Assumption Mutual Life Insurance Company agrees to pay the benefits provided under the terms and conditions of this group insurance contract.

This contract was made in consideration of the policyholder's signed application and the payment of the first monthly premium.

POLICY NUMBER	:	**66719**
GROUP NUMBER - MAJOR		**55823**
POLICYHOLDER	:	**Heritage College Student Association (HCSA)**
OTHER AFFILIATES OF POLICYHOLDER	:	
EMPLOYER	:	**Heritage College Student Association (HCSA)**
BENEFITS	:	**Critical Illness Insurance** **Health Insurance** **Dental Insurance**
EFFECTIVE DATE OF THE CONTRACT	:	**January 1, 2019**
EFFECTIVE DATE OF THE POLICY	:	**August 15, 2023**
DATE OF THE NEXT RENEWAL	:	**August 15, 2025**

This policy, which covers the period from August 15, 2023 to August 14, 2025, is issued in Moncton, New Brunswick, on

Sébastien Dupuis
President and Chief Executive Officer

Lina Gagnon
Countersigned

August 25, 2023
Date

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CRITICAL ILLNES INSURANCE

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BENEFIT SCHEDULE

CATEGORY:

Description 01 All Eligible Students

All students who have not withdrawn during the period provided for this purpose will be eligible for this insurance plan.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

1. CRITICAL ILLNESS INSURANCE

CRITICAL ILLNESS FOR STUDENT

Amount of critical illness insurance	$2,500
Maximum amount of insurance	$2,500
Satisfactory proof of insurability must be provided for amount exceeding	$2,500

Benefits will terminate at the earliest of the following:

(a) The date on which the participant reaches 65 years of age.

(b) The date of his/her retirement.

(c) The date on which his/her insurance terminates.

2. HEALTH CARE INSURANCE

Hospitalization

Coinsurance: 100%

Expenses for a semi-private hospital room.
$30 per day (maximum of 5 consecutive days), up to a maximum of $400 per insured person per coverage period.

Ambulance

Coinsurance: 60%

Ambulance transportation (ground or air) to the nearest hospital.
Up to a maximum of $350 per insured person per coverage period.

Nursing Services

Coinsurance: 70%

The professional services rendered by a registered private nurse outside of a hospital.
Up to a maximum of $500 per insured person per coverage period.

Extended Health Benefits*

Coinsurance: 70%

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

- Oral contraceptives, Intra-Uterine Devices (IUD), contraceptive injections, contraceptive rings, contraceptive patches and contraceptive implants.
- Neurostimulants.
- Antidepressants.
- Vaccines that are not covered under the provincial Medicare plans (or RAMQ for Quebec), up to a maximum of $100 per coverage period.

*** Extended Health Benefits above are subject to an overall maximum of $300 per insured person per coverage period.**

Extended Health Benefits**

Coinsurance: 60%

- External breast prostheses (following a mastectomy) up to a maximum of $200 per coverage period.
- Pressure garments for burns up to $350 per coverage period.
- Wigs (required for pathological conditions or following chemotherapy treatments) up to a maximum of $350 per lifetime.
- X-ray, private ultrasound (including maternal ultrasounds) and laboratory tests (excluding check-ups), up to a maximum of $200 per coverage period.
  (Medical recommendation required.)
- Blood tests (including health assessments), for diagnostic purposes, up to a maximum of $100 per coverage period.

**** Extended Health Benefits above are subject to an overall maximum of $350 per insured person per coverage period.**

Vision Care***

Coinsurance: 100%

- The expenses for eye examination up to a maximum of $30 per 12 consecutive months.
- The expenses for prescribed eyewear and contact lenses up to a maximum of $200 per 24 consecutive months.

Paramedical Services***

Coinsurance: 100%

The expenses for the services provided by an acupuncturist or a dietician or a chiropractor or a massage therapist or a physiotherapist or a podiatrist, $40 per visit to a combined maximum of $400 per coverage period.

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

The expenses for a psychometric assessments provided by a licensed therapist up to a maximum of $300 per 36 months period.

***** Vision Care and Paramedical Services are subject to a combined maximum of $500 per insured person per coverage period.**

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

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

(b) The date on which the insurance terminates.

3. DENTAL CARE

Deductible:

Individual	$0
Family	$0
Part I Basic dental care services	75%
- Diagnostic	75%
- Prevention	75%
- Recall Exam **(every 12 months)**	75%
- Minor Restoration (Fillings)	75%
- Endodontics	N/A
- Periodontics (Gum Treatment)	75%
Part II Root Canal & Oral Surgery (Teeth Extraction Including Wisdom Teeth)	75%
Part III Prosthodontics	N/A
Part IV Orthodontics (for children under 21 years of age)	N/A
Maximum benefit per insured person:	
Global maximum per coverage period for parts I & II	$500
Expenses for Part IV per lifetime	N/A

The applicable dental fee guide is: Current

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

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

(b) The date on which the insurance terminates.

GENERAL PROVISIONS

1. DEFINITIONS

For the purposes of this coverage:

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

A **Student** is a member of **Heritage College Student Association (HCSA).**

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

The **Dependent** of a participant is:

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

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

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

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

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

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

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

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

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

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

Hospitalization is admission to a hospital as:

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

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

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

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

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

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

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

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

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

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

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

2. TERMS OF THE CONTRACT

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

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

3. CHANGES TO THE CONTRACT

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

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

4. ELIGIBILITY

(a) Student

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

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

(b) Dependents

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

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

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

5. APPLICATION FOR GROUP INSURANCE AND PROOF OF INSURABILITY

(a) Student

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

(b) Dependents

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

6. EFFECTIVE DATE OF INSURANCE

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

(a) you are actively studying;

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

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

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

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

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

7. STUDENT'S RIGHTS ON EFFECTIVE DATE OF BENEFITS

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

(a) they were insured under the contract that has terminated;
(b) the termination of their insurance results exclusively from the termination of the former coverage;
(c) the participants belong to a category included in the new coverage; and
(d) they are eligible for insurance under the provisions of the present contract.

8. TERMINATION OF INSURANCE

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

(a) The date of termination of this contract.

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

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

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

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

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

9. TERMINATION OF THE CONTRACT

This contract terminates upon the earliest of the following dates:

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

(1) The date indicated in the notice.
(2) The date that the insurer received the notice.

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

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

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

10. PREMIUMS

(a) Premium Rate Changes

The insurer may change premium rates at the following dates:

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

(2) At any other date, provided:

- the benefits or categories of students eligible for insurance under this contract are changed;

- there is a change in the nature, content or cost of government plans.

(b) Premium Payments

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

11. GRACE PERIOD

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

12. RENEWAL

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

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

13. CERTIFICATE

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

14. POLICYHOLDER ADMINISTRATION

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

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

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

Ontario Residents only:

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

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

15. WAIVER

Any waiver or omission on the part of the insurer to demand execution or observance of any provision of this contract shall not be interpreted as a waiver on the part of the insurer to its right to take necessary measures against any default subsequent to the execution or observation of this same provision. Furthermore, the insurer's approval of any action on the part of a policyholder or participant when this approval was required shall not be interpreted as release of the policyholder or participant of their obligation to repeat such request for approval from the insurer for any similar subsequent action.

16. INCONTESTABILITY

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

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

17. COLLECTION

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

18. MEDICAL REQUIREMENTS

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

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

19. ASSIGNMENT OR PLEDGE

Insurance under this contract may not be assigned or pledged.

20. CURRENCY

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

21. SUBROGATION AND REIMBURSEMENT – THIRD-PARTY LIABILITY

(a) Health and Dental Insurance Coverage

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

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

22. GENERAL PROVISIONS

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

CRITICAL ILLNESS INSURANCE

1. SCOPE AND BENEFIT

Provided that this coverage is in force when a Critical Illness is diagnosed for an Participant, and subject to all the conditions, exclusions and limitations herein, the Insurer shall pay to the Participant a benefit equal to the amount of insurance specified in the Benefit Schedule.

In order for the benefit to be paid to the Participant, the claim must be submitted and approved during the diagnosed Participant's lifetime. If a claim is submitted or approved after death of the diagnosed Participant, the benefit payable shall be paid to the Participant's estate.

2. CRITICAL ILLNESSES COVERED ARE THE FOLLOWING:

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Aplastic Anemia is defined as a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

1) marrow stimulating agents;
2) immunosuppressive agents;
3) bone marrow transplantation.

Bacterial Meningitis is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

Benign Brain Tumour is defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

Exclusions: No benefit will be payable under this Critical illness if, within the first 90 days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, as applicable, the Participant has any of the following:

1) signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or

2) a diagnosis of Benign Brain Tumour (covered or excluded under the policy).

The medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Assumption Life within 6 months of the date of the diagnosis. If this information is not provided within this period, Assumption Life has the right to deny any claim for Benign Brain Tumour or, any Critical Illness caused by any Benign Brain Tumour or its treatment.

No benefit will be payable under this Critical Illness for pituitary adenomas less than 10 mm.

No benefit will be payable under this Critical Illness for viral meningitis.

Blindness is defined as a definite diagnosis of the total and irreversible loss of vision in both eyes due to an illness, evidenced by:

1) the corrected visual acuity being 20/200 or less in both eyes; or,
2) the field of vision being less than 20 degrees in both eyes.

Cancer (life-threatening) means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. However, this definition of Cancer excludes the following conditions:

1) Carcinoma in situ;
2) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
3) Any non-melanoma skin cancer that has not metastasized; or
4) Stage A (T1a or T1b) prostate cancer.

The diagnosis of Cancer (life-threatening) is subject to the Moratorium Period Exclusion.

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

Exclusion: No benefit will be payable under this Critical Illness for:

1) a medically induced coma; or,
2) a coma which results directly from alcohol or drug use; or,
3) a diagnosis of brain death.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or lockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

Deafness is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears due to an illness, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Dementia, including Alzheimer's Disease is defined as a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

1) aphasia (a disorder of speech);
2) apraxia (difficulty performing familiar tasks);
3) agnosia (difficulty recognizing objects); or
4) disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Participant must exhibit:

1) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
2) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The diagnosis of Dementia must be made by a Specialist.

Exclusion: No benefit will be payable under this Critical Illness for affective or schizophrenic disorders, or delirium.

Heart Attack means a definite diagnosis of the heart muscle due to obstruction of blood flow that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

1) Heart Attack symptoms;
2) New electrocardiogram (ECG) changes consistent with a heart attack;
3) Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Exclusions: Heart Attack does not include the following which are expressly excluded:

1) Elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
2) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as above.

Heart Valve Replacement means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to correct defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under the definition of "repair or replacement of a heart valve" in case of angioplasty, intra-arterial surgery or percutaneous transcatheter or a non surgical procedure.

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation s initiated.

Loss of Independent Existence is defined as a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of Daily Living are defined as follows:

1. Bathing : the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
2. Dressing : the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
3. Toileting : the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;

4. Bladder and Bowel Continence : the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
5. Transferring : the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
6. Feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Exclusion: No benefit will be payable under this Critical Illness if the Loss of Independent Existence is related directly or indirectly to a psychiatric condition or illness.

Loss of Limbs is defined as a definite diagnosis following an illness of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of medically required amputation.

Loss of Speech is defined as a definite diagnosis following an illness of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

Major Organ Failure on Waiting List for Transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow for which transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List for Transplant, the Participant must become enrolled as the recipient in a recognized transplant centre in Canada or in the United States of America that performs the required form of transplant surgery.

For the purposes of the Survival Period, the date of Diagnosis is the date of the Participant's enrolment in the transplant centre

Major Organ Transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Participant must undergo a transplantation procedure as the recipient of a heart, lung liver, kidney or bonemarrow.

Motor Neurone disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy.

Multiple Sclerosis means a definite diagnosis of multiple sclerosis with at least one of the following:

1) Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
2) Well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
3) A single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Participant's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy.

Payment under this condition requires satisfaction of all of the following conditions:

1) The accidental injury must be reported to the insurer within 14 days of the accidental injury;
2) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
3) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
4) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

1) The Participant has elected not to take any available licensed vaccine offering protection against HIV; or,
2) A licensed cure for HIV infection has become available prior to the accidental injury; or,
3) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis is defined as a definite diagnosis of the total loss of muscle function of two or more limbs as a result of a disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Parkinson's disease means a definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses). To qualify under Parkinson's Diseases the Participant must require substantial physical assistance from another adult to perform at least 2 of his/her Activities of Daily Living.

No benefit will be payable under this coverage for any other type of Parkinsonism.

Severe Burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolisms from an extra-cranial source with:

1) Acute onset of new neurological symptoms, and
2) New objective neurological deficits on clinical examination
   both persisting for more than 30 days following the date of the diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

However, Stroke (cerebrovascular accident) does not include transient ischaemic attacks, intracerebral vascular event due to trauma or lacunar infarcts which do not meet the definition of Stroke (cerebrovascular accident) as defined herein.

3. ADDITIONAL DEFINITIONS

In addition to the Definitions provided in the General Provisions section of this contract, the following definitions will apply for the purposes of this coverage, unless otherwise specified:

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

b) **Diagnosis** means a written diagnosis by a Specialist of the Participant's critical illness. The effective date of the diagnosis will be the date the Diagnosis is established by the Specialist as indicated by the Participant's medical records. The date of Diagnosis must be made after the effective date of insurance.

c) **Immediate family** means the spouse, son, daughter, father, mother, brother or sister of the Participant or of his/her spouse.

d) **Specialist** means an individual who is licensed to practice medicine, who acts within the scope of that license and who has completed advanced education and clinical training in a specific area of medicine which is relevant to the Critical Illness. The term Specialist only refers to a physician licensed and practicing in Canada. Specialist does not include the Participant or a person who lives with the Participant, or a person who is a member of the Participant's Immediate Family.

e) **Cancer and Benign Brain Tumor Moratorium Exclusion**

No benefit is payable for any Cancer or Benign Brain Tumour for the entire duration of the Participant's coverage, if:

- the date of Diagnosis for any Cancer or Benign Brain Tumour, whether covered or excluded under this coverage,

- the date the Participant experiences signs or symptoms leading to of any Cancer or Benign Brain Tumour, whether covered or excluded under this coverage or
- the date at which the Participant undergoes medical consultations or tests leading to a diagnosis of Cancer or Benign Brain Tumour, whether covered or excluded under this coverage

occurs within ninety (90) days of the Participant's effective date of coverage or date of date of reinstatement of the coverage.

4. PRE-EXISTING CONDITIONS

If the onset of the illness occurs during the 24 months following the date that the participant first obtained the current insurance coverage or similar coverage under another contract, no benefit is payable under this coverage if, during the 24 months before the date that this or similar coverage became effective, whichever is applicable, the participant has:

(a) consulted a healthcare professional;
(b) received medical care; or
(c) taken medications prescribed by a physician

for any symptom, condition or illness, whether diagnosed or not, related to the illness causing the disability and for which benefits are claimed under this coverage**.**

5. INCREASE IN BENEFIT COVERAGE

Should an Participant suffers from a Critical Illness at any time during the 24 month period following the date on which an increase in the amount of benefit payable under this coverage is approved by Assumption Life, and that this Critical Illness results directly or indirectly from or is in any way associated with a pre-existing condition, as defined herein, then the amount payable under this coverage, if any, shall not exceed the amount of coverage which would have been payable prior to the increase being approved by Assumption Life.

6. PARTICIPANT'S DUTY TO DISCLOSE CANCER

The Participant must provide the Insurer, at its head office, with a written notice advising the Insurer of the Participant's diagnosis of cancer, within six months following any diagnosis of a covered or excluded cancer under this coverage that occurs within 90 days following the later of the following two dates: the effective date of the Critical Illness coverage for the Participant or the last date of reinstatement of the coverage for the Participant, if applicable.

7. OTHER EXCLUSIONS

This coverage does not apply and no benefit is payable if the Critical Illness results directly or indirectly from any of the following causes:

1) suicide or attempted suicide by the Participant, whether of sound mind or not;

2) self-inflicted injuries, physical or mental damages, whether of sound mind or not;

3) committing or attempting to commit a criminal offence;

4) driving a vehicle when the Participant's blood alcohol level exceeds 80 milligrams of alcohol per 100 millilitres of blood, or exceeds the legal limit permitted by law;

5) inhalation by the Participant of toxic gases, unless this inhalation occurs in the ordinary course of the Participant's employment;

6) consumption by the Participant of medication, pharmaceutical products or legal drugs unless taken in accordance with the recommendations and prescription of a duly qualified physician or in accordance with the instructions of a duly authorized pharmacist;

7) consumption by the Participant of illegal drugs;

8) cosmetic surgery or any other treatment of a mainly esthetic nature; or

9) injuries sustained by the Participant while taking part in civil unrest, a riot, an insurrection or a military operation, whether or not war has been declared.

For the purpose of this coverage, "insane" includes situations in which the Participant is under the influence of narcotics, drugs, medication, or alcohol, as well as any mental disorder or mental state that prevents the Participant from forming intent.

8. SURVIVAL PERIOD

This coverage does not apply and no benefit is payable if the Participant does not survive for a period of at least thirty (30) days following the date of diagnosis of a Critical Illness diagnosis or such longer period as described in the definitions of covered conditions without being kept alive by artificial means, in the absence of which there would be irreversible cessation of all of the brain's functions.

9. TERMINATION

This coverage for the Participant terminates automatically when a benefit is paid under this coverage or when he or she reaches the age indicated to this effect in the Benefit Schedule, whichever comes first.

10. BENEFICIARY

The beneficiary is the Participant.

The Participant may dispose of the rights attributed to him or her under this coverage without the consent of the beneficiary even if designated irrevocably.

If a claim is submitted or approved after death of the Participant, then the beneficiary shall be deemed to be the Participant's Estate.

11. NOTICE AND PROOF OF CLAIM

In the event of a request for a benefit under this coverage, the Policyholder and the Participant or the Beneficiary, as applicable, must provide written notice of satisfactory medical proof to the Insurer within 30 days of the diagnosis of critical illness that gives him or her the right to the benefit under this coverage.

The Participant or the Beneficiary, depending on the circumstances, must also, within the 60-day period following death as indicated above, forward to the Insurer all information on the extent of the claim that the Insurer might reasonably expect under the circumstances. However, if the Participant or Beneficiary can demonstrate that it was impossible for him or her to act within the required period, he or she remains eligible for benefits as long as notice is sent to the Insurer within 12 months following the date of Diagnosis or death.

12. AUTOPSY

The Insurer reserves the right to require an autopsy of the deceased Participant within the limits of the law.

13. PAYMENT OF BENEFITS

All benefits under this coverage are payable within 30 days of the receipt of the claim accompanied by all the supporting documentation in the event that the claim is accepted.

14. APPEALING A DECISION

Any Participant or beneficiary who disagrees with a decision made by the Insurer may request a review within 60 days following this decision by forwarding a written request to the Insurer together with any new supporting documentation.

The Insurer will proceed with a review and will notify the Participant or beneficiary of its decision within 30 days following the receipt of the written request accompanied by any new supporting documentation.

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

15. INCOME TAX STATUS

The Insurer makes no representations as to the tax consequences related to the payment of any benefit during the lifetime of the Participant.

HEALTH INSURANCE

1. SCOPE

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

2. DEFINITIONS

For purposes of this coverage:

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

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

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

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

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

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

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

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

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

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

(c) have been approved by the insurer;

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

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

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

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

Generic Drugs refer to medication approved by provincial legislation that contain the same active ingredients in the same amounts and dosages as those listed in the prescription.

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

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

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

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

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

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

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

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

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

Specialty Drug Program:
The Specialty Drug program identifies high cost drugs which can only be approved for payment or reimbursement once an insured person has tried and failed all other appropriate first-line therapies, in the sole opinion of the insurer, for the insured person's medical condition.

3. CONDITIONS AND ELIGIBILITY

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

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

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

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

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

4. ELIGIBLE EXPENSES

(a) Hospitalization Expenses in Canada

The insurer pays the following expenses, without any deductible:

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

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

(b) Extended Health Benefits in Canada

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

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

- X-ray, ultrasound (including maternal ultrasounds) and laboratory tests (excluding check-ups) up to the maximum amount indicated in the Benefit Schedule.
- Blood tests, for diagnostic purposes, up to the maximum indicated in the Benefit Schedule.

(2) The following expenses supported by a medical prescription:

- Registered private nurse: The professional services of a registered private nurse outside of the hospital up to the maximum amount indicated in the Benefit Schedule. However, these services must be preauthorized by the insurer and supported by a medical prescription indicating:

  - the state of health and the prognosis;
  - the type and frequency of the services required; and
  - the anticipated duration of the services.

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

- The purchase of **external breast prostheses** following a mastectomy, up to the maximum indicated in the Benefit Schedule;

- The purchase of **pressure garments** for burns up to the maximum indicated in the Benefit Schedule;

- The purchase of **Wigs** (required for pathological conditions or following chemotherapy treatments) up to the maximum indicated in the Benefit Schedule.

(3) The expenses for **paramedical services** provided by a acupuncturist or a dietician or a chiropractor or massage therapist or a physiotherapist or podiatrist, provided that these services are in their field of specialty and these professionals are members of their professional associations, up to the maximum for that specialist per insured person as indicated in the Benefit Schedule. The expenses for paramedical x-rays, if applicable, are included in the paramedical services maximum amount.

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

4) Psychometric assessments provided by a licensed therapist up to the maximum indicated in the Benefit Schedule.

5) The expenses for **vaccines** that are not covered under the provincial Medicare plans (or RAMQ for Quebec), up to the maximum indicated in the Benefit Schedule.

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

7) **Antidepressants** listed and non-listed on the RAMQ list (2nd payer), up to the maximum indicated in the Benefit Schedule.

(c) Vision Care Expenses

The insurer pays the following expenses:

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

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

5. COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. TERMINATION, LIMITATIONS AND EXCLUSIONS

(a) Termination

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

(b) Limitations and Exclusions

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

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

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

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

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

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

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

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

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

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

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

(11) Expenses related to a sex change.

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

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

(14) Expenses incurred following:

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

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

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

(17) Expenses for insulin pumps.

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

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

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

(21) Administrative costs or expenses for completing documentation.

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

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

7. TERMS FOR APPLYING THE DEDUCTIBLE

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

8. NOTICE AND PROOF OF CLAIM

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

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

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

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

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

9. SURVIVOR BENEFITS

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

(a) The date that the insurance contract terminates.

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

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

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

DENTAL INSURANCE

1. SCOPE

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

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

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

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

2. DEFINITIONS

For purposes of this coverage:

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

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

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

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

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

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

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

3. ELIGIBLE EXPENSES

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

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

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

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

(c) have been approved by the insurer;

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

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

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

SECTION I - Basic Care

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

(a) Diagnosis and Prevention

(1) Clinical oral examination:

- The initial full examination up to a maximum of one such examination per period of 60 consecutive months;

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

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

(2) X-rays:

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

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

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

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

(3) Laboratory tests;

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

(5) Topical fluoride application up to a maximum of 1 treatment per period as outlined in the Benefit Schedule up to age 16;

(6) Scaling up to a maximum of 6 units per 12 consecutive months.

(**b) Minor Restoration**

(1) Cavities, trauma

(2) Amalgam-based restoration (non-bonded), restoration using acrylic or composite resin (bonded and non bonded)

(3) Dentinal retentive pins

(4) Repair of removable prostheses up to a maximum of $500.

(5) Repair of fixed prosthesis

(6) Sedative dressings

(c) Additional Services

(1) I.V. sedation up to a maximum of 6 units per 12 consecutive months

(d) Periodontics

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

SECTION II – Root Canal and Teeth Extraction (including Wisdom Teeth)

(a) Root canal therapy

(b) Oral Surgery

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

4. COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. TERMINATION, LIMITATIONS AND EXCLUSIONS

(a) Termination

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

(b) Limitations

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

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

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

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

(c) Exclusions

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

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

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

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

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

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

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

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

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

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

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

(11) Expenses incurred following:

- Self-inflicted wounds or physical or mental damages, whether or not the insured person was of sound mind at the time;

- The commission of or an attempt by the insured person to commit a criminal act; or

- Injuries sustained by the insured person during active participation in a civil commotion, a riot, an insurrection, or a military action, whether war has been declared or not; and

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

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

6. TERMS FOR APPLYING THE DEDUCTIBLE

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

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

7. PRELIMINARY ASSESSMENT

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

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

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

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

8. NOTICE AND PROOF OF CLAIM

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

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

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

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

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

9. SURVIVOR BENEFITS

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

(a) The date that the insurance contract terminates.

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

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

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