metal, porcelain, ceramic or resin
- Precision attachments
- Supplement for preparation of crown under existing partial denture clasp

Orthodontic Services (Dental Care Insurance)

Expenses covered

Reimbursement of the eligible expenses described below is calculated based on the information provided in the "Schedule of Insurance".

Eligible expenses are provided under this contract for the following orthodontic services:

- Specific orthodontic examination: once per period of 12 months
- Complete orthodontic examination
- Orthodontic emergencies
- Corrective orthodontics
- Osseous anchorage
- Repairs, alterations, recementation
- Retention appliances
- Orthodontic treatment
- Radiograph: hand and wrist (as diagnostic aid for dental treatment)
- Complete treatment of dental malocclusion

Discover our on-line services by registering today at our secure site for insureds.

SSQ Customer Service
Toll free: 1-888-651-8181

B88H00_001A