

ACT RESPECTING PRESCRIPTION DRUG INSURANCE**CHAPTER I****ESTABLISHMENT AND PURPOSE**

1. A basic prescription drug insurance plan is hereby established.

1996, c. 32, s. 1.

2. The purpose of the basic plan is to ensure that all persons in Québec have reasonable and fair access to the medication required by their state of health.

To that end, the plan provides for a minimum level of coverage for the cost of pharmaceutical services and medications, and requires a financial participation on the part of persons or families covered by the plan depending, in particular, on their economic situation.

1996, c. 32, s. 2; 2005, c. 40, s. 1.

3. Coverage under the basic plan shall be provided by the Régie de l'assurance maladie du Québec, hereinafter referred to as the Board, or by the insurers transacting group insurance or the administrators of private-sector employee benefit plans, as provided by this Act.

1996, c. 32, s. 3; 1999, c. 89, s. 53.

4. "Insurer" means a legal person holding a licence issued by the Autorité des marchés financiers that authorizes it to transact insurance of persons in Québec.

"Employee benefit plan" means a funded or unfunded uninsured employee benefit plan that provides coverage that may otherwise be obtained under an insurance contract of insurance of persons.

1996, c. 32, s. 4; 2002, c. 45, s. 199; 2004, c. 37, s. 90.

CHAPTER II**BASIC PLAN COVERAGE****DIVISION I****ELIGIBILITY**

5. Every person who is a resident of Québec within the meaning of the Health Insurance Act ([chapter A-29](#)) and who is duly registered with the Board in accordance with that Act is eligible for the basic plan.

1996, c. 32, s. 5.

5.1. Despite section 6 of the Health Insurance Act ([chapter A-29](#)), a person eligible for the basic plan who settles in another province of Canada ceases to be eligible on the date the person leaves Québec.

2005, c. 40, s. 2.

6. The classes of persons determined by government regulation who are otherwise entitled to coverage under another Act of Québec, an Act of the Parliament of Canada or the laws of another province of Canada or another country or under a program administered by a government or by a government department or agency that is determined by government

regulation to be at least equivalent to the coverage of the basic plan, are not covered by the basic plan.

1996, c. 32, s. 6.

DIVISION II COVERAGE

7. The basic plan provides coverage to every eligible person for the cost of pharmaceutical services and medications provided in Québec, to the extent provided for in this Act, regardless of the risk associated with that person's state of health.

1996, c. 32, s. 7.

8. Coverage under the basic plan includes, to the extent provided for by this Act, the pharmaceutical services determined by government regulation under subparagraph 1.2 of the first paragraph of section 78 and the medications entered on the list of medications drawn up by the Minister in a regulation made under section 60, when provided in Québec by a pharmacist on the prescription of a physician, a medical resident, a dentist, a midwife or another professional authorized by law or a regulation under subparagraph *b* of the first paragraph of section 19 of the Medical Act ([chapter M-9](#)). Certain medications on the list shall be covered only in the cases, on the conditions or for the therapeutic indications determined in the regulation of the Minister. Coverage also includes, in the cases, on the conditions and in the circumstances determined in the regulation, any other medication except medications or classes of medications determined in the regulation.

The same coverage applies when a person obtains medications in a pharmacy outside Québec from a person legally authorized to practise as a pharmacist in the place concerned and with whom the Board has entered into an individual agreement for that purpose, if the pharmacy is situated in a region bordering on Québec and if no pharmacy situated in Québec within a radius of 32 kilometres of that pharmacy provides services to the public.

In addition, coverage includes, in the cases and on the conditions and for the classes of persons determined by government regulation, the medications specified in the regulation that are provided as part of the services provided by an institution within the meaning of the Act respecting health services and social services ([chapter S-4.2](#)) or the Act respecting health services and social services for Cree Native persons ([chapter S-5](#)) or any other institution recognized for that purpose by the Minister that is situated outside Québec in a region bordering on Québec.

The Government may, in a regulation made under subparagraph 1.2 of the first paragraph of section 78, limit the coverage for pharmaceutical services whose payment is borne by the Board to those relating to a medication that is on the list of medications drawn up by the Minister under section 60. Such a limitation on the coverage for those pharmaceutical services may also be imposed in a group insurance contract or an employee benefit plan.

1996, c. 32, s. 8; 1999, c. 37, s. 1; 1999, c. 24, s. 15; 2002, c. 27, s. 1; 2002, c. 33, s. 9; 2015, c. 8, s. 183.

NOTE

The following provisions are not in force:

in the third paragraph, the words “or any other institution recognized for that purpose by the Minister that is situated outside Québec in a region bordering on Québec”.

The above provisions will come into force on the date or dates to be fixed by the Government (1996, c. 32, s. 119).

8.1. If a pharmaceutical service referred to in section 8 is provided to a person covered by a group insurance contract or an employee benefit plan, an owner pharmacist may not claim fees from anyone unless a tariff is established for the service in an agreement under section 19 of the Health Insurance Act ([chapter A-29](#)) to which pharmacists are subject or in the cases and on the conditions determined in a regulation made under subparagraph 1.3 of the first paragraph of section 78. Such fees, except those claimed for the filling or renewing of a prescription, may not exceed the tariff established in the agreement.

2015, c. 8, s. 184; 2015, c. 25, s. 1.

In force: 2017-09-15

8.1.1. A pharmacist must give an itemized invoice to a person from whom payment of a pharmaceutical service, except a service for which no contribution is payable under subparagraph 1.4 of the first paragraph of section 78, or of a medication or supply covered by the basic plan is claimed. The invoice must list separately the pharmacist's professional fees for every service provided, the price paid by the basic plan for every medication or supply provided and the wholesaler's profit margin, if any.

The invoice must also show any other information the Government determines by regulation, based on whether the insurance coverage is provided by the Board or by a group insurance contract or an employee benefit plan.

An accredited wholesaler must give the pharmacist to whom the wholesaler sells a medication or supply covered by the basic plan an itemized invoice which lists separately the price of that medication or supply and the wholesaler's profit margin.

2016, c. 28, s. 39.

Not in force

8.1.2. No pharmacist may sell a medication covered by the basic plan to a person covered by that plan at any other price than the price the pharmacist paid. In the case of a compounded medication, a parenteral therapy, an ophthalmic solution or any other medication requiring preparation, the price that the pharmacist paid includes the cost of all the ingredients used in the preparation and the fees of the compounding pharmacist.

No compounding pharmacist who, at the request of another pharmacist, prepares a compounded medication, a parenteral therapy, an ophthalmic solution or any other medication requiring preparation may sell such a medication to that other pharmacist at any other price than the price paid by the basic plan, or bill that other pharmacist, if the person concerned is covered by the public plan, for fees other than those established according to the tariffs determined in the agreement under section 19 of the Health Insurance Act ([chapter A-29](#)).

2016, c. 28, s. 39.

8.2. If a medication costs more than the maximum amount covered by the basic plan, the excess amount is borne

(1) by the eligible person covered by the Board; or

(2) by the eligible person who is a member of a group insurance contract or an employee benefit plan or who is the beneficiary under such a contract or plan, if the contract so provides.

In either case, the excess amount is not included in the contribution to be paid and does not count toward the maximum contribution.

2015, c. 8, s. 184.

9. Coverage under the basic plan does not include the cost of pharmaceutical services and medications that an eligible person may obtain, and to which that person is otherwise entitled, pursuant to an Act of Québec, an Act of the Parliament of Canada or the laws of another province of Canada or another country, or under a program administered by a government or by a government department or agency.

1996, c. 32, s. 9.

DIVISION III

FINANCIAL PARTICIPATION

10. Unless exempted by the Act, an eligible person must pay any applicable annual premium or assessment.

1996, c. 32, s. 10.

11. A person may be required to make a contribution towards the payment of the cost of the pharmaceutical services and medications provided up to a maximum contribution for each reference period. The contribution may consist in a deductible amount or a coinsurance payment. However, no contribution is payable for the pharmaceutical services determined by government regulation under subparagraph 1.4 of the first paragraph of section 78.

The deductible amount is the portion of the cost of pharmaceutical services and medications borne entirely by the person covered by the plan during the reference period.

The coinsurance payment is the portion of the cost of pharmaceutical services and medications borne by the person covered by the plan until the maximum contribution is reached.

The maximum contribution is the total amount borne by the person covered beyond which the cost of pharmaceutical services and medications is borne entirely by the Board or by an insurer or employee benefit plan, as the case may be.

1996, c. 32, s. 11; 2015, c. 8, s. 185.

12. The coinsurance percentage to be borne by an eligible person shall not exceed 34.5% of the cost of pharmaceutical services and medications.

1996, c. 32, s. 12; 2002, c. 27, s. 2.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

13. The maximum contribution for a reference period of one year shall not exceed \$1,046 per adult; this amount includes any amounts paid by the adult as a deductible amount and coinsurance payment for a child of the adult or a person suffering from a functional impairment who is domiciled with the adult.

1996, c. 32, s. 13; 2002, c. 27, s. 3.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

13.1. The percentage provided in section 12 and the amount provided in section 13 shall be revised on 1 July each year, according to the rate of adjustment fixed annually by the Board pursuant to section 28.1.

2002, c. 27, s. 4.

14. If a change occurs in an eligible person's situation, the contribution to be paid is the contribution applicable to the person's new situation at the time of obtaining a pharmaceutical service or medication.

For the purposes of the deductible amount and maximum contribution, all costs of pharmaceutical services and medications that are borne by the eligible person for a reference period, according to the original plan, shall be taken into account, even if, during that period, there was a change in the person's status, income level or employee benefit plan, or if another person began providing coverage during that period.

The insurer or employee benefit plan administrator or the Board shall, following a request made within six months by the person affected by such a change, communicate to the person providing coverage after the change the information permitting the application of the deductible amount and the maximum contribution for that period.

1996, c. 32, s. 14; 2002, c. 27, s. 5.

CHAPTER III

APPLICATION OF THE BASIC PLAN

DIVISION I

MANDATORY NATURE OF PLAN

15. The Board shall provide coverage for the following eligible persons:

(1) persons 65 years of age or over who are not members of a group insurance contract or employee benefit plan that is applicable to a group with private coverage within the meaning of section 15.1 and that includes basic plan coverage, and who are not beneficiaries under such a contract or plan;

(2) persons or families eligible under a last resort financial assistance program provided for in the Individual and Family Assistance Act ([chapter A-13.1.1](#)) or receiving an allowance paid under the second paragraph of section 67 of the Social Aid Act (Statutes of Québec, 1969, chapter 63), and holding a valid claim booklet issued by the Minister of Employment and Social Solidarity pursuant to section 70 of the Health Insurance Act ([chapter A-29](#));

(3) persons 60 years of age or over and less than 65 years of age who hold a valid claim booklet issued by the Minister of Employment and Social Solidarity pursuant to section 71 of the Health Insurance Act;

(4) all other eligible persons who are not required to become members of a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1, and in whose respect no person is required, in accordance with section 18, to ensure coverage as beneficiaries under such a contract or plan.

1996, c. 32, s. 15; 1997, c. 63, s. 138; 1998, c. 36, s. 173; 2001, c. 44, s. 30; 2005, c. 40, s. 3; 2005, c. 15, s. 148.

15.1. For the purposes of this Act, a "group with private coverage within the meaning of section 15.1" means a group formed for purposes other than contracting insurance coverage for its members and composed of persons eligible for the basic plan who

(1) are part of the group on the basis of current or former employment or belong to

(a) a professional order,

(b) a professional association whose membership consists of members of one or more professional orders,

(c) an association whose membership consists of persons engaged in the same trade or occupation, or

(d) a union or association of employees

that offers coverage under a group insurance contract or employee benefit plan or under an individual insurance contract concluded on the basis of one or more of the distinctive characteristics of group insurance to, makes such coverage available to or facilitates such coverage for its active members or retirees, either directly or through a legal person; and

(2) qualify for coverage under the group insurance contract, employee benefit plan or individual insurance contract applicable to the group, which includes coverage for the cost of pharmaceutical services and medications.

2005, c. 40, s. 4; 2017, c. 1, s. 19.

16. All persons who are eligible for the basic plan, other than those referred to in paragraphs 1 to 3 of section 15, and who are part of a group with private coverage within the meaning of section 15.1 must become members under the group insurance contract or employee benefit plan applicable to the group for coverage at least equivalent to the basic plan coverage.

The obligation to become a member does not apply to a person who, as a spouse, a child or a person suffering from a functional impairment, already benefits from coverage for the cost of pharmaceutical services and medications under a group insurance contract or employee benefit plan referred to in the first paragraph.

1996, c. 32, s. 16; 2005, c. 40, s. 5.

17. For the purposes of this Act,

(1) “child” means

(1) an eligible person under 18 years of age in whose respect a parent or tutor exercises parental authority;

(2) a spouseless eligible person 25 years of age or under who attends or is deemed to attend an educational institution on a full-time basis as a duly registered student, and who is domiciled with the parent or tutor who would exercise parental authority were the person a minor;

“person suffering from a functional impairment” means a spouseless eligible person of full age suffering from a functional impairment, referred to in a government regulation, that has existed since before the person’s eighteenth birthday, who receives no benefits under a last resort financial assistance program provided for in the Individual and Family Assistance Act ([chapter A-13.1.1](#)), and who is domiciled with the parent or tutor who would exercise parental authority were the person a minor;

“educational institution” means a legal person or a body providing instruction at the secondary, college or university level;

(2) “spouse” must be construed in accordance with section 2.2.1 of the Taxation Act ([chapter I-3](#)).

1996, c. 32, s. 17; 1998, c. 36, s. 174; 2005, c. 40, s. 6; 2005, c. 15, s. 149.

18. Eligible persons, other than those to whom section 15 applies, who are members under a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1 must ensure that the same coverage is provided to the following persons as beneficiaries under the group insurance contract or employee benefit plan:

- (1) their children;
- (2) persons suffering from a functional impairment who are domiciled with them.

Such persons must also ensure that the same coverage is provided to their spouse, if they share the same domicile, unless the latter is already a beneficiary under a group insurance contract or employee benefit plan referred to in the first paragraph.

The same applies to persons 65 years of age and over who are members of a group insurance contract or employee benefit plan referred to in paragraph 1 of section 15.

1996, c. 32, s. 18; 2005, c. 40, s. 7.

18.1. For the purposes of section 18, if the father and mother of a child do not share the same domicile, the parent with whom the child is domiciled must ensure that coverage is provided to the child.

However, if the parent with whom the child is domiciled is an eligible person to whom section 15 applies and the child's other parent is required to be a member or qualifies for coverage under a group insurance contract or an employee benefit plan, that other parent must ensure that coverage is provided to the child as a beneficiary under the contract or plan.

If the father and mother of a child are eligible persons to whom section 15 applies and the spouse of the parent with whom the child is domiciled is required to ensure that coverage is provided to that parent, the spouse must also ensure that coverage is provided to the child.

2005, c. 40, s. 8.

DIVISION II

PROVISIONS APPLICABLE TO PERSONS COVERED BY THE BOARD

§ 1. — *Registration*

19. Persons to whom paragraph 4 of section 15 applies must register with the Board on the conditions and in the manner prescribed by government regulation.

Where pharmaceutical services or medications are provided to persons referred to in the said paragraph 4 who are not duly registered with the Board, they may apply to the Board for the reimbursement of the cost of the services or medications in the manner prescribed in section 33, provided that they register with the Board and that the services and medications were provided in the three months preceding registration.

The same applies to persons to whom section 15 applies if they received pharmaceutical services or medications but did not tell the pharmacist that they were registered with the Board. Such persons may apply to the Board for reimbursement of the cost of the services or medications in the manner prescribed in section 33, provided that the services or medications were provided in the three months preceding the application for reimbursement.

1996, c. 32, s. 19; 2002, c. 27, s. 6.

20. Persons to whom paragraphs 1, 3 and 4 of section 15 apply must register their children and persons suffering from a functional impairment who are domiciled with them with the Board, unless another person is required to ensure that coverage is provided to the children or to the impaired persons as beneficiaries under a group insurance contract or employee benefit plan.

1996, c. 32, s. 20.

21. Any change relating to the information provided in support of the registration of a person, a child of the person or a person suffering from a functional impairment who is domiciled with the person must be notified to the Board, by the person, within 30 days of the change.

1996, c. 32, s. 21.

§ 2. — *Coverage*

22. The Board shall pay, in addition to the cost of the pharmaceutical services referred to in the first paragraph of section 8, the cost of the other pharmaceutical services determined by government regulation under subparagraph 2 of the first paragraph of section 78, according to the tariff established in an agreement under section 19 of the Health Insurance Act ([chapter A-29](#)) to which pharmacists are subject. However, the government regulation may limit the coverage for those other pharmaceutical services to services relating to a medication that is on the list of medications drawn up by the Minister under section 60.

It shall also pay the cost of medications according to the price indicated in the list of medications drawn up by the Minister pursuant to section 60 and, with respect to medications provided by an institution, according to the price established in that list.

If, after an investigation, the Board believes that a pharmacist has received rebates, gratuities or other benefits not authorized by government regulation for pharmaceutical services or medications and the pharmacist is claiming payment for those services or medications or has received payment for them in the preceding 60 months, the Board may deduct an amount corresponding to the value of the rebates, gratuities or other benefits from the payment for those pharmaceutical services or medications or obtain the reimbursement of that amount by way of compensation or otherwise, as the case may be.

For the purposes of the third paragraph, any benefit received by a pharmacist is presumed, in the absence of any evidence to the contrary, to have been received in connection with pharmaceutical services or medications for which the pharmacist has claimed or received payment.

Sections 22.2 to 22.4 of the Health Insurance Act govern the procedure applicable to a decision made by the Board under the third paragraph as if the decision had been made under the second paragraph of section 22.2 of that Act.

The information contained in a decision made by the Board under the third paragraph that is not contested within the time prescribed or the contestation of which has been withdrawn is public information, except the personal information concerning a person to whom the decision does not apply. The Board shall send such a decision to the Ordre professionnel des pharmaciens du Québec.

Notification of a notice of investigation to the pharmacist by the Board suspends the 60-month prescription provided for in the third paragraph until the expiry of one year from the notification or until the investigation report is completed, whichever comes first.

1996, c. 32, s. 22; 2005, c. 40, s. 9; 2015, c. 8, s. 186; 2016, c. 28, s. 40.

§ 3. — *Premium and contribution*

23. The amount of the annual premium for persons to whom coverage is provided by the Board shall be determined in accordance with section 37.6 of the Act respecting the Régie de l'assurance maladie du Québec ([chapter R-5](#)). It shall not exceed \$660 per eligible person.

1996, c. 32, s. 23; 1999, c. 89, s. 53; 2000, c. 23, s. 1; 2002, c. 27, s. 7; 2009, c. 5, s. 1.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

24. The following persons are exempted from payment of the premium for a given month:

- (1) a child in whose respect parental authority, during that month, was exercised by a person to whom paragraph 1, 3 or 4 of section 15 applies, or would have been exercised had the child been a minor;
- (2) a person suffering from a functional impairment who, during that month, was domiciled with a person to whom section 15 applies;
- (3) a person to whom paragraph 2 or 3 of section 15 applies;
- (4) *(paragraph repealed)*.

1996, c. 32, s. 24; 2007, c. 17, s. 1; 2009, c. 5, s. 2.

24.1. The following persons are exempted from payment of the premium for a calendar year:

- (1) persons 65 years of age or over throughout the year who receive monthly guaranteed income supplements in the year under the Old Age Security Act (R.S.C. 1985, c. O-9), the aggregate of which supplements represents at least 94% of the maximum amount that may be paid in that respect annually; and
- (2) persons who reach 65 years of age in the year, if paragraph 2 of section 15 applies to them for each of the months in the year that precede the month following the month in which they reach that age and if they receive, for each of the months in the year that follow the month in which they reach that age, at least 94% of the maximum amount of monthly guaranteed income supplement under the Old Age Security Act.

For the purposes of subparagraphs 1 and 2 of the first paragraph, an amount received by a person as a monthly guaranteed income supplement under the Old Age Security Act and the maximum amount that may be paid in that respect must be determined without taking into account the amount that may be added to the amount of the supplement under section 12.1 or 22.1 of that Act.

2009, c. 5, s. 3; 2011, c. 34, s. 8.

25. Eligible persons who remain outside Québec during an entire calendar year, and who retain their status as residents of Québec under the Health Insurance Act ([chapter A-29](#)) despite their absence from Québec, are exempted from payment of the premium for that year in the cases and on the conditions prescribed by government regulation.

1996, c. 32, s. 25.

26. The deductible amount shall be \$226.20 per year, divided into equal parts for each month.

1996, c. 32, s. 26; 1997, c. 38, s. 1; 2002, c. 27, s. 8.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

27. The coinsurance percentage shall be 34.5%.

1996, c. 32, s. 27; 2002, c. 27, s. 9.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

28. The maximum contribution shall be \$626 per year, divided into equal parts for each month, for persons 65 years of age and over who receive a fraction below 94% of the maximum amount of monthly guaranteed income supplement under the Old Age Security Act (R.S.C. 1985, c. O-9).

The maximum contribution shall be \$1,046 per year, divided into equal parts for each month, for all other persons.

For the purposes of the first paragraph, an amount received by a person as a monthly guaranteed income supplement under the Old Age Security Act and the maximum amount that may be paid in that respect must be determined without taking into account the amount that may be added to the amount of the supplement under section 12.1 or 22.1 of that Act.

1996, c. 32, s. 28; 1997, c. 38, s. 1; 1999, c. 37, s. 2; 2002, c. 27, s. 10; 2007, c. 17, s. 2; 2011, c. 34, s. 9.

NOTE

See rate of adjustment: (2016) 148 G.O. 1, 685.

28.1. The amounts provided in sections 23, 26 and 28 and the percentage provided in section 27 shall be revised on 1 July each year according to the rates of adjustment fixed annually by the Board pursuant to the rules determined by regulation of the Government, in order to provide for the increase in the costs of the plan attributable to persons for whom coverage is provided by the Board.

The rates of adjustment and the revised amounts and percentages shall be published by the Board in the *Gazette officielle du Québec* except where the rates of adjustment determined by the Board are nil and the amounts and percentages remain unchanged.

2002, c. 27, s. 11.

28.2. (*Repealed*).

2005, c. 40, s. 10; 2015, c. 8, s. 187.

29. Children and persons suffering from a functional impairment are exempted from the payment of any contribution.

The following persons are also exempted from the payment of any contribution:

(1) persons referred to in paragraph 1 of section 15 receiving 94% or more of the maximum amount of monthly guaranteed income supplement under the Old Age Security Act (R.S.C. 1985, c. O-9);

(2) persons to whom paragraph 2 or 3 of section 15 applies.

For the purposes of subparagraph 1 of the second paragraph, an amount received by a person as a monthly guaranteed income supplement under the Old Age Security Act and the maximum amount that may be paid in that respect must be determined without taking into account the amount that may be added to the amount of the supplement under section 12.1 or 22.1 of that Act.

1996, c. 32, s. 29; 1999, c. 37, s. 3; 2005, c. 40, s. 11; 2005, c. 15, s. 150; 2007, c. 17, s. 3; 2011, c. 34, s. 10.

30. A person referred to in section 15 shall, unless the person is exempted or the pharmaceutical service is one for which no contribution is payable, contribute towards the payment of the cost of the pharmaceutical services and medications provided,

(1) by paying all or part of the cost of the pharmaceutical services and medications obtained, according to the terms and conditions prescribed by government regulation, until the applicable deductible amount for the month has been reached;

(2) by paying, once the deductible amount has been reached, only the portion of the cost to be borne as a coinsurance payment with respect to the cost of the pharmaceutical services and medications obtained, until the maximum contribution fixed for the month has been reached.

When a prescription filled or renewed in a given month is renewed in advance within the same month even though it would normally have been renewed the following month, the renewal is considered to have taken place in the following month, and the deductible amount and the coinsurance payment for the following month shall, where applicable, be payable at that time.

For the purpose of computing the contribution, when a prescription that exceeds 31 days is filled or renewed for a period of more than 31 days even though it could have been filled or renewed for a shorter period, the prescription is considered to have been filled or renewed as many times as if it had been filled or renewed for periods of not more than 31 days ; the deductible amount and the coinsurance payment for that month and for each of the following months shall, where applicable, be payable at that time.

1996, c. 32, s. 30; 1997, c. 38, s. 1; 2002, c. 27, s. 12; 2015, c. 8, s. 188.

31. Any person providing pharmaceutical services and medications covered by the basic plan to a person referred to in section 15 must require from that person payment of the applicable contribution.

1996, c. 32, s. 31.

32. Once the maximum contribution required from a person for the month has been entirely paid, the person is exempted, for the remainder of the month, from any payment to a pharmacist or institution, as the case may be, for pharmaceutical services and medications covered by the basic plan, unless the amount of the maximum contribution applicable at the time the pharmaceutical services and medications are provided is greater than the contribution paid up to that time as a result of a change in the person's situation.

1996, c. 32, s. 32; 1997, c. 38, s. 1.

33. When a person referred to in section 15 exacts payment from the Board, in accordance with section 12 of the Health Insurance Act ([chapter A-29](#)), of the cost of covered pharmaceutical services and medications furnished by a non-participating pharmacist referred to in section 30 of that Act, or the reimbursement of the cost of pharmaceutical services and medications obtained without presenting a health insurance card or claim booklet in accordance with section 13.1 of that Act, the Board shall

(1) apply the deductible amount applicable to the beneficiary to the payment or reimbursement;

(2) deduct from the payment or reimbursement the portion of the cost to be borne by the beneficiary in the form of a coinsurance payment for those services and those medications until the maximum contribution for the month has been reached.

1996, c. 32, s. 33; 1997, c. 38, s. 1; 1999, c. 89, s. 53.

DIVISION III

COVERAGE BY THE PRIVATE SECTOR

§ 1. — Application

34. This division applies to all persons eligible for the basic plan to whom section 15 does not apply. It also applies to insurers transacting group insurance and to the administrators of an employee benefit plan.

1996, c. 32, s. 34.

§ 2. — Obligations relating to coverage

35. Despite any stipulation to the contrary, every group insurance contract and every employee benefit plan providing coverage for the cost of pharmaceutical services and medications in case of illness, accident or disability is deemed to provide basic plan coverage.

1996, c. 32, s. 35.

36. Despite any stipulation to the contrary, a group insurance contract or an employee benefit plan that includes basic plan coverage is divisible for that part of the coverage.

1996, c. 32, s. 36.

37. No person may, as regards the part of coverage corresponding to the basic plan, refuse to allow a person to become a member of a group insurance contract or employee benefit plan on the grounds of the specific risk associated with the age, sex or state of health of the person, the person's spouse or child, or a person suffering from a functional impairment who is domiciled with the person.

1996, c. 32, s. 37.

38. No insurer may, in transacting insurance of persons, conclude or maintain in force a group insurance contract including coverage for accident, illness or disability for a group of persons referred to in section 16 unless, for the duration of the contract, coverage at least equal to the coverage under the basic plan is provided to the group under the clauses of

- (1) the contract;
- (2) a group insurance contract otherwise binding the policy-holder; or
- (3) an employee benefit plan administered by or on behalf of the policy-holder.

In addition, insurers must accept the membership of every eligible person 65 years of age or over who applies therefor and of every eligible person required to become a member of such a contract pursuant to section 16, as regards basic plan coverage, on payment of the applicable premium.

Such insurers must also provide coverage to the persons to whom an eligible person referred to in the second paragraph is required, under section 18, to ensure that coverage is provided.

1996, c. 32, s. 38.



The following provisions are not in force:

The words "otherwise binding the policy-holder" in subparagraph 2 of the first paragraph and

the words "administered by or on behalf of the policy-holder" in subparagraph 3 of the same paragraph.

The above provisions will come into force on the date or dates to be fixed by the Government (1996, c. 32, s. 119).

39. No person may establish or maintain in force an employee benefit plan including coverage for accident, illness or disability for a group of persons referred to in section 16 unless, for the period of application of the plan, coverage at least equal to the coverage under the basic plan is provided to the group under the clauses of

- (1) the employee benefit plan;
- (2) an employee benefit plan otherwise binding the plan administrator; or
- (3) a group insurance contract binding the plan administrator.

In addition, plan administrators must, as regards basic plan coverage, accept the membership of every eligible person 65 years of age or over who applies for membership and of every eligible person required to become a member of such a plan pursuant to section 16, on payment of the applicable contribution.

Such plan administrators must also provide coverage to the persons to whom an eligible person referred to in the second paragraph is required, under section 18, to ensure that coverage is provided.

1996, c. 32, s. 39.

NOTE

The following provisions are not in force:

the words “otherwise binding the plan administrator” in subparagraph 2 of the first paragraph and

the words “binding the plan administrator” in subparagraph 3 of the first paragraph.

The above provisions will come into force on the date or dates to be fixed by the Government (1996, c. 32, s. 119).

Not in force

40. Insurers must send to the Board, by way of electronic filing or of a computer-generated medium, in accordance with section 16.1 of the Act respecting the Régie de l'assurance maladie du Québec ([chapter R-5](#)), the information, prescribed by government regulation, that is required for the purposes of this Act in relation to a person's membership in a group insurance contract, in the manner determined by the regulation.

This section, adapted as required, applies to administrators of an employee benefit plan.

1996, c. 32, s. 40; 1999, c. 89, s. 53.

41. For the purposes of the basic plan, no person may, with respect to group insurance or an employee benefit plan, determine a group on the basis of the age, sex or state of health of members.

1996, c. 32, s. 41; 2005, c. 40, s. 30.

42. Where a group insurance contract or employee benefit plan includes coverage for the cost of pharmaceutical services and medications for a group with private coverage within the meaning of section 15.1, the insurer or plan administrator must provide coverage to all members of the group.

In such a case, the insurer or plan administrator must provide coverage for all the persons to whom the members of the group are required to ensure that coverage is provided.

This section does not apply in the case of a person 65 years of age or over who elects not to become a member of such a contract.

1996, c. 32, s. 42; 2005, c. 40, s. 12.

42.1. If a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1 includes coverage for the cost of pharmaceutical services or medications, that coverage under the contract or plan may not be offered to, made available to or maintained for persons who are not members of the group although they may have the same employment or engage in the same profession, trade or occupation as the members of that group.

2005, c. 40, s. 13.

42.2. No individual insurance contract that includes coverage for accident, illness or disability and has one or more of the distinctive characteristics of group insurance may be offered to, made available to or maintained for a group of persons to whom section 16 applies, or facilitated for such persons by any means whatsoever, unless it includes coverage at least equivalent to the basic plan coverage.

A uniform annual premium, coverage offered regardless of the risk associated with state of health, rates or financial arrangements based on the history of the group, a contract negotiated between an insurer and an intermediary on behalf of the group and any other condition or circumstance specified by regulation are considered to be distinctive characteristics of group insurance.

A contract that must include coverage at least equivalent to the basic plan coverage under this section is governed by the provisions of this Act that are applicable to a group insurance contract. The insurer or the policy-holder and the persons who are part of the group to whom the contract is offered or made available or for whom it is maintained must fulfill all their respective obligations under this Act.

2005, c. 40, s. 13.

42.2.1. No group insurance contract or employee benefit plan may restrict a beneficiary's freedom to choose a pharmacist.

2016, c. 28, s. 41.

§ 3. — *Pooling of risks*

43. All insurers transacting group insurance and all administrators of employee benefit plans who provide coverage for the cost of pharmaceutical services and medications must pool the risks arising from the basic plan coverage they provide according to the terms and conditions they determine.

The terms and conditions must be communicated by the representatives of the insurers and administrators, in writing, to the Minister not later than 1 November each year. Failing that, the terms and conditions shall be determined by government regulation for the period it indicates.

1996, c. 32, s. 43.

§ 4. — *Premiums and assessments*

44. The premium or assessment pertaining to basic plan coverage that is stipulated in a group insurance contract or employee benefit plan shall be negotiated or agreed to by the parties.

The same applies to any contribution in the form of a deductible amount or coinsurance payment, subject to sections 12, 13 and 13.1.

1996, c. 32, s. 44; 2002, c. 27, s. 13.

44.1. The employer of the members of a group referred to in section 16 and formed on the basis of employment status must deduct the premium or assessment pertaining to the basic plan coverage stipulated in a group insurance contract or employee benefit plan to be paid by each employee concerned from the employee's remuneration, and remit the deducted sums to the insurer or plan administrator.

However, an employee who submits proof of status as the beneficiary of coverage at least equivalent to the basic plan coverage under another group insurance contract or employee benefit plan is exempted from the deduction of the premium or assessment, except if membership under the employer's contract or plan is a condition of employment.

2005, c. 40, s. 14.

§ 5. — *Continuity of coverage*

45. As regards basic plan coverage, every group insurance contract is renewed by operation of law each year on the contract's date of expiry, for the premium or assessment fixed pursuant to subdivision 4, unless the insurer, the policy-holder or the member has given notice to the contrary. Any notice of non-renewal or of a change in the premium or assessment from the insurer must be sent to the last known address of the member not later than 30 days preceding the date of expiry. A copy of a notice of non-renewal from the insurer or the policy-holder must be sent to the Board.

1996, c. 32, s. 45; 2005, c. 40, s. 30; 2005, c. 40, s. 15.

NOTE

The following provisions are not in force:

the words "or the member" in the first sentence; and

the second sentence.

*The above provisions will come into force on the date or dates fixed by the Government.
(1996, c. 32, s. 119).*

46. No insurer may, as regards that part of coverage that corresponds to the basic plan, invoke against a policy-holder, beneficiary or member any policy clause or Civil Code provision under which the insurer would otherwise be authorized to deny or reduce coverage.

1996, c. 32, s. 46; 2005, c. 40, s. 30.

47. No insurer or administrator of an employee benefit plan may cancel a contract or the prescription drug insurance component of a plan, with regard to the basic plan coverage, unless the policy-holder or the member fails to pay the premium or assessment. In such a case, the cancellation may not take effect until 30 days have elapsed since the date on which the insurer or administrator sent a notice of intent to the last known address of the policy-holder or member. A copy of the notice must be sent to the Board.

1996, c. 32, s. 47; 2005, c. 40, s. 30; 2005, c. 40, s. 16.

48. No administrator of an employee benefit plan may terminate basic plan coverage of the cost of pharmaceutical services and medications until 30 days have elapsed since the date on which the administrator sent a notice of intent to the last known address of all the members of the plan. A copy of the notice must be sent to the Board.

1996, c. 32, s. 48; 2005, c. 40, s. 17.

49. Where employees who are members of a group insurance contract or of an employee benefit plan providing basic plan coverage are involved in a lockout, strike or other work stoppage, the insurer or the administrator of the plan must maintain coverage during a period of at least 30 days from the date on which the lockout, strike or work stoppage began.

1996, c. 32, s. 49.

50. An eligible person must inform the insurer or the administrator of the employee benefit plan concerned of any change of address without delay. Where no notice of change of address has been received, the last address given by the member to the insurer or the administrator of the employee benefit plan is presumed accurate.

1996, c. 32, s. 50; 2005, c. 40, s. 30.

CHAPTER IV

ADMINISTRATIVE PROVISIONS

DIVISION I

POLICY RESPECTING MEDICATIONS

51. A policy respecting medications shall be drawn up by the Minister of Health and Social Services.

The policy shall endeavour to integrate the use of medications into the overall set of actions intended to improve the health and well-being of the population, in particular by means of a basic prescription drug insurance plan, and, subject to the availability of financial resources, shall pursue the following main objectives:

- (1) fair and reasonable access to the medications required by the state of health of each person;
- (2) optimal use of medications;
- (3) better information and training for the public and health professionals;
- (4) the implementation of effective and efficient strategies and actions.

1996, c. 32, s. 51; 2002, c. 27, s. 14.

52. The Minister may establish an advisory group to advise the Minister on the policy, and designate its members.

1996, c. 32, s. 52.

52.1. The Minister may make agreements with drug manufacturers for the purpose of funding activities to promote improved use of medications.

The Minister may also make the following agreements with drug manufacturers:

- (1) financial risk-sharing agreements for specific medications; and
- (2) agreements providing for compensatory measures to mitigate the negative impact of a price increase on the public plan.

The agreements may specify, among other particulars, the sums of money the manufacturers undertake to pay and those that may be added by the Minister, as well as the manner in which the sums are to be managed.

2002, c. 27, s. 15; 2005, c. 40, s. 18.

DIVISION II

PRICE OF MEDICATIONS

2002, c. 27, s. 16; 2010, c. 15, s. 58.

53. (Repealed).

1996, c. 32, s. 53; 2002, c. 27, s. 16; 2010, c. 15, s. 59.

54. (Repealed).

1996, c. 32, s. 54; 2002, c. 27, s. 17, s. 31; 2010, c. 15, s. 59.

54.1. (Repealed).

2002, c. 27, s. 18; 2010, c. 15, s. 59.

55. (Repealed).

1996, c. 32, s. 55; 2002, c. 27, s. 31; 2010, c. 15, s. 59.

56. (Repealed).

1996, c. 32, s. 56; 2002, c. 27, s. 31; 2010, c. 15, s. 59.

57. The Board is responsible for making recommendations to the Minister on changes in the price of medications already entered on the list provided for in section 60.

1996, c. 32, s. 57; 2002, c. 27, s. 20; 2010, c. 15, s. 60.

NOTE

As of 1 March 2012, the Régie de l'assurance maladie du Québec exercises the functions entrusted to it by this section; Order in Council 95-2012 dated 16 February 2012, (2012) 144 G.O. 2, 569.

57.1. (Repealed).

2002, c. 27, s. 20; 2005, c. 40, s. 19; 2010, c. 15, s. 61.

57.2. (Repealed).

2002, c. 27, s. 20; 2005, c. 40, s. 20; 2010, c. 15, s. 61.

57.3. (Repealed).

2002, c. 27, s. 20; 2010, c. 15, s. 61.

57.4. (Repealed).

2002, c. 27, s. 20; 2010, c. 15, s. 61.

58. For the purposes of section 57, the Board may require accredited manufacturers and wholesalers, or manufacturers and wholesalers who have applied for accreditation, to provide information on the price of the medications they offer for sale.

1996, c. 32, s. 58; 2002, c. 27, s. 31; 2010, c. 15, s. 62.

NOTE

As of 1 March 2012, the Régie de l'assurance maladie du Québec exercises the functions entrusted to it by this section; Order in Council 95-2012 dated 16 February 2012, (2012) 144 G.O. 2, 569.

59. (Repealed).

1996, c. 32, s. 59; 1999, c. 89, s. 53; 2002, c. 27, s. 31; 2010, c. 15, s. 63.

59.1. (Repealed).

2002, c. 27, s. 21; 2010, c. 15, s. 63.

DIVISION II.1

Repealed, 2010, c. 15, s. 64.

2005, c. 40, s. 21; 2010, c. 15, s. 64.

59.2. (Repealed).

2005, c. 40, s. 21; 2010, c. 15, s. 64.

59.3. (Repealed).

2005, c. 40, s. 21; 2010, c. 15, s. 64.

DIVISION III**LIST OF MEDICATIONS****§ 1. — Establishment and updating**

60. The Minister shall draw up and update periodically, by regulation, after considering the recommendations made by the Institut national d'excellence en santé et en services sociaux established by the Act respecting the Institut national d'excellence en santé et en services sociaux ([chapter I-13.03](#)), except with respect to what is specified in the sixth paragraph, and taking into account any listing agreement under section 60.0.1, a list of the medications the cost of which is covered by the basic plan. The list may also include certain supplies that the Minister considers essential for the proper administration of prescription drugs.

Only a medication from a manufacturer accredited by the Minister may be considered for entry on the list. However, the Minister may enter on the list the medication of a manufacturer who has not been granted accreditation if the medication is unique and essential.

The list shall, in particular, indicate generic names, brand names and manufacturer's names for each medication covered by the basic plan and the conditions on which the medication may be obtained from a manufacturer or wholesaler accredited by the Minister, and the manner in which the price of each medication provided as part of the services provided by an institution in accordance with the third paragraph of section 8 is established.

The list shall also, for medications provided by a pharmacist, in the cases and on the conditions determined in the list, indicate the price of the medications or supplies sold to a pharmacist by an accredited manufacturer or wholesaler, the manner in which the price of a medication or supply is established, the cost payable by the basic plan for a medication or supply and the accredited wholesalers' maximum profit margins.

Furthermore, the list shall include, where applicable, the cases in which and the conditions on which payment of the cost of a medication, including an exceptional medication, is covered by the basic plan, in particular the therapeutic indications concerned, the maximum quantity

covered for that medication, the duration of the pharmacological treatment, the necessity of obtaining the Board's authorization and the restrictions relating to the age of the eligible person.

The list shall, in addition, set out the conditions, cases and circumstances on or in which the cost of any other medication, except medications or classes of medications specified in the list, is covered. The list also sets out the cases in which a temporary exclusion under section 60.0.2 does not apply.

A regulation made under this section or a correction made under section 60.2 is not subject to the requirements concerning publication and date of coming into force set out in sections 8, 15 and 17 of the Regulations Act ([chapter R-18.1](#)). The regulation or correction shall come into force on the date of its publication on the Board's website or on any later date specified. Publication of the regulation or correction on the Board's website imparts authentic value to the regulation or correction.

1996, c. 32, s. 60; 1999, c. 37, s. 4; 2002, c. 27, s. 22; 2005, c. 40, s. 22; 2010, c. 15, s. 65; 2015, c. 8, s. 189; 2016, c. 28, s. 42.

60.0.0.1. The Minister may, for the purposes of the list of medications, issue a call for tenders to enter with an accredited manufacturer into a contract establishing the price of a medication or supply and the conditions for its entry on the list. The medication or supply that is the subject of such a contract is entered on the list and all other medications or supplies covered by the call for tenders are excluded from the list. However, the Minister may, where applicable, include the brand-name medication in the list, in which case the brand-name medication is subject to the Board's authorization.

2016, c. 16, s. 1; 2016, c. 28, s. 43.

60.0.0.2. The Minister may, for the purposes of the supply to owner pharmacists of a medication or supply that is the subject of a contract referred to in section 60.0.0.1, issue a call for tenders to enter with an accredited wholesaler into a contract establishing the supply conditions and the profit margin. Such a contract grants the wholesaler exclusivity for the supply of the medication or supply to owner pharmacists, who may procure it from the wholesaler only.

[2016, c. 16, s. 1](#)

60.0.0.3. A call for tenders under sections 60.0.0.1 and 60.0.0.2 is issued in accordance with the conditions and mechanics the Minister determines by regulation.

[2016, c. 16, s. 1](#)

60.0.1. The Minister may, before entering a medication on the list of medications, make a listing agreement with its manufacturer. The purpose of such an agreement is to provide for the payment of sums by the manufacturer to the Minister in particular by means of a rebate or discount which may vary according to the volume of sales of the medication.

The price of the medication indicated on the list does not take into account the sums paid pursuant to the listing agreement.

2015, c. 8, s. 190.

60.0.2. For the purpose of making a listing agreement, the Minister may temporarily exclude a medication whose cost is covered under the sixth paragraph of section 60 from the basic plan coverage. The exclusion does not apply to a person whose application for authorization for payment of the cost of the medication was accepted before the publication

date of the notice of its exclusion or in the cases prescribed by a regulation made under the sixth paragraph of section 60.

The notice of a medication's exclusion is published on the Board's website and comes into force on the date of its publication or any later date specified in the notice. A notice of the end date of the exclusion is also published on the website. Publication on the Board's website imparts authentic value to such notices. The notices are not subject to the requirements concerning publication and date of coming into force set out in sections 8, 15 and 17 of the Regulations Act ([chapter R-18.1](#)).

2015, c. 8, s. 190.

60.0.3. Despite section 9 of the Act respecting Access to documents held by public bodies and the Protection of personal information ([chapter A-2.1](#)), no person has a right of access to a listing agreement. Only the following information is to be published in the annual financial report required under section 40.9 of the Act respecting the Régie de l'assurance maladie du Québec ([chapter R-5](#)):

- (1) the name of the drug manufacturer;
- (2) the name of the medication; and
- (3) the annual total sum received pursuant to listing agreements, but only to the extent that at least three agreements made with different drug manufacturers are in force in the fiscal year.

2015, c. 8, s. 190.

60.0.4. The Minister may suspend the insurance coverage of a manufacturer's medication or supply, end it or not re-enter a medication or a supply of that manufacturer on the list of medications when the list is updated in the following cases:

- (1) if the manufacturer fails to comply with a condition or commitment prescribed by ministerial regulation, a provision of a listing agreement or a provision of a contract entered into following a call for tenders;
- (2) if the selling price guaranteed by the manufacturer for a medication is higher than the maximum amount payable by the basic plan;
- (3) if a competing medication or supply is the subject of a listing agreement;
- (4) if the Institut national d'excellence en santé et en services sociaux recommends doing so; or
- (5) if the Minister considers that the public interest so requires.

The Minister suspends or ends the insurance coverage by publishing a notice on the Board's website. The suspension or end of the insurance coverage applies on the date of publication of the notice or on any later date specified in the notice. Where applicable, a notice of the end date of the suspension is also published on the website. Publication imparts authentic value to such notices. The notices are not subject to the requirements concerning publication and date of coming into force set out in sections 8, 15 and 17 of the Regulations Act ([chapter R-18.1](#)).

However, the Minister may, in a suspension or end-of-coverage notice or on an updating of the list, maintain the insurance coverage of a medication or supply for persons undergoing pharmacological treatment.

A medication for which the Minister has issued a suspension or end-of-coverage notice or which has not been re-entered on the list of medications is excluded from the application of the sixth paragraph of section 60.

2016, c. 28, s. 44.

60.0.5. If the Minister considers that the available stock of a medication entered on the list of medications is becoming scarce and there is a serious risk of a stock shortage, the Minister may, by publishing a notice on the Board's website, suspend, if applicable, the application of any preferential procurement agreement relating to that medication. The suspension applies on the date of publication of the notice or any later date specified in the notice. A notice of the end date of the suspension is also published on the Board's website.

The accredited manufacturer or wholesaler or the intermediary within the meaning of the second paragraph of section 80.1 governed by such an agreement must then supply any pharmacist who requests it.

2016, c. 28, s. 44.

60.0.6. At the Minister's request, a manufacturer or wholesaler must provide, within 24 hours following the request and in the requested format, any information on the manufacturer's or wholesaler's stocks and back orders, including, if requested, the medication or supply, the format, dosage, lot numbers and expiry dates and the sales to pharmacists with an account. The Minister may request that the Board send the information to pharmacists.

2016, c. 28, s. 44.

60.1. If the Board is informed that a medication on the list is out of stock, the president and chief executive officer or, in that officer's absence, the person that officer designates may temporarily authorize use of an alternative. A notice that the medication is to be replaced by an alternative is published on the Board's website and comes into force on the date of its publication or any later date fixed in the notice. The effect of the notice may be retroactive to the date on which the medication is out of stock. Publication of the notice on the Board's website imparts authentic value to the notice. The notice is not subject to the requirements concerning publication and date of coming into force set out in sections 8, 15 and 17 of the Regulations Act ([chapter R-18.1](#)).

2005, c. 40, s. 23; 2007, c. 21, s. 33; 2010, c. 15, s. 66; 2016, c. 28, s. 45.

60.2. If the Board is informed that the price of a medication has dropped or that a medication is produced by a different manufacturer, has a different name or identification number or is in a different therapeutic class than was formerly the case, or if the Board finds that the list contains a manifest clerical error or any other error of form, it shall make the necessary correction and specify the effective date, which may be the effective date of the price drop or of the provision for which the correction was requested.

2005, c. 40, s. 23; 2010, c. 15, s. 67.

60.3. Before 1 April of each year, the Board shall publish, in Part 2 of the *Gazette officielle du Québec*, a notice of the dates on which the list of medications was drawn up anew or updated, a medication was excluded under section 60.0.2, a medication on the list was replaced by an alternative under section 60.1 or a correction was made under section 60.2 during the preceding calendar year. The notice shall include the address of the website on which the list is published.

2005, c. 40, s. 23; 2015, c. 8, s. 191.

Not in force

60.4. No person may charge a fee or receive payment for filling out an application for authorization with respect to coverage of the medications referred to in the fifth or sixth paragraph of section 60, except in the cases prescribed in a regulation or provided for in an

agreement made under section 19 of the Health Insurance Act ([chapter A-29](#)) and on the conditions set out in the regulation or agreement.

2005, c. 40, s. 23.

61. *(Repealed).*

1996, c. 32, s. 61; 1999, c. 37, s. 5.

§ 2. — *Accreditation of wholesalers and manufacturers*

62. The Minister may, for the purposes of the list of medications, grant accreditation to a manufacturer or wholesaler on the conditions he determines by regulation.

1996, c. 32, s. 62.

62.1. Manufacturers and wholesalers must establish rules to govern their commercial practices and mutually agreed mechanics for those rules. The rules must include a dispute resolution process.

The rules must be sent in writing to the Minister by the manufacturers' representatives no later than 21 April 2009 and by the wholesalers' representatives no later than 21 April 2010. Any amendments to the rules must be sent to the Minister as soon as possible after their adoption.

The Minister may ask the manufacturers and wholesalers to make specified amendments to those rules or their mechanics within a specified time.

If the manufacturers or wholesalers fail to comply with the first paragraph, if the Minister does not agree with the rules and mechanics established by them or if they fail to make the specified amendments within the specified time, the Minister may, by regulation, establish those rules and their mechanics.

2005, c. 40, s. 24.

63. The Minister may, on the recommendation of the Board, temporarily withdraw accreditation from a drug manufacturer or wholesaler who fails to comply with the conditions or commitments prescribed by ministerial regulation.

In the case of a manufacturer, the withdrawal of accreditation shall entail the exclusion from the list of all the medications produced by the manufacturer for a period of three months.

In the case of a wholesaler, the Board shall cease to reimburse the payment of the medications sold by the wholesaler, for a period of three months.

If the manufacturer or wholesaler has been subject to temporary disaccreditation in the five preceding years, the periods prescribed in the second and third paragraphs shall be extended to six months for any subsequent withdrawal.

1996, c. 32, s. 63; 2002, c. 27, s. 23; 2010, c. 15, s. 68.

64. A manufacturer or wholesaler referred to in section 63 shall, before the end of the period of temporary withdrawal, repay to the Board,

(1) in the case of a manufacturer, the difference between the selling price as defined in the manufacturer's commitment prescribed by ministerial regulation and the actual price of a medication sold by the manufacturer, based on the list of medications drawn up under section 60;

(2) in the case of a wholesaler, the difference between the selling price as defined in the wholesaler's commitment prescribed by ministerial regulation and the actual price of a medication sold by the wholesaler, based on the list of medications drawn up under section 60;

(3) in either case, the expenses incurred to advise health care professionals of the temporary withdrawal of the manufacturer's or wholesaler's accreditation.

The failure of a manufacturer or wholesaler to comply with the first paragraph is deemed to constitute a breach of commitment.

1996, c. 32, s. 64; 2002, c. 27, s. 24.

65. The Minister may also, on the recommendation of the Board, withdraw the accreditation of a manufacturer or wholesaler permanently if the manufacturer or wholesaler has, in the five preceding years, been subject to two temporary withdrawals and has again failed to comply with the conditions and commitments prescribed by ministerial regulation.

1996, c. 32, s. 65; 2002, c. 27, s. 25; 2010, c. 15, s. 69.

66. A manufacturer or wholesaler whose recognition has been permanently withdrawn may submit a new application for recognition. However, in addition to complying with the conditions prescribed by ministerial regulation, the manufacturer or wholesaler must, before being again granted recognition, repay the following amounts to the Board:

(1) in the case of a manufacturer, the difference between the selling price as defined in the manufacturer's commitment prescribed by ministerial regulation and the actual price of a medication sold by the manufacturer, based on the list of medications drawn up under section 60;

(2) in the case of a wholesaler, the difference between the selling price as defined in the wholesaler's commitment prescribed by ministerial regulation and the actual price of a medication sold by the wholesaler, based on the list of medications drawn up under section 60;

(3) in either case, the expenses incurred to advise health care professionals of the permanent withdrawal of recognition from the manufacturer or wholesaler.

1996, c. 32, s. 66; 2002, c. 27, s. 26.

67. The Minister shall give prior notice of not less than 30 days of the acts alleged against a manufacturer or wholesaler before withdrawing accreditation.

The manufacturer or wholesaler may present observations before the expiry of the 30-day period.

1996, c. 32, s. 67.

68. A manufacturer or wholesaler whose accreditation has been temporarily or permanently withdrawn pursuant to section 63 or 65 may contest the decision before the Administrative Tribunal of Québec within 60 days of notification of the decision.

1996, c. 32, s. 68; 1997, c. 43, s. 826.

69. A decision by the Minister to withdraw an accreditation shall take effect on the date of publication of a notice containing the decision in the *Gazette officielle du Québec*, and the three-month or six-month period of temporary withdrawal shall be calculated from that date.

1996, c. 32, s. 69.

70. No notice may be published by the Minister under section 69 before the period for bringing a proceeding under section 68 has expired or, if the decision is contested before the Tribunal, before the Tribunal has made a decision.

1996, c. 32, s. 70; 1997, c. 43, s. 827.

70.0.1. The Minister may, by regulation, prescribe the monetary administrative penalties that may be imposed by the Board in the case of a failure by a manufacturer or wholesaler to comply with a condition or commitment prescribed by ministerial regulation. The regulation determines the amount of the penalty by taking into account the nature and seriousness of the failure to comply; however, the amount may not exceed \$2,500.

The imposition of such an administrative penalty is prescribed two years after the date of the failure to comply.

2016, c. 28, s. 46.

70.0.2. Sections 22.2 and 22.3 of the Health Insurance Act ([chapter A-29](#)) govern the procedure applicable to a decision made by the Board under section 70.0.1 as if the decision had been made under the third paragraph of section 22.2 of that Act, with the necessary modifications.

2016, c. 28, s. 46.

DIVISION III.1

VERIFICATION OF GROUP INSURANCE CONTRACTS AND EMPLOYEE BENEFIT PLANS

2005, c. 40, s. 25.

70.1. Every insurer transacting group insurance or administrator of an employee benefit plan must provide the Board, in accordance with the regulations, with the full list of their current group insurance contracts or employee benefit plans.

2005, c. 40, s. 25.

70.2. Every insurer transacting group insurance or administrator of an employee benefit plan must inform the Board of any amendment to a group insurance contract or employee benefit plan causing eligible persons covered by that contract or plan to be transferred to the public plan. That obligation also applies to every insurance representative or life and health insurance representative who offers, or obtains the signature of, an insurance contract having the same effect.

2005, c. 40, s. 25.

70.3. The Board may, for the purposes of this Act, require any insurer transacting group insurance, insurance representative, life and health insurance representative or administrator of an employee benefit plan to produce any current group insurance contract or employee benefit plan and any other relevant explanatory document.

2005, c. 40, s. 25.

DIVISION IV

Repealed, 2002, c. 27, s. 27.

2002, c. 27, s. 27.

71. *(Repealed).*

1996, c. 32, s. 71; 2002, c. 27, s. 27.

72. (Repealed).

1996, c. 32, s. 72; 2002, c. 27, s. 27.

73. (Repealed).

1996, c. 32, s. 73; 2002, c. 27, s. 27.

74. (Repealed).

1996, c. 32, s. 74; 2002, c. 27, s. 27.

75. (Repealed).

1996, c. 32, s. 75; 2002, c. 27, s. 27.

76. (Repealed).

1996, c. 32, s. 76; 2002, c. 27, s. 27.

77. (Repealed).

1996, c. 32, s. 77; 2002, c. 27, s. 27.

DIVISION V
REGULATIONS

78. In addition to the regulatory powers otherwise conferred on it by this Act, the Government may, after consulting the Board, make regulations to

(1) determine, for the purposes of section 6, the classes of persons who are otherwise entitled to coverage equivalent to basic plan coverage;

(1.1) determine classes of persons eligible for the basic plan other than those determined in this Act, and the conditions those persons must meet;

(1.2) determine, for the purposes of section 8, the services required for pharmaceutical reasons and provided by a pharmacist that are covered by the basic prescription drug insurance plan and determine, among those whose cost is paid by the Board, the services that must relate to a medication on the list of medications drawn up by the Minister under section 60;

(1.3) determine, for the purposes of section 8.1, the cases in and conditions on which an owner pharmacist may claim fees for a pharmaceutical service provided to a person covered by a group insurance contract or an employee benefit plan;

(1.4) determine, for the purposes of section 11, the pharmaceutical services for which no contribution is payable; those services may vary according to whether the insurance coverage is provided by the Board or by a group insurance contract or an employee benefit plan;

(2) determine, for the purposes of section 22, the other services required for pharmaceutical reasons and provided by a pharmacist whose cost is borne by the Board, and prescribe the frequency with which certain services described in that section must be provided to remain covered; the frequency may vary in the cases and on the conditions it determines;

(2.0.1) determine, for the purposes of section 22, the other pharmaceutical services that must relate to a medication that is on the list of medications drawn up by the Minister under section 60;

(2.1) determine what information on the medications provided must be given by a pharmacist when providing pharmaceutical services and medications covered by the Board to an eligible person;

(3) *(subparagraph repealed)*;

(4) determine the cases in which and conditions on which the medications determined by the Government, that are provided as part of the services provided by an institution within the meaning of the Act respecting health services and social services ([chapter S-4.2](#)) or the Act respecting health services and social services for Cree Native persons ([chapter S-5](#)) or by any other institution recognized for that purpose by the Minister that is situated outside Québec in a region bordering on Québec, are covered for the classes of persons it determines;

(5) prescribe the cases in which and conditions on which eligible persons who remain outside Québec during the entire year, and who retain their status as persons resident in Québec under the Health Insurance Act ([chapter A-29](#)) despite their absence from Québec, may be exempted from payment of the premium for that calendar year;

(6) list the types of impairment which constitute functional impairment for the purposes of section 17 and the cases in which and conditions on which a person suffering from a functional impairment is deemed to attend an educational institution on a full-time basis;

(7) determine, for the purposes of sections 13.1 and 28.1, the rules pursuant to which rates of adjustment are to be fixed annually and specify the class of persons to which each rate is applicable, where that is the case;

(8) *(subparagraph repealed)*;

(9) prescribe, for the purposes of section 40, the information that the Board may require from an insurer transacting group insurance or the administrator of an employee benefit plan, and prescribe the manner in which such information may be communicated;

(9.1) determine any conditions or circumstances considered to be distinctive characteristics of group insurance in addition to those set out in the second paragraph of section 42.2;

(9.2) prescribe, for the purposes of sections 70.1 to 70.3, the procedure for communicating lists of group insurance contracts and employee benefit plans, group insurance contracts and employee benefit plans, and information on any amendments to those contracts and plans causing eligible persons to be transferred to the public plan, as well as the intervals at which they must be communicated and the information the lists must contain;

(10) determine, for the purposes of section 43, the terms and conditions on which the risks arising from the basic plan coverage must be pooled, and the period during which they are to apply;

(11) determine the provisions of a regulation the contravention of which constitutes an offence.

A regulation made under this section shall have effect, with respect to health care professionals bound by a valid agreement and despite any contrary stipulation contained in the agreement, on the date or dates fixed in the regulation.

1996, c. 32, s. 78; 1999, c. 37, s. 6; 2000, c. 23, s. 2; 2002, c. 27, s. 28; 2005, c. 40, s. 26; 2015, c. 8, s. 192.

79. (Repealed).

1996, c. 32, s. 79; 1999, c. 37, s. 7.

80. In addition to the other regulatory powers conferred by this Act, the Minister may make regulations to;

- (1) determine the conditions governing the accreditation of a manufacturer or wholesaler of medications;
- (2) determine the content of the commitment to be signed by a manufacturer or wholesaler to be granted accreditation;
- (3) determine rules to regulate the practices of manufacturers and wholesalers with regard to medication pricing;
- (4) determine the benefits intermediaries may grant or receive within the scope of their activities in the supply chain for medications entered on the list of medications or in the marketing of such medications in pharmacies; and
- (5) determine the elements for which a certificate or report must be prepared by an independent auditor.

1996, c. 32, s. 80; 1999, c. 37, s. 8; 2002, c. 27, s. 29; 2005, c. 40, s. 27; 2016, c. 28, s. 48.

CHAPTER IV.1

PROHIBITED COMMERCIAL PRACTICES

2016, c. 28, s. 49.

80.1. An accredited manufacturer may not enter into an exclusive agreement with an accredited wholesaler or an intermediary to supply a pharmacy with a medication or supply entered on the list of medications.

For the purposes of this Act, an intermediary is

- (1) any person with whom owner pharmacists identify within the scope of their professional or commercial activities, in particular by using, with the person's consent, the person's name or image or a trademark the person owns; or
- (2) any person who intervenes, directly or indirectly, in the supply chain for the medications entered on the list of medications or in the marketing of such medications in pharmacies, except accredited manufacturers or wholesalers or owner pharmacists or any of their employees.

2016, c. 28, s. 49.

80.2. An accredited manufacturer or wholesaler may not, nor may an intermediary,

Not in force

- (1) pay or reimburse to a person covered by the basic plan all or part of the price of a medication or supply covered by the plan, except to the extent provided for by ministerial regulation, in particular for humanitarian reasons;
- (2) limit the supply of medications or supplies entered on the list of medications to a restricted number of owner pharmacists, unless a notice of compliance with conditions has been issued by Health Canada to the contrary;
- (3) require that an owner pharmacist procure from the manufacturer, wholesaler or intermediary, on an exclusive basis, medications or supplies entered on the list of medications;

(4) require that an owner pharmacist procure from the manufacturer, wholesaler or intermediary, on a preferential basis, medications or supplies entered on the list of medications, unless an agreement between them explicitly provides for the possibility of procuring medications or supplies otherwise when, in the pharmacist's opinion, a person's state or condition requires a medication or supply that is not available on a preferential basis;

(5) directly or indirectly induce or require an owner pharmacist to sell on a preferential basis a specific brand of medication or supply entered on the list of medications; or

(6) grant to or receive from an accredited manufacturer or wholesaler, intermediary or pharmacist, directly or indirectly, any benefit in connection with the sale or purchase of a medication entered on the list of medications covered by the basic plan, except a benefit authorized by regulation or a discount or, in the case of a wholesaler, a profit margin not provided for in the commitment.

2016, c. 28, s. 49.

80.3. An accredited manufacturer or wholesaler may not, nor may an intermediary or owner pharmacist, grant any benefit, directly or indirectly, in connection with the sale or purchase of a medication entered on the list of medications covered by the basic plan, to the author of a prescription or an operator or employee of a private seniors' residence governed by the Act respecting health services and social services ([chapter S-4.2](#)).

The author of a prescription or the operator or employee of a private seniors' residence may not receive such a benefit from an accredited manufacturer or wholesaler or from an intermediary or owner pharmacist.

2016, c. 28, s. 49.

80.4. If, after an investigation, the Board believes that an accredited manufacturer or wholesaler or an intermediary has granted or received, within the preceding 60 months, a benefit, a discount or a profit margin contrary to paragraph 6 of section 80.2, the Board may require that the accredited manufacturer or wholesaler or the intermediary reimburse it.

If, after an investigation, the Board believes that an accredited manufacturer or wholesaler or an intermediary or owner pharmacist has granted, within the preceding 60 months, any benefit contrary to the first paragraph of section 80.3, the Board may require that the accredited manufacturer or wholesaler or the intermediary or owner pharmacist reimburse it.

Notification of a notice of investigation to the accredited manufacturer or wholesaler, the intermediary or owner pharmacist by the Board suspends the 60-month prescription provided for in the first or second paragraph, as the case may be, until the expiry of one year from the notification or until the investigation report is completed, whichever comes first.

Sections 22.2 to 22.3 of the Health Insurance Act ([chapter A-29](#)) govern the procedure applicable to a decision made under the first or second paragraph, as if the decision had been made under the second paragraph of section 22.2 of that Act, with the necessary modifications.

The information contained in a decision made under the first or second paragraph that is not contested in the time prescribed or the contestation of which has been withdrawn is public information, except the personal information concerning a person to whom the decision does not apply.

For the purposes of this section, any benefit granted or received is presumed, in the absence of any evidence to the contrary, to have been granted or received in connection with the sale or purchase of a medication entered on the list of medications covered by the basic plan.

2016, c. 28, s. 49.

CHAPTER V

PENAL PROVISIONS

81. Every person making a statement that the person knows, or ought to have known, to be incomplete or to contain false or misleading information or transmitting an incomplete document or a document containing false or misleading information in order

(1) to obtain a pharmaceutical service or medication to which the person is not entitled, or

(2) to receive a payment or reimbursement without entitlement or in excess of the amount to which the person is entitled,

is guilty of an offence and is liable to a fine of \$1,000 to \$10,000.

1996, c. 32, s. 81; 2016, c. 28, s. 51.

82. Every person who assists or who incites, advises, encourages, allows, authorizes or orders another person to commit an offence referred to in section 81 is guilty of an offence.

Every person who assists or encourages another person to obtain or receive a benefit, in particular a brand-name medication, to which that other person is not entitled under this Act or who provides information the person knows to be false or inaccurate to allow the other person to enjoy such a benefit is guilty of an offence.

A person found guilty of an offence under this section is liable to a fine of \$1,000 to \$10,000.

1996, c. 32, s. 82; 2016, c. 28, s. 52.

82.1. Every person who threatens or intimidates a person, or takes reprisals in any manner whatever against the person, including demoting, suspending or dismissing the person or taking any disciplinary or other measure that adversely affects the person's employment or conditions of employment because the person is complying with this Act, is exercising a right provided for by this Act or has reported conduct that contravenes this Act is guilty of an offence and is liable to a fine of \$2,000 to \$20,000 in the case of a natural person and \$10,000 to \$250,000 in any other case.

The Board must take all necessary measures to protect the identity of persons making a disclosure. The Board may however communicate the identity of such persons to the Director of Criminal and Penal Prosecutions.

2016, c. 28, s. 53.

83. Every person who contravenes a provision of sections 37 to 42 is guilty of an offence and is liable to a fine of not less than \$500 and not more than \$5,000.

1996, c. 32, s. 83.

84. Every insurer and every person administering an employee benefit plan who, in contravention of section 43, fails or neglects to pool the risks presented by insured members is guilty of an offence and is liable to a fine of \$2,500 to \$250,000.

1996, c. 32, s. 84; 2016, c. 28, s. 54.

84.1. If a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1 includes coverage for the cost of pharmaceutical services or medications, every person who offers that coverage under the contract or plan to, makes such coverage available to or maintains such coverage for persons

who are not members of the group although they may have the same employment or engage in the same profession, trade or occupation as the members of that group is guilty of an offence and is liable to a fine of \$2,500 to \$250,000.

2005, c. 40, s. 28; 2016, c. 28, s. 54.

84.2. Every person who, in contravention of section 42.2, offers an individual insurance contract that does not include coverage at least equivalent to the basic plan coverage to persons who are part of a group of persons to whom section 16 applies, makes such a contract available to them or maintains such a contract for them is guilty of an offence and is liable to a fine of \$2,500 to \$250,000.

2005, c. 40, s. 28; 2016, c. 28, s. 54.

84.2.1. An insurer transacting group insurance or an administrator of an employee benefit plan who, in contravention of section 42.2.1, restricts a beneficiary's freedom to choose a pharmacist is guilty of an offence and is liable to a fine of \$10,000 to \$1,000,000.

2016, c. 28, s. 55.

84.2.2. An accredited manufacturer or wholesaler or an intermediary who contravenes the second paragraph of section 60.0.5 is guilty of an offence and is liable to a fine of \$2,500 to \$250,000.

2016, c. 28, s. 55.

84.3. Every insurer contracting group insurance, insurance representative, life and health insurance representative or administrator of an employee benefit plan who refuses, neglects or fails to produce the documents required under section 70.1 or 70.3 or to inform the Board as required under section 70.2 is guilty of an offence and is liable to a fine of \$1,000 to \$100,000.

2005, c. 40, s. 28; 2016, c. 28, s. 56.

84.3.1. An accredited manufacturer who contravenes section 80.1 is guilty of an offence and is liable to a fine of \$10,000 to \$1,000,000.

An accredited manufacturer or wholesaler or an intermediary who contravenes section 80.2 or 80.3 is guilty of an offence and is liable to a fine of \$10,000 to \$1,000,000.

A pharmacist who contravenes section 80.3 is guilty of an offence and is liable to a fine of \$10,000 to \$100,000.

2016, c. 28, s. 57.

84.3.2. The operator of a private seniors' residence or author of a prescription who contravenes the second paragraph of section 80.3 is guilty of an offence and is liable to a fine of \$5,000 to \$50,000.

The employee of a private seniors' residence who contravenes the second paragraph of section 80.3 is guilty of an offence and is liable to a fine of \$1,000 to \$10,000.

2016, c. 28, s. 57.

84.4. Every employer of members of a group referred to in section 16 and formed on the basis of employment status that refuses, neglects or fails to deduct, as required by section 44.1, the amount of the premium or assessment to be paid by the members of the group or that refuses, neglects or fails to remit the deducted sums to the insurer or plan administrator is guilty of an offence and is liable to a fine of \$2,500 to \$25,000.

2005, c. 40, s. 28; 2016, c. 28, s. 58.

84.5. Every person who helps, incites, advises, encourages, allows, authorizes or orders another person to commit an offence referred to in section 84.1, 84.2, 84.3 or 84.4 is guilty of an offence and is liable to a fine of not less than \$1,000 and not more than \$10,000.

2005, c. 40, s. 28.

84.6. A pharmacist who receives a benefit in connection with pharmaceutical services or medications for which the pharmacist has claimed or received payment, except a benefit authorized by regulation, is guilty of an offence and is liable to a fine of \$10,000 to \$100,000.

2016, c. 28, s. 59.

84.7. An accredited manufacturer or wholesaler who contravenes a condition or commitment prescribed by ministerial regulation is guilty of an offence and is liable to a fine of \$2,500 to \$250,000.

2016, c. 28, s. 59.

85. Subject to section 84.7, every person who contravenes a provision of a regulation the contravention of which constitutes an offence is liable to a fine of not less than \$100 and not more than \$1,000.

1996, c. 32, s. 85; 2016, c. 28, s. 60.

85.0.1. Penal proceedings for an offence under this Act or the regulations must be brought within one year from the date on which the prosecutor became aware of the commission of the offence. However, no proceedings may be instituted if more than five years have elapsed since the date of the commission of the offence.

2016, c. 28, s. 61.

85.0.2. In the case of a subsequent offence, the minimum and maximum fines prescribed in this Act are doubled.

2016, c. 28, s. 61.

CHAPTER VI

MISCELLANEOUS PROVISIONS

85.1. *(Repealed).*

2005, c. 40, s. 29; 2016, c. 28, s. 62.

85.2. The Board is also authorized, within the scope of any action it institutes to recover a sum collected in contravention of this Act, to act on behalf of any insurer transacting group insurance or administrator of an employee benefit plan if it has previously informed the insurer or administrator of its intention and given the insurer or administrator reasonable time to bring an action itself.

The sums collected on behalf of insurers or administrators are distributed among them by the Board in the manner and on the conditions prescribed by regulation. As consideration, the insurer or administrator shall take the necessary measures to use them for the purpose of benefiting its insured.

2016, c. 28, s. 63.

85.3. No decision to impose a monetary administrative penalty may be notified to a person for a failure to comply with this Act or the regulations if a statement of offence has already been served for a failure to comply with the same provision on the same day, based on the same facts.

2016, c. 28, s. 63.

86. The Minister shall, not later than 1 January 2000, present a report to the Government on the application of this Act and on the opportunity of amending it.

The report shall be tabled in the National Assembly within 15 days or, if the Assembly is not sitting, within 15 days of resumption. The report shall be examined by the appropriate committee of the National Assembly.

1996, c. 32, s. 86.

86.1. Before the percentages and amounts set out in sections 12, 13, 23 and 26 to 28 are modified on 1 July 2005 and at the latest on 1 January 2005, the Minister shall report to the Government on the application of sections 13.1 and 28.1 and on the advisability of amending them.

The report shall be tabled in the National Assembly within the next 15 days or, if the Assembly is not sitting, within 15 days of resumption. It shall be examined by the appropriate committee of the Assembly.

2002, c. 27, s. 30.

87. The Minister of Health and Social Services is responsible for the administration of this Act.

1996, c. 32, s. 87.

CHAPTER VII

AMENDING PROVISIONS

HEALTH INSURANCE ACT

88. *(Amendment integrated into c. A-29, s. 1).*

1996, c. 32, s. 88.

89. *(Amendment integrated into c. A-29, s. 3).*

1996, c. 32, s. 89.

90. *(Omitted).*

1996, c. 32, s. 90.

91. *(Amendment integrated into c. A-29, s. 10).*

1996, c. 32, s. 91.

92. *(Omitted).*

1996, c. 32, s. 92.

93. *(Amendment integrated into c. A-29, s. 15).*

1996, c. 32, s. 93.

94. (*Amendment integrated into c. A-29, s. 22.0.2).*

1996, c. 32, s. 94.

95. (*Amendment integrated into c. A-29, s. 21.1.0.1).*

1996, c. 32, s. 95.

96. (*Amendment integrated into c. A-29, s. 22.2).*

1996, c. 32, s. 96.

97. (*Amendment integrated into c. A-29, s. 37).*

1996, c. 32, s. 97.

98. (*Omitted).*

1996, c. 32, s. 98.

99. (*Amendment integrated into c. A-29, s. 66.0.1).*

1996, c. 32, s. 99.

100. (*Amendment integrated into c. A-29, s. 67).*

1996, c. 32, s. 100.

101. (*Amendment integrated into c. A-29, s. 69).*

1996, c. 32, s. 101.

102. (*Amendment integrated into c. A-29, s. 69.0.2).*

1996, c. 32, s. 102.

103. (*Omitted).*

1996, c. 32, s. 103.

ACT RESPECTING THE COMMISSION DES AFFAIRES SOCIALES

104. (*Amendment integrated into c. C-34, s. 21).*

1996, c. 32, s. 104.

ACT RESPECTING THE RÉGIE DE L'ASSURANCE-MALADIE DU QUÉBEC

105. (*Amendment integrated into c. R-5, s. 20).*

1996, c. 32, s. 105.

106. (*Amendment integrated into c. R-5, ss. 37.1-37.15).*

1996, c. 32, s. 106.

107. (*Amendment integrated into c. R-5, ss. 40.1-40.9).*

1996, c. 32, s. 107.

108. (*Amendment integrated into c. R-5, s. 42*).

1996, c. 32, s. 108.

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES

109. (*Amendment integrated into c. S-4.2, s. 116*).

1996, c. 32, s. 109.

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES FOR CREE NATIVE PERSONS

110. (*Amendment integrated into c. S-5, s. 150*).

1996, c. 32, s. 110.

111. (*Omitted*).

1996, c. 32, s. 111.

CHAPTER VIII

TRANSITIONAL AND FINAL PROVISIONS

112. The Government may, not later than 31 December 1996, make a regulation under section 78 or section 113 even if the regulation has not been published as required by section 8 of the Regulations Act ([chapter R-18.1](#)). Such a regulation shall come into force, notwithstanding section 17 of that Act, on the date of its publication in the *Gazette officielle du Québec* or on any later date fixed in the regulation. Such a regulation may, if it so provides, apply to any class of eligible persons it determines and from any date not prior to 20 June 1996.

1996, c. 32, s. 112.

113. The Government may make any transitional provision to prescribe, with regard to the persons or classes of persons referred to in Division I of Chapter III of this Act, for the reference period it determines,

(1) what is to be done with the contributions referred to in section 14.3 of the Health Insurance Act ([chapter A-29](#)), as it read before being repealed by section 92 of chapter 32 of the statutes of 1996, paid by a beneficiary from a date determined in the regulation;

(2) the date of the expiry of a proof of exemption issued by the Board during a period determined in the regulation in accordance with sections 14.7 and 14.8 of the Health Insurance Act, as they read before being repealed by section 92 of chapter 32 of the statutes of 1996;

(3) the cases in which the Board shall issue proof of exemption and the validity period of such proof;

(4) the amount of and cases in which the Board shall effect a reimbursement to an eligible person referred to in section 15;

(5) the conditions to be met by a pharmacist to be entitled to remuneration from the Board for the pharmaceutical services and medications referred to in section 8 provided by the pharmacist;

(6) the percentage of the cost of pharmaceutical services and medications that remains chargeable to an eligible person and the amount of the maximum contribution payable by the person, and to provide for cases of exemption with or without conditions; the coinsurance percentage and the maximum contribution for a reference period may vary according to classes of persons and within classes of persons.

1996, c. 32, s. 113.

114. The provisions of the regulations made by the Government or by the Minister under the third paragraph of section 39, subparagraphs *f* and *u* of the first paragraph of section 69 and section 69.1 of the Health Insurance Act ([chapter A-29](#)) that are repealed by chapter 32 of the statutes of 1996 shall continue to have effect until they are amended, replaced or repealed under this Act.

The list of medications drawn up by the Minister before 1 August 1996 is valid until replaced pursuant to this Act.

1996, c. 32, s. 114.

115. The Conseil consultatif de pharmacologie established under the Health Insurance Act ([chapter A-29](#)) is continued and its members remain in office until the appointment of the members of the new council established under section 53 of this Act.

1996, c. 32, s. 115.

116. The Government may, by regulation, not later than 1 August 1997, make any other transitional provision to remedy any omission and ensure the implementation of the basic prescription drug insurance plan as soon as possible after the plan is established by this Act.

A regulation made under this section is not subject to the publication requirements set out in section 8 of the Regulations Act ([chapter R-18.1](#)). It shall come into force on the date of its publication in the *Gazette officielle du Québec* or on any later date fixed in the regulation, notwithstanding section 17 of that Act. A regulation may, once published and where it so provides, apply from any date not prior to 1 August 1996.

1996, c. 32, s. 116.

117. Where, by reason of the first paragraph of section 37.10 of the Act respecting the Régie de l'assurance-maladie du Québec ([chapter R-5](#)), enacted by section 106,

(1) section 1025 of the Taxation Act ([chapter I-3](#)) applies, for 1997, for the purpose of computing the payments payable for the year by an individual referred to in section 37.6 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, Division I.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, is deemed, for the purposes of the said section 1025, to have been in force since 1 January 1996;

(2) section 1026 of the Taxation Act applies, for 1997 and 1998, for the purpose of computing the payments payable for the year by an individual referred to in section 37.6 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, Division I.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, is deemed, for the application of the said section 1026

(a) to 1997, to have been in force since 1 January 1995;

(b) to 1998, to have been in force since 1 January 1996.

1996, c. 32, s. 117.

118. When ordering the coming into force of a provision of this Act, the Government may determine the date or dates on which the provision takes effect in respect of the classes of persons it determines.

1996, c. 32, s. 118.

119. *(Omitted).*

1996, c. 32, s. 119.

REPEAL SCHEDULE

In accordance with section 9 of the Act respecting the consolidation of the statutes and regulations (chapter R-3), chapter 32 of the statutes of 1996, in force on 1 March 1997, is repealed, except section 119, effective from the coming into force of chapter A-29.01 of the Revised Statutes.