# COSTI IMMIGRANT SERVICES

# (CLASS F)

COSTI IMMIGRANT SERVICES

**Class F - LINC Instructors**

This Booklet provides you with a brief outline of the benefits for which you and, if applicable, your dependents are eligible. This booklet does not confer or create any contractual or other rights.

The exact terms of the benefits are described in the Group Policy G23294 issued by Industrial Alliance Insurance and Financial Services Inc. All rights with respect to the benefits will be governed solely by the Group Policy and in the event of a discrepancy between the Booklet and the Group Policy, the terms of the Group Policy will apply.

All matters and questions which you may have regarding your benefits should be handled by your employer or, if applicable, the plan administrator who has been appointed by your employer.

GROUP INSURANCE PROGRAM

ARRANGED BY:

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# SUMMARY OF BENEFITS

This section provides a summary of the benefits for which you and, if applicable, your dependents, are eligible to be covered for. A more detailed description of the benefits follows this section.

## SUMMARY OF BENEFITS

### DENTAL EXPENSE BENEFIT FOR EMPLOYEES AND DEPENDENTS

**Covered Expenses**

**Part A Services**

- Diagnostic
- Preventive
- Restorative
- Minor Surgical
- Other (includes denture rebasing and relining)

**Part B Services**

- Endodontic Services
- Periodontic Services
- Oral Surgery

**Cash Deductible**

| | |
|---|---|
| - All Covered Expenses | Not subject to a Cash Deductible |

**Benefit Percentage**

| | |
|---|---|
| **Part A Services** | 80% |
| **Part B Services** | 80% |

The Benefit Percentage means that part of the Covered Expense that the Insurer pays after the Cash Deductible has been satisfied.

**Schedule of Fees**

Current Provincial Fee Schedule for General Dental Practitioners less two years.

**Covered Expense Maximums**

| | |
|---|---|
| Part A and Part B Services (combined) | $1,000 in any calendar year. |

Benefits for some dental procedures are limited. You should refer to the Benefit description for these limits.

**Termination**

This Benefit will terminate on attainment of age 70 by the insured person.

# DENTAL EXPENSE BENEFIT FOR EMPLOYEES AND DEPENDENTS

## Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you or your insured dependents. Payment will be made up to the amount set for General Practitioners in the Provincial Association Schedule of Fees subject to the Benefit Percentage, Cash Deductible and any dollar maximums shown in the Summary of Benefits and the limitations and exclusions included in this Benefit.

## Alternative Courses of Treatment

When there are two or more courses of treatment available with respect to a dental condition, the amount payable under this Benefit will be limited to the least expensive treatment which will produce a professionally adequate result.

## Pre-Determination of Benefits

When a course of treatment is expected to exceed $500 or when an alternative course of treatment is available, you may want to submit a treatment plan, prepared by the dentist, for review prior to the treatment commencing. This will enable the Insurer to determine for you what level of coverage will be provided under this Benefit with respect to the proposed treatment, thus avoiding any potential misunderstandings.

## Covered Expenses

A charge made for any of the following services shall be considered to be a covered expense provided:

(1) The charge was incurred after the person became insured under this Benefit.

(2) The services for which the charge was incurred are deemed by the Insurer to be necessary.

(3) The services for which the charge was incurred were performed by a legally licensed dentist.

(4) Coverage of the services for which the charge was incurred is not prohibited by law.

**PART A SERVICES**

**(1) Diagnostic**

(a) Clinical oral examinations
- complete oral examinations – limited to one in any 3 calendar years
- recall examinations – limited to 2 in any calendar year
- all other limited and specific examinations – limited to 2 in total in any calendar year

(b) X-rays
- complete series – limited to one in any 3 calendar years
- bitewings – limited to 6 films in any calendar year
- panoramic – limited to one in any 3 calendar years

(c) Histological, cytological and pulp vitality tests and analyses

(d) Treatment planning and consultation with the dentist – limited to 2 units in any calendar year

**(2) Preventive Services**

(a) Polishing of teeth – limited to 2 units in any calendar year

(b) Scaling of teeth – limited to 2 units in any calendar year*
* If Periodontal Services are covered under this Benefit, any additional units of scaling will be combined with root planing.

(c) Topical application of fluoride – limited to twice in any calendar year

(d) Oral hygiene instruction – limited to once per lifetime

(e) Application of fissure sealants for children under 18 years of age

(f) Space maintainers for children under 18 years of age – maintenance limited to twice in any calendar year

(g) Finishing restorations provided the restorations are at least 2 years of age

(h) Interproximal disking of teeth – limited to 2 units in any calendar year

(i) Recontouring of teeth for functional reasons – limited to 2 units in any calendar year

**(3) Minor Restorative Services** – only covered if necessitated by decay or traumatic injury to the teeth

(a) Caries, trauma and pain control

(b) Amalgam, prefabricated (for children under 18 years of age), tooth coloured composite and gold foil restorations

(c) Retentive pins

**(4) Minor Surgical**

(a) Removal of teeth and residual roots

(b) Control of hemorrhages

**(5) Additional Services**

(a) Anesthesia – local, general, deep and conscious sedation

(b) Special professional visits (home, office and institutional visits) – limited to $250 in total during any calendar year

(c) Therapeutic injections

(d) Repairs or additions to dentures – limited to twice in any calendar year

(e) Relining or rebasing of dentures – limited to once in any 2 years

(f) Repairs to porcelain/ceramic inlays, onlays and crowns

(g) Recontouring of existing crowns

**PART B SERVICES**

**(1)** **Endodontic Services** (includes pulpotomy/pulpectomy, root canal therapy, apexification and periapical services) – a claim for services on a tooth within 3 months of a previous claim on the same tooth will be reduced by the amount of the previous benefit paid

**(2)** **Periodontic Services** (includes non-surgical, surgical and adjunctive services)

- occlusal adjustment/equilibration – limited to 2 units in any calendar year
- root planing – limited to 8 units in any calendar year*
  * Will be combined with any units of scaling which are in excess of the limit stated under the Preventive Section.
- periodontal appliances (includes impression, insertion and adjustment) – limited to one in any 4 years
- repair, maintenance and adjustments of periodontal appliances – limited to 2 units in any calendar year

**(3)** **Oral Surgery**

(a) Transplantation or repositioning of tooth – limited to a maximum of $150

(b) Remodelling and recontouring of oral tissues (includes alveoloplasty, gingivoplasty, stomatoplasty and vestibuloplasty)

(c) Surgical excision provided not in conjunction with tooth removal

- excision of benign or malignant tumors – if over 1 cm. in diameter will be limited to a maximum of $150
- enucleation of cysts/granulomas – if over 1cm. in diameter will be limited to a maximum of $150
- marsupialization of cyst – if over 1cm. in diameter will be limited to a maximum of $150
- excision of cyst – if over 1cm. in diameter will be limited to a maximum of $150

(d) Surgical incisions
- removal of foreign bodies – limited to a maximum of $150

(e) Treatment of fractures (includes treatment of mandibular, maxillary and alveolar fractures)
- mandibular or maxillary fractures (includes wiring) – if open reduction will be limited to a maximum of $750

- alveolar fractures - repairs and lacerations - if over 6 cm. will be limited to $750

(f) Frenectomy/ frenoplasty

(g) Antral surgery

**Coordination of Benefits**

The Group Policy includes a Coordination of Benefits provision. This provision operates in the event that you and/or your insured dependents are covered under the policy as an employee and as a dependent or as a dependent of more than one employee, or under another Group Plan, or individual insurance plan, or any government legislated automobile insurance plan and ensures that payments made by all plans do not exceed the actual expenses incurred.

**Survivor Benefit**

If you die while insured under this Benefit and prior to any continuation of insurance that may be provided, the insurance under this Benefit will be continued with respect to your dependents who are insured under this Benefit on

the date of your death, without payment of premiums. The insurance will terminate on the earliest of

(1) 2 years following the date of your death, and

(2) the date the dependent no longer qualifies as a dependent, and

(3) the date of termination of this Benefit with respect to active employees.

### Limitations

If the date your or your dependent's insurance commenced is more than 31 days after the date you or your dependent became eligible, covered expenses will be limited to $200 for the first 12 months of coverage, during which time full premiums must be paid.

### Exclusions

The determination of "Covered Expenses" shall not include any charge:

(1) For services or treatments due to insurrection or war, declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.

(2) For services or treatments due to participation in any riot or civil commotion.

(3) For services or treatments due to the commission of or attempted commission of a criminal offense or provoking an assault.

(4) For services or treatments due to an intentionally self-inflicted injury, while sane or insane

(5) For services or an examination performed by a dentist solely for the use of a third party.

(6) For recent duplication of services by the same or a different dentist.

(7) For a broken appointment.

(8) For services or treatments which the insured person received while attending an accredited educational institute, college or university outside of Canada.

(9) For services or treatments for which an insured person is not required to pay, including any expenses reimbursed, assumed or allowed under any other non-contractual plan, scheme or arrangement.

(10) For services for which the insured person receives payment as a result of legal action or settlement.

(11) For which the insured person may apply for and receive indemnity or compensation under any Workers' Compensation Act.

(12) For services or treatments performed by a specialist and which are only included under a Specialist's Dental Fee Guide.

(13) For services or treatments considered by the Insurer to be experimental and not recognized by the Canadian Dental Association as an established, standard treatment for the condition.

(14) For services or treatments which are due to or related (directly or indirectly) to implants.

(15) For a full mouth reconstruction, for a vertical dimension correction, or for a correction of a temporomandibular joint dysfunction.

(16) For services or treatments performed for primarily cosmetic reasons.

(17) For the placing of crowns to restore occlusal height or as a preventive measure.

(18) For the permanent splinting of teeth.

(19) For services or treatments furnished before the date on which the insured person on whose account the charge was made became insured under this Benefit.

## Conversion Privilege

If your coverage under the Group Policy is cancelled due to termination of

(1) your employment; or

(2) your group membership,

you will be able to convert your dental care insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer, provided you are also converting your supplementary health insurance. Failure to convert your supplementary health insurance will prevent you from converting your dental care insurance.

The individual insurance contract that will be provided will be in accordance with the rates and terms and conditions established by the insurer.

You must make application and pay all required premium for the individual insurance contract within 60 days of the termination date of your insurance under the Group Policy. Failure to submit the application and premium within such 60 days will prevent you from obtaining the insurance under the individual insurance contract.

The individual insurance contract will take effect on the date that both the application and the premium have been received by the insurer.

## GENERAL INFORMATION

### Your Eligibility

You are eligible, and will continue to be eligible, to be covered for the insurance described in this booklet while you meet all of the following conditions:

(3) You are a full-time employee and are actively working for your employer.

(4) You are a full-time resident of Canada.

(5) You have been continuously employed by your employer for at least as long as the waiting period defined below.

(4) You are under 70 years of age.

(5) You are insured under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence. (This condition only applies to the insurance provided under the Supplementary Health Insurance Benefit.)

**Your waiting period:** 3 months of continuous employment for your employer.

### Date Your Coverage Commences

Your coverage will commence on the latest of:

(1) the date you satisfy the conditions of eligibility,

(2) the date you complete an application for coverage, and

(3) the date of approval by the Insurer of any required evidence of insurability,

provided you are then actively at work. If you are not actively at work on the date your coverage is to commence, your coverage will not commence until you return to work.

If you complete your application for coverage more than 31 days after you have satisfied the conditions of eligibility, you will be required to provide satisfactory evidence of your insurability to the Insurer for all coverages.

### Date Changes In Your Coverage Take Effect

An increase in your coverage will take effect on the later of:

(1) the date you become eligible for the change in coverage, and

(2) the date of approval by the Insurer of any required evidence of insurability,

provided you are then actively at work. If you are not actively at work on the date your coverage is to increase, the increase will not take effect until you return to work.

A decrease in your coverage will take effect automatically on the date of the change.

Evidence of insurability will be required as specified in the Summary of Benefits and as detailed in the Group Policy.

### Date Coverage On Your Dependents Commences

If you are insured, you may apply to cover your dependents. The coverage on your dependents will commence on the date you apply for it provided you applied within 31 days of first being eligible to do so. If you apply for the coverage more than 31 days after you were first eligible to do so, you will be required to furnish satisfactory evidence of insurability of your dependents to the Insurer, at your expense, before the coverage on your dependents may commence.

If you already have dependents covered, all future dependents will become covered automatically on the date they become dependents.

If on the date a dependent is to become covered, the dependent is confined to a hospital or other treatment facility for the purpose of medical care or treatment, the coverage with respect to the dependent shall not become effective until the

date the dependent is no longer so confined. This paragraph will not result in postponing the effective date of the coverage on a child born while you have other dependents covered.

For the purposes of the Supplementary Health Insurance Benefit a dependent will not become covered unless the dependent is covered under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence.

### Conditions Under Which You May Waive Coverage

If your spouse is covered for benefits which are comparable to the benefits under the Supplementary Health Insurance Benefit and/or Dental Expense Benefit you may decline to cover yourself and your dependents or your dependents only, for such benefits under the Group Policy.

If the coverage under your spouse's plan should cease because the plan terminated or eligibility for such coverage ceased, you may make application to cover under the Group Policy those persons who had been covered under your spouse's plan.

Such application must be made within 31 days after the cessation of the coverage under your spouse's plan and the coverage under the Group Policy shall be effective on the day following the date of termination of the coverage under your spouse's plan.

No benefits, other than the Supplementary Health Insurance Benefit and the Dental Expense Benefit may be waived.

# GENERAL INFORMATION

## Conditions Under Which Your Coverage Terminates

Your coverage under the Group Policy terminates when your employment terminates, unless otherwise provided in the Summary of Benefits.

Information may be obtained from your employer regarding the status of your coverage in the event of layoff, leave of absence, or absence caused by disability.

## Submission Of Claim

Written proof stating the occurrence, character and extent of the loss for which a claim is being made must be furnished to the Insurer as follows:

(1) With respect to the Dental Expense Benefit, the claim must be submitted in the calendar year in which the claim was incurred or the calendar year immediately following the calendar year in which the claim was incurred.

However:

(a) If your employment should terminate, proof of loss must be submitted to the Insurer within 90 days of the date of your termination, or if the plan should terminate during the 90 days, proof of loss must be submitted on or prior to the plan's termination date. Any Dental Expense claims submitted after the earlier of the 90th day following your termination of employment and the plan's termination date will not be eligible for reimbursement from the Insurer, regardless of whether or not they were incurred prior to the date your employment terminated.

(b) If the plan should terminate, proof of loss must be submitted to the Insurer on or prior to the date of termination. Any Dental Expense claims submitted after the date of termination will not be eligible for reimbursement by the Insurer, regardless of whether or not they were incurred on or prior to the plan's termination date.

If proof of loss has not been submitted by the dates specified above, the Insurer will not be responsible for the claim.

### Investigation of Fraudulent Claims

The insurer will undertake all necessary actions to detect and investigate fraudulent claims under the group policy.

It is a crime if an insured person should knowingly and with the intent to defraud the insurer and the group plan to file a claim that contains any false, incomplete or misleading information. These actions, as well as submission of a claim with materially false information, will result in a denial of the insured person's claim. In addition, the insurer will have the right to undertake the prosecution of the insured person in accordance with provincial and/or federal law as well as informing the policyholder of the fraudulent action against the group plan.

### Discontinuance of the Group Policy

Your employer hopes and expects to continue the plan indefinitely, but the possibility of unforeseen circumstances makes it necessary to reserve the right to amend, suspend or entirely discontinue the plan at any time.

### Medical Services and/or Supplies Covered by a Government Sponsored Plan or Program

There will be no coverage under the group policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the insured person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

## DEFINITIONS

The following terms are used in this Booklet.

"Actively at Work" means that you are:

(1) at work and performing all of the usual and customary duties of your occupation on a full-time basis, if it is a scheduled work day, or

(2) capable of performing all of the usual and customary duties of your occupation on a full-time basis, if you are not at work due to it being a non-scheduled work day, holiday or vacation day. You will not be considered to be actively at work if you are either hospital confined or disabled to a degree that you could not have reported to work.

"Dependent" shall mean:

(1) Your spouse. Spouse shall mean either:

(a) an individual who is married to you by reason of a valid religious or civil marriage ceremony, while not legally separated from you,

or

(b) your common-law spouse.

If you have had more than one spouse, spouse shall mean the individual most recently qualified.

(2) Each unmarried child, step-child, legally adopted child or common-law child of yours provided the child is not employed on a full-time basis, relies fully upon you for support and maintenance and fits one of the following descriptions:

(a) the child is under 21 years of age, or

(b) the child is at least 21 years of age but under 25 years of age and is attending an accredited educational institute, college or university on a full-time basis.

(3) each unmarried child, step-child, legally adopted child or common-law child of yours, regardless of such child's age, if the child, due to a mental or physical handicap, is incapable of earning their own living and relies fully upon you for support and maintenance provided such handicap commenced while the child was a dependent child as defined in clause (2) and that proof of such handicap was received by the Insurer within 31 days of the applicable of the maximum ages stated in clause (2).

However, for the purpose of this plan, anyone who is:

(a) in the armed forces of any country or state or international organization or a civilian force auxiliary to any military force, or

(b) at least 70 years of age,

will be excluded from this definition.

“Common-law spouse” shall mean a person who resides with you and who has resided with you for at least 12 months and whom you publicly represent as your spouse.

“Common-law child” shall mean a child of your common-law spouse from another relationship and who resides with you and is in your and your common-law spouse's care and custody.

“Full-time employee” shall mean a person who customarily works a regularly scheduled work week of at least 21 hours per week with the employer.

“Calendar year” shall mean the period from any January 1st to the next following December 31st, both inclusive.

“Emergency” means a sudden, unexpected occurrence that requires immediate medical attention.

## PROTECTING PERSONAL INFORMATION

Industrial Alliance is committed to protecting the privacy of your (including your dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

When you enroll under the Group Plan, Industrial Alliance will establish a confidential file containing the personal information collected. The file will be kept at Industrial Alliance's offices.

Access to the file will be limited to Industrial Alliance employees, agents and service providers who require access in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

At Industrial Alliance the personal information that is collected is used to perform administrative services with respect to the Group Plan. Administrative services include, but are not limited to,

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling participants under the Group Plan;
- Adjudicating claims; and
- Underwriting (includes determining the rates applicable to the Group Plan).

**Your Right to Access Your Personal Information**

You have the right to access your personal information and to request, in writing, that any inaccurate information be corrected. In addition, you can request that any outdated or unnecessary information be deleted.

If Industrial Alliance has medical information about you which was not obtained directly from you, Industrial Alliance will release the information to you only through your physician.

## PROTECTING PERSONAL INFORMATION

To request access to your personal information or to have your name removed from the list to be shared within the Industrial Alliance Group, you must send a written request to

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West,
P.O. Box 1907, Station Terminus
Quebec City, Quebec
G1K 7M3

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