SSQ insurance

communities make us

Group insurance

Your plan



Policy 48C00

Members - Dental Care Insurance

ORDRE DES COMPTABLES PROFESSIONNELS AGRÉÉS DU QUÉBEC

January 1, 2022

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

SSQ, LIFE INSURANCE COMPANY INC.

YOUR GROUP INSURANCE PLAN

ORDRE DES COMPTABLES PROFESSIONNELS AGRÉÉS DU QUÉBEC

This document shows the contractual provisions in force on January 1, 2022, for the following participants:

Members - Dental Care Insurance
(Policy No.: 48C00)

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

NOTICE OF CONSTITUTION OF A FILE AND PERSONAL INFORMATION USE

Notice of constitution of a file
The protection of the personal information that we obtain through our activities is very important to SSQ Insurance. This is why, to maintain the confidentiality of personal information, SSQ Insurance (SSQ, Life Insurance Company Inc., SSQ Distribution Inc. and their subsidiaries) will create an insurance file to contain your personal information. The information we collect in different instances, including insurance applications, renewals, modifications or claims, will be added to your file. Except for certain exceptions stipulated by law, access to this file is restricted to those SSQ Insurance employees, service providers, agents or any other person you may authorize to access this information when required to fulfill their contract or mandate.

This file is kept at SSQ Insurance's offices or authorized third-party premises. You have the right to consult the personal information held in your file and, if necessary, have it changed by submitting a written request to the Personal Information Protection Officer at the address below.

Personal Information Protection Officer
SSQ Insurance, 2525 Laurier Boulevard, P.O. Box 10500, Stn Sainte-Foy, Quebec City QC G1V 4H6

Collection and use of your personal information
SSQ Insurance only collects information that is necessary for the management and administration of the business relationship we have with you and any other information obtained through your interactions with us.

The personal information we collect, store and use allows us to verify your identity, validate your eligibility for our products and services, estimate insurance risk, determine premiums, process your claims, manage your file and meet legal requirements. It also may be used to improve our products, services, campaigns and promotions based on statistical analyses. If you have given us your social insurance number, it will only be used for administrative and fiscal purposes.

To learn more about our personal information protection practices, go to ssq.ca.

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, 2022.

Category of individuals eligible as participants	**A:** All members in good standing with the Ordre des comptables professionnels agréés du Québec of less than 65 years of age **C:** All members in good standing with the Ordre des comptables professionnels agréés du Québec of 65 years of age and over
Eligibility date for new members and salaried employees	On the date of admission of the member to the Ordre des comptables professionnels agréés du Québec

SCHEDULE OF INSURANCE

Health Care Insurance Plan

Dental Care Insurance

Unless otherwise indicated, the maximums specified below apply per calendar year per insured.

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

Claims Submission Method: Electronic

Coverage	Basic Plan	Full Plan
Diagnostic and Preventive Services		
Percentage of reimbursement	**80%**	**80%**
Diagnostic Services Preventive Dental Care	Maximum combined with Basic Dental Care	
Basic Dental Care		
Percentage of reimbursement	**80%**, except for Endodontics and Periodontics which are covered at **50%**	**80%**, except for Endodontics and Periodontics which are covered at **50%**
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 $1,000 reimbursement	Combined maximum of $1,500 reimbursement
Major Restorative Services		
Percentage of reimbursement	N/A	**50%**
Major Restorative Services and Fixed Prosthodontics Removable Dentures Fixed Bridges	Not covered	Maximum combined with Basic Dental Care

SCHEDULE OF INSURANCE

Health Care Insurance Plan

Dental Care Insurance (continued)

Coverage	Basic Plan	Full Plan
Orthodontic Services		
Percentage of reimbursement	N/A	**50%**
Orthodontics (for insured dependent children between age 6 and age 18 inclusively)	Not covered	$1,500 lifetime reimbursement
Frequency of recall examinations	2 per calendar year	
Termination of insurance	**A:** The day you reach age 65 or the last day of the month during which the plan administrator is informed that you are no longer a member, whichever occurs first **C:** The last day of the month during which the plan administrator is informed that you are no longer a member	

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.

Contract

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

Actively at work

A salaried employee is deemed to be "actively at work" when present at his or her place of work and capable of carrying out normal duties in accordance with the regular work schedule and on full pay. Employees who are not disabled are also deemed to be actively at work if their absence is due only to a period of leave or a non-working day. All references to "actively at work" are not applicable to members.

Dependent child

A child for whom you or your spouse exercise parental authority, or would exercise if a minor, and whom you or your spouse support. To be eligible, the child must also be unmarried and:

- under age 21

  or

- age 21 or over but under age 26 and a full-time student in an accredited educational institution, subject to proof of registration deemed satisfactory by SSQ;

  or

- regardless of age, be suffering from a functional impairment, as defined in applicable legislation; SSQ may require any evidence it deems necessary; the child must be residing with an individual who would exercise parental authority if the child were a minor.

The child must also reside in Canada and be covered under the public health and hospitalization insurance plan of a Canadian province.

Insured

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

Participant

An individual enrolled in the insurance plan that is part of a class of eligible individuals. The individual must also be covered under the public health and hospitalization insurance plan of a Canadian province. In addition, employees will not be considered as participants unless they reside in Canada and their usual place of work is located in Canada.

Plan administrator

Le Groupe Vigilis (Vigilis), third party administrator in charge of this group insurance plan.

Premium period

Period for which premiums are payable, as agreed by SSQ and the group Policyholder.

Spouse

An individual who resides in Canada and is covered under the public health and hospitalization insurance plan of a Canadian province, provided that this is an individual who:

- is married to you through a civil union or other legally recognized marriage;

  or

- you are able to prove lives with you on a regular basis and whom you have designated in writing to SSQ as your spouse, provided that a child has been born of your union;

  or

- you are able to prove has been living with you on a regular basis for at least 12 months and whom you have designated in writing to SSQ as your spouse.

The status of spouse ends when:

- in the case of a marriage or civil union, you and this person have been separated for more than 3 months or have obtained a divorce or annulment of your marriage or civil union;
- in the case of a common-law union, you and this person have been separated for more than 3 months.

In the case of more than one spouse, only the last person you have designated as such in writing to SSQ will be recognized as your spouse. If no spouse is designated, only a person linked to you by civil union or marriage will be recognized as your spouse.

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.

You

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

Participation Requirements

1. Participation

Participation in your group insurance plan is optional.

2. Eligibility conditions

Any individual residing in Canada, who is actively at work and who meets the eligibility conditions specified in the "Schedule of Insurance", is eligible for insurance as a participant, unless specified otherwise. Individuals who are absent because they are on leave or because their eligibility date is a non-working day, are also eligible for insurance.

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 SSQ for insurance to become effective, even in cases where participation in insurance is compulsory.

On the effective date of this policy, if you are already eligible for insurance as a participant, the same status of protection and coverage option you had with the previous insurer will apply under the current policy.

If you become eligible at a later time, you must choose the status of protection (individual, single-parent, couple or family) and the plan ("Basic" or "Full") that will apply to the Dental Care Insurance benefit. The same status of protection will apply to both benefits, but you can choose a different plan for each benefit. Your choice will have to be made in the 31 days following your eligibility. In the absence of such a choice in the 31 days following your eligibility, you will have to wait until January 1 of the following year to enrol in the Dental Care Insurance benefit.

Certain events, such as marriage or the birth of a child, may enable you to make changes to the insurance 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.

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

Your insurance becomes effective on the date you become eligible for insurance, subject to contract provisions in the section entitled "Participation Requirements".

Insurance for your spouse or dependent children

Their insurance becomes effective on the date they become eligible for insurance, subject to contract provisions in the section entitled "Participation Requirements".

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 chosen plans

Requests for increase in coverage are possible in the 31 days following January 1 of each year, if you currently have "Intermediate" or "Full" plan for the Health Insurance.

If you select your plan on January 1 of any year, it is possible to make a request for decrease in coverage but only after 2 years of participation in a same plan have elapsed.

If you select your plan at any other time, you must wait until January 1 of the year following a minimum period of participation of 1 year in a same plan , to make a request for decrease in coverage.

You must submit your modification request in the 31 days following the January 1 allowing you to change plan, according to the minimum period of participation provisions.

Requests for increase or decrease can be done one plan or two plans at a time, for example, from the "Basic" plan to the "Full" plan, or from the "Full" plan to the "Basic" plan. It is possible to terminate coverage under the Dental Care Insurance benefit at any time, regardless of the plan selected.

Outside designated re-enrollment periods, it is possible to select a new plan only after one of the following events occurs, provided your request is made in the 31 days following that event:

- a group insurance plan by which you were covered as a participant is involuntarily lost;
- a group insurance plan by which your spouse was covered as a participant is involuntarily lost;
- a person becomes or ceases to be your spouse;

- a person becomes your first dependent child;
- a person ceases to be your sole dependent child;
- one of your dependent dies.

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 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 SSQ receives the application more than 31 days after the date of the event justifying an increase in insurance, the increase in insurance will become effective on the date SSQ receives the application. If required by the nature of the request for increase in coverage for any reason, you must provide evidence of insurability. In this case, the increase in insurance will become effective on the date SSQ approves such evidence.

3.3 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 SSQ receives a written application to such effect .

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

In the event of your death, your insured spouse and dependent children may maintain participation in insurance without premium payment for the Health Insurance plan, until the earliest of the following:

- The end of a period of 24 months immediately following your death.
- The date when their participation in insurance would have ended, if your death had not occurred.
- The date when they become eligible for similar coverage under another insurance benefit.
- The date the contract terminates.

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) 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;

e) 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.

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.

SSQ may also request that an autopsy be performed in accordance with applicable legislation.

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.

HEALTH CARE INSURANCE PLAN

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.

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.

Expenses for dental care described below are eligible for reimbursement based on the chosen plan. When covered, the expenses are indicated in the "Schedule of Insurance".

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.

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 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. However, reimbursement for such expenses may be reimbursed up to the cost of an eligible alternate treatment, once the prosthesis is inserted and subject to approval by SSQ

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. Conversion privilege

Individuals insured under this benefit who exercise a conversion privilege under an SSQ group health insurance benefit may convert their insurance under this benefit at the same time to SSQ individual dental care insurance without having to provide evidence of insurability. This conversion privilege only applies at the time of application of the Health Insurance conversion privilege. In addition, all conditions applicable to the Health Insurance conversion privilege also apply to this conversion privilege.

7. 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: 2 examinations per calendar year
   - 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
   - Recall periodontal examination: 2 examinations per calendar year
   - Emergency examination
   - Specific oral examination

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 or complete series of X-rays: one film or series 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: 2 visits per calendar year
    - Scaling: 6 units of time per calendar year
    - Topical application of fluoride: 2 visits per calendar year
    - 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 60 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

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