This document is not a copy of the policy. It is a summary of the insurance coverages provided under the policy and your coverage may not necessarily include all of them. In the event of a difference of wording between the document and the policy, the policy will prevail, to the extent permitted by law.

GROUP INSURANCE POLICY NUMBER: **330010 - 00**

Subject to the terms and conditions of this policy issued to:

FÉDÉRATION ÉTUDIANTE DE L'UNIVERSITÉ DE SHERBROOKE (FEUS)

« the Policyholder »

HUMANIA ASSURANCE INC.

« the Insurer »

Class 1: All Eligible Students

agrees to pay the benefits or indemnities provided in this policy, provided that the Policyholder pays the required premiums.

Effective Date: **September 1, 2024**

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SCHEDULE OF BENEFITS
Health Care Insurance

General Provisions

Class 1	All Eligible Students
Coverage period	September 1, 2024 to August 31, 2025
Termination	The coverage for this benefit ends upon the first of the following events: 1. When the participant reaches age ninety-nine (99); 2. The termination date of this benefit or of the insurance policy.

Coverage

Deductible	None
Drug deductible	None
Direct payment service	Yes
Mandatory generic substitution	For prescription drugs not included on the RAMQ list.
Overall benefit maximum	$10,000/coverage period for all eligible fees, except for prescription drugs, hospitalization, preventive vaccines vision care and education expenses.

SCHEDULE OF BENEFITS
Health Care Insurance

Gender Affirmation

Hormone therapy drugs	Supplementary to the RAMQ, 100% of eligible costs for generic, brand name with generic equivalent, and brand name (single source), up to a maximum of $1,000 / coverage period.
Surgeries and treatments not covered by the Régie de l'assurance maladie du Québec (RAMQ): • Chest and torso surgeries; • Genital surgeries; • Thyroid chondroplasty (Adam's apple surgery); • Vocal cord surgeries; • Electrolysis or laser hair removal.	80% of eligible fees, maximum $4,000/ surgery type and $10,000/ lifetime.

Prescription Drugs (included and not included on the RAMQ list)

Contraceptives, antidepressants and psychostimulants	Supplementary to the RAMQ, 100% of eligible costs for generic, brand name with generic equivalent, and brand name (single source).

Supplemental Expenses

Hospitalization (semi-private room)	100% of eligible fees
Stipend allocated during a short-term hospitalization (up to 30 days) in a semi-private room	100% of eligible fees Maximum $50/day, up to 30 days
Convalescent home (semi-private room)	100% of eligible fees Maximum 100 days /hospitalization
Preventive vaccines	100% of eligible fees Maximum $150/coverage period
Education expenses – private tutor	100% of eligible fees Maximum $10/hour and $300 /accident or illness
Nursing care	100% of eligible fees Maximum $10,000/coverage period
Ambulance (ground)	100% of eligible fees

SCHEDULE OF BENEFITS
Health Care Insurance

Ambulance (airway)	100% of eligible fees

Diagnostic Services

X-rays and ultrasounds performed in a private clinic (excluding maternity ultrasounds)	100% of eligible fees

Respirators

Oxygen and the equipment necessary to administer it	100% of eligible fees
Apnea monitor	100% of eligible fees
Drainage pump and accessories	100% of eligible fees

Orthotics and Prostheses

Orthopaedic shoes	100% of eligible fees Maximum $200/coverage period
Podiatric orthotics and prostheses	100% of eligible fees
Artificial limbs and myoelectric prostheses	100% of eligible fees Maximum $10,000/prosthesis
Artificial eyes	100% of eligible fees
External breast prostheses	100% of eligible fees
Hearing aids	100% of eligible fees Maximum $250/period of 2 consecutive years

Medical Supplies

Metal corset (or one made of similar materials), provided the corset is essential for spinal support	100% of eligible fees

SCHEDULE OF BENEFITS
Health Care Insurance

Sling, hernia truss or cast	100% of eligible fees
Hospital bed (basic model)	100% of eligible fees
Transcutaneous electrical nerve stimulator (T.E.N.S)	100% of eligible fees
Other therapeutic devices medically necessary to cure or treat a medical condition	100% of eligible fees
Ostomy supplies (colostomy, ileostomy, or ureterostomy)	100% of eligible fees
Compression stockings of 20 mm of HG or more, in the case of venous or lymphatic system insufficiency	100% of eligible fees
Paraplegia supplies	100% of eligible fees
Catheters	100% of eligible fees
Tube-feeding supplies	100% of eligible fees
Tracheostomy supplies	100% of eligible fees
Opaque glasses required for radiotherapy or psoriasis treatment	100% of eligible fees
Compression garments for the severely burned	100% of eligible fees
Medicated bandages	100% of eligible fees

Health Care Professionals

Chiropractor	100% of eligible fees Maximum $40/visit and $320 / coverage period
Occupational therapist	100% of eligible fees Maximum $20/visit and $400 / coverage period

SCHEDULE OF BENEFITS
Health Care Insurance

Physiotherapist/Physician	100% of eligible fees Maximum $50/visit and $400 / coverage period
Psychologist/Psychotherapist/Social worker/Psychoeducator/Sexologist	100% of eligible fees Maximum $80/visit and $800 / coverage period
Imaging technologies used by a chiropractor, osteopath, podiatrist or chiropodist	100% of eligible fees Maximum one (1) / coverage period included in the maximum of the associated professional.

Vision Care

Eye examination	100% of eligible fees Maximum $60/ coverage period
Eyeglasses and contact lenses	100% of eligible fees Maximum $150/ 24 consecutive months
Repair or replacement of eyeglasses in case of accidental breakage	100% of eligible fees Maximum $150/ 24 consecutive months
Laser eye surgery	100% of eligible fees Maximum $150/ coverage period

SCHEDULE OF BENEFITS
Dental Care Insurance

General Provisions

Class 1	All Eligible Students
Coverage period	September 1, 2024 to August 31, 2025
Termination	The coverage for this benefit ends upon the first of the following events: 3. When the participant reaches age ninety-nine (99); 1. The termination date of this benefit or of the insurance policy.

Coverage

Deductible	None
Fee guide	Current year guide in the province of residence of the insured person
Direct payment service	Yes
Overall benefit maximum	$1,000/coverage period

Diagnostic and Preventive Care

Diagnostic Examinations and X-rays	60% of eligible fees
Preventive Cleaning and Polishing	60% of eligible fees

SCHEDULE OF BENEFITS
Dental Care Insurance

Basic Care

Surgery Extractions	50% of eligible fees
General Anaesthesia During surgery or treatment	50% of eligible fees
Minor Restoration Fillings*	50% of eligible fees
Periodontics Gum treatment	50% of eligible fees
Endodontics Root canal	50% of eligible fees

***** Fillings: Amalgam (grey) - for molars
Composite (white) - for all other teeth

IDENTIFICATION OF PARTIES

Plan Administrator

The organization responsible for administrating this group policy and paying claims for Health Care and Dental Care benefits. Under this contract, the plan administrator is Plan Major Inc.

Insured person

The participant and his or her dependent(s) at the time the insurance comes into effect, according to the terms and conditions of the policy.

Insurer

The insurer is Humania Assurance inc.

Employee

The employee is a worker, employed by the Fédération Étudiante De L'université De Sherbrooke.

Student

The student is a member of the Fédération Étudiante De L'université De Sherbrooke. Also covered by this term are students who are not members of the student association but are participating in an internship authorized by the institution.

Participant

The participant is the student or employee who meets the requirements of insurability and is insured under this contract.

Dependent

The spouse or dependent child of a participant who has been reported to the Insurer, as defined below:

Spouse

The person:

1. who is married to and resides with the participant; or
2. who is living in a spousal relationship with the participant for at least twelve (12) consecutive months ; or immediately if a child is born of this union and

IDENTIFICATION OF PARTIES

a. is designated by the participant as the spouse on the “Declaration of Matrimonial Status” form; and

b. is publicly presented as his or her spouse.

However, annulment of the marriage, divorce or separation results in the loss of spousal status.

Dependent Child

To be eligible, the child of the participant or of his/her spouse must be single and without full-time employment, be a Canadian resident and depend on the participant or his/her spouse for financial support. Furthermore, the child must:

- be under age twenty-one (21); or
- be between age twenty-one (21) and twenty-five (25) inclusively and attend a recognized educational institution as a registered full-time student; or
- whatever his age, have become totally disabled before his or her eighteenth (18th) birthday.

Policyholder

The policyholder is designated as such in the group insurance application and represents one of the two parties of this contract.

University

The University is the educational institution, as indicated in the group insurance application.

DEFINITIONS

A

Accident

A non-intentional, sudden, accidental and unexpected event that is exclusively due to an external cause of violent nature and resulting, directly and independently of any other cause, in bodily injury.

Amendment and Withdrawal Period

The period predetermined by the student association and the plan administrator during which a member may make changes to or withdraw from the plan. This period is indicated on the plan administrator's website.

B

Bodily Injury

Body injury resulting directly from an accident sustained by the insured person while the policy is in effect.

C

Coinsurance

Percentage of eligible expenses paid by the Insurer

Convalescent Hospital

Institution recognized as a hospital center for prolonged care under the Quebec Hospital Insurance Act and governed by this act or by a similar act outside of Quebec, and the prolonged care unit or the care unit reserved for convalescing patients in a hospital.

DEFINITIONS

D

Day

Calendar day, unless otherwise indicated under the benefit coverage.

Day Surgery

Surgery requiring an anaesthetist's intervention

Deductible

Part of the eligible expenses that the Insured must pay before the Insurer will make a reimbursement. The deductible is applicable only once per year of coverage.

The eligible expenses paid by the participant during the last three (3) months of a calendar year and used to cover in whole or in part the yearly deductible, are applied to reduce the following year's deductible.

Dentist

A dentist or dental surgeon who is a member in good standing of his or her provincial professional association or a professional association recognized by the legislative authorities where the dentist practices and who actively practices his or her profession in Canada.

Denturologist

Any denturologist who is member in good standing of his or her provincial professional association or professional association recognized by the legislative authorities where the denturologist practices and who actively practices his or her profession in Canada.

Diagnostic Services

The medical examinations and tests necessary to identify the nature or extent of an illness or injury and that are administered to the Insured in the offices of a physician or dentist, in a hospital or in a private health care facility that has been pre-approved by the Insurer, where such examinations and tests have been prescribed by a physician, dentist or nurse practitioner.

DEFINITIONS

Disease

Deterioration of health or bodily disorder not caused by an accident and assessed by a physician.

Drug Deductible

The amount to be paid by the Insured for each eligible drug before coinsurance is applied.

E

Eligible Expenses

Costs incurred by the Insured for medical supplies or services, which are considered reimbursable expenses as they:

- are included in coverage under the Schedule of Benefits; and
- are reasonable, ordinary and customary expenses; and
- are recommended, approved or prescribed by a health care professional; and
- are approved by the Insurer; and
- exceed the amounts reimbursed or reimbursable by any other insurer or government plan

F

Fee Guide

The *Fee Guide and Description of Dental Treatment Services* listed in the Schedule of Benefits. If there is no applicable guide in the concerned province or territory, the fee guide for the province of Quebec is used.

DEFINITIONS

G

Gender Dysphoria

Gender dysphoria is a significant feeling of distress or difficulty functioning associated with the persistent feeling that a person's assigned sex at birth does not align with their sense of themselves as being masculine, feminine, mixed, neutral, or other (gender identity).

Government Plan

Any insurance plan established by or under the administrative control of any government or government agency.

H

Health Care Professional

A person who is legally authorized to practice a profession for which medical services are administered. The Health Care Professionals include doctors, pharmacists, dentists, nurse-practitioners or all other professional approved by the Insurer.

Hospital

Institution recognized as a hospital center for short-term care under Quebec Hospital Insurance Act and governed by this act by a similar act outside of Quebec. However, the definition of hospital does not include a prolonged-care unit or convalescent hospital.

Hospitalization

Hospital stay with a minimum duration of eighteen (18) hours as an bedridden patient or following day surgery.

M

Maximum

DEFINITIONS

The maximum amount of coverage available for a specified period for each insured person, as indicated in the Schedule of Benefits, after application of the deductible, drug deductible and coinsurance, if applicable.

P

Physician

A health care professional who is legally authorized to practice medicine in Canada within the scope of his or her medical degree (M.D.), who is a member in good standing of his or her professional association and who actively practices his or her profession in Canada.

R

Reasonable, Ordinary and Customary Charges

Fees or charges that do not exceed the rate usually charged by other professionals, similar health care facilities or pharmacies in the same jurisdiction when providing identical or comparable care, services or supplies.

Retirement Date

The date on which an insured employee starts retirement according to:

- The pension plan in which he was participating; or
- The collective agreement in effect with his employer; or
- The practice in use at his place of employment.

T

Total Disability

During the twenty-four (24) months immediately following the onset of disability: A member's inability as a result of accident or sickness to perform each and every of the essential duties of his or her occupation, provided that during such period he or she does not hold other employment and is under the continuous and appropriate treatment and care of a physician.

DEFINITIONS

If the disability lasts for more than twenty-four (24) months: A member's inability to perform any gainful job or occupation for which he or she is reasonably qualified by his or her training, education or experience, without regard for the availability of employment, provided he or she does not hold any employment, except in the case of a rehabilitation program approved by the Insurer, and is under the continuous and appropriate treatment and care of a physician.

A total disability, starting more than thirty-one (31) days after an accident, is considered as a result of an illness.

GENERAL PROVISIONS

Enrolment

Student

Enrolment is automatic for all eligible students, with the possibility of withdrawing during the modification and withdrawal period.

Employee

An eligible employee enrols under the policy contract by completing the required form and by providing evidence of insurability, satisfactory to the Insurer in the case of coverage other than health care insurance when it is one of the conditions of insurance. The employee must provide evidence of insurability when the enrolment form comes to the Insurer more than thirty (30) days after the service requirement expires.

Enrolment for Health Care Insurance is mandatory for the eligible employee and his dependent(s), unless satisfactory proof is given to the Insurer that they are covered under another group insurance plan that includes at a minimum the drug insurance coverage required by law. No evidence of insurability is required in order to enrol for the Health Care Insurance benefit.

Dependent

Students who wish to insure their dependents under this policy must complete and forward to the plan administrator a request for insurance to that effect during the amendment and withdrawal period.

Eligibility

Student

A student who is a member of the Fédération Étudiante de l'Université de Sherbrooke and insured by the health insurance plan of their province of residence.

Notwithstanding the above, members of the Fédération Étudiante de l'Université de Sherbrooke who are neither Canadian citizens nor residents, will be eligible for coverage only if they are covered by the health insurance plan of their province of residence or by an equivalent private plan.

Employee

Enrolment under the policy and its coverage is available only to an employee who falls within the description class for each benefit and who satisfies the three (3) following conditions:

GENERAL PROVISIONS

- Is less than seventy (70) years old;
- Works for the employer as a permanent employee of the Fédération Étudiante de l'Université de Sherbrooke at least twenty (20) hours a week, provided that he is indeed at work full time, as of the effective date of his insurance and for the duration of the policy;
- Is a worker as defined under the Law on work-related accidents and illnesses.

Dependent

The dependent of a participant becomes eligible for insurance at the later of:

- the date on which the participant on whom they are dependent becomes eligible for insurance
- the date on which they meet the definition of a dependent under this policy.

Beneficiary

Subject to the provisions of the law, the participant can at any time designate or revoke one or more beneficiaries of his insurance by sending a written notice to the Insurer's head office. The rights of a beneficiary who dies before the participant revert to the latter.

The Insurer assumes no responsibility regarding the validity of any designation or revocation of a beneficiary.

The insured amount payable upon the death of an insured dependent is paid to the participant, if he is alive. If the participant is deceased, the amount is paid according to the following terms:

1. In the event of the death of the spouse, to the legal heirs of the spouse;
2. In the event of the death of a dependent child of the participant:
    a. To the spouse, if living;
    b. Otherwise, to the legal heirs of the dependent child.

Cession

Neither the policy contract nor the insurance of an insured employee can be transferred or mortgaged.

Changes to Governmental Policies

The premium is established taking into account the benefits payable under current governmental social programs. In the event of modification to laws and programs that affect the Insurer's obligations, the Insurer can adjust the premium consequently and this, starting the effective date of the modification.

GENERAL PROVISIONS

Furthermore, in the event of differences between the terms and conditions of the policy and the Quebec Act Respecting Prescription Drug Insurance, the Act will have precedence.

Continuation of Coverage (Unpaid leave and Temporary Lay-off)

While the policy is in force, the insurance of any participant and of his dependent, excluding the disability benefits, can be maintained in force at the Policyholder's request during a maximum period of twelve (12) months, as long as the premiums continue to be paid. To benefit from this privilege, the request must be received by the Insurer within the thirty (30) days that immediately follow the beginning of the leave of absence, or temporary lay-off.

Contract

The policy, the insurance application and the participants' enrolment forms constitute the contract.

When an effective date is stated for the termination or the modification of any coverage, the effective date occurs on that date at 12:01 a.m., at the place of establishment of the Policyholder.

Notice and Proof of Claim

All claims must be detailed to the Insurer's satisfaction, produced in writing and sent to the head office of the Insurer within ninety (90) days of the event. Expenses are considered as incurred as of the date that the services or the articles were provided.

In the event of cancellation of the contract, no benefits are payable by the Insurer for claims received after the ninety (90) days following the cancellation date of the contract.

Any payment is made in Canadian legal tender.

Life Insurance, Critical Illness Insurance and Disability Insurance

The policyholder or the insured must inform the Insurer in writing of the incident within the thirty (30) days following the date of the event.

Subject to the *Obligation to inform the Insurer* of certain critical illnesses as described above, failure to transmit the notice of claim or to provide the proof and information within the time prescribed does not prevent the payment of any benefit, as long as the claim, the proof and the information are provided as soon as it is reasonably possible to do so. However, no benefit will be paid if the claim, the proof and the information given are provided more than one (1) year after the date of the event giving rise to a claim under the contract.

GENERAL PROVISIONS

At the Insurer's request, the insured must submit to any medical exam relative to the nature of the disability.

Insured's Right Upon Change of Insurers

Any employee eligible for insurance, whether at work or off work temporarily, will continue to be entitled to the insurance coverages and the corresponding benefit amounts that were in force at the time of a change of Insurers, under the new provisions set out in this replacement policy.

The Policyholder is required to provide the new Insurer with all information relating to its employees' coverage at the date of change of Insurers.

Effective Date of Coverage

Student

The student's insurance will be effective on the effective date of the contract for the school year, provided that the student meets the following conditions:

- is actively a student;
- is covered by the health insurance plan of the province of residence or by an equivalent private insurance;
- has not withdrawn during the amendment and withdrawal period;
- tuition fees have been paid in full. Any claim made after the start of the current session but before the payment of tuition fees will be eligible for reimbursement after the payment of tuition fees, and provided that all other conditions for the effective date of insurance are met.

Employee

Coverage of the insured employee begins:

- In the case of coverage for which he does not have to establish his insurability, the date on which the service requirement indicated in the Schedule of Benefits ends provided his group application form is received by the Insurer before this date, or within the thirty (30) days immediately following the end of the service requirement.
- When he has to establish his insurability, at the date on which the Insurer considers the insurability of the insured employee satisfactory.

GENERAL PROVISIONS

Dependent

Dependent coverage begins:

- at the same date as the effective date of the insured employee's coverage, provided the Insurer has received the form concerning the insured employee's dependent within the thirty (30) days immediately following the effective date of the insured employee's insurance coverage;
- in all other circumstances, as of the date when the person meets the definition of dependent if the Insurer receives the request within the thirty (30) days immediately following the day when this person became dependent, otherwise, as of the date the request is received by the Insurer.

Notwithstanding what precedes, in the case of benefits other than Health Care Insurance, the effective date of the insurance of any dependent who is hospitalized at the time of the request, is delayed until the date the person is discharged from the hospital.

However, the Health Care Insurance of a newborn dependent of the plan member, will enter into force immediately at birth, provided it is a live birth and that a family plan or single parent plan is already in force.

At no time does dependent coverage begin before the effective date of the participant's coverage.

However, it is understood that any benefit or portion of benefit that requires evidence of insurability deemed satisfactory by the insurer cannot take effect until the insurer has accepted this proof of insurability. The date of acceptance would then be the insurer's reception date of the last elements of proof of insurability required by the insurer.

Misrepresentations and Omissions

Subject to the provisions of the law, all misrepresentations or omissions likely to influence the evaluation of the risk cancel the insurance of the said insured employee or of the said dependent.

End of Coverage

1. Coverage of the participant ends at the earliest of the following dates:
    a. the date of cancellation, annulment or termination of the insurance policy contract;
    b. the date on which he no longer meets the conditions of eligibility;

c. with respect to a specific coverage, other than the Health Care Insurance benefit, as of the date where he reaches termination age for the benefit;

d. the date on which the insured employee dies;

The Insurer reserves the right to terminate the participant's insurance in the event of non-payment of the premium within a reasonable time frame.

2. Dependent coverage ends at the earliest of the following dates:
   a. the date on which the participant ceases to be insured;
   b. the date the dependent ceases to be an eligible dependent;
   c. as of the date upon which the dependent reaches the termination age for the coverage;
   d. as of the date the dependent insurance ends according to the terms of the contract;
   e. the date on which the dependent dies.

   The Insurer reserves the right to terminate the dependent's insurance in the event of non-payment of the premium within a reasonable time frame.

End of Insurance Policy

The policy ends:

1. as of the date of reception, by the Insurer, of a written notice from the Policyholder or as of the date stipulated in this notice, if after the reception date;
2. subject to the provisions of the law, as of the date stipulated in the termination notice given by the Insurer to the Policyholder;
   The Insurer reserves the right to terminate the insurance policy in the event of non-payment of the premium within a reasonable time frame.

Strike or Lock-out

While the policy is in force, the Extended Health Care Insurance coverage of any insured employee and of his dependent is maintained in force during a minimum of thirty (30) days, starting the date work stopped due to a strike or a lock-out. The other coverages are suspended during the period of work stoppage, unless a written agreement exists between the Policyholder and the Insurer.

Amount of Coverage

At the time of enrolment, the amount of benefit under each coverage for each insured employee is established according to the occupational classification of the insured employee. This amount varies,

either upward or downwards, according to subsequent modifications made to the classification or the salary of the insured employee.

When an increase of the amount of coverage results from a change of salary or of occupational classification, the additional coverages for the insured employee concerned are effective:

1. As of the effective date of the change if a written notice is received by the Insurer within the thirty (30) days following the date of the change;
2. As of the reception date of the written notice if it is received more than thirty (30) days after the date of the change;
3. As of the date the insurability of the insured employee is considered satisfactory by the Insurer, if the insured employee must provide evidence of insurability to meet the requirements of the insurance policy.

Consequently, any claim based on an event that occurred before this effective date will be paid according to the insurance in force at the time of the event.

When a reduction in the amount of coverage results from a change of salary or class, the amount of benefit for each coverage impacted by these changes is adjusted automatically from the date of the change.

In case of disability of an insured employee or when an insured employee receives maternity or parental benefits under the Employment Insurance Act, the amount of coverage provided by covered benefits remains unchanged until his return to work full-time. However, conditions outlined in the contract continue to apply.

Conditions of Participation

The insurance policy is subject to the following conditions of participation:

- Participation is mandatory for eligible employees.
- For the Health Care Insurance benefit coverage, the participation of the insured employee's dependent is mandatory.
- However, an eligible employee or dependent can, by way of a written notice to the Plan Administrator, refuse or stop participating in the Health Care Insurance and Dental Care Insurance benefits, provided that he certifies he is insured under the terms of a group insurance plan with similar benefits.

GENERAL PROVISIONS

An employee or a dependent who has refused or stopped participation can enroll for this coverage by establishing, to the Insurer's satisfaction, that he no longer qualifies to be insured under the terms of this other plan.

Responsibilities of the Policyholder

For the purposes of administering this contract, the Policyholder is the student's mandatary, except for the rights and obligations assigned to them personally.

The Policyholder must inform the students of their rights and obligations under this contract, as well as of any subsequent changes that may be made to it. The member and the beneficiary have the right to consult the insurance policy at the Policyholder's premises and to take a copy of it.

The Policyholder must diligently provide the Insurer with any information necessary for the administration of this contract. It is the duty and responsibility of the Policyholder to transmit to the Insurer all information and documents with regard to enrolments and the modification notices of the students and employees eligible for group insurance, as well as all information necessary to establish the insurance class. The Policyholder authorizes the Insurer to review its records and files at any reasonable time, while this policy is in effect and for the three (3) years following its termination.

Ontario residents only:

- Any action or proceeding brought against an insurer for the recovery of insurance amounts payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act of 2002.

If you had designated a beneficiary for the benefits provided by your previous group insurance provider, this designation shall automatically apply under this policy, unless you make a request to change the beneficiary by submitting a beneficiary change form.

Payment of premium

The educational institution will be responsible for collecting members' premiums and remitting them to the plan administrator within a reasonable time frame.

Evidence of Insurability

The participant is responsible for all expenses incurred for the preparation and production of evidence of insurability required by the Insurer.

GENERAL PROVISIONS

Premium

The Insurer may change the premium rates on the following dates:

1. on the renewal date, if the Insurer provides written notice to the Policyholder or the plan administrator no later than thirty-one (31) days before that date; or
2. on any other date, if:
    a. the benefits or classes of students eligible for insurance under this contract are changed;
    b. there is a change in the nature, content or cost of government plans.

Reinstatement

The insurance cancelled during the absence for any insured employee temporarily laid-off or on leave authorized by the employer can be reinstated under the condition that this absence has not exceeded twelve (12) months, and that the request to that effect is received by the Insurer within the thirty (30) days immediately following the return-to-work date.

Waiver

Any waiver or omission on the part of the Insurer to require the performance or observance of any provision of this contract shall not be construed as a waiver of the Insurer's right to take the necessary measures against any subsequent failure to perform or observe the same provision. In addition, the fact that the Insurer has approved any action by the Policyholder or a member where such approval was required does not relieve the Policyholder or member of the requirement to obtain the Insurer's approval for any subsequent similar action.

Renewal

The policy is automatically renewed yearly on the renewal date for a period of twelve (12) months, except if a written notice of non-renewal or of modification is transmitted by the Insurer to the Policyholder or to his representative of record, at least one hundred and twenty (120) days before the date of renewal.

The Insurer reserves the right to modify the rates whenever changes affect the underwriting cost basis or the cost to service the group insurance policy, such as:

1. Any change in the nature of the risk;
2. Any change requested by the Policyholder;
3. Any material change in size or demographic exceeding 15%.

GENERAL PROVISIONS

Subrogation and Reimbursement – Third Party Liability

Health Care Insurance and Dental Care Insurance Benefits

When any amount is paid to the Insured under this contract under Extended Health or Dental Insurance coverage as a result of an illness or accident for which legal liability is attributable to a third party, the Insurer is subrogated to the rights of the Insured and may recover from that third party the amounts it has paid, where permitted by law.

The joint and several liability or contributory negligence of the member shall not affect the member's obligations and the rights of the Insurer under this section.

DESCRIPTION OF BENEFITS
Health Care Insurance

Class 1: All Eligible Students

When the participant or the dependent is insured under the present coverage, the following eligible amounts are reimbursed, for each insured person, subject to the deductible, the reimbursement level and limited to the maximum specified in the Schedule of Benefits.

Gender Affirmation

Medical and surgical expenses incurred in Canada related to the insured person's gender affirmation, as specified in the Summary of Benefits. To be eligible, the insured person must have:

- a diagnosis of persistent gender dysphoria;
- approval from the public health insurance plan of their province or territory of residence;
- prior approval from the insurer, accompanied by documents confirming acceptance into the gender affirmation program of their provincial medical care plan.

Medical and surgical expenses incurred to reverse a gender affirmation surgery are not eligible.

Prescription Drugs

When prescribed by a doctor and dispensed by a licensed pharmacist, this coverage reimburses any part of the cost not assumed by a governmental insurance plan for the following prescription drugs:

- As a supplementary (secondary payer) to the Régie de l'assurance maladie du Québec (RAMQ), oral contraceptives, hormonal IUDs, contraceptive injections, contraceptive rings, contraceptive patches, contraceptive implants, antidepressants, and neurostimulants.

Supplemental Expenses

Hospitalization (semi-private room)

The cost of stay in a semi-private room in a hospital in Canada, which is in excess of any cost paid for by any governmental insurance plan.

Stipend allocated during a short-term hospitalization

Daily stipend allocated during a short-term hospitalization in Canada (up to 30 days), as specified in the Schedule of Benefits.

DESCRIPTION OF BENEFITS
Health Care Insurance

Convalescent Home

The excess amount of the cost of stay in a semi-private room as opposed to a ward stay in a convalescent home in Canada, provided that the insured person be admitted to this establishment less than fourteen (14) days after the end of a hospital stay.

Preventive Vaccines

Vaccines not covered by a governmental insurance plan, excluding the cost of administering the vaccine.

Education Expenses – Private Tutor Program

The service cost of a private tutoring service in case of accident or illness.

Nursing Care

The cost for home care provided by a nurse or nursing assistant who is a member in good standing of a professional body, when the care is medically necessary and ordered by the attending physician. The nurse cannot be a relative or an individual normally residing with the insured.

Ground Ambulance

The cost of ambulance transportation to the nearest hospital where the insured can receive proper treatment.

When the health of the insured requires it, and if prescribed by a physician, the costs of transportation for the return home.

Air Ambulance

The cost of air transportation, in the case of an emergency, if there are no other means of transportation available.

Diagnostic Services

Except for genetic screening, the cost of the exams listed in the Summary of Benefits are reimbursed, provided that they are prescribed by the attending physician for diagnostic purposes.

DESCRIPTION OF BENEFITS
Health Care Insurance

Respirators

The expenses listed in the Summary of Benefits are reimbursed provided they are prescribed by the attention physician:

- Oxygen and the equipment necessary to administer it: purchase or rental, at the Insurer's discretion
- Apnea monitor: purchase or rental, at the Insurer's discretion
- Drainage pump and accessories: purchase.

Orthotics and Prostheses

The incurred costs are eligible only for items manufactured by laboratories licensed under the terms of a public health protection act.

The following costs are reimbursed provided they are prescribed by the attending physician:

- Orthopaedic shoes, excluding running shoes and sandals
- Podiatric orthotics and prostheses, and arch supports
- Artificial eye: Initial cost only for the same eye, provided that the event that caused the loss of the eye and the purchased of this prosthetic occurred while the individual is insured under the terms of this benefit
- Artificial limb: Initial cost only for the same limb, provided that the event that caused the loss of the limb and the purchased of this prosthetic occurred while the individual is insured under the terms of this benefit
- Breast prosthesis required following a radical mastectomy, including the purchase of a maximum of two (2) bras adapted for breast prostheses. No physician's prescription is required for a breast prosthesis.
- Hearing aid: The cost of purchase, repair and maintenance are covered.

Medical Supplies

Provided they are prescribed by the attending physician's prescription, the expenses listed in the Summary of Benefits are reimbursed (purchase or rental, at the Insurer's discretion).

The following are not covered: stethoscopes, sphygmomanometers or other appliances of similar nature as well as domestic appliances such as whirlpool baths, air purifiers, humidifiers, air conditioners or other appliances of similar nature.

DESCRIPTION OF BENEFITS
Health Care Insurance

Health Care Professionals

The professional fees of the specialists listed in the Summary of Benefits are reimbursed, provided that they are members in good standing of their corporation or of their professional association recognized by the Insurer.

Vision Care

Eye Examination

The costs of an eye examination by a licensed optometrist are reimbursed .

Eyeglasses and Contact Lenses (including replacement costs)

The expenses listed in the Summary of Benefits are reimbursed, provided they are prescribed by a licensed ophthalmologist or optometrist.

Laser Eye Surgery

The expenses listed in the Summary of Benefits are reimbursed, provided they are prescribed by a licensed ophthalmologist or optometrist.

Exclusions

The following are not reimbursed:

1. Prescription drugs, except for hormone therapy drugs, contraceptives, antidepressants and psychostimulants;
2. Service charges, treatments, devices, accessories, drugs or medications used on an experimental basis or not commonly recognized for use or that exceed normal and reasonable standards;
3. The cost of investigation, manipulation, medication or treatment related to infertility, baldness, aesthetics or genetics;
4. Surgery expenses that the insured must assume entirely, except if this surgery was preapproved by the Insurer;
5. Services, care or products not included in the list of eligible costs ;

6. The costs covered by a government plan, even if the insured is not eligible for said government plan, or for any other insurance plan that includes medications provided during a hospital stay;
7. Services rendered by a relative or a friend of the insured, with the exception of situations specifically covered herein;
8. The costs incurred as a result of an intentionally self-inflicted injury or disease or an attempted suicide, whether he is conscious of his actions or not;
9. The costs incurred following an injury sustained by the insured, which is the result of:
    a. The commission or attempted commission of a criminal act;
    b. Military operation or active service in the armed forces of any country;
    c. Active participation in a public confrontation, a riot or an insurrection, real or perceived, or as a result of a war or any other hostile action, whether such war is declared or undeclared;
    d. The insured driving any land or water motor vehicle while under the influence of narcotic drugs or with a blood-alcohol level that exceeds the limit allowed by applicable laws at the place of the accident or under the influence of medication not taken as prescribed or not at the dosage recommended by the manufacturer;
10. Should Health Canada approve a new medication that can significantly affect the cost of coverage, the Insurer reserves the right to exclude said medication from the coverage if it is not included in the RAMQ's Public Prescription Drug Insurance Plan or to modify the insurance premium commencing on the date of the approval.

Coordination of Benefits

If the insured is covered under the terms of another group or individual insurance plan or through a governmental plan, the sum of all benefits payable cannot exceed 100% of expenses incurred.

The order of payment of benefits is as follows:

the plan that does not include a coordination of benefits provision becomes the first payer; or

1. The plan that does not include a coordination of benefits provision becomes the first payer; or
2. The plan that covers an insured as an employee has priority over the plan that covers the insured as a dependent; or
3. When an insured is covered by more than one plan, the order of payment is as follows:
    a. First payer: the group plan in which he or she participates as an active, full-time employee;

b. Second payer: the group plan in which he or she participates as an active, part-time employee;

c. Third payer: the group plan in which he or she participates as a retiree; or

4. When a person is covered as a spouse, priority is as follows:

   a. first payer: the group plan in which he or she participates as an employee;

   b. second payer: the group plan that covers him or her as a dependent;

If a person is covered as a spouse or surviving spouse under more than one group plan, priority is as follows:

a. First payer: the group plan covered that person for the least amount of time;

b. Second payer: the other plan;

5. When dependent children are covered under more than one group plan, priority is as follows:

   a. First payer: the group plan of the parent with the earlier birthdate (month/day) in the calendar year;

   b. Second payer: the group plan of the parent with the later birthdate (month/day) in the calendar year;

   c. Third payer: if both parents have the same birthdate, the plan of the parent whose first name begins with the earlier letter in the alphabet.

6. Where coverage is available for a dependent child under a survivor benefit arrangement, the order of payment for the group plans which were in effect prior to the parent's death will be maintained, unless additional parental coverage becomes effective. If additional parental coverage becomes effective, the survivor plan becomes last payer.

   In the case of single custody of a dependent child, priority for payment is established as follows:

   a. First payer: the group plan of the parent with custody of the dependent child;

   b. Second payer: the group plan of the spouse of the parent with custody of the dependent child;

   c. Third payer: the group plan of the parent not having custody of the dependent child;

   d. Fourth payer: the group plan of the spouse of the "third payer" parent.

DESCRIPTION OF BENEFITS
Health Care Insurance

Extension of Coverage for Insured Dependents

Upon the death of the participant insured under the present coverage, the Health Care insurance of his dependents is extended, without payment of premiums up to the earliest of the following dates:

1. The end date of the current academic year paid by the participant;
2. The date upon which the Health Care insurance of the dependent would have ended;
3. The date of annulment of the present insurance coverage or of the insurance policy.

General Provisions

The general conditions and definitions apply to this coverage.

DESCRIPTION OF BENEFITS
Dental Care Insurance

Class 1: All Eligible Students

When the insured is covered by this benefit, eligible expenses are the expenses reasonably incurred, recommended by a dentist and justified by the standard practice of dentistry for the care described below and for which the costs do not exceed those listed in the fee guide of the Quebec Association of Surgical Dentists, subject to the deductible amount, reimbursement level and maximum amounts indicated in the Schedule of Benefits.

When a fee is not published for a given year, the term fee can also mean an adjusted tariff determined by the Insurer.

Treatment Plan

When the total estimated cost of a comprehensive dental treatment proposed for an insured individual exceeds $500, the insured must submit a detailed treatment plan to the insurer before starting the treatment. The insurer then confirms to the insured the reimbursement to which he is entitled according to the provisions of the contract. The treatment plan must indicate the type of treatments that will be provided, the dates on which the treatments are to take place and the cost of each treatment.

The submitted treatment plan must be performed by the dentist from whom the plan originates, within twelve (12) months following the date of approval by the insurer; otherwise, the insured must submit a new treatment plan to the insurer for reassessment.

Diagnostic and Preventive Care

Diagnostic

- Comprehensive exam, once (1) per period of thirty-six (36) consecutive months
- Follow-up exam, once (1) per period of six (6) consecutive months
- Complete series of periapical and panoramic x-rays, both limited to one (1) series every thirty-six (36) consecutive months
- Other x-rays and their interpretation, once (1) per period of six (6) consecutive months
- Emergency consultations

Preventive

- Teeth cleaning and polishing, once (1) per period of six (6) consecutive months

DESCRIPTION OF BENEFITS
Dental Care Insurance

Basic Care

Surgery

- All extractions

General Anaesthesia

- During oral surgery
- During the treatment of fractures or luxations
- During periodontal surgery

Minor Restoration

- Cavity ablation and sedative dressing
- Bacterial cultures/smears for the purpose of identifying pathological agents
- Biopsy
- Staining of oral mucosa for diagnostic purposes
- Fillings: Amalgam for molars and composite for all other teeth
- Veneer fabricated on-site, once (1) per period of sixty (60) consecutive months for the same tooth
- Prostheses repair, rebasing and packing

Periodontics

- Scaling, two (2) units per period of twelve (12) consecutive months
- Care for acute infection and other lesions
- Application of desensitizing agent
- Periodontal surgery
- Gingival curettage and root planing
- Splinting (with the exception of splinting with Maryland-type wing)
- Occlusion adjustment / alignment
- Periodontal devices (to control bruxism)

DESCRIPTION OF BENEFITS
Dental Care Insurance

Endodontics

- Pulp capping
- Pulpotomy / pulpectomy
- Root canal treatment
- Apexification
- Apectomy
- Retrograde filling
- Root amputation
- Hemisection
- Intentional reimplantation
- Intraosseus endodontic stabilizer
- Emergency treatments

Exclusions

The following are not reimbursed:

1. The cost of treatments started or planned before the effective date of coverage;
2. The cost of general anaesthesia, except if necessary or in direct relation to oral or periodontal surgery;
3. Treatments for aesthetic purposes;
4. Treatments that are not provided by a physician or dentist or under the direction and supervision of one of these specialists;
5. Costs that the insured would not have been required to pay if he had not been insured, or costs that he is not required to pay or that he would not be required to pay if he had availed himself of the provisions of any public insurance plan, social security measure or governmental plan to which he could have been eligible;
6. The procedures that are not listed in the fee guide indicated in the Schedule of Benefits, as well as the costs exceeding the fees listed in this guide;
7. The costs incurred as a result of an intentionally self-inflicted injury or disease or an attempted suicide, whether conscious of his actions or not;
8. The costs incurred following an injury sustained by the insured, which is the result of:
    a. the commission or attempted commission of a criminal act;
    b. a military operation or active service in the armed forces of any country;

c. active participation in a public confrontation, a riot or an insurrection, real or perceived, or as a result of a war or any other hostile action, whether such war is declared or undeclared;

d. the insured driving any land or water motor vehicle while under the influence of narcotic drugs or with a blood-alcohol level that exceeds the limit allowed by applicable laws at the place of the accident or under the influence of medication not taken as prescribed or not at the dosage recommended by the manufacturer;

9. The cost of replacing dental prostheses or appliances which have been lost, misplaced or stolen, as well as any duplicating of a prosthesis or other appliance;
10. Dental treatments that are related to implants, the implants and any prosthesis that is supported by the latter, the cost of any separator and all costs for periodontal treatment using the twinning technique;
11. The cost of any consultation related to oral or dietary hygiene as well as any plaque control program;
12. Any costs of missed appointments or for completing benefit request forms or additional information required by the Insurer; as well as the fees invoiced by the dentist for his travel time, his transportation expenses and all advice provided through any means of telecommunications;
13. The fees invoiced by a dentist for any extra time for explanation due to the complexity of the treatment plan, or when the insured requires this extra time for explanation, when the diagnostic material comes from another source, for consultation with the insured or for consultation with another dentist;
14. Services rendered by a relative or a friend of the insured.

Limitations

When, for the chosen treatment, the restoration technique or materials used exceed the usual standard, the additional expenses thus incurred shall be paid by the insured.

In addition, if there are several types of treatment for the insured's dental condition, the Insurer will reimburse the expenses for the least expensive standard and appropriate treatment.

DESCRIPTION OF BENEFITS
Dental Care Insurance

Coordination of Benefits

If the insured is covered under the terms of another group or individual insurance plan or through a governmental plan, the sum of all benefits payable cannot exceed 100 % of the expenses incurred.

The order of payment is as follows:

1. The plan that does not include a benefit coordination provision becomes the first payer; or
2. The plan that covers an insured as a participant has priority over the one that covers him as a dependent; or
3. When an insured is covered by more than one plan, the order of payment is as follows:
    a. First payer: the group plan in which he or she participates as an active, full-time employee;
    b. Second payer: the group plan in which he or she participates as an active, part-time employee;
    c. Third payer: the group plan in which he or she participates as a retiree; or
4. When a person is covered as a spouse, priority is as follows:
    a. First payer: the group plan in which he or she participates as an employee;
    b. Second payer: the group plan that covers him or her as a dependent;

    If a person is covered as a spouse or surviving spouse under more than one group plan, priority is as follows:
    a. First payer: the group plan covered that person for the least amount of time;
    b. Second payer: the other plan;

5. When dependent children are covered under more than one group plan, priority is as follows:
    a. First payer: the group plan of the parent with the earlier birthdate (month/day) in the calendar year;
    b. Second payer: the group plan of the parent with the later birthdate (month/day) in the calendar year;
    c. Third payer: if both parents have the same birthdate, the plan of the parent whose first name begins with the earlier letter in the alphabet.
6. When coverage is available for a dependent child under a survivor benefit arrangement, the order of payment for the group plans which were in effect prior to the parent's death will be

maintained, unless additional parental coverage becomes effective. If additional parental coverage becomes effective, the survivor plan becomes last payer.

In the case of single custody of a dependent child, priority for payment is established as follows:

a. First payer: the group plan of the parent with custody of the dependent child;
b. Second payer: the group plan of the spouse of the parent with custody of the dependent child;
c. Third payer: the group plan of the parent not having custody of the dependent child;
d. Fourth payer: the group plan of the spouse of the “third payer” parent.

Extension of Coverage for Insured Dependents

Upon the death of the participant insured by the present coverage, the Dental Care insurance of his dependents is extended, without payment of premiums up to the earliest of the following dates:

1. The current academic year end date paid for by the participant;
2. The date upon which the Dental Care insurance of the dependent would have ended;
3. The date of cancellation of the present insurance coverage or of the insurance policy.

General Provisions

The general conditions and definitions apply to this coverage.

NOTICE

To ensure the confidentiality of the personal information held about you, Humania Assurance will set up an insurance file in which will be entered the information provided on your insurance application, as well as any insurance claim information.

Only those employees or representatives responsible for underwriting, investigating and processing claims or any other person authorized by you, will have access to this file.

Your file will be kept in the company's offices.

You are entitled to consult the personal information contained in this file and to have it rectified, if necessary, by sending a written request to the following address:

Access to Information Officer

Humania Assurance Inc.

1555 Girouard Street West

Saint-Hyacinthe (Quebec) J2S 2Z6