

Health Coverage Choice

Health Choice B with Dental

The following policy wording is provided solely for your convenience and reference. It is incomplete and reflects only some of the general provisions that may be found in some of our insurance policies. We periodically make changes to policy wording and therefore this incomplete sample may not duplicate the wording of any actual issued policy. It is not to be construed or interpreted in any manner as a contract or an offer to contract. The actual policy issued to any given client will govern that relationship.

Sun Life Assurance Company of Canada agrees to provide the benefits of this policy according to its terms and conditions.

In this document, *you* and *your* mean the owner of this policy. *We, us, our,* and *the company* mean Sun Life Assurance Company of Canada.

Sun Life Assurance Company of Canada is the insurer, and is a member of the Sun Life Financial group of companies.

Signed at Waterloo, Ontario

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Your out of province insurance coverage is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your policy before you travel as your coverage may be subject to certain limitations or exclusions.

A pre-existing condition may apply to medical conditions and/or symptoms that existed prior to your trip. Check to see how this impacts your policy coverage and how it relates to your departure date, date of purchase or effective date.

In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.

If you require medical treatment during travel, you may be required to notify the designated assistance company prior to treatment. Your policy may limit benefits if you do not contact the assistance company within a specified time period.

Please read your policy carefully before you travel.

It's important that you read your entire policy carefully. It sets out the benefits payable and has exclusions and limitations. To help you understand insurance terms, refer to the explanations described under the heading, *Insurance terms*.

**THESE DOCUMENTS CONTAIN IMPORTANT INFORMATION ABOUT YOUR INSURANCE.
PLEASE KEEP THEM IN A SAFE PLACE**

If you have any questions or require more information, please contact your advisor or call us toll-free at 1 877 SUN-LIFE (1-877-786-5433):

Sun Life Assurance Company of Canada
227 King St. S
PO Box 1601, Stn Waterloo
Waterloo ON N2J 4C5

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Policy particulars

**THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR INSURANCE.
PLEASE KEEP IT IN A SAFE PLACE.**

Plan: Health Coverage Choice
Policy number: xxxx ID number:
Owner (Insured person): First & Last Name
Additional insured person(s): First & Last Name
Effective date of your policy: MMMM d, yyyy
Policy Anniversary: MMMM d, yyyy

ATTENTION: THE POLICY INCLUDES RESTRICTED BENEFITS

This personal health insurance product is restricted to certain benefits and has exclusions and limitations. It is important that you read your policy carefully.

Payment schedule

As the owner, you must pay all premiums and any applicable taxes for this policy by the payment due date.

Payments are due monthly on the 1st day of the month, starting on January , .

Premium: \$ *
Provincial sales tax: \$0.00
Total monthly payment: \$

*** Your premium is not guaranteed. We may change your premium from time to time. We will give you at least 30 days written notice before any change is made.** To help you understand how your premium is determined, refer to the *Premiums* section of the *Other information about your policy* pages. We may apply an administrative fee if a payment is returned.

This *Policy particulars* page is included in and forms part of your policy. It replaces any previous *Policy particulars* page issued to you under this policy. The information contained in this *Policy particulars* page is subject to the provisions, terms and conditions of the policy.

Plan summary

Benefit	Reimbursement	Maximum per person
Drug	80%	\$1,300 in a calendar year
Extended health	100%	Described in the <i>Extended health provision</i> section
Vision	100%	\$200 every two calendar years
Emergency travel medical coverage	100%	60 days per trip \$1,000,000 lifetime
Semi-private hospital room	85%	Described in the <i>Semi-private hospital room provision</i> section
Optional Benefits		
Dental	80% Preventive 50% Restorative	Combined Preventive & Restorative: \$700 in a calendar year

Note:

We will **only** reimburse medical expenses that are not covered by the insured person's provincial or territorial health care plan.

Drug (for Quebec residents only)

If you have prescription drug insurance through the Régie de l'assurance maladie du Québec (RAMQ), this means that your prescription drug claims must first be submitted to RAMQ. Any remaining, unpaid portion that is eligible under this policy can then be submitted to us for reimbursement. The coinsurance and deductible that an insured person must pay under their plan with the RAMQ are eligible under this policy.

If you have group drug coverage and are not covered by RAMQ prescription drug insurance, your prescription drug claims must first be submitted to your group policy. Any remaining, unpaid portion that is eligible under this policy can then be submitted to us for reimbursement. If your group drug coverage is with us please contact us to co-ordinate drug benefits between your group policy and this policy. If your group drug coverage ends, you must then obtain RAMQ prescription drug insurance to remain eligible under this policy.

Waiting period

Dental

An insured person becomes eligible for the restorative dental coverage one year after the *effective date* of this policy.

Lifetime maximum

The amount we will reimburse for each insured person over the lifetime of this policy is limited to \$250,000 in total for the following eligible expenses:

- Drug,
- Extended health,
- Vision, and
- Semi-private hospital room.

If you change your mind within 10 days

You may send us a written request to cancel your policy within 10 days of receiving it from us.

You are considered to have received your policy 5 days after it's mailed from our office.

When we receive your written request we'll refund, without interest, any amount paid. This is called rescission.

If you want to cancel your policy at any time

Your decision to cancel your policy is your personal right. When we receive your request to cancel it, all of our obligations and liabilities under this policy end immediately. The cancellation is binding on you and any person entitled to make a claim under this policy, whether their entitlement is revocable or irrevocable.

To cancel your policy, send your request in writing to:

Sun Life Assurance Company of Canada

PO Box 1601, Stn Waterloo

Waterloo ON N2J 4C5

Nurse Practitioner

Reference to a physician may also include a nurse practitioner. If the applicable provincial and territorial legislation permits nurse practitioners to prescribe or order certain supplies or services, we will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a physician.

Drug provision

Prescription drugs

Drugs covered under this plan must have a Drug Identification Number (DIN).

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$250 per person.

Payments for any single purchase are limited to quantities that can reasonably be used in a three-month period.

Eligibility criteria for drugs and drug supplies

We will cover eligible expenses up to the limit specified on the *Plan summary* page.

For a drug or a related supply to be an eligible expense, it must meet all of the following criteria. It must be:

- medically necessary for the treatment of injury or illness,
- reasonable and customary charges for the treatment of injury or illness,
- prescribed by a doctor, dentist, or other authorized medical professional, as determined by the province where the professional is licensed, registered and is prescribing, and
- dispensed by a registered pharmacist or doctor.

Generic substitution

The maximum amount we pay for an eligible brand name drug is limited to the lowest priced item in the appropriate generic category. If the physician or dentist has stated on the prescription form that there should not be any substitution then we cover eligible expenses up to the limit specified on the *Plan summary* page.

Exclusions

We will not pay for the following, even when prescribed:

- drugs for the treatment of infertility,
- drugs for the treatment of sexual dysfunction,
- anti-obesity drugs,
- dietary supplements, infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments,
- contraceptives,
- the cost of giving injections, serums and vaccines,
- over-the-counter products designed to help a person quit smoking, and
- expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Extended health provision

Eligible expenses

- reasonable and customary charges for the services or supplies listed below,
- determined by us to be medically necessary for the treatment of illness or injury, and
- prescribed by a physician unless otherwise indicated.

All maximum amounts set out in this provision apply individually to each insured person.

We will pay for the services of the paramedical practitioners listed below. The service performed must be within the paramedical practitioner's area of expertise and require the skills and qualifications of that practitioner

- acupuncturist,
- physiotherapist,
- psychologist or social worker,
- registered massage therapist, or
- speech language pathologist,
- chiropractor, including one x-ray examination in a calendar year,
- naturopath,
- osteopath, including one x-ray examination in a calendar year, or
- podiatrist or chiropodist, including one x-ray examination in a calendar year.

The amount we pay is limited to a maximum of \$300 in a calendar year for each practitioner, and a combined maximum for all practitioners of \$500 in a calendar year.

For the services of a podiatrist and chiropodist, we will reimburse expenses before you exceed the annual maximums under the provincial or territorial health care plan.

The amount we pay for the services of a psychologist/social worker is \$70 per visit up to seven visits in a calendar year. To qualify as an eligible expense, the service must be performed within the psychologist's/social worker's area of expertise and require the skills and qualifications of a psychologist or social worker.

We will pay for the services of a dental surgeon required to treat a fractured jaw or accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means. These services include a dental prosthesis. We will not pay for any services required to treat a fracture or injury because of a condition that existed before the fracture or injury. The amount we pay in total for all fractures or injuries is limited to a lifetime maximum of \$5,000. Services must be performed within 12 months of the date of the fracture or injury. We do not require a physician's prescription for these services to be eligible.

We will pay for licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the insured person prevents the use of another means of transportation. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for hearing aids and repairs to them, excluding batteries, limited to \$400 in a five-year period. The five-year period begins from the date the first expense is incurred. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay when we receive proof that the insured person has applied for the applicable government funding for the services of a nurse provided in the insured person's home. The insured person's treatment must require the level of expertise of a nurse, limited to a calendar year maximum of \$5,000 and a lifetime maximum of \$25,000.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of \$2,500.

We will pay when we receive proof that the insured person has applied for the applicable government funding for:

- artificial limbs or other prosthetic appliances, breast prosthesis are limited to \$200 in a calendar year,
- braces, provided they are not solely for athletic use,
- oxygen,
- walker, if we have approved either its purchase or rental,
- wheelchair, limited to a lifetime maximum of \$4,000, if we have approved either its purchase or rental, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the Plan summary page.

We will pay without proof that the insured person has applied for the applicable government funding for:

- continuous glucose monitor receivers, transmitters or sensors, only for persons diagnosed with Type 1 diabetes. The insured person must provide us with a doctor's note confirming the diagnosis,
- blood glucose monitors, limited to \$250 per each five year period,
- diagnostic laboratory tests and x-ray examinations,
- custom made orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required to correct a deformity of the bones and muscles and not solely for athletic use. They must be prescribed by a physician, podiatrist, chiropodist or chiropractor. The amount we pay is limited to \$250 in a calendar year,

- durable equipment (but not walkers or wheelchairs) if we have approved either its purchase or rental. An example of durable equipment in this provision is a hospital bed or a traction kit. For hospital beds, the amount we pay is limited to a lifetime maximum of \$1,500,
- plaster of paris or fibreglass casts,
- splints and crutches, limited to \$300 in a calendar year,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a lifetime maximum of \$350, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the insured person's basic medical needs.

For Quebec residents only, we will pay for magnetic resonance imaging (MRI), computerized axial tomography (CAT) and computerized tomography (CT) scans, and ultrasounds.

Exclusions

We will not pay for:

- the services of a homemaker or home service worker,
- items purchased solely for athletic use,
- dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth,
- additional fees which are imposed by the provincial or territorial health care plan for the use of a service, and
- expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Vision care provision

Eligible expenses

We will cover eligible expenses up to the limit specified on the *Plan summary* page.

Eligible expenses are the reasonable and customary charges for the following items or expenses:

- eye examinations by an ophthalmologist or optometrist limited to one examination in a two calendar year period (one calendar year period for an insured person under 18 years of age) and \$50 per examination. The reimbursement for eye examinations is included in the vision maximum described in the *Plan summary* page, and
- laser eye surgery, eyeglasses, prescription sunglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist.

Exclusions

We will not pay for expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Emergency travel medical coverage

Allianz Global Assistance is the emergency travel assistance provider.

Eligible expenses

We will cover eligible expenses up to the limit specified on the *Plan summary* page and those described below.

Hospital and medical services and emergency travel assistance expenses must satisfy all of the following criteria to be eligible.

They must be:

- medically necessary,
- incurred due to an emergency which occurs during the first 60 days of travelling outside the province in which the insured person lives. The 60-day travel period starts on the first day of departure from the province where the insured person lives,
- incurred as a result of emergency treatment of an illness or injury which occurs outside the province in which the insured person lives, and
- for an insured person who is under the age of 80. This coverage ends on the insured person's 80th birthday.

Emergency is a sudden, unexpected occurrence of an acute illness or accidental injury requiring immediate, medically necessary treatment prescribed by a physician which cannot be delayed until the insured person returns to their province of residence.

Emergency services covered under the emergency travel medical coverage include any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established treatment program that existed before they left their home province.

When 60 days of coverage ends

The 60 days of coverage ends, whether a claim has been made or not, when the insured person has left the province where they live and hasn't returned for the length of time needed to obtain another 60 days of coverage. The insured person must return to the province where they live for the required 24 hours or 20 consecutive day period to be eligible for another 60 days of emergency travel medical coverage.

If emergency travel medical coverage has ended and the insured person is:

- under age 65, they become eligible for another 60 days of coverage when they return to the province where they live for 24 hours.
- 65 or older, they become eligible for another 60 days of coverage when they return to the province where they live for 20 consecutive days.

Examples

Example #1

Regardless of age, if the insured person departs from the province where they live on January 1st and travels for 60 days, they will have emergency travel medical coverage for the entire 60 days. If they have not returned to their province before the 61st day, they are no longer covered. To be eligible for another 60 days they must return to their province for the time specified based on their age.

Example #2

If the insured person departs from the province where they live on January 1st and travels for 30 days, returns to their province for two days, then departs on February 2nd for another 10 days, and they are:

- under 65, the first trip is covered because it is within the first 60 days of travel. The second trip is covered because they have returned for more than 24 hours so they are eligible for another 60 days of coverage, which begins the day they leave on the February 2nd trip.
- 65 or older, the first trip is covered because it is within the first 60 days of travel. The second trip is covered because it is within 60 days from January 1st. The two trips plus the two days in between is less than 60 days so both trips will be covered under the same 60-day emergency travel medical coverage, and the remaining days of coverage expire 18 days later. The insured person will be eligible for another 60 days of emergency travel medical coverage once they have returned to their province for 20 days.

Example #3

If the insured person departs from the province where they live on March 1st and travels for 40 days, returns to their province for 10 days, and leaves on April 20th for another 50 days, and they are:

- under 65, they have met the requirement to return to their province for 24 hours and are eligible for another 60 days of coverage starting April 20th.
- 65 or older, they have not met the required eligibility period and coverage ends on April 29th. They are only covered for the first trip of 40 days and 10 days of the second trip. The insured person did not return to their province for the required 20 days and is only eligible for emergency travel medical coverage for the first 10 days of the 50 days of travel.

Travel assistance services

We will provide a toll-free number which gives insured persons 24-hour access to a worldwide assistance network. For a medical emergency which occurs during the 60-day travel period, the network will provide the following emergency assistance services:

- physician and hospital referrals,
- ongoing monitoring of medical treatment if an insured person is hospitalized,
- coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return an insured person to Canada or transfer them to another hospital that is equipped to provide the required treatment,
- payment assistance for hospital and medical expenses,
- legal referrals,
- a telephone interpretation service, and
- a message service for insured persons; messages will be held up to 15 days.

Emergency payment assistance

At the time of an emergency, the insured person or someone with the insured person must contact the emergency travel assistance provider. If contact with the emergency travel assistance provider cannot be made before services are provided, contact with the emergency travel assistance provider must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency. If we've paid for hospital and medical expenses on behalf of an insured person, you must sign an authorization form allowing us to recover the amount we've paid from the appropriate provincial health care plan.

If we've paid or have agreed to pay for expenses that require a portion to be paid by the insured person under this policy or the provincial or territorial health care plan, or are not covered under this policy, you must reimburse us for any amount payable by the insured person or not covered under these policies.

If we haven't paid for expenses incurred, we will only reimburse you when we receive proof satisfactory to us of your claim for reimbursement.

Hospital and medical services

We cover reasonable and customary charges for the following items, less the amount payable by a provincial or territorial health care plan:

- public ward accommodation and auxiliary hospital services in a general hospital,
- services of a physician,
- economy air fare to return the insured person to the province where they live for medical treatment,
- licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider,
- emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada as determined by us or our emergency travel assistance provider, when the insured person's physical condition prevents the use of another means of transportation, and
- the services and return air fare for a registered nurse when the insured person's physical condition prevents the use of another means of transportation, and the insured person requires a registered nurse during the flight.

The maximum lifetime amount we will pay for hospital and medical services is \$1,000,000 for each insured person.

Expenses that are included as eligible expenses under other health benefits in this policy are also eligible while travelling outside Canada. These expenses are subject to the reimbursement percentages listed under the appropriate benefit in the *Plan summary* page.

Family travel assistance benefits

We cover reasonable and customary charges for the following family assistance benefits:

- return transportation for an insured person who is under age 16, or is handicapped, and they are left unattended because you or an insured person is hospitalized outside the province where they live due to a medical emergency. We will provide an escort to accompany them, if we or our emergency travel assistance provider determine it's necessary. The maximum payable for the return transportation is a one-way economy fare for each insured dependant who is under age 16, or who is handicapped,
- return transportation of any insured person, if their hospitalization or another insured person's hospitalization prevents them from returning home on the originally scheduled, pre-paid transportation, and they must purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused return tickets,
- a visit of a spouse, parent, child, brother or sister, of the insured person when that insured person is hospitalized for more than seven days while travelling without a relative. The visit includes meals and accommodation up to a maximum of \$150 per day, and round-trip economy transportation, for the person visiting. These expenses are also covered when it is necessary for one of them to identify a deceased insured person before the release of their body, and

- meals and accommodation up to a maximum of \$150 per day (in total, not per person) up to a maximum of seven days, if another insured person's trip is extended because an insured person is hospitalized.

The combined maximum amount we will pay for family assistance benefits is \$5,000 for each travel emergency.

Repatriation

If an insured person dies while outside of the province where they lived, we will arrange for the necessary authorizations and the return of the deceased to the province where they last lived. Preparation of the deceased for repatriation includes expenses for cremation at the place of death. Return of the deceased includes a basic shipping container, but excludes expenses for burial, such as burial caskets and urns.

The maximum amount we will pay for the preparation and return of the deceased is \$5,000.

Vehicle return

If an insured person is unable to operate a vehicle (owned or rented) because they are being returned to Canada for medical treatment, we will pay the cost of returning the vehicle to the province where they live, or the nearest appropriate rental agency. We will also pay this benefit when the insured person dies.

The maximum amount we will pay for returning the vehicle is \$1,000.

Exclusions and limitations

At the time of an emergency, the insured person or someone present with the insured person must contact our emergency travel assistance provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by our emergency travel assistance provider before being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If you are not able to contact our emergency travel assistance provider before receiving services, you or someone present with the insured person must do so as soon as is reasonably possible afterward. If you don't contact our emergency travel assistance provider and emergency services are received in circumstances where you could have reasonably contacted our emergency assistance provider, then we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the insured person is medically stable to return to the province where they live.

We will not pay the expenses:

- for services that are not immediately required or which could reasonably be delayed until the insured person returns to the province where they live,
- for services relating to an illness or injury which caused the emergency, if they were received after the emergency ended,
- for services provided to the insured after the date that we or our emergency travel assistance provider, based on available medical evidence, determine that the insured person can be returned to the province where they live,
- for services received by the insured person for an illness or injury, including any complications if the insured person unreasonably refused or neglected to receive recommended medical services for that illness or injury,

- for services related to an illness or injury, including any complications or any emergency arising directly or indirectly from that illness or injury, where the trip was taken to obtain medical services for that illness or injury,
- incurred by an insured person for an emergency which occurs when their 60 days of coverage has expired,
- for the regular treatment of a chronic injury or illness. Emergency services do not include treatment provided as part of an established management program that existed before the insured person left the province where they live,
- due to or related to a pre-existing medical condition. A “pre-existing” medical condition is one where symptoms appeared or required medical attention, hospitalization or treatment (including changes in medication or dosage) in the nine-month period before the insured person departs from the province where they live,
- due to pregnancy and incurred within four weeks of the insured person’s expected date of delivery,
- for a child born outside of Canada until the later of their coverage *effective date*, or the date the child returns to Canada,
- incurred on a non-emergency or referral basis, and
- incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

To determine eligibility, we may require the attending physician to provide medical evidence certifying that the insured person’s medical condition was stable for a minimum period of nine months before the insured person traveled outside the province where they live. “Stable” means that the attending physician has stated that they do not expect a recurrence of the same medical condition or any problems related to that condition while the insured person travels outside the province where they live.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries.

Neither we nor the emergency travel assistance provider providing the assistance services is responsible for the availability, quality or results of the medical treatment received by the insured person, or for the failure to obtain medical treatment.

Liability of Sun Life or Allianz Global Assistance

Any physician or other health care professional who provides direct services to an insured person will be acting on the person's behalf only and will not be considered acting on behalf of Sun Life or Allianz Global Assistance.

Neither Sun Life nor Allianz Global Assistance assume any responsibility or liability for:

- any medical advice given by any physician or other health care professional.
- the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services under this plan.

No person will have any recourse against Allianz Global Assistance or Sun Life because Allianz Global Assistance suggested, or contracted with, a physician or other health care professional.

Decisions by a physician or other health care professional as to the medical need for providing any of the services covered by this benefit are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

Semi-private hospital room provision

Eligible expenses

We will cover eligible expenses up to the limit specified on the *Plan summary* page.

Eligible expenses mean the reasonable and customary charges for semi-private accommodation in a hospital limited to \$175 per day up to a calendar year maximum of \$5,000. If the insured person was pregnant when they applied for personal health insurance, we will only pay up to two days of hospitalization due to the pregnancy. If accommodation is in a convalescent hospital, we will pay \$20 per day up to 180 days for hospital admission due to the same or related cause.

Exclusions

We will not pay for:

- any expenses when they are not medically necessary for the insured person's treatment, such as telephones or television rental charges, and
- expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Dental provision

Eligible expenses

We will cover eligible expenses up to the limit specified on the *Plan summary* page.

If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us at 1-877-786-5433 **before** you incur the expense to confirm whether an expense is eligible. We may deny a claim if we have not confirmed with you whether the expense is eligible.

Description of coverage

Dental care coverage pays for eligible expenses that an insured person incurs for dental procedures performed by a licensed dentist, denturist, dental hygienist or anaesthetist.

For each dental procedure, only reasonable expenses will be covered if they are:

- up to the usual charge for the most economical alternate procedure, service or treatment,
- consistent with accepted dental practice, and
- appropriate for the insured person's condition.

We may obtain a second opinion at your expense before a procedure is performed to verify if the treatment is appropriate. We will never pay more than the fee stated in the dental fee guide for the province in which the insured person incurs the expense.

How claims are paid

We will pay for eligible expenses taking into account all limitations and exclusions described in this provision.

An expense is incurred on the date the dentist performs a single appointment procedure. For procedures which take more than one appointment, an insured person incurs an expense once the entire procedure is complete.

If an insured person receives any temporary dental service, we consider it part of the final dental procedure used to correct the problem and not a separate procedure. The fee for the final dental procedure will be used to determine the usual and reasonable charge for the temporary dental service.

To determine eligibility, you or the dentist providing the service may need to provide us with a statement of the treatment received, pre-treatment x-rays and any additional information we consider necessary.

What is covered

The following dental procedures are considered eligible expenses.

Preventive dental procedures

- oral examinations:
 - one complete examination every five years,
 - one recall examination every nine months,
 - emergency or specific examinations,
- x-rays:
 - one complete series of x-rays or one panorex every five years,
 - one set of bitewing x-rays every 18 months,
 - x-rays to diagnose a symptom or examine progress of a particular course of treatment,
- consultation with another dentist, if required by the insured person's dentist,
- polishing (cleaning of teeth) and topical fluoride treatment once every nine months,
- interproximal discing (limited to one for each insured person under 12 years of age),
- recontouring of teeth for functional reasons,
- caries control,
- trauma control,
- emergency services,
- palliative services,
- diagnostic tests and laboratory examinations,
- space maintainers for missing primary teeth (for insured persons under 12 years of age),
- pit and fissure sealants (for insured persons under 19 years of age),
- fillings – amalgam, composite, acrylic, or the equivalent of these fillings. When a bonded amalgam filling is placed on any tooth, we will determine eligible expenses on the basis of the cost of an equivalent non-bonded amalgam,
- uncomplicated removal of teeth (procedure does not require surgical flap or sectioning of the tooth),
- prefabricated metal or plastic restorations and repairs to prefabricated metal or plastic restorations, other than in conjunction with the placement of permanent crowns, and
- scaling and root planing (not to exceed eight time units per year).

Restorative dental procedures

- endodontics, such as root canal therapy, root canal fillings, and treatment of disease of the pulp tissue,
- periodontics – the treatment of disease of the gum and other supporting tissue,
- occlusal adjustment, also described as equilibration (not to exceed four time units per year),
- periodontal appliances (once every five years),
 - appliance maintenance (once every six months),
 - appliance relines,
 - post treatment evaluation,
- onlay restorations,
- crowns and repairs to crowns, other than prefabricated metal restorations,
- partial and complete dentures and repairs or additions to them,

- rebase or relin of a partial or complete denture,
- fixed bridgework and repairs to them,
- surgical services, limited to:
 - alveoplasty,
 - dislocations,
 - enucleation of cysts,
 - frenectomy,
 - lacerations,
 - miscellaneous surgical services,
 - surgical excision,
 - surgical extractions and repositioning (surgery requires surgical flap or sectioning of the tooth),
- anaesthesia (if performed in conjunction with oral surgery),
 - conscious sedation,
 - deep sedation,
 - general anaesthesia, and
- drug injections.

Dental benefit – anaesthesia and laboratory charges

When an insured person incurs anaesthesia and laboratory charges, these charges will only be reimbursed if incurred while receiving eligible dental services. The reimbursement for the anaesthesia and laboratory charges is limited to the reimbursement percentage of the services they were performed with.

Limitations

The amount payable for an eligible expense is limited to the least expensive treatment that produces a professionally adequate result. If the insured person and dentist choose a more expensive course of treatment, payment is limited to the lower cost of the alternative treatment that we determine.

The amount payable for an eligible restorative crown on a molar is limited to the fee charged for a metal restorative crown.

To determine the extent of damage to a crown or onlay, we will require you to submit x-rays and study models.

Replacement of an existing denture, bridgework, crown or onlay is an eligible expense if the replacement is required to replace an existing denture, bridgework, crown or onlay that was installed at least eight years before the replacement. We determine the maximum eligible expense based on the value and quality of the original denture, bridgework, crown or onlay.

The addition of teeth to an existing partial denture or bridgework is an eligible expense if the addition is required to replace one or more teeth removed while the insured person is insured under this policy.

Each year the Canadian Dental Association (CDA) publishes a list of services and procedure codes. If there is a change in the CDA procedure codes, or, if we cannot determine that the expenses incurred are eligible expenses, payment may be based on the charges for similar services which are eligible expenses.

Exclusions

We will not pay for:

- replacement of periodontal appliances and space maintainers which have been lost, stolen or misplaced,

- expenses incurred for the treatment of malocclusion or for orthodontic treatment,
- services rendered in conjunction with surgical services payable under a government plan,
- crowns and onlays placed on a tooth not functionally impaired by incisal angle or cuspal damage,
- prosthetic devices which are ordered while an insured person is insured under this policy, but are installed after termination of this optional dental provision,
- initial dentures, bridgework or crowns to replace a tooth or teeth missing before becoming insured under this benefit or to replace a tooth or teeth congenitally missing,
- replacement of dentures, crowns, onlays or bridgework and addition of teeth to existing dentures, crowns, onlays or bridgework except as provided above,
- replacement dentures which have been lost, stolen or misplaced,
- permanent splinting,
- full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- replacement of orthodontic appliances which have been lost, stolen or misplaced,
- implants and transplants, and repositioning of the jaw,
- dental services required due to congenital malformation,
- charges for appointments that an insured person does not keep,
- charges for completing claim forms, and
- expenses incurred under any of the conditions specified in the *When we will not pay (exclusions)* section of the *Other information about your policy* pages.

Making a claim for benefits

When to make a claim

We must receive your claim within 12 months of the date that the eligible expense is incurred. An eligible expense is incurred on the date the services are received or on the date supplies are purchased or rented. If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us at 1-877-786-5433 **before** you incur the expense to confirm whether an expense is eligible. We may deny a claim if you have not confirmed with us whether the expense is eligible.

We may require itemized bills, attending physician statements, commercial laboratory receipts, reports, records, x-rays, study models or other information we consider necessary to assess the claim. You must pay any additional cost associated with providing this information.

After your policy ends:

We must receive your claim within three months of the date your policy ended. We will not pay for any claims received by us more than three months after the date your policy ended, regardless of when the eligible expense was incurred.

Payment of claims

We will pay benefits when we receive proof you have incurred an eligible expense. We determine the amount to be paid by:

- applying the reimbursement percentage, and
- then applying the maximums.

How we calculate the amount we'll pay:

We confirm whether the expense you submitted is an eligible expense. We determine if there are any limitations and exclusions which are described in the applicable provisions. If any of the expenses aren't eligible, we subtract that expense from the total amount you are claiming.

For each eligible expense, we compare:

- the amount you are claiming,
- the customary charge for the expense, and
- the maximum amount you can claim as described on the *Plan summary* page.

The amount we pay is based on the lowest of these three amounts.

Eligibility requirements

To be eligible, and continue to be eligible for coverage under this policy, a person must be:

- a resident of Canada,
- covered under provincial or territorial health insurance,
- Quebec residents must also have and continue to have health and drug coverage through a group benefit plan or through Régie de l'assurance maladie du Québec (RAMQ). A person not covered under a group benefit plan or through RAMQ, is not eligible for coverage under this policy.
- related to you in one of the following ways:
 - spouse:
 - your spouse by marriage or under any other formal union recognized by law, or
 - a partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least one year. If you reside in Quebec, there is no minimum cohabitation period for common-law spouses if a child is born out of their relationship.

Only one person at a time can be covered as your spouse under this policy.

- child:
 - your child or spouse's child, other than a foster child, who does not have a spouse and who is:
 - i) under 21, or
 - ii) age 21 or over but under age 25 who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) and is dependent on you for financial support.

You must provide us proof of the above within six months of the date the child attains the age limit.

- a child who becomes disabled before the age limit and remains continuously disabled, qualifies as long as the child:
 - i) is incapable of financial self-support because of a disability,
 - ii) depends on you for financial support, and
 - iii) does not have a spouse.

It is your responsibility to tell us when an insured person no longer meets the eligibility requirements.

We will add your new born children without evidence if you ask us to add them within 30 days of their birth.

For any child you ask us to add, we may require you to prove the child's relationship to you. We will also tell you if you need to provide evidence of insurability for the child you want to add who is age 31 days or older.

Applying for changes to your policy

Adding an insured person

Adding a child

You may apply in writing to add a child as an insured person under this policy. This change takes effect:

- on the later of the date we approve your request or,
- the beginning of the next monthly coverage period for your policy.

You may apply to add any child who is:

- your child or spouse's child, other than a foster child, who does not have a spouse and who is:
 - i) under 21, or
 - ii) age 21 or over but under age 25 who is a full-time student attending an educational institution recognized under the *Income Tax Act (Canada)* and is dependent on you for financial support.
- a child who becomes disabled before the age limit and remains continuously disabled, qualifies as long as the child:
 - i) is incapable of financial self-support because of a disability,
 - ii) depends on you for financial support, and
 - iii) does not have a spouse.

Adding other eligible persons

You may ask us to add a person to the list of insured persons. You must make this request in writing. The person must meet our *eligibility requirements* and give evidence of insurability satisfactory to us. This change takes effect:

- on the later of the date we approve your request or,
- the beginning of the next monthly coverage period for your policy.

Removing an insured person

If you ask us in writing, we will remove an insured person from this policy. This change takes effect at the beginning of the next monthly coverage period for your policy.

When your policy ends

Your coverage will end on the earliest of:

- the date you no longer meet *eligibility requirements*,
- the date you fail to pay the required premium for this policy, subject to the *Grace Period*,
- the last day of the month we receive your written request to end your coverage; or
- the date of your death.

Your spouse and/or child coverage will end on the earliest of:

- the date your spouse and/or child no longer meet *eligibility requirements*,
- the date you fail to pay the required premium for this policy, subject to the *Grace Period*,
- the last day of the month we receive your written request to end your coverage;

- the date of your or your spouse's death.

The emergency travel medical coverage ends at age 80.

Other information about your policy

Information about our contract with you

Once your policy is in effect, the following documents make up our entire contract with you:

- your application for insurance, including any evidence of insurability,
- the *Policy particulars* page, and
- this policy, including any amendments.

THESE DOCUMENTS CONTAIN IMPORTANT INFORMATION ABOUT YOUR INSURANCE. PLEASE KEEP THEM IN A SAFE PLACE.

All of our obligations to you are contained in the documents described above. Any other document or oral statement does not form part of this contract. This policy or any part of this policy may not be amended or waived except by a written amendment signed by two authorized signing officers of the company.

Recovering payments from a third party (Subrogation)

If we've paid a benefit under this policy as a result of an illness, injury or accident that a third party is or may be responsible for, we'll assert our right of reimbursement, where permitted by law.

Your obligation to reimburse us will not exceed the amount of the benefit we've paid. Our right of reimbursement will apply to any full or partial payments you are entitled to or may receive from a third party.

We won't be bound or affected by any compromised settlement between you and the third party unless you have our prior written consent. When a claim is settled and a lump sum payment is made, it is your responsibility to prove that no amount of that lump sum was intended as payment for eligible expenses we have paid under this policy.

If you do not assert your rights against the third party, you agree, where permitted by law, to assign all of your legal rights against the third party to us.

Currency of this policy

All amounts of money referred to in this policy are in Canadian dollars.

Premiums

Premiums are due on the date shown on the *Policy particulars* page.

Premiums vary by age and by how much provincial and territorial health plans cover. This means your premium reflects how old each insured person is and in which province they live.

We may change your premium from time to time for a variety of reasons, including our claims experience for insured persons with similar policies, how long these policies remain active, and our expenses.

If we change your premium, we will give you at least 30 days written notice before the change is made.

Grace period

The grace period for the premium payments is 31 days and is allowed for each premium except the first. During the grace period, insurance remains in force and premiums continue to be payable by you.

We will terminate the policy when payment has not been made before the end of the grace period. We will send you written notice of termination. Any claims for expenses incurred after the policy has terminated are not eligible for payment.

Right to copies of documents

You or a claimant may obtain copies of the following documents:

- your application for insurance
- any written statement or other record, not otherwise part of the application, that you provided to us as evidence of insurability.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

Other insurance

Coverage under this policy is provided on a second payer basis. Any benefit payable to you under similar plans or insurance policies, contracts, government health insurance plans, any private, public, provincial or territorial automobile insurance plan providing hospital, medical or therapeutic coverage or benefits, or any other third party liability insurance that is also in force will be coordinated with this policy to the extent that the total amount paid to you does not exceed the eligible expenses actually incurred by you.

Integration with government programs

This policy will integrate with benefits payable or available under the government-sponsored plan or program (the "government program").

The covered expense under this policy is that portion of the expense that is not payable or available under the government program, regardless of:

- whether you have made an application to the government program,
- whether coverage under this policy affects your eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

When we will not pay (exclusions)

We will not pay for:

- expenses that we are not legally allowed to pay,
- for services or items that we consider cosmetic,
- for services or items that we consider experimental,
- for delivery, transportation and administration charges,
- for services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage,
- for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described in *Integration with government programs* unless explicitly listed as covered under this benefit,

- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. Experimental or investigational treatments mean treatments that are not approved by Health Canada or other government regulatory body for the general public,
- for services or supplies that do not qualify as medical expenses under the *Income Tax Act (Canada)*, and
- elective (non-emergency) medical treatment or surgery which is received or performed out of the province where they the insured person lives.

We will not pay benefits when the claim is for an illness resulting from:

- hostile action of any armed forces, insurrection or participation in a riot or civil commotion, and
- participation in a criminal offence.

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Insurance terms

The following describes insurance terms that may or may not apply to this policy.

Calendar year	January 1 to December 31.
Dental fee guide	the current fee guide for general practitioners approved by the dental association in the province where the expense was incurred. When a dental fee guide is not published for a given year, "dental fee guide" means an adjusted fee guide established by us.
Dentist	a person licensed to practice dentistry by the provincial or territorial licensing authority.
Effective Date	Effective date is the date your coverage begins as shown on your <i>Policy Particulars</i> page
Emergency	a sudden, unexpected occurrence of an acute illness or accidental injury requiring immediate, medically necessary treatment prescribed by a physician which cannot be delayed until the insured person returns to their province of residence.
Evidence of insurability	written proof that a proposed insured person meets our underwriting requirements. Evidence of insurability submitted to us is at the proposed insured person's expense.
Hospital	a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. Hospital does not include a nursing home, rest home, home for the aged, or chronically ill, residential and long term care centres, sanatorium, convalescent hospital, unless provided for in the <i>Semi-private hospital room provision</i> , or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital. If convalescent hospital is covered, we consider it to be a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. It does not include hospital accommodation for custodial care.
Insured person	a person accepted by us to be insured under this policy and who meets and continues to meet all of the eligibility requirements.
Lifetime maximum	the maximum amount we will pay for each insured person, while this policy is in effect.

Paramedical Practitioners

Paramedical practitioners must be qualified. Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Qualified paramedical practitioners must:

- belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us,
- be licensed or registered, as required by the applicable provincial regulatory body,
- have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered,
- maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association,
- produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and
- not engage in administrative practices unacceptable to us.

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.

Physician

a doctor of medicine (M.D.) licensed to practice medicine.

Policy anniversary

the month and day every year that is the same as the *Effective date of your policy* shown on the *Policy particulars* page.

Reasonable and customary charges

for dental professional fees, fees which are usually charged to a person without insurance and which are not greater than the fees in the dental fee guide.

for health expenses and dental laboratory charges, mean amounts which are usually charged to a person without insurance and are not greater than the general level of charges in the area where the expenses are incurred.

Statutory conditions

1. The contract

- 1) The application, this policy, any document attached to this policy when issued, and any amendments to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver

- 2) Except for residents of Alberta, British Columbia, Manitoba, Ontario and Saskatchewan, the insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

Copy of application

- 3) The insurer shall, on request, provide to the insured or to a claimant under the contract a copy of the application.

2. Termination of insurance

- 1) The contract may be terminated:
 - a) by the insurer giving to the insured 15 days' notice of termination by registered mail or five days' written notice of termination personally delivered; or
 - b) by the insured at any time on request.
- 2) If the contract is terminated by the insurer:
 - a) the insurer must refund the excess of premium actually paid by the insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract; and
 - b) the refund must accompany the notice.
- 3) If the contract is terminated by the insured, the insurer must refund as soon as is practicable the excess of premium actually paid by the insured over the short rate premium calculated to the date of receipt of the notice according to the table in use by the insurer at the time of termination.
- 4) The 15-day period mentioned in clause (1)(a) of this condition starts to run on the day following the day the registered letter or notification of it is delivered to the latest postal address of the insured on the records of the insurer.

3. Material facts

No statement made by the insured or a person insured at the time of application for the contract may be used in defence of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers provided as evidence of insurability.

4. Notice and proof of claim

- 1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, must:
 - a) give written notice of claim to the insurer not later than 30 days after the date a claim arises under the contract on account of an accident, sickness or disability,
 - (i) by delivery of the notice, or by sending it by registered mail, to the head office or chief office of the insurer in the province/territory; or
 - (ii) by delivery of the notice to an authorized agent of the insurer in the province/territory;

- b) within 90 days after the date a claim arises under the contract on account of an accident, sickness or disability, provide to the insurer such proof, as is reasonably possible in the circumstances, of:
 - (i) the happening of the accident or the start of the sickness or disability;
 - (ii) the loss caused by the accident, sickness or disability;
 - (iii) the right of the claimant to receive payment;
 - (iv) the claimant's age; and
 - (v) if relevant, the beneficiary's age; and
- c) if so required by the insurer, provide a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim is made under the contract and, in the case of sickness or disability, its duration.

5. Failure to give notice or proof

- 2) Failure to give notice of claim or provide proof of claim within the time required by this condition does not invalidate the claim if:
 - a) for residents of Saskatchewan,
 - a. the notice or proof is given or provided as soon as reasonably possible, and not later than the limitation period set out in *The Limitations Act* after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or provide the proof in the time required by this condition, or
 - b. in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or provided no later than the limitation period set out in *The Limitations Act* after the date a court makes the declaration.
 - b) for residents of any other province, the notice or proof is given or provided as soon as reasonably possible, and in no event later than one year after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or provide the proof in the time required by this condition, or.
 - c) for residents of Alberta, British Columbia, Manitoba and Ontario, in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or provided no later than one year after the date a court makes the declaration.

6. Insurer to provide forms for proof of claim

The insurer must provide forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

7. Rights of examination

As a condition precedent to recovery of insurance money under the contract:

- a) the claimant must give the insurer an opportunity to examine the person of the person insured when and as often as it reasonably requires while a claim is pending,
- b) in the case of death of the person insured, the insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies, and

- c) for residents of Saskatchewan, the insurer shall bear the costs of any examination or autopsy and shall provide copies of reports of any examination or autopsy to the insured or insured's representative.

8. When money is payable other than for loss of time

All money payable under the contract, other than benefits for loss of time, must be paid by the insurer within 60 days after it has received proof of claim.

9. Limitation of actions

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under this policy is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under this policy is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

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