Assumption Life
Group Insurance

Association générale étudiante du Collège Universel

All Eligible Students

Contract Number: 66751
Group Number – Major: 56028
Effective Date: September 1, 2019
Renewal: September 1, 2023
Prepared on: September 27, 2023

Covered period: September 1, 2023 to August 31, 2024

The purpose of this document is to provide you with the principal features of your group program. As such, it has no contractual value. Only the terms and provisions of the contract between the Policyholder and the Insurer prevail.

The information contained in this document will answer most of the questions related to your group coverage. Additional information may be obtained from your Group Administrator or Group Representative.

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BENEFIT SCHEDULE

CATEGORY:

Description	01	All Eligible Regular Students
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All students who have not withdrawn during the period provided for this purpose will be eligible for this insurance plan. The withdrawal is performed annually by each student and is applicable for all benefits offered in the plan.

1. HEALTH CARE INSURANCE

Hospitalization*

Coinsurance: 100 %

Expenses for a semi-private hospital room.
Direct payment to the hospital
$30 per day (maximum of 5 consecutive days), up to a maximum of $300 per covered period for class 01 and per 12 consecutive months for class 02.

Extended Health Benefits

Ambulance*:

Coinsurance: 60 %

Transportation by ambulance (ground and air) to the nearest hospital.
Up to a maximum of $250 per covered period for class 01 and per 12 consecutive months for class 02.

Blood Tests*:

Coinsurance: 60 %
Reimbursement for the eligible expenses

Blood tests for diagnostic purposes, subject to a maximum of one claim per period of 12 consecutive months up to a maximum of $100. Medical check-ups are covered. ***Medical recommendation required.***

Registered private nurse*:

Coinsurance: 70%
Reimbursement for the eligible expenses

The professional services of a registered private nurse outside of the hospital up to a maximum of $400 per covered period for class 01 and per 12 consecutive months for class 02, following an accident or sickness. ***Medical recommendation required.***

X-Rays and Ultrasounds*:

Coinsurance: 60%
Reimbursement for the eligible expenses

Private x-rays and ultrasounds, including maternity ultrasounds, up to a maximum of $100 per insured per covered period for class 01 and per 12 consecutive months for class 02.

***Hospitalization, Ambulance, Blood Test, Private Nurse and X-Rays and Ultrasounds are subject to an overall maximum of $400 per period of coverage for class 01 and per 12 consecutive months for class 02.**

Vaccines:**

Coinsurance: 70%
Reimbursement for the eligible expenses

Vaccines not covered by the provincial insurance plan, excluding administration fees and allergy shots, up to a maximum of $100 per period of coverage for class 01 and per 12 consecutive months for class 02.

Contraceptive:**

Coinsurance: 70%
The amount claimed must have been submitted to a private or public plan first (RAMQ 2nd payer).
Included are oral contraceptives, IUDs, contraceptive injections, contraceptive rings, contraceptive patches and contraceptive implants.

Neuro-Stimulants:**

Coinsurance: 70%
The amount claimed must have been submitted to a private or public plan first (RAMQ 2nd payer).

Antidepressants:**

Coinsurance: 70%
The amount claimed must have been submitted to a private or public plan first (RAMQ 2nd payer).

****Contraceptives, neuro-stimulants, antidepressants and vaccines are subject to an overall maximum of $500 per period of coverage for class 01 and per 12 consecutive months for class 02.**

Vision Care***

Coinsurance	100%
Expense for eye examination per 12 consecutive months	$35
Expense for prescription glasses and contact lenses per 24 consecutive months	$75

Paramedical Services***

Coinsurance: 100 %

The expenses for the services provided by a chiropractor, or a dietitian, or massage therapist, or osteopath, or a physiotherapist or a podiatrist, $35 per visit up to a combined maximum of $350 per covered period for class 01 and per 12 consecutive months for class 02.

Expenses for paramedical X-rays if applicable are included in the paramedical services maximum amount.

***Vision Care and paramedical services are subject to an overall maximum of $400 per covered period for class 01 and per 12 consecutive months for class 02.**

Benefits for students terminate upon the earliest of the following events:

(a) The date on which the student reaches 99 years of age.

(b) The date on which the insurance terminates.

2. DENTAL CARE

Deductible:	
Individual	$0
Family	$0
Part I Basic dental care services	70%
- Diagnostic - Prevention - Recall Exam	70%
Class 01 (one per covered period)	70%
Class 02 (one per 12 consecutive months)	70%
- Oral Surgery	70%*****
- Minor Restoration (Fillings)	70%*****
- Endodontics (Root Canal)	70%*
- Periodontics (Gum Treatment)	70%*
Part II Major Restoration and Surgery	N/A
Part III Prosthodontics	N/A
Part IV Orthodontics	
(for children under 21 years of age)	N/A
Accidental Dental	N/A
Maximum benefit per insured person:	
Combined maximum for endodontics, periodontics, oral surgery and minor restoration per covered period for class 01 and per 12 consecutive months for class 02.	$300*
Overall maximum per covered period for class 01 and per 12 consecutive months for class 02.	$400
Expenses for Part IV per lifetime	$---

The applicable dental fee guide is: Current

Benefits for a student terminate upon the earliest of the following events:

(a) The date on which the student reaches 99 years of age.

(b) The date on which the insurance terminates.

GENERAL PROVISIONS

1. DEFINITIONS

For the purposes of this coverage:

An **Accident** is a sudden, fortuitous and unforeseeable event that causes, directly and independently of all other causes, bodily injuries resulting exclusively from an external cause that is of a violent nature and unintended by the insured person.

A **Student** is a member of l'Association générale étudiante du Collège Universel.

The **College** is the educational institution designated as such in the Group Insurance Plan Application.

The **Dependent** of a participant is:

(a) His or her spouse, that is, the only person of the opposite sex or of the same sex considered to be his or her spouse, either:

(1) through a marriage that has not been dissolved by divorce, annulment or discontinuance of permanent cohabitation with the participant for more than one year;

(2) through permanent cohabitation with the participant for more than one year and having been openly presented by the participant as being his or her spouse; or

(3) through living in a conjugal relationship, having had a child together, and who have not been separated for 90 days or more because of the failure of their union.

(b) An unmarried child of the participant (including natural children, stepchildren and adopted children), of his or her spouse (as defined in Article 1), or of both of them, who depends on the participant for his or her support and who:

(1) is older than 24 hours and younger than 21 years of age;

(2) is under the age 21 and must not be working more than 20 hours a week, unless he is a full time student;

(3) is 21 or older but younger than 26 if he or she is a regular full-time day student in a recognized academic institution; or

(4) regardless of age, has a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability must have begun while the child was considered a dependent as defined previously and be of such nature that the dependent is totally incapable of pursuing a gainful occupation.

A **Hospital** is a centre for confinement of limited duration, recognized as such by law, which dispenses care and treatment to ill or injured people and provides diagnostic procedures, surgical services and continuous nursing services. For purposes of this definition, hospitals do not include homes for the elderly, convalescent homes, medical clinics or centres specialized in treating alcoholism and/or drug dependency or any other type of dependency.

Hospitalization is admission to a hospital as:

a) An in-patient for a period of at least 18 hours for emergency medical treatment; or
b) For surgery that is not mainly of a cosmetic nature.

Illness is deterioration in health or an organic dysfunction diagnosed by a physician. Pregnancy is not considered an illness, except in the event of pathological complications.

The **Insurer** is Assumption Mutual Life Insurance Company.

The **Participant** is the student who is eligible for insurance and is insured under this contract.

The **Period of modification and withdrawal** is the period predetermined by the student association and Major Plan during which a participant can modify the plan or withdraw from the plan. The period is pre-determined by Plan Major and the Policyholder and is communicated on the Plan Major website.

A **Physician** is a doctor of medicine who is a member of the professional medical association of the state or province in which he or she practices.

The **Policy Number** is the number used by the insurer to identify the issued policy.

The **Group Number – Major** is the number used for processing claims in the administrative system designated by Group Major. If this reference number becomes null, this does not constitute a waiver of any other clause or condition of this contract.

A **Policyholder** is the entity designated as such in the Group Insurance Plan Application. Along with the insurer, the policyholder is one of the two parties to this contract.

Sound mind or not includes situations in which the insured is under the influence of narcotics, drugs, medication or alcohol or suffers from any psychological or nervous disorder that prevents the insured from forming intent.

The use of masculine nouns and pronouns in this contract is assumed to include the feminine equivalents. The same is true of the singular and plural.

2. TERMS OF THE CONTRACT

This Policy, the Policyholder's Group Insurance Plan Application, the Benefit Schedule, the Riders and Appendices, as well as any proof of insurability and any student's application for insurance constitute the entire contract between the parties.

Any rider affixed to the contract at a later date is deemed to be an integral part of the contract in accordance with the terms set out in the rider.

3. CHANGES TO THE CONTRACT

This contract may be modified at the written request of the policyholder, although the insurer must agree in writing to any modification. Any agreement of this type must be approved by an authorized signatory of the insurer.

The insurer may modify the provisions of the contract at any time by sending written notice to the policyholder at least thirty (30) days before the effective date of the modification. The payment of a premium after the date of the modification will be taken as consent to the change.

4. ELIGIBILITY

(a) Student

A student insured by the RAMQ or the equivalent of any other equivalent medical insurance program of another province.

The above notwithstanding, any student who is not a citizen or Canadian resident can only benefit from the protection of this contract if they are insured by an equivalent private insurance plan or the Québec health insurance plan.

(b) Dependents

A student's dependents become eligible for insurance upon the latest of the following dates:

(1) The date that the student upon whom they are dependent becomes eligible for insurance.

(2) The day that they comply with the definition of a dependent under this contract.

5. APPLICATION FOR GROUP INSURANCE AND PROOF OF INSURABILITY

(a) Student

The enrollment to this plan is automatic for all eligible students, with the option to withdraw during the period of modification and withdrawal.

(b) Dependents

If a student wishes to insure his or her dependent(s) under this contract, he or she must complete an application during the period of modification and withdrawal for group insurance and forward it to Groupe Major.

6. EFFECTIVE DATE OF INSURANCE

The insurance of a student is inforce at the date effective of the contract for the applicable school year as long as the following criteria are met:

(a) you are actively studying;

(b) you are insured by your province's health insurance plan, or an equivalent private insurance plan;

(c) you have not withdrawn during the period of modification and withdrawal;

(d) your tuition fees have been paid in full. Any claim made after the beginning of the current session but before the payment in full of your tuition fees will be eligible for reimbursement following the payment of your tuition, provided that you meet the other eligibility conditions.

Any insurance coverage or part thereof that requires proof of insurability deemed to be satisfactory by the insurer shall, however, take effect only on the day the insurer has accepted such proof of insurability. The date of acceptance shall then be the reception date by the insurer or any such final proof of insurability required by the insurer.

The insurer then notifies the policyholder in writing as to its decision to grant or deny coverage or any part thereof for the insurance so requested. Upon notification by the insurer of its decision, the policyholder then immediately notifies the student of this decision in writing.

7. STUDENT'S RIGHTS ON EFFECTIVE DATE OF BENEFITS

Whenever coverage from this contract replaces, all or in part, comparable coverage by any other contract applicable to the same group within 31 days of termination of the previous coverage, participants under the former coverage are automatically insured by the new coverage from the date of termination of the former coverage, provided that:

(a) they were insured under the contract that has terminated;

(b) the termination of their insurance results exclusively from the termination of the former coverage;

(c) the participants belong to a category included in the new coverage; and

(d) they are eligible for insurance under the provisions of the present contract.

8. TERMINATION OF INSURANCE

The insurance of a participant and, as the case may be, that of his dependents terminates automatically upon the earliest of the following dates:

(a) The date of termination of this contract.

(b) The last day of the grace period following the day when, under this contract, any amount due as a premium has not been paid.

(c) The date that the insurer receives written notice from the policyholder to this effect or on any later date mentioned in said notice.

(d) The day that the participant makes false representations to the insurer or the date that he or she commits a fraudulent act that affects the insurer.

(e) The day that the participant no longer meets the eligibility criteria for the contract.

(f) The termination date indicated in the Benefit Schedule for the coverage.

9. TERMINATION OF THE CONTRACT

This contract terminates upon the earliest of the following dates:

(a) Upon written notice from the policyholder to the insurer, on the latest of the following dates:

(1) The date indicated in the notice.

(2) The date that the insurer received the notice.

(b) Upon written notice from the insurer to the policyholder issued at least 31 days prior to the date that the contract would have been renewed;

(c) Upon written notice from the insurer to the policyholder, the date given in the notice if, in the opinion of the insurer, the policyholder has not provided with due diligence all the information needed to administer this contract or has failed without reasonable ground to fulfill any of his obligations under the contract;

(d) On the final day of the grace period, if the policyholder has not paid the premium required by the contract. However, the policyholder is still liable to the insurer for any premium owed during the grace period.

10. PREMIUMS

(a) Premium Rate Changes

The insurer may change premium rates at the following dates:

(1) At the policy renewal date, provided the insurer notifies the policyholder in writing at least 31 days prior to this date.

(2) At any other date, provided:

- the benefits or categories of students eligible for insurance under this contract are changed;
- there is a change in the nature, content or cost of government plans.

(b) Premium Payments

The educational institution is responsible for collecting the premiums from each student.

11. GRACE PERIOD

For the payment of each premium, the policyholder must remit the premium to the Third Party Administrator or the insurer within a reasonable delay following the receipt of the student's premium.

12. RENEWAL

Provided that no premium is overdue on the last day of an insurance year, this contract is automatically renewed for a period of 12 months unless written notice to the contrary from the insurer is forwarded to the policyholder at least 31 days prior to the date of renewal.

The period from the effective date of this contract up until the date of the first renewal, such as these dates are indicated in the Benefit Schedule, is considered to be the first year of insurance. Subsequent insurance years, each having a 12-month period, are calculated from the date of first renewal.

13. CERTIFICATE

The certificate is not an integral part of this contract. In the event of a discrepancy between certificate provisions and those of this contract, the contract provisions shall prevail.

14. POLICYHOLDER ADMINISTRATION

For purposes of administering this contract, the policyholder is the mandatary for the students, except for rights and obligations that are attributed to them personally.

The policyholder shall inform students of their rights and obligations under this contract as well as of any changes that were made to it thereafter. The participant and the beneficiary are entitled to consult, at the policyholder's place of operation, the master policy and to make a copy thereof.

The policyholder shall diligently provide the insurer with any information necessary for administering this contract. The policyholder authorizes the insurer to examine his or her records and files at any reasonable time while this contract is in force and for a period of two years following its termination.

Ontario Residents only:

- If you made a beneficiary designation for benefits provided by your previous benefits carrier, this designation is automatically transferred under this contract, unless you change this designation by submitting a Beneficiary Designation form to your benefits administrator.

15. LIMITATION OF ACTIONS

Every action or proceeding against the insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the applicable Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other provinces and territories).

16. WAIVER

Any waiver or omission on the part of the insurer to demand execution or observance of any provision of this contract shall not be interpreted as a waiver on the part of the insurer to its right to take necessary measures against any default subsequent to the execution or observation of this same provision.

Furthermore, the insurer's approval of any action on the part of a policyholder or participant when this approval was required shall not be interpreted as release of the policyholder or participant of their obligation to repeat such request for approval from the insurer for any similar subsequent action.

17. INCONTESTABILITY

In the absence of fraud, and once coverage has been in force for two years, no misrepresentation or misstatement may serve as a basis for cancelling or reducing the insurance.

However, this rule does not apply in the event of disability that began during the first two years of coverage.

18. COLLECTION

No provision in this contract may be interpreted as preventing the insurer from recovering any amount that has been overpaid.

19. MEDICAL REQUIREMENTS

The insurer reserves the right, at any time and at its sole discretion, to have any insured person provide one or more specific medical certificates.

The insurer also reserves the right, at any time and at its sole discretion, to request that an insured person submit to one or more medical examinations carried out by a physician or a dentist designated by the insurer or to one or more evaluations or examinations carried out by any health professional.

20. ASSIGNMENT OR PLEDGE

Insurance under this contract may not be assigned or pledged.

21. CURRENCY

All amounts payable under this contract either to or by the insurer shall be paid in legal tender dollars and cents of Canadian currency. All benefit limitations and ceilings are also expressed in Canadian currency.

22. SUBROGATION AND REIMBURSEMENT – THIRD-PARTY LIABILITY

(a) Health and Dental Insurance Coverage

When any amount is paid out to a person under the health or dental insurance coverage provided by this contract subsequent to an accident or illness for which a third party is legally liable, the insurer is subrogated in the rights of the insured person and may recover from the liable third party the amounts paid out to the extent permissible by law.

The joint and several liability of the insured or his or her contributory negligence in no way changes his or her obligations or the rights of the insurer under this section.

23. GENERAL PROVISIONS

The general provisions of this contract apply to all coverage insofar as these provisions are not incompatible with the terms of each benefit provision.

HEALTH INSURANCE

1. SCOPE

Provided that this coverage is in force on the day an insured person incurs expenses following an illness or accident, the insurer shall reimburse, in accordance with the settlement terms indicated in the Benefit Schedule and all other provisions of the contract, the eligible expenses described below.

2. DEFINITIONS

For purposes of this coverage:

Coinsurance means the percentage of eligible expenses reimbursed by the insurer to the insured person for certain types of health and/or dental care.

Co-payment is the amount of eligible expenses payable by the participant for each claim.

A **Consultation** takes place when the insured person is referred by a health professional for an appointment with another health professional who can make recommendations or provide an opinion because he or she has expertise that is pertinent to the case.

The **Convention** refers to those drugs that by law do not require a prescription but that would not ethically be dispensed by a pharmacist without one.

The **Deductible** is that portion of the eligible expenses for which the insured person is responsible every calendar year before being reimbursed for these expenses. The deductible can be for an individual or for a family. In the case of a family deductible, if one insured person in the family takes the entire deductible, no additional deductibles can be charged against the expenses contracted by other members of the family for the rest of that year.

Diagnostic Services refer to the medical examinations and tests necessary to identify the type or extent of an illness or an injury that are administered to the insured person in the office of a physician or dentist, in a hospital, or in a private health care institution previously approved by the insurer, when these examinations and tests have been prescribed by a physician or dentist or a nurse practitioner.

Drugs and Compounds refer to those drugs and compounds listed in the most up-to-date edition of the *Compendium of Pharmaceuticals and Specialties.*

Eligible Expenses are those costs incurred by the insured person for medical supplies or services that are considered to be refundable because they:

(a) are reasonable, usual, or customary expenses;

(b) have been recommended, approved, or prescribed by a health professional;

(c) have been approved by the insurer;

(d) exceed the amounts refunded or refundable by another insurer or government plan;

(e) have not been provided by a person who lives with the insured person or who is part of his or her immediate family, be his or her business partner or be his or her employer. These expenses are reimbursable up to the maximum amount indicated in the Benefit Schedule.; or

(f) were incurred while this coverage was in force.

The **Fee Schedule** means the fee schedule suggested for dental services and indicated in the Benefit Schedule in the province of residence of the policyholder. In the absence of an applicable fee schedule for the province or territory of the policyholder, the New Brunswick Fee Guide shall be used.

Government Plan means any insurance plan established by or under the administrative control of any level of government or any government agency.

Health Professional means any person who is legally licensed to practice a profession that involves the administration of medical services. Health professionals include physicians, pharmacists, dentists, nurse practitioners and any other professional approved by the insurer.

Immediate Family refers to the spouse, child, or parent of the insured person.

The expression **In Case of Emergency** means in the event of a sudden deterioration of health that requires immediate care from a health professional.

The **Maximum Amount of Coverage** means the amount of coverage available for a specified period for each insured person as indicated in the Benefit Schedule, without taking into account any coinsurance.

Necessary From a Medical Point of View means any type of care, supplies, or services that are generally accepted by health professionals, considered appropriate and necessary for the diagnosis or treatment of an illness or injury, and dispensed according to standards that are generally accepted and recognized by health professionals.

Pharmacist means any person licensed to practice the profession of pharmacy and who is a member of a recognized association of professional pharmacists.

A **Private Nurse** means any registered nurse or licensed practical nurse who is a member in good standing of her respective professional association and who does not reside with the insured person and is not a member of his or her immediate family.

Reasonable, Usual, and Customary Expenses are fees or charges that do not exceed the amounts generally charged by other professionals, similar health care establishments, or pharmacies in the same jurisdiction for identical or comparable care, services, or supplies.

3. CONDITIONS AND ELIGIBILITY

This coverage provides for the reimbursement of reasonable, usual, and customary expenses contracted for the services, supplies, and medical care described in the "Eligible expenses" section, except for the applicable limitations and exceptions.

This coverage is not intended to replace the health insurance plan of the province in which the insured person resides or any other government health insurance plan.

An insured person is eligible for this coverage only if he or she is also eligible for the benefits available under government hospitalization plans and provincial health care programs.

Only reasonable, usual, and customary fees in excess of the fees paid or reimbursed by any government program will be reimbursed under this coverage.

Claims payments after your policy ends:
We must receive your claim within 90 days of the date your coverage or policy ended. We will not pay for any claims received by us more than 90 days after the date your policy ended, regardless of when the eligible expense was incurred.

4. ELIGIBLE EXPENSES

(a) Hospitalization Expenses in Canada

The insurer pays the following expenses, without any deductible:

Hospitalization expenses in Canada in excess of those payable under any governmental insurance plan, up to the cost of a private or semi-private room as indicated in the Benefit Schedule.

The term hospital excludes a retirement home, a nursing home, a maternity home, or an institution for the blind, alcoholic, drug addict, mentally handicapped and any other similar institution.

(b) Extended Health Benefits in Canada

The insurer pays, after the deductible and based on the percentage indicated for this purpose in the Benefit Schedule, the following reasonable, usual, and customary fees:

(1) Fees incurred for the following services on the recommendation of a physician:

- Ambulance: When required but not covered by the government plan, the expenses for transportation by ambulance (ground or air) to the nearest hospital that delivers the appropriate level of care, up to the maximum amount indicated in the Benefit Schedule.

- Blood tests for diagnostic purposes: subject to a maximum of one claim per period of 12 consecutive months up to the maximum amount indicated in the Benefit Schedule. Medical check-ups are not covered.

- Registered private nurse: The professional services of a registered private nurse outside of the hospital up to the maximum amount indicated in the Benefit Schedule.

- Vaccines: Vaccines not covered by the provincial insurance plan, excluding administration fees and allergy shots, up to a maximum amount indicated in the Benefit Schedule.

- Private x-rays and ultrasounds: including maternity-related ultrasound, up to a maximum amount indicated in the Benefit Schedule.

- Contraceptives: listed and not listed on the RAMQ list (2nd payer), including Oral contraceptives, Intra-Uterine Devices, contraceptive injections, contraceptive rings, contraceptive patches and contraceptive implants, up to the maximum indicated in the Benefit Schedule.

- Antidepressants: listed and non-listed on the RAMQ list (2^{nd} payer), up to the maximum indicated in the Benefit Schedule

- Neuro-Stimulants: listed and non-listed on the RAMQ list (2^{nd} payer), up to the maximum indicated in the Benefit Schedule

(c) Vision Care Expenses

The insurer pays the following expenses:

(1) The cost of an eye examination by a certified optometrist or ophthalmologist, up to the amount indicated in the Benefit Schedule

(2) The cost of corrective lenses plus frames for eyeglasses and contact lenses prescribed by a physician or an optometrist, up to the amount indicated in the Benefit Schedule.

(d) Paramedical Services

The expenses for **paramedical services** provided by the practitioners indicated in the summary of benefits provided that these services are in their field of specialty and these professionals are members of their professional associations, up to the maximum for that specialist per insured person as indicated in the Benefit Schedule. The expenses for paramedical x-rays, if applicable, are included in the paramedical services maximum amount.

The provider cannot reside in the home of the insured person, be part of his or her immediate family, be his or her business partner or be his or her employer. These expenses are reimbursable up to the maximum amount indicated in the Benefit Schedule.

5. COORDINATION OF BENEFITS

If benefits are claimed under more than one section of this coverage, the claim will be evaluated according to the section that provides the highest benefits.

Benefits payable under this coverage are reduced in accordance with the payment sequence below in such a way that, when these benefits are added to any other benefits provided through any other insurance plan covering these same insurable expenses, the overall benefits do not exceed the true amount of expenses incurred. Amounts insured under another group insurance plan include benefits that would have been payable if a proper claim for them had been made to the other insurer.

The order in which benefits are paid is established as follows when the person insured under this coverage is also covered by another similar insurance coverage:

(a) Any group insurance plan that does not contain a coordination of benefits clause becomes the first payer;

(b) The amount of benefits payable by a plan under which the person is insured as a participant or employee takes priority over any amount payable by a plan that insures the person as a dependent or student. If the participant is a member of more than one plan as a participant, priority is set as follows:

The plan where the participant is an active full-time employee;
(1) The plan where the participant is an active part-time employee; then
(2) The plan where the participant is a retiree.

(c) The amount of benefits payable by a plan under which the person is insured as a student takes priority over any amount payable by a plan that insures the person as a dependent. If the participant is a member of more than one plan as a participant, priority is set as follows:

(1) The plan where the participant is an active full-time student*; then
(2) The plan where the participant is an active part-time student*;

* The status of full-time or part-time student is established by the educational institution. If the participant participates in more than one insurance plan as a participant with the same status, the order of precedence of the first payer is established by the earliest date of coverage.

(d) When a dependent is insured under more than one insurance plan, the plan of the participant whose birthday is the closest to the beginning of the calendar year takes precedence.

(e) In situations where the parents of a dependent are separated or divorced, then the following priority applies for this dependent:

(1) The plan of the parent with custody of the child.
(2) The plan of the spouse of the parent with custody of the child.
(3) The plan of the parent not having custody of the child.
(4) The plan of the spouse of the parent not having custody of the child.

(f) For dental accidents, if the participant is covered under a health plan with accidental dental coverage, this coverage determines benefits before the dental coverage;

(g) When it is impossible to establish the order of priority for payment using subparagraphs (a), (b), (c), (d), or (e), benefits will be prorated between the plans in proportion to the amounts that would have been paid out under each plan.

6. TERMINATION, LIMITATIONS AND EXCLUSIONS

(a) Termination

Participant and, if applicable, dependent coverage under this plan cease when the participant reaches the age indicated in the Benefit Schedule.

(b) Limitations and Exclusions

No benefits are payable under this coverage for the following expenses:

(1) Expenses that the insurer does not consider reasonable, usual, or customary.

(2) Expenses for routine examinations or blood work or any expenses incurred during a medical examination or treatment for purposes other than curative.

(3) That part of expenses covered by workers' compensation legislation, hospitalization insurance, health insurance, automobile insurance, or any other equivalent law in force in Canada or any other country, if applicable.

(4) Expenses incurred, including drugs, for surgery or treatment that the insurer considers experimental or cosmetic in nature.

(5) Expenses incurred when purchasing more than a three-month supply of a prescribed medication.

(6) Expenses for the adjustment of eyeglasses and contact lenses and the purchase of sunglasses or safety glasses.

(7) Services or supplies obtained or contracted exclusively for the purpose of facilitating participation in a sport or recreational activity.

(8) Expenses for the adjustment or maintenance of hearing aids.

(9) Expenses for fertility treatment, including *in vitro* fertilization.

(10) Expenses related to a sex change.

(11) Expenses incurred because of a wound suffered or an illness contracted during or as the result of a military operation.

(12) Expenses for rest cures, convalescent care, custodial care, or rehabilitation services in a chronic care facility, or any expense that, in the insurer's opinion, is related to care that should be provided in a chronic care facility.

(13) Expenses incurred following:

- self-inflicted injuries or physical or mental damage, whether or not the insured person was of sound mind at the time;
- the commission of or an attempt by the insured person to commit a criminal act;
- injuries sustained by the insured person during active participation in a civil commotion, a riot, an insurrection, or a military action, whether war has been declared or not;

(14) Expenses incurred outside Canada when the medical condition of the insured person would have allowed him to return home but he or she refused.

(15) Expenses incurred outside Canada when these expenses did not receive prior approval from the insurer.

(16) Expenses for insulin pumps.

(17) Expenses that would not normally have been charged to the insured person if he or she had not been covered by this policy.

(18) Expenses for cosmetic procedures or those not considered necessary from a medical point of view.

(19) Expenses for medications that are not approved by federal or provincial legislation.

(20) Administrative costs or expenses for completing documentation.

(21) Any expense not listed among the eligible expenses.

(22) All expenses covered or reimbursed under any governmental plan.

7. TERMS FOR APPLYING THE DEDUCTIBLE

The amount of the deductible is indicated in the Benefit Schedule. The deductible is applied only once per calendar year to the aggregate of the eligible expenses incurred by the participant and, if applicable, his or her insured dependents. In the event of a change in insurer, that part of the expenses incurred under the preceding plan is used to reduce the deductible in whole or in part.

8. NOTICE AND PROOF OF CLAIM

The insured person or any other person acting on his or her behalf must advise the insurer within 24 hours of the accident or illness that resulted in eligible expenses under this coverage or, if unable to do so, as soon as possible thereafter.

In the event of a request for payment, the participant or the insured person must present his or her claim to the insurer while coverage is in force, accompanied by all the supporting documentation considered necessary by the insurer, within 12 months following the date that the expenses were incurred, or that request will not be accepted.

Eligible expenses are reimbursed or paid out within 30 days after receipt of the claim accompanied by all the necessary supporting documentation.

The participant or the insured person who disagrees with a decision of the insurer may request a review within the 30 days following this decision by sending a written request to the insurer and adding any new supporting documentation.

No request for a review will be considered if it is received more than 12 months after the insurer's original decision.

9. SURVIVOR BENEFITS

If, at the time of the participant's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. However, this coverage ends on the first of the following dates:

(a) The date that the insurance contract terminates.

(b) The date that the academic year in progress is completed and paid by the member.

(c) The date that a similar coverage with another insurer goes into effect.

(d) The date that the dependents cease to be eligible dependents for any reason, except in the case where there is no eligible participant.

DENTAL INSURANCE

1. SCOPE

Provided that this coverage is in force when the insured person incurs expenses, the insurer will reimburse eligible expenses deemed medically necessary, subject to all other provisions of the contract and in accordance with the terms of payment outlined in the Benefit Schedule.

Eligible expenses are reimbursable or payable only for dental care administered by all members of a provincial association of his or her respective professional body or, under the supervision of the latter, a dental hygienist or any member of his or her respective professional body. Expenses are considered to have been incurred on the date that the dental service was provided or, for dental services requiring multiple appointments, on the last date of treatment.

All the eligible expenses described in this coverage are available as of the date that the participant becomes covered as long as the participant enrols for this coverage within 31 days of the date that he or she becomes eligible for this coverage.

In the event that a participant enrols for this coverage more than 31 days after the above-mentioned date, benefits payable under this policy will be limited to a total amount of $250 for the first 12 months of coverage. However, this restriction is not applicable to fees for professional services rendered by dentist or dental specialist and deemed medically necessary to repair damage caused to natural teeth as the result of an accident that occurs while the patient is insured by this coverage.

2. DEFINITIONS

For purposes of this coverage:

Coinsurance means the percentage or eligible expenses reimbursed by the insurer to the insured participant for certain types of health and/or dental care.

Deductible is the amount of eligible expenses payable by the insured person on each claim.

The **Fee Schedule** means the fee schedule suggested for dental services provided by general practitioners and in force in the province of residence of the insured person. In the absence of an applicable guide for the province or territory of the insured person, the New Brunswick Fee Guide shall be used. Any dental professional could charge a fee higher or lower than the regular fee guide.

Government Plan means any insurance plan established by or under the administrative control of any level of government or any government agency.

Immediate Family refers to the spouse, child, or parent of the insured person.

Medically Necessary means any type of care, supplies, or services that are generally accepted by health professionals and dispensed according to standards that are generally accepted and recognized by health professionals. The insurer reserves the right to independently evaluate what is deemed medically necessary and by doing so, could refuse the claim if judged otherwise.

Reasonable, Usual, and Customary Expenses are fees or charges that do not exceed the amounts generally charged by other professionals, similar health care establishments, or pharmacies in the same jurisdiction for identical or comparable care, services, or supplies.

3. ELIGIBLE EXPENSES

The insurer pays, after subtracting the deductible and based on the percentage indicated for this purpose in the Benefit Schedule, reasonable, usual, and customary expenses for the following dental services.

Eligible Expenses are those costs incurred by the insured person for medical supplies or services that are considered to be refundable because they:

(a) are reasonable, usual, or customary expenses;

(b) have been recommended, approved, or prescribed by a health professional;

(c) have been approved by the insurer;

(d) exceed the amounts refunded or refundable by another insurer or government plan;

(e) have not been provided by a person who lives with the insured person , who is part of his or her immediate family, who is a business partner or who is his or her employer; or

(f) were incurred while this coverage was in force.

SECTION I - Basic Care

The following are the expenses eligible for reimbursement and subject to the deductible coinsurance and maximums outlined in the Benefit Schedule, if applicable.

(a) Diagnosis and Prevention

(1) Clinical oral examination:

- The initial full examination up to a maximum of one such examination per period of 36 consecutive months;

- A recall or periodic examination, subject to 1 examination only for the period outlined in the Benefit Schedule;

- Additional examinations or consultations (with the exception of orthodontic treatments);

(2) X-rays:

- One complete series of x-rays up to a maximum of one series per period of 36 consecutive months;

- A panoramic x-ray up to a maximum of one film per period of 36 consecutive months;

- Interproximal x-rays up to a maximum of one serie of 2 units per period of 12 consecutive months; and

- Intra-oral photograph up to a maximum of 4 per 12 consecutive months;

(3) Laboratory tests;

(4) Tooth polishing up to a maximum of 1 unit per period as outlined in the Benefit Schedule;

(5) Scaling up to a maximum of 2 units per 12 consecutive months.

(**b) Minor Restoration**

Amalgam-based restoration (non-bonded), restorations using acrylic or composite resin (bound and non bound). Composite fillings (white) are covered only for the teeth in the front of the mouth. A reimbursement equivalent to the amount reimbursed for an amalgam filling will be paid for any composite filling on the back teeth.

(c) Oral Surgery

Eligible expenses in this category include expenses for simple and surgical extractions of teeth or roots, surgical excision or incision, including preoperative and postoperative care. Surgical extractions includes wisdom teeth.

(d) Endodontics

Root canal

Expenses payable in this category include expenses for pre-treatment consultation, clinical procedures considered medically necessary and x-rays deemed appropriate and necessary by the insurer.

(e) Periodontics

Expenses payable in this category include expenses for services considered medically necessary to treat pathological conditions affecting the bone or tissue supporting the teeth, such as gingivectomy, root planing up to a maximum of 2 units per year.

4. COORDINATION OF BENEFITS

If benefits are claimed under more than one section of this coverage, the claim will be evaluated according to the section that provides the highest benefits.

Benefits payable under this coverage are reduced in accordance with the payment sequence below in such a way that, when these benefits are added to any other benefits provided through any other insurance plan covering these same insurable expenses, the overall benefits do not exceed the true amount of expenses incurred. Amounts insured under another group insurance plan include benefits that would have been payable if a proper claim for them had been made to the other insurer.

The order in which benefits are paid is established as follows when the person insured under this coverage is also covered by another similar insurance coverage:

(a) Any group insurance plan that does not contain a coordination of benefits clause becomes the first payer;

(b) The amount of benefits payable by a plan under which the person is insured as a participant or employee takes priority over any amount payable by a plan that insures the person as a dependent or student. If the participant is a member of more than one plan as a participant, priority is set as follows:

(1) The plan where the participant is an active full-time employee;
(2) The plan where the participant is an active part-time employee; then
(3) The plan where the participant is a retiree.

(c) The amount of benefits payable by a plan under which the person is insured as a student takes priority over any amount payable by a plan that insures the person as a dependent. If the participant is a member of more than one plan as a participant, priority is set as follows:

(1) The plan where the participant is an active full-time student*; then
(2) The plan where the participant is an active part-time student*;

* The status of full-time or part-time student is established by the educational institution. If the participant participates in more than one insurance plan as a participant with the same status, the order of precedence of the first payer is established by the earliest date of coverage.

(d) When a dependent is insured under more than one insurance plan, the plan of the participant whose birthday is the closest to the beginning of the calendar year takes precedence.

(e) In situations where the parents of a dependent are separated or divorced, then the following priority applies for this dependent:

(1) The plan of the parent with custody of the child.
(2) The plan of the spouse of the parent with custody of the child.
(3) The plan of the parent not having custody of the child.
(4) The plan of the spouse of the parent not having custody of the child.

(f) For dental accidents, if the participant is covered under a health plan with accidental dental coverage, this coverage determines benefits before the dental coverage;

(g) When it is impossible to establish the order of priority for payment using subparagraphs (a), (b), (c), (d), or (e), benefits will be prorated between the plans in proportion to the amounts that would have been paid out under each plan.

5. TERMINATION, LIMITATIONS AND EXCLUSIONS

(a) Termination

Participant and, if applicable, dependent coverage under this plan cease when the participant reaches the age indicated in the Benefit Schedule.

(b) Limitations

No benefits are payable under this plan for the following expenses:

(1) That part of the expenses in excess of the fees indicated in the fee guide in force in the province of residence of the insured person;

(2) Amounts per insured person exceeding the maximum benefit amounts indicated in the Benefit Schedule;

(3) Orthodontic procedures performed within the first 24 months of coverage under this policy in the event that the insured person became covered under this policy more than 31 days after the date that he or she became eligible for coverage.

(c) Exclusions

No benefits are payable under this plan for the following expenses:

(1) Expenses exceeding those deemed reasonable, usual or customary for the least expensive dental procedure recognized as acceptable in dental medicine;

(2) That part of the expenses covered by workers' compensation legislation, health insurance, automobile insurance, or any other equivalent law in force in Canada;

(3) Expenses covered under another coverage under this policy;

(4) Expenses incurred during treatment primarily for aesthetic reasons or for other than curative purposes;

(5) Expenses incurred in relation to a surgical procedure or treatment that the insurer considers experimental;

(6) Expenses for replacement of lost, misplaced or stolen prostheses;

(7) Expenses incurred in relation to dietary analysis, recommendations, oral hygiene instructions, dental plaque control programs or corrective procedures relating to a congenital or progressive malformation;

(8) Expenses for the purchase of dentures, except for the purchase of the first denture required after an accident that occurs while this coverage is in force.

(9) Expenses charged by a dental surgeon for an appointment that the insured person missed or for completing any insurance form or other document;

(10) Expenses for dental care incurred for complete reconstruction of the mouth, correction of vertical dimension or treatment of the temporomandibular joint;

(11) Expenses for orthodontic treatments, including the correction of malocclusion;

(12) Expenses incurred following:

- Self-inflicted wounds or physical or mental damages, whether or not the insured person was of sound mind at the time;
- The commission of or an attempt by the insured person to commit a criminal act; or
- Injuries sustained by the insured person during active participation in a civil commotion, a riot, an insurrection, or a military action, whether war has been declared or not; and

(13) Any expense not listed among the eligible expenses.

(14) Any expenses relating to implant dentistry. Including x-rays, bone grafts, sinus lift and related implant work.

6. TERMS FOR APPLYING THE DEDUCTIBLE

The amount of the deductible is indicated in the Benefit Schedule. The deductible is applied only once per calendar year to the aggregate of the eligible expenses incurred by the participant and, if applicable, his or her insured dependents.

In the event of a change in insurer, that part of the expenses incurred under the preceding plan is used to reduce the deductible in whole or in part for the current calendar year.

7. PRELIMINARY ASSESSMENT

A detailed treatment plan is to be presented to the insurer prior to the start of treatment if the cost for any individual dental service prescribed by a dental surgeon is expected to exceed $300.

The above-mentioned assessment by the insurer notwithstanding, benefits are disbursed in accordance with the terms of the coverage in effect on the date that a procedure was performed.

The insurer forwards to the insured person, within 31 days of receipt of all required documentation, information regarding the amount of any benefit provided under this policy that the insurer is prepared to disburse if the procedure is carried out.

A preliminary assessment is recommended for any treatment done exceeding $300 in order to avoid any unexpected refusals.

8. NOTICE AND PROOF OF CLAIM

In the event of a request for payment, the participant or the insured person must present his or her claim to the insurer while coverage is in force, accompanied by all the supporting documentation considered necessary by the insurer, within the 12 months following the date that the expenses were incurred.

Eligible expenses are reimbursed or paid out within 30 days after receipt of the claim accompanied by all the necessary supporting documentation. (new x-ray, photos, study models should be sent before treatment is rendered)

The participant or the insured person who disagrees with a decision of the insurer may request a review within 30 days following this decision by sending a written request to the insurer and adding any new supporting documentation.

No request for a review will be considered if it is received more than 12 months after the insurer's original decision.

Claims payments after your policy ends:
We must receive your claim within 90 days of the date your coverage or policy ended. We will not pay for any claims received by us more than 90 days after the date your policy ended, regardless of when the eligible expense was incurred.

9. SURVIVOR BENEFITS

If, at the time of the participant's death, his or her dependents are covered by this coverage, this insurance coverage remains in force without further payment of premiums. However, this coverage ends on the first of the following dates:

(a) The date that the insurance contract terminates.

(b) The date that the academic year in progress is completed and paid by the member.

(c) The date that a similar coverage with another insurer goes into effect.

(d) The date that the dependents cease to be eligible dependents for any reason, except in the case where there is no eligible participant.